Collaboration of doctors and nurses with ethnomedical practitioners

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Doctors and nurses in Bolivia are working with ethnomedical healers to improve the health of rural populations.

Herbalists, healers and other practitioners of ethnomedicine provide basic health services in many villages and cities throughout the world, and in developing countries they form the nucleus of primary care workers in up to 90% of rural populations.

In Bolivia, doctors and nurses are beginning to collaborate with such practitioners. The Aymara and Quechua Indians of the Andes prefer to deal with illnesses in a symbolic manner so as to make them endurable and acceptable. Although some doctors equate this with ignorance, it is clear that diviners use symbols and rituals as adaptive mechanisms enabling people to cope with ill-health, and that ethnomedical practitioners can handle complex behavioural and social problems.

Workshops

Collaboration between biomedical and ethnomedical practitioners commenced after the holding of workshops in which information was shared about illnesses that were often perceived in cultural, biological and social terms. Doctors and nurses were given cross-cultural training in which special attention was given to the beliefs and practices of ethnomedicine. Joint therapy sessions were held, and role-playing was introduced when no patients were available. Curing rituals were demonstrated by ethnomedical practitioners with doctors and nurses as participants.

The workshops also allowed biomedical and ethnomedical practitioners to compare and link their experiences of illnesses and to focus on joint strategies for improving health. For example, a session was held in which the participants listed the names, symptoms, causes and treatment of diarrhoea in two columns, one for biomedicine and the other for ethnomedicine. Aymara and Quechua words were listed which described diarrhoea: *curso* (flow), *wijchuy* (expel rapidly; also used for vomiting), *mal de pato* (duck disease), *aika* (diarrhoea from change), *wila curso* (flow of blood), and *mancharisga* (emotional diarrhoea, often associated with *susto* [loss of vital fluids, generally attributed to fright]).

Once the doctors and nurses realized that the Indians distinguished different degrees of
diarrhoea, they were better able to question patients and to educate them about treatment. The ethnomedical terms for categories of diarrhoea were translated into biomedical ones. Disagreement arose over symptoms because each type of practitioner was relating diarrhoea to different causes. Although ethnomedical practitioners recognized the importance of dehydration they did not associate diarrhoea with thirst, sunken eyes, or crying without tears, believing diarrhoea to be a wet disease with wet symptoms; they treated the disease with absorbent cereals as a means of drying patients out. The ethnomedical practitioners were advised that this increased the probability that patients would die of dehydration, and they accepted this, admitting that diarrhoea could also be a dry disease. Agreement was also reached that herbal teas with sugar provided a rehydration formula which was readily acceptable to the Indian people and could be prescribed by both biomedical and ethnomedical practitioners.

Promoting immunization

Doctors and nurses are collaborating with ethnomedical practitioners in an endeavour to overcome fear of and resistance to vaccination. In certain areas of the country, women have resisted vaccination with tetanus toxoid, partly because they believe neonatal tetanus to be a supernatural event with psychological, cosmological and social connotations. Mothers do not know why four injections are needed, nor how these protect their infants. Sensitive to this background, health educators advocate preventive immunization of mothers in biological and culturally acceptable terms. Thus it is explained that vaccinations are encoded messages that enter the mother’s body, then that of the child, to provide an opportunity to recognize and fend off certain harmful things. An explanation is also given of how vaccines help the body to recognize and respond to antigens that produce harmful toxins or exploit cells. Unsterilized knives used to cut umbilical cords are examined under the microscope to show the presence of tetanus toxoid.

Midwives and traditional birth attendants

By and large, midwives and traditional birth attendants are still not respected by doctors for their skills and knowledge of indigenous customs and resources. Doctors expect midwives to refer complicated cases to them, yet it is rare for doctors to refer simple births to midwives. Midwives complain that after referral to a doctor they receive little recognition and are excluded from the delivery room. However, some doctors do invite midwives to assist them with deliveries. Doctors are also beginning to realize that they should encourage referred patients to continue as clients of the referring ethnomedical practitioners. The critical attitude adopted by doctors towards these practitioners has been a major obstacle to referral.

Because doctors and nurses often either discount the value of ethnomedicine or are uninformed about it, there are numerous instances where trainers have replaced healthy practices of midwives and traditional birth attendants with unhealthy ones. Thus midwives have been taught to cut the umbilical cord with scissors, resulting in increased rates of neonatal tetanus because scissors are more difficult to sterilize than the broken ceramics used traditionally; pregnant women have been given
synthetic drugs instead of herbal teas; formula feeding for infants has been introduced; and so on.

Doctors and technicians are often unsuitable trainers for midwives because of their ignorance about birth, insensitivity towards women, overbearing attitude and scientific prejudices. The best trainers have been women who have studied medical anthropology, cross-cultural communication and public health, and have gained experience in working with midwives. The most effective training courses have covered prenatal nutrition, prenatal screening, aseptic delivery, cord treatment, and family planning.

Supervision is the key to the improvement of midwives’ skills and their integration into health programmes. All too often, after being trained, midwives have been left without supervision and support.

**Integrated services**

Clinics in which doctors, nurses, herbalists, diviners and midwives collaborate have helped to coordinate activities between biomedical and ethnomedical practitioners. The rural health care delivery system has expanded greatly but there has only been a small increase in utilization, whereas herbalism and ritual healing have increased in popularity. Integrated clinics provide a culturally holistic approach to illness and attract more patients than orthodox clinics. A clinic in La Paz, the Consultorio SIENS, has been notably successful in this respect and has also become a centre for research on medicinal plants, although it caters largely for members of the middle class.

The health needs of peasant communities are better met by a clinic of the Bolivian Society for Natural Medicine in Oruro, where the organizers are four herbalists, two nature healers, two masseurs, and two diviners; two physicians also work here; this clinic has been particularly successful in treating *susto*. One of the physicians uses herbal remedies instead of synthetic drugs wherever possible, and collaborates with diviners in therapy for mental illness. For instance he helped a facially disfigured woman suffering from epilepsy to accept herself, strengthen her maternal feelings, and build up her self-confidence; medicine was provided to control her epileptic attacks. Meanwhile she consulted one of the diviners, who convened a gathering of community members for an all-night ritual during which evils that had been attributed to her by a church minister were symbolically removed. Plastic surgery was performed and she became a happier person.

In Oruro the Ministry of Rural Health and Project Concern are raising funds for an integrated hospital with appropriate technology. It is intended to erect an adobe building and to have sleeping platforms, like those that Andeans have in their huts, rather than standard metal beds. Each patient will have a room and there will also be one for family members where they can cook, eat and sleep, in accordance with the practice of herbalists, who rarely separate patients from their families.

**Guidelines on collaboration**

The following guidelines on collaboration have been offered to doctors in Bolivia.
Recognition

Doctors and nurses should study the work of ethnomedical practitioners in an environmental, social and cultural context, so as to have a basis for the evaluation of practices and for working out how to achieve collaboration. Healers, who can provide information on the values, perceptions and attitudes of clients, should participate in the planning and implementation of health programmes. Doctors and nurses should recognize the many contributions that ethnomedical healers can make towards the implementation of health programmes.

Respect

Doctors should treat ethnomedical practitioners with trust and dignity. Equality and autonomy should be promoted (the appointment of a director of indigenous medicine in the Ministry of Health has been a step in this direction).

Ethnomedical healers have formed associations that are independent of doctors. In the case of harmful beliefs held by ethnomedical practitioners, doctors have taught them, in a sensitive manner, how to replace them. Doctors and nurses have been instructed to respect the part of magic and ritual in healing.

Reward

Doctors should be rewarded with salary increments for collaborating with ethnomedical practitioners, who in turn should be rewarded for their collaboration, for instance with training courses, equipment, certificates and diplomas.

Health records

In rural Bolivia, doctors and nurses keep records of treatments but these are neither available to patients nor transferred: when patients change treatments or are referred, coordination is difficult because peasants are seldom told what diagnosis has been arrived at and they usually forget their prescriptions. One solution is to issue health cards giving details of vaccinations, medical treatments, and so on; these may have to be filled in by community health workers, as many ethnomedical practitioners are illiterate. People should be trained to carry their cards with them at all times. These cards allow the various biomedical and ethnomedical practitioners to review patients’ medical histories. Symbols can be used to overcome the difficulty presented by illiteracy among ethnomedical practitioners. Community health workers distribute the health cards to individuals or families and help them fill in the required information; they also train and assist ethnomedical practitioners to make entries for their patients. If the ethnomedical practitioners fail to do this for any reason, the community health workers may insert information.

For patients, the benefits of using health cards are that ineffective therapies are not repeated and that treatments are complementary. For ethnomedical practitioners the advantages are that health cards make them aware of patients’ illnesses and previous treatments, provide information on patients’ backgrounds, and facilitate the evaluation of therapies. Community health workers periodically review the health cards and communicate their findings to the ethnomedical practitioners.
Health cards should only be used as a means of improving and coordinating treatments. They greatly help the process of referral, allowing each kind of practitioner to study the other’s actions and patients’ clinical histories. In the interest of collaboration, ethnomedical practitioners should be able to feel confident that the records cannot be used against them in any way.

A substantial number of people consult both types of practitioner, but doctors rarely refer patients to healers and should therefore be trained on when and how to do this. They should be able to recognize psychosocial and cultural illnesses and should know which ethnomedical practitioners can treat them.

Doctors should also be trained to work with midwives and should assist them with difficult deliveries, but should not compete with them when their skills are adequate.

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Doctors and nurses should recognize, respect and reward ethnomedical practitioners, and pharmaceutical companies should make financial contributions for medicines derived from ethnomedical sources. For their part, ethnomedical practitioners should strive for solidarity, recognition, training and referral.

Smoke-free environments

A smoke-free environment, in public or at home, is self-promoting. A young girl who is used to living in a smoke-free environment is likely to perceive the odour of tobacco smoke as unpleasant and later on to insist on clean air at work as well as at home, thus contributing to the concept of a tobacco-free society and life-style as the social norm.

Smoke-free workplaces prevent people from starting to smoke in stressful situations, which are reported to be a cause of smoking initiation among young workers. Smoke-free public places such as restaurants are important in underlining the prevailing social norm, and also in helping smokers to quit and preventing relapse. Smoke-free environments are particularly important in schools, where they should form part of a comprehensive policy on smoking which includes staff and students.