Traditional healers may cause dangerous delays

EDITOR,—Rajendra Kale's article on traditional healers in South Africa commends traditional medicine for its holistic approach but acknowledges that "unfortunately there have been no studies of the efficacy of traditional remedies."[1] Some traditional remedies used in Africa are effective—for instance, simple purgatives in constipation. Others use the placebo effect and are used in illnesses recognised by traditional healers as self limiting or due to anxiety states. In many cases, however, efficacy has not been established, while some remedies are unsafe and their use may delay patients seeking effective treatment for life threatening illnesses. At a rural hospital in eastern Zambia we have frequent evidence of this.

A 2 month old baby developed a discharge from the left eye and was taken to a traditional healer, who instilled an irritant herbal extract into the affected eye. The discharge stopped, but the child was left with a left sided corneal ulcer. He received treatment with topical antibiotics at our hospital but was left with permanent corneal scarring in the left eye and partial sight.

A 9 month old child became unwell with fever and vomiting. Her mother took her to a traditional healer, who painted her bulging fontanelle with wood ash. When she reached our hospital she had been ill for three days. Although her meningitis was treated promptly, neurological sequelae were inevitable because of the delay. She became blind and deaf and suffered frequent convulsions.

Collaboration with herbalists could produce innovative treatments, but active ingredients and doses would need to be established before such treatments could be used. Encouraging traditional healers to become village health workers who treat a limited range of conditions and refer more difficult cases to orthodox practitioners is another option. Successful herbalists are often, however, encouraged by their local community to become "witch finders," which would make it difficult for orthodox practitioners to cooperate with them.

We question the concept of traditional medicine as "a parallel health care system." Any future role alongside orthodox medicine must be carefully regulated.

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1 Kale R. Traditional healers in South Africa: a parallel health care system. *BMJ* 1995;310:1182-5. (6 May.)

Author's reply

EDITOR,—Barbara J M Graham says that I walked into a trap. Commenting on South Africa's health and apartheid is easy. Apartheid was bad for the health of black people and good for that of white people. There is no trap there. She narrates an anecdote as do I. She fails, however, to convince me that appreciable numbers of white people were denied treatment in hospitals meant for black people.

The free health care scheme affected only those treating children and pregnant women. The striking workers came from all sections of the hospitals. I criticised the lack of planning in this scheme.[1]

The worst of Third World medicine exists in South Africa. Alexander R P Walker and Isidor Segal ignore the former "homelands"—where reliable data are lacking—and concentrate on urban areas. They state that the infant mortality for poor single Swiss mothers is 21/1000 live births. What is the figure for similar South African mothers? The maternal mortality in white mothers is stated as 1/1000 in Benatar's article.[2] This 1991 reference is useful because it includes data on death rates due to lung cancer, homicide, and suicide. Moreover, this article and the one by Blumsohn document the situation at the peak of apartheid. In the past few decades health has improved globally, even in the poorest countries.[3] The improvement seen in South Africa is perhaps a part of this phenomenon.

Walker and Segal justify the difference in health variables in the different population groups in South Africa by quoting similar differences elsewhere. As I stated in my article, such differences do exist. In South Africa they were caused by apartheid, which Walker and Segal trivialise as "unfairness of past state health practices."

Walker and Segal ask, "Pragmatically, can South Africa with its small white and very large black population be expected to accomplish what rich Western countries have found to be impossible?" By this, they show their patronising belief that it is still the small white population that has to deliver the goods and the black population that is to be the burden. Walker and Segal need to wake up to today's political reality. They should opine on my perspective after reading my entire series, including the last article.[1]

De Vries worries about strange figures in the study from the Orange Free State reported by Freeman *et al*.[4] These are the best available data and not a fallacy created by me. Why should we be surprised if South Africa turns out to be an internationally unique transcultural phenomenon?

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1 Kale R. Restructuring South Africa's health care: dilemmas for planners. *BMJ* 1995;310:1397-9. (27 May.)
2 Benatar SR. Medicine and health care in South Africa—five years later. *N Engl J Med* 1991;325:30-6.
3 World Bank. *Overview. World development report 1993. Investing in health.* Oxford: Oxford University Press, 1993: 1-4.
4 Freeman M, Lee T, Titian V. *Evaluation of mental health. Evaluation of mental health services in the Orange Free State.* Parktown, South Africa: Centre for Health Policy, Department for Community Health, Wits Medical School, 1994.

Health psychologists make an important contribution to care

EDITOR,—The editorial on the psychological care of medical patients[1] and the report to which it refers[2] serve to highlight the issue of psychological care in physical illness. In calling for an expansion of services, however, the editorial seems to suggest that liaison psychiatrists are the sole professional experts.

While liaison psychiatrists are clearly experts in liaison psychiatry ("the subspecialty of psychiatry concerned with clinical service, teaching, and research in non-psychiatric health care settings,"[1]) psychological care is particularly informed by the discipline of healthy psychology. Health psychology may be broadly defined as "the application of psychological methods to the study of behaviour relevant to health, illness and health care."[3] Research in this field has grown tremendously over the past two decades; this is reflected in the proliferation of journals, texts, and taught courses in health psychology and related topics (for example, behavioural medicine). Research in health psychology has already made a substantial contribution to developments in evidence based practice in health and medicine.

The remit for psychological care in physical health and illness is broad: primary and secondary as well as tertiary prevention are included, with health psychologists working in a range of settings and applications, including health promotion, preparation for investigations and surgery, rehabilitation (for example, cardiac and pulmonary), pain and stress management programmes, coping with chronic illness, palliative care, and bereavement. Health psychologists are increasingly taking consultancy roles—for example, advising other health care professionals on psychological aspects of the care of people with physical illnesses to promote physical and psychological wellbeing; in addition, clinically qualified health psychologists work directly with patients.

Given the current emphasis on quality of life (which is ultimately a psychological variable) as a critical outcome for all patients, we recommend that health psychologists should be included in future policy statements about the provision of psychological care. Close collaboration with a wide range of health and social care professionals (as well as other groups) is intrinsic to the promotion of psychological care in physical illness, and we hope that health psychologists will be consulted before future reports are published on this subject.

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1 House A, Farthing M, Peveler R. Psychological care of medical patients. *BMJ* 1995;310:1422-3. (3 June.)
2 Royal College of Physicians and Psychiatrists. *Joint working party report: the psychological care of medical patients: recognition of need and service provision.* London: Royal Colleges of Physicians and Psychiatrists, 1995.
3 Johnston M, Wright SJ, Weinman J. *Measures in health psychology: a user's portfolio.* Windsor: NFER-Nelson, 1995.

Treating temporarily incompetent patients

Depression calls into question patients' capacity to refuse treatment

EDITOR,—In the ethical debate on a doctor's legal position in treating temporarily incompetent patients Petra Wilson, a lecturer in law, expresses views that are inconsistent with current English law.[1] One of the cases discussed is of a patient who had taken an overdose of co-dydramol, temporarily regained consciousness after an injection of naloxone, and then refused further treatment. Wilson argues "that, in law, it would be difficult to justify the gastric lavage of the suicide patient since he had explicitly refused to consent to life saving treatment."

In English law, for a patient to consent to (or refuse) treatment he or she has to have the capacity to do so.[2] This patient could have been incapacitated for two main reasons. The first is the effects of the opiate overdose. It would be unwise to assume that naloxone could completely reverse the effects and allow the patient to make an informed decision. The second reason to doubt the patient's capacity was his mental state. There was a history of a breakdown in a relationship; "extreme distress"; repeated chants of "leave me alone, I want to die"; and a deliberate overdose. This would provide enough evidence for a working diagnosis of depression; patients who take large, deliberate overdoses rarely do so in an informed, rational manner and in the absence of any mental disorder.

Once depression is suspected a patient's capacity to refuse treatment immediately comes into question, and a doctor would be justified in treating the patient in his or her best interests.[3] If a patient with depression was considered to be at considerable risk of self harm, detention under the