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THE ROLE OF MEDICAL ANTHROPOLOGY IN PRIMARY HEALTH CARE[1]

George M. Foster[2]

In order to provide health care, it must be presented in a form acceptable to the patient. Therefore, the beliefs of a people regarding health, illness, and curing—the realm of medical anthropology—must be considered. To this end, study of the ways in which the prevailing folk or traditional medical systems can interrelate with the Western medical system may be fruitful. The author introduces some basic concepts of medical anthropology, particularly related to the Mexican-United States border area.

Begining about 1950 small numbers of anthropologists began to show interest in the social, cultural, and psychological processes involved when "modern" health services became available to people whose previous health care had been "traditional." "Modern" health services refer to public and private preventive and curative services that constitute "official" or "establishment" medicine in greater or lesser degree in all countries. While this medicine has not always been fully scientific, it has sought answers to health problems within the context of the scientific developments—particularly of the West—of the past four centuries; hence, it is often referred to as "Western" medicine. As such, it stands in contrast to "traditional" medicine, a catch-all term for what have variously been described as "primitive," "indigenous," "folk," and "non-Western" medical systems.

Modern medicine, in large part the product of a single historical evolution, is a reasonably coherent, unitary system wherever it is found: physicians in Japan, India, Britain, and the United States base their practice on common premises. In contrast, traditional medicine—traditional medical systems is perhaps a better term—represents a large number of independent lines of development, and its practitioners reflect far greater differences of opinion about etiologies and treatment than do modern physicians. Whereas there is a single modern medical system, there are many traditional systems.

All traditional medical systems share one important characteristic: when modern medical services intrude into their domain, their premises are questioned and their existence is threatened. People now have options not previously available to them. They can, as in the past, consult the shaman or traditional curer, or they may turn to the physician. Not infrequently we know, they seek help from both. Few if any traditional medical systems have completely disappeared under the onslaught of modern health care, but the numbers of their practitioners have declined, and less and less do they satisfy the expectations of patients. It is striking how recent reports on the utilization of medical services in traditional areas agree that the physician is now the first choice of a majority of people. When good modern health services are available to traditional peoples at a cost, and under conditions they deem acceptable, modern medicine usually wins out.

But this acceptance is not immediate, and

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[2]Professor of Anthropology, University of California, Berkeley, California.

it is never complete. Perhaps it never should be complete, for no medical system in itself seems capable of satisfying every medical expectation of all people who have the opportunity to utilize it. As traditional (in the sense of ancient) medical systems decline, new alternative systems arise to meet needs that modern medicine has been unable to satisfy.

The interplay of changing modern, traditional, and alternative medical systems has drawn increasing attention from a new brand of anthropologist—the "medical" anthropologist—whose primary interests center on health and illness behavior in cross-cultural perspective. Some of the research of medical anthropologists has been theoretical and descriptive, dealing with beliefs about disease causation and cures, the types of curers found and their medical and social roles, and medicine as a major institution in every culture. And some has been practical or applied, designed to facilitate the introduction of modern medicine to peoples whose previous medical experiences have been traditional.

In the latter enterprise medical anthropologists have sometimes been discouraged because many planners and practitioners of modern medicine have seemed reluctant to acknowledge that medicine is as much a cultural as a clinical problem. They have wondered why it is so difficult to demonstrate that traditional beliefs, social forms, patterns of perception, and many other social, cultural, and psychological factors bear importantly on the behavior of peoples who for the first time find themselves with the option of patronizing modern health care services. They have also been discouraged because of the tendency of health personnel working in cross-cultural programs to assume that traditional medical health beliefs and practices offer little if anything of therapeutic value.

Happily, this picture appears to be undergoing rapid change. As a consequence of the World Health Organization's recent concern with adequate primary health care in the developing world, a great many governments, private organizations, and international and bilateral health organizations are taking a new look at traditional medical systems. Questions unthinkable a few years ago are now asked on all sides: Are there roles in national health care systems for indigenous curers? Are there health problems for which traditional treatments and remedies are appropriate? Can traditional and modern health personnel and approaches to health care be combined, or coordinated, to achieve more comprehensive primary health care? There is evidence of new openness on the part of official medicine to the problems of extending health care coverage to all people.

It is clear that there is no consensus among medical anthropologists. They express points of view that reflect their research findings, their political beliefs, their ethnic affiliations, and their life experiences. Thus, no definitive answers to health policy questions are offered nor can they be inferred. At the same time, dialogue among them provides data and points of view that should facilitate the formulation of health care delivery policies that will more completely meet the needs of the people in the border area.

Traditional vs. Alternative Medical Systems

Perhaps the most important fact to emerge, concerning the Mexican-United States border area, is that a relatively recent alternative medical system—spiritualism—and not traditional Mexican popular medicine, is the dominant form of medical care sought by patients in the border area who do not consult physicians. Far from being indigenous, spiritualism is a 19th-century European transplant that has taken vigorous root in urban areas of Latin America where it caters particularly to the economically lower and less-educated classes. Historically it is more "modern"—i.e., more

recent—than scientific medicine. Therefore, insofar as the Mexican-United States border area is concerned, the question is not so much possible roles for those who cure *empacho* (prolonged and severe indigestion), *mal de ojo* (evil eye), *mollera caída* (fallen fontanelle), and *susto* (fright) as it is possible roles for spiritualists and spiritualistic practices. However, it seems likely that physicians will be even more reluctant to collaborate with spiritualists than with herbalist *curanderos*—the *real* traditional Mexican curers.

The Dangers of Stereotypes

One of the most valuable realizations by anthropologists and health personnel alike is that stereotypes about traditional medicine have been popularized over the past generation that may adversely affect serious consideration of its possible usefulness in official health programs. A discussion of four of these stereotypes follows.

Traditional medicine is holistic; modern medicine sees only the disease. One of the principal arguments advanced in favor of co-opting traditional curers is that they know the family background of their patients and can hence weigh psychosocial as well as clinical factors in deciding what to do. In relatively isolated peasant villages this is certainly true. But the border area is overwhelmingly urban and semiurban and marked by much population movement. Traditional *curanderos* (or *curanderas*) inevitably will know much less about most of their patients than in stable villages. Spiritualists will know even less. The spiritualists described in the papers that follow seem just as impersonal and just as ignorant of the family background of the patient as is the physician. When, as in the case of El Niño Fidencio and others like him, patients come from hundreds and even thousands of miles for consultations, any improvement in the patient's condition can hardly be attributed to the spiritualist's knowledge of the family setting.

Even in stable villages the cures for such illnesses as *empacho, mal de ojo, susto,* and *bilis,* seem to be remarkably standardized. Sufferers are treated much in the same way by the same *curandero,* and the latter's knowledge of the family plays a minimal role in therapy. Hence, the family-oriented, holistic argument for the incorporation of traditional curers into contemporary health services would appear to be far weaker than it is often thought to be.

Traditional curers are relatively old, highly respected people in every community, and because of their status they should be valuable allies in primary health care. It is certainly true that elderly herbalists with a profound knowledge of traditional remedies, or famous shamans, inspire confidence in their patients. But to assume that because they fulfill this role well in a traditional setting they will do so in another setting is careless generalizing. In the early years of the National Indian Institute's work in Chiapas, it was assumed that working through local shamans would facilitate the introduction of health services. Health practitioners were astonished to find "enormous resistance" to this approach. Old and prestigious people were found *not* to be the best intermediaries for sociocultural change. Specialized health training for young literate people proved to be a more practical approach to the problems encountered. This is not to argue that mature traditional curers who enjoy high respect should never be considered for new health roles. But this experience shows that a particular stereotype should not be automatically accepted.

Traditional people dichotomize illness into two categories: the first, illnesses that physicians quickly cure; the second, "folk" illnesses—such as mollera caída, susto, empacho, *and* mal de ojo*—the very existence of which physicians deny.* This adversary model, perhaps the first medical anthro-

pology model, has been widely accepted as a predictor of the choices in care that will be made by traditional peoples. It does appear to have had some validity in the early years following the introduction of modern medicine, but after a fairly short time it no longer has much predictive value. The striking thing along the Mexico-United States border, and in many other parts of the world, is that today the physician's services have been available for a sufficient length of time so that he is the first choice of most people for most complaints.

Physicians practicing in traditional settings frequently are ignorant of traditional medicine; they fail to understand its vocabulary and its underlying rationale, and hence they have difficulties in communicating with their patients. Like the adversary model, this is another early stereotype developed by anthropologists. Yet it may often fail to describe reality. In doctor-patient interviews observed among people from Tzintzuntzan, Michoacán, the author has been impressed with the physician's skills in eliciting information by use of traditional vocabularies and disease concepts. Far from not understanding these usages and beliefs, they are perfectly familiar with them, and they know how to use them to best advantage to obtain the information they need for their diagnosis. Probably many researchers are guilty of underestimating the insight and sensitivity that physicians must display when many of their patients are traditional people.

With these stereotypes, and the pitfalls inherent in them, in mind, we can turn to a primary question asked of health practitioners:

Official Medical Roles for Traditional Curers and Traditional Medicine?

In asking this question, it is natural to consider experience gained to date. Most of it is limited to two areas: the upgrading of indigenous midwives, and the use of traditional curers for mental illness. It has been proposed that these two areas will continue to be the most fruitful ones for border area populations. But success with midwives and mental illness treatment does not necessarily mean that other curers can as easily be incorporated into official health services.

In the case of pregnancy, both midwife and physician agree about the onset of the condition, its course and duration, and its probable outcome. In the absence of complications, both do about the same thing.

With respect to the treatment of mental illness, psychiatry is the least exact of all forms of medicine, the field in which—at least in stress-induced conditions—it is most difficult to predict the outcome. The symbolic and supportive roles of traditional curers do often seem to lead to successful outcomes, at least to the alleviation of symptoms in sufficient degree so that a patient can continue to live at home.

But beyond these two fields, the problems become more difficult. When the physician diagnoses a malignant tumor requiring surgery, and the medicine man an intruded disease object that can be removed by sucking, are there real grounds for cooperation? The greatest danger in the use of traditional curers, it has often been noted, is that in really serious cases the patient may be brought to the physician when it is too late to help.

With respect to the general question of the desirability of incorporating traditional curers into contemporary health services, one feels that most anthropologists *want* the idea to work, that they believe there must be much good in traditional systems that can be highly useful in primary health care, that traditional systems have avoided many of the pitfalls into which modern medicine has fallen. Yet even with this bias, considerable skepticism has been expressed by a number of anthropologists as to how feasible this approach is. It should be remembered that in the border area the majority of non-establishment healers are spiritualists.

The similarities to modern medicine that characterize spiritualistic curing are superficial; its healing rationale is based on concepts of disease and healing fundamentally different from those of modern medicine. "Acculturation to the modern medical model would doubtless entail a denial of their own basic concepts and practices. It would even reduce the effectiveness of spiritual healing for the culturally patterned psychological and psychophysiological conditions for which it is best suited."

Another reason why incorporation of traditional healers into official health systems probably would not work well is the fact that removing *curanderos* from their neighborhood environments and subsuming them within a clinical organization and setting would destroy the therapeutic advantages provided by the intimate, magicoreligious ambiance of their home consultation rooms. Some even doubt that there is much role for indigenous midwives. Some of the reasons, however, are based on political and professional reality: opposition of established health personnel. Nonetheless, in Tucson, hospital births are supplanting *partera*-delivered births for most Mexican-American women.

Still another reason to doubt the practicality of incorporating traditional curers into official medicine has been pointed out in a study of the Navaho: there are not as many singers as in the past, and those remaining appear to be less knowledgable and less competent than in former times. Reliance upon "white medicine" probably explains this decline. This point is true of much—perhaps most—of the developing world. Serious consideration of incorporating traditional personnel into contemporary health systems is based on a false assumption: that traditional curers continue to be produced at the same rate as in the past. Abundant evidence indicates that this is not the case. Wherever the matter has been investigated the same situation recurs: many curers a generation ago; few, and less well-prepared curers today.

Do doubts as to the advisability of incorporating traditional curers into official health services in the border area mean that anthropologists feel traditional medicine can be ignored? The answer, clearly, is "no." Probably all anthropologists agree that health personnel should know more about, and understand, and appreciate, the contributions traditional (and "alternative") medicine makes, and can continue to make, to health care. The ability of practitioners of modern medicine to modify their normal practices to more nearly meet patient expectations is one example of how this understanding can contribute to better medical care. For example, hospitalized Mexican patients expect family company and care to a degree that would disturb the routine in most American hospitals. Yet abundant experience indicates that American hospital rules are formulated to meet the convenience of doctors, nurses, and other employees—not primarily according to the demands of patient care. They can and are being modified, and in the direction of the Mexican-American's expectations.

In the field of mental health "cooperative relationships" between traditional and professional mental health care providers have been suggested by many medical anthropologists. The community health medic is another very promising approach for primary health care on Indian reservations. This program, which has something in common with the Chinese barefoot doctor program, trains Indians in primary health care for two years. The trainees, of course, are full participants in their own culture, with a good understanding of the health values and cultural norms of their people. But their medical knowledge is that of official medicine, and their work is under the direction of its medical personnel. This approach may well be the most viable alter-

native to attempts to incorporate traditional curers into official medicine.

To conclude, it is clear that far more research is necessary on health services, and health programs in the border area before the most satisfactory primary (and more advanced) health services can be provided to all of the peoples in need of help. Formal experiments should be made to see if, in fact, spiritualists and traditional healers can play useful roles. To date, we hold opinions and we have our prejudices, but we do not really know. Only formal experimental programs will give us the answers we need.

SUMMARY

This article introduces basic concepts of medical anthropology. Practitioners of modern medicine seem increasingly ready to accept the idea that medicine is as much a cultural as a clinical problem. There is also increasing interest in understanding of prevalent cultural beliefs about health, illness, and curing as a means of facilitating efforts to reach populations especially those in which alternative medical systems are endemic, and to encourage them to seek and accept treatment founded on scientific principles. The author raises the question of incorporating traditional curers into the Western medical system—to date only successful with midwives and curers of mental illness. More research is necessary to replace opinions and prejudices with data, and to provide the most satisfactory primary (and more advanced) health services to all.

GORGAS MEMORIAL LABORATORY

The 50th anniversary of the Gorgas Memorial Laboratory in Panama was celebrated at the Pan American Union building (OAS building) by the Gorgas Memorial Institute of Tropical and Preventive Medicine on 26 September 1978. Retired Senator Lister Hill of Alabama who participated in the formation of the Laboratory in 1928 was guest of honor. Other guests were Ambler H. Moss, Jr., Ambassador-Designate of the United States to Panama; Representatives Daniel J. Flood and Tim Lee Carter; Señor Ricardo Bilonick, Chargé d'Affaires of Panama in Washington; and the Very Reverend Francis B. Sayre, Jr. Thomas H. Weller, M.D., Professor of Tropical Public Health at Harvard and 1954 Nobel Laureate in Medicine and Physiology, presented the address, "The Field of Tropical Medicine, and Research in the Field—Perfectionism at the End of the Line."