PHYSICIANS' ATTITUDES TOWARD COLLABORATION WITH TRADITIONAL HEALERS

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INTRODUCTION

In Canada and internationally, western biomedicine has emerged as the dominant health care system. However, contemporary medical anthropology has demonstrated that people simultaneously seek care and advice from a wide range of alternative resources (Foster and Anderson 1978: 259). Simultaneous use of biomedical, folk and traditional non-western healing systems is known as medical pluralism and is present in most societies. Although biomedicine has emerged as the dominant or officially legitimated health care system, many societies accept and rely heavily on traditional practitioners. Governments in China and India have supported both western and traditional medicine by allowing them to operate as parallel and equal systems (Leslie 1976).

Recognition of the persistence and growth of plural systems has stimulated increasing interest in examining the potential benefits of traditional medicine. Traditional forms of healing have been found to provide a more adequate framework for interpreting lay concepts of illness and treatment (Maretzki 1985: 23). As a result, collaboration between traditional and western medicine has been credited with providing more holistic care and achieving improved compliance with therapeutic regimens. The World Health Organization (WHO) recognized the advantages of utilizing alternate health care systems and in 1978 passed a resolution recommending that member nations encourage and facilitate collaboration between western (or biomedical) medicine and

alternate health care systems, including traditional medicine (Bannerman 1983).

In Canada, traditional healing practices and continuing use of traditional practitioners have been documented. In a study of Native health concerns, Stymeist (1976) emphasized that the recognition of traditional medicine was indeed a priority. Recent health policy documents have recognized the prospects for collaboration. The authors of a 1980 report from the Medical Services Branch of National Health and Welfare recommended "a closer working relationship between traditional healers and physicians..." (1980: 37).

Despite the growing legitimacy of efforts to foster collaboration between biomedical and traditional practitioners, examples of collaboration between Native healing practices and biomedical practice are rare and usually occur on an ad hoc basis. A psychiatrist working with west coast Salish Indians reports collaborating with traditional healers and commends their "impressive skills" in psychotherapy (Jilek 1981). Rodgers (1983) reports similar prospects for collaboration with traditional healers in delivering psychiatric services in Manitoba. In Alberta, Young et al. (1988) have described the success of a traditional healer who treated psoriasis patients referred by tertiary care physicians.

In Kenora, Ontario, some physicians have also recognized the benefits of traditional medicine and have collaborated with healers over the past decade. Collaboration between Kenora physicians and traditional practitioners was not restricted to psychotherapeutic involvement. An informal system is utilized to refer Native patients with a wide range of medical and psychiatric problems to local traditional healers. The Kenora medical community's recognition of the value of traditional medicine is documented in an inscription on a plaque in the lobby of Lake of the Woods District Hospital. The inscription states: "We believe traditional Native healing and culture have a place in our provision of health care services to the Native people."

Despite earlier predictions of decline, traditional medicine still serves approximately 30% of Manitoba Natives and is

increasing in visibility and legitimacy (Smith 1987). This revitalization may increase the potential for conflict between physicians and traditional practitioners. Conflict may be even more likely when the two systems come into contact in a hospital setting. Unfortunately, the greatest impact of conflict or confrontation between healers and healing systems may be upon Native patients, who have the least power to control their own treatment. Through referral to specialists and tertiary hospitals in urban centres, Native patients from rural and remote communities are removed from sources of support and understanding and often find themselves with little cultural, linguistic and organizational understanding of the hospital. Native patients frequently do not feel empowered to assert traditional beliefs in the unfamiliar setting of the hospital. Research indicating that Native patients are more likely to accept explanations of the etiology of their illness based upon their own culturally-based models reinforces the need for interpretation services and collaborative programs (Maretzki 1985: 23). Collaborative programs inevitably entail both risks and benefits. Confrontation between traditional and biomedical practices often causes a decrease in compliance which may prolong the illness, jeopardize recovery and, in the long run, increase costs to the health care system (Kleinman 1980). With pediatric patients, integration of Native healing practices may be blocked by the health care and child protection systems. Interventions by clinicians and welfare workers preventing traditional healing practices in the care of Native children may risk both alienating the parents and further removing the patient from the context of culturally appropriate care.

RESEARCH OBJECTIVES

The resource limitations and time constraints of this research program precluded either comprehensive documentation of current patterns of traditional healing or assessment of the validity and psychosocial impact of healing practices. Our research therefore focused on the less documented issue of physicians' attitudes towards Native medicine and traditional healers. Physicians'

knowledge level and history of exposure to traditional medical practices were hypothesized to influence willingness to participate in collaborative activities. We also anticipated that those physicians with positive evaluations of the contribution of traditional medicine to the well-being of Native patients would be more open to collaboration. Our formal research objectives included:

1. to document physicians' attitudes toward traditional medicine and assess the impact of their attitudes on their acceptance and participation in collaborative activities;
2. to document differences in professional exposure to Native culture among physicians practicing in alternate contexts;
3. to assess the impact of practice context upon physicians' attitudes towards collaboration and involvement with Native healers and healing practices.

METHODS

The research was done in four phases. Phase I involved a literature review and key informant interviews with Native interpreter staff at two Winnipeg tertiary care hospitals. Phase II consisted of open-ended interviews with 16 physicians selected to represent both general practitioners and consultants, including individuals with varying degrees of involvement in treating Native clients. A preliminary 50 item, structured questionnaire was developed and tested using questions based on themes emphasized by physicians in the open-ended interviews. Phase III involved the administration of a questionnaire through a postal survey of a purposive sample of physicians and medical students. Phase IV of the research involved scale development, univariate and multivariate analysis of the data.

Following completion of a small pilot study of the survey instrument, the final questionnaire was distributed to a purposive sample of physicians (N=102) and medical students (N=16). The sample of physicians was selected from a range of practice contexts, areas of specialization, and degrees of clinical

involvement with Native client populations. The sample was developed to determine whether physicians with more practical experiences in working with traditional Native healers have more positive evaluations of the contributions of traditional medicine to the well being of Native patients. The sample was also structured to determine whether physicians with varying specialty, background, practice experience and Native health program involvement also vary in their knowledge of, and respect for, traditional healing practices.

A number of subsamples were identified. The first consisted of physicians from a practice context with a high proportion of Native patients and where there was a relatively high level of collaboration with traditional healers. This subsample includes all general practitioners from the attending staff affiliated with the community hospital in Kenora, Ontario. The second subsample consisted of general practitioners and specialist consultants working in a university-based program providing primary and specialized services to Native communities (J.A. Hildes Northern Medical Unit). The Northern Medical Unit (NMU) includes both general practitioners residing in Native communities and specialists and family physicians who serve Native communities through a fly-in program. This practice context subsample was characterized by a high proportion of Native patients but no formal program for incorporating Native healing practices. General practitioners and family physicians affiliated as preceptors for the undergraduate primary care teaching program of the University of Manitoba's Department of Family Medicine constituted the third subsample. These physicians come from a wide range of practice contexts and have varying degrees of contact with Native patients. Finally, the fourth subsample consisted of a group of fourth year medical students completing their community medical clerkship. This latter group was selected because they have received formal instruction on Native culture but have minimal clinical experience with Native patients.

To insure a high response rate from each subsample a postal survey protocol was used. Surveys were sent to each respondent

on the practice list with an introductory letter. When necessary a follow-up letter was sent two weeks later. A second reminder with an enclosed questionnaire followed after another two weeks. If by six weeks the questionnaire had not been returned, the physician was contacted by telephone. The response rate from each of the subsample groups was: Kenora G.P.'s (General Practitioners) 82%; Northern Medical Unit G.P.'s 80%; Northern Medical Unit consultants 92%; Family Medicine preceptors 71%; and medical students 100%. The response rate from the total pooled sample was 82%.

The questionnaire was divided into two sections. The first examined personal background and practice characteristics including: practice experience and the demographic characteristics of physicians' client population; physicians' level of awareness of patterns of patient participation in traditional healing practices; level of physician's involvement in Native cultural activities and health practices; and physicians' level of knowledge about traditional practitioners and healing practices.

The second section of the questionnaire examined physicians' attitudes toward traditional medicine, including: general perspectives on traditional medicine and the prospectus for collaboration; beliefs about the validity and viability of traditional medicine; and perception of the biological, psychosocial and political role of traditional healers.

Clusters of questions dealing with each of the above mentioned dimensions were grouped together and scaled to form quantitative indices. For example, an index of physicians' knowledge of traditional healing practices was developed by rank ordering all questions asking for a description of traditional medical practices and structures. Physicians' scores on individual questions were summed to form an index which could be compared across subsamples of physicians and students working in each practice context.

GENERAL CHARACTERISTICS OF PHYSICIAN GROUPS

Table 1 presents the characteristics of the respondents within each subsample. In terms of overall years of practice experience, general practitioners from the Northern Medical Unit (NMU) had the least number of years of practice experience. NMU G.P.'s included the highest proportion of physicians (94%) with more than 25% of their patient population of Native origin, followed by 31% of the NMU specialists and 29% of the Kenora physicians. The comparison group of G.P.'s and family physicians from the sample of Family Medicine preceptors included 18% who indicated that more than a quarter of their patients were Native.

Kenora (85%) and NMU G.P.'s (77%) were also significantly more aware than other physician groups (<40%) that any of their Native patients had ever consulted a traditional healer. The Kenora group indicated the highest level of active "referral" (54%) of Native patients to traditional healers. Given the high degree of familiarity that NMU G.P.'s and specialists have with Native patients, their low referral rates are significant.

PHYSICIAN'S ATTITUDES TOWARDS COLLABORATION

A number of trends were first identified in the exploratory interviews with physicians and confirmed by the survey. For example, most respondents were in favour of some form of collaboration but indicated a reluctance to relinquish control as reflected in statements such as "the physicians would have to have the last word." In the open-ended pilot interviews, physicians with the most knowledge and experience in working with Native patients appeared generally to have the most positive attitude towards the prospect of collaborating with traditional Indian healers. It was initially anticipated that other variables such as specialization, length of time in practice, or proportion of Native patients would be positively associated with collaborative attitudes. However, in the preliminary interview, these variables were not found to be reliable predictors of attitudes toward collaborative programs incorporating traditional healers. Some of the open-ended interviews illustrated the range of attitudes

TABLE 1

PHYSICIANS' CHARACTERISTICS AMONG RESPONDENTS IN FIVE PRACTICE CONTEXTS*

Summary Scales	Kenora G.P.'s	Northern Med. Unit G.P.'s	Northern Med. Unit Specialists	Family Practice Preceptors	Students
% of physicians in practice less than 5 years	39	82	18	21	N/A
% of physicians with greater than 25% of their practice being Natives	29	94	31	18	N/A
% of physicians who were AWARE that their patients were also seeing a traditional healer	85	77	38	39	33
% of physicians who have ADVISED a patient to see a traditional healer	54	18	9	12	0

*All data significant for level of variation across practice ($p. < .01$).

towards collaboration among several physicians. For example, two experienced physicians working in the university-based Northern Medical Unit were asked how they would handle a patient who complained that his illness was due to a curse. One physician stated that he would ignore the client's interpretation of his illness, while a second physician in the same unit reported that he would advise the patient to seek the advice of a healer.

The range of perspectives on collaboration and anomalies in practitioners' attitudes was confirmed in the analysis of physicians response to the survey instrument. Physicians' general willingness to collaborate was exemplified by the large proportion (78%) who felt that a collaborative program would benefit the patient by providing health care in a familiar context. Traditional healers were also acknowledged by most respondents (90%) as playing an important psycho-social role in health care for Native people.

In more specific questions probing mechanisms for collaboration and physicians' perspectives on control of healing practices, more global perspectives on general acceptance were qualified by the respondent. Reservations about collaboration were most often expressed about situations which would involve a loss of control on the part of the physician or hospital. While 70% of physicians judged it to be acceptable for traditional healers to treat patients on hospital wards, only 55% of the respondents would allow a healing ceremony to be held in a hospital. As these responses indicate, some physicians' support for involvement of traditional healers at the community level did not always extend to support for involvement of healers in hospital-based care. A majority (73%) of survey respondents agreed that traditional medical practice should not interfere with biomedical practices. Reciprocal beliefs about non-interference in traditional healing practices were supported by a minority of the respondents. In items dealing with proposals for controlling traditional practice, 55% of physicians felt it was necessary to have an auditing system for traditional healers in which the College of Physicians and Surgeons would play a part.

The survey also explored physicians' evaluations of organizational approaches to co-participation with traditional healers. These questions explored both reactions to proposals, and the respondents actual experience in referral. Most (77%) of the respondents indicated that they would utilize traditional healers if a formal referral system was in place. However, only 15% of the sample had actually referred a patient to a traditional healer. This discrepancy may reflect the absence of formal protocols for referring patients to traditional practitioners and a perception that in the absence of formal protocols, referral might invoke collegial disapproval. The low proportion of physicians who have actually made referrals is further complicated by the surprising finding that 57% of the respondents believed that traditional healers could provide cures for some illnesses which did not respond to biomedical interventions.

The absence of formal opportunities for collaboration or referral programs were structural barriers to cooperation. However, the respondents general knowledge and attitudes towards traditional healing practices also influenced involvement. One significant factor was the perception of the viability of traditional medicine. Fifty percent of the respondents felt that Indian medicine was disappearing. The perception of diminishing adherence to traditional beliefs and healing practices contributed to a perception that developing collaborative structures was no longer necessary.

The survey data showed a clear discrepancy between a general willingness to collaborate with traditional practitioners and the respondents actual clinical practice. Although 90% of respondents felt that it was important to know and monitor patients who are taking herbal medication, only 45% reported ever having inquired about similar medicine use in their treatment of their own patients. The respondents reluctance to inquire about patterns of involvement may reflect the general perception that traditional healing practices are secret knowledge. Seventy-eight percent of the respondents agreed that Native people were secretive about their use of traditional healers. Another

explanation was offered during an exploratory interview in which a physician suggested that "the necessity for a physician to limit the amount of time per patient causes him to priorize."

Probing respondent's reactions to more specific proposals for collaboration also revealed some systematic variation among physicians in individual practice contexts. Respondents were asked whether traditional healers should be asked to participate in hospital rounds. The proposal was favored by 31% of the Kenora practitioners, 87% of the G.P.'s and 53% of the specialists from the Northern Medical Unit, 47% of the family practice preceptors and 56% of the students. The perspective of the Kenora physicians was explained by one respondent who stated that collaboration was necessary but that the two systems must operate separately.

CONCLUSION

Our preliminary analysis of the survey and in-depth interviews suggests that more knowledgeable physicians believe that collaboration with Native traditional healers is not harmful and potentially beneficial. The range of levels of knowledge among individual respondents emphasizes the need for more systematic training and practice exposure to Native healers and healing practices in both undergraduate and continuing medical education.

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