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.

ALAN SMYTH
Paediatrician

MICHAEL MARTIN
Physician

JAMES CAIRNS
Medical superintendent

St Francis Hospital Private Bag 11,
Katete,
Zambia

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?

RAJENDRA KALE
Neurologist

Laxmi-Kunj,
37 Shanwar,
Pune 411 030,
India

1 Kale R. Restructuring South Africa's health care: dilemmas for planners. *BMJ* 1995;310:1397-9. (27 May.)

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3 World Bank. *Overview. World development report 1993. Investing in health*. Oxford: Oxford University Press, 1993: 1-4.

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Health psychologists make an important contribution to care

EDITOR,—The editorial on the psychological care of medical patients¹ and the report to which it refers² 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.

STEPHEN WRIGHT
Clinical psychologist

Department of Medical Psychology,
Leicester General Hospital NHS Trust,
Leicester LE5 4PW

JOHN WEINMAN
Professor

Unit of Psychology,
United Medical and Dental Schools,
London SE1 9RT

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.

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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

Mental Health Act 1983 would be a standard course of action if he or she refused voluntary admission. It is wrong to suggest that if such a patient took an overdose his or her refusal of treatment while distressed should be considered to be valid. In most cases of self poisoning presenting to casualty departments the history is scanty, the patient is uncooperative, and treatment is needed immediately. If fleeting refusals of treatment were to be honoured many lives would negligently be lost; this is not what English law requires of doctors. The common law allows doctors to act in the best interests of patients if they do not have the capacity to consent.

KAISER CHAUDHRI
General practitioner

Broadway Surgery,
Fulwood, Preston PR2 5QA

- 1 Hodgkinson DW, Gray AJ, Dalal B, Wilson P, Szawarski Z, Sensky T, *et al.* Doctors' legal position in treating temporarily incompetent patients. *BMJ* 1995;311:115-8. (8 July.)
- 2 Re T (adult: refusal of medical treatment) [1993] Fam 95.
- 3 Re F [1990] 2 AC 1.

Failure to treat outweigh risk of non-voluntary treatment

EDITOR,—Petra Wilson, the legal contributor to the debate on doctors' legal position in treating temporarily incompetent patients, adopts a pessimistic position concerning the legal justification for treating the two patients discussed.¹ The intuition of most doctors would suggest that these incompetent patients should be spared the immediate consequences of their disastrous decisions. Fortunately, in Re F the House of Lords confirmed that it was possible for a doctor to give surgical or medical treatment to incompetent adult patients provided the treatment was in their best interests.² Furthermore, the involvement of the court was not necessary, which must be a relief to hard pressed casualty officers. In Re T the Court of Appeal found that T, a pregnant Jehovah's Witness, could be given a blood transfusion even after her apparent refusal (as in the case discussed in which the patient had taken an overdose) since her mental state had deteriorated to the extent that she could not make a competent choice between having a blood transfusion and probable death.³ This is similar to the problem of advance directives in that patients, in giving their wishes, may not have anticipated all the circumstances that can occur when they are unconscious.

Failure to treat in such circumstances could itself leave a doctor open to the possibility of an action for negligence, in which case the reasonableness of any decision not to treat would presumably be assessed according to whether it accorded with a responsible body of medical opinion—the Bolam test.⁴

I also strongly doubt the application of the case of *Majewski* to questions of consent to treatment.⁵ It may be good public policy that criminals cannot use intoxication to prevent the requisite criminal intent being proved against them, but this does not alter the fact that autonomy is decreased by alcohol and that when necessary doctors should treat intoxicated patients as they would any other incompetent subject. The case of *Malette v Shulman*, cited by Wilson, is a Canadian case.

I have no doubt that for most doctors the legal risks of non-treatment outweigh those of non-voluntary treatment by a substantial margin.

JD BUDD
General practitioner

East Quay Medical Centre,
Bridgwater, Somerset TA6 5AZ

- 1 Hodgkinson DW, Gray AJ, Dalal B, Wilson P, Szawarski Z, Sensky T, *et al.* Doctors' legal position in treating temporarily incompetent patients. *BMJ* 1995;311:115-8. (8 July.)
- 2 Re F; *F v Berkshire Health Authority* [1990] 2 AC 1.
- 3 Re T [1992] 4 All ER 649.
- 4 *Bolam v Friern Barnet HMC* [1957] 2 All ER 118.
- 5 *DPP v Majewski* [1977] AC 443.

No reliable evidence that folate is harmful in B-12 deficiency

EDITOR,—E H Reynolds cites his interesting observations on a case of subacute combined degeneration caused by an abnormal vitamin B-12 binding protein.¹ He suggests that administration of folic acid may have precipitated the neurological condition.² Recently I carefully examined the literature before and after the discovery and introduction of folic acid and vitamin B-12 but found no reliable evidence that folic acid is a neurological poison,³ although many people still think it is. Before liver and B-12 therapy for pernicious anaemia were introduced, neurological deterioration was often very rapid, whether or not folic acid had been given. Furthermore, as Reynolds and colleagues have shown, not only can folic acid deficiency in the mother cause neural tube defects in the fetus, but in adults it is associated with neuropsychiatric, especially affective, disorders.⁴

Food additives always excite controversy, even when the additive is a normal and essential vitamin whose deficiency can be devastatingly damaging. Fortification is needed; otherwise, avoidable harm will continue. A standing committee should be set up to monitor the efficacy and safety of a national fortification policy, and to amend the guidelines as appropriate.

C JOHN DICKINSON
Emeritus professor of medicine

Wolfson Institute of Preventive Medicine,
St Bartholomew's Hospital Medical College,
London EC1M 6BQ

- 1 Reynolds EH, Bottiglieri T, Laundry M, Stern J, Payan J, Linnell J, *et al.* Subacute combined degeneration with high serum vitamin B12 level and abnormal vitamin B12 binding protein. New cause of an old syndrome. *Arch Neurol* 1993;50:739-42.
- 2 Reynolds EH. Folic acid and the prevention of neural tube defects. *BMJ* 1995;311:257. (22 July.)
- 3 Dickinson CJ. Does folic acid harm people with vitamin B12 deficiency? *Q J Med* 1995;88:357-64.
- 4 Shorvon SD, Carney MWP, Chanarin I, Reynolds EH. The neuropsychiatry of megaloblastic anaemia. *BMJ* 1980;281:1036-8.

Qualitative study on patients with stroke

Leaves questions unanswered

EDITOR,—Pandora Pound and colleagues' qualitative research on the views of patients with stroke on their admission to hospital raises several issues.¹

Firstly, how representative of patients with stroke was the study population? The information provided is mainly on exclusions. What proportion of all patients with stroke admitted to the two hospitals were included? How many patients had had more than one stroke?

Secondly, is it "probably safe to assume that a reasonable spread of different views has been achieved," particularly with a 49% response rate?

Thirdly, it would be helpful if the full methodology had been described. Despite reading the related publications² we had to contact the authors to establish that the scores comparing responders and non-responders in table I were derived from a variety of questionnaires completed by carers, interviewers, and patients, involving a mixture of telephone, postal, and personal interviews. Are P values meaningful for the subsequent lack of differences in the mean scores derived? Why did the population that was interviewed decrease by 5% (2/40) but the population that was not interviewed decrease by 32% (13/41)?

Fourthly, why was patients' satisfaction in the above two groups not compared?

Fifthly, it is stated that "carers are sometimes present... and their accounts were also included here." Is this a study of the views of patients with

stroke or their carers? A qualitative study should have been able to distinguish these views more clearly than quantitative methods.

Sixthly, cross tabulation of combined categories of components of care is not given, and 8% (3/40) of interviews were excluded because they talked about housing. If housing is what patients with stroke (rather than researchers) are interested in 10 months after their stroke why was the opportunity not taken to explore this qualitatively? The same number of people (3/40) were dissatisfied with the information they received, yet this merits a whole section in the results.

Seventhly, why were quantitative methods used at six months but qualitative methods at 10 months? The possibility of bias being introduced by the questionnaires used four months previously is not discussed.

Finally, while this study confirms the findings of Anderson⁴ and others, what does it add? Are there good grounds for repeated surveys of the same group of frail patients on a stroke register?

We raise these issues because we believe that the value of qualitative research will become apparent only if the methodology of the research is sound.

ANN F BISSET
Senior registrar

Department of Public Health Medicine,
Grampian Health Board,
Aberdeen AB9 1RE

ROSEMARY CHESSON
Reader

Department of Health Sciences,
Robert Gordon's University,
Aberdeen

- 1 Pound P, Bury M, Gompertz P, Ebrahim S. Stroke patients' views on their admission to hospital. *BMJ* 1995;311:18-22. (1 July.)

- 2 Pound P, Bury M, Gompertz P, Ebrahim S. Views of survivors of stroke on benefits of physiotherapy. *Quality in Health Care* 1994;1:37-43.

- 3 Pound P, Gompertz P, Ebrahim S. Patients' satisfaction with stroke services. *Clin Rehabil* 1994;8:7-17.

- 4 Anderson R. *The aftermath of stroke. The experience of patients and their families.* Cambridge: Cambridge University Press, 1992.

Authors' reply

EDITOR,—The study population was representative of survivors of stroke admitted to hospital within the inner city; it did not claim that it was representative of all patients with stroke. We are confident that a reasonable spread of different views was achieved since we have information about non-responders, which was presented in the paper.

As we have already explained to Ann Bisset, the methodology used in the stroke outcome study follows the standard practice of seeking the best available source of information. While we recognise the danger of patients' views being misinterpreted, carers who were able to contribute to interviews with patients with cognitive or speech impairments were highly valued. Asking carers to be absent from the interviews would have been unnecessarily distressing for many of the patients.

The three interviewees who discussed their housing problems were excluded from this analysis since people's views of their care, not housing, was the topic of this paper. Their interviews will be used in other analyses of the data—for example, those relating to the consequences of stroke. This paper confirms only one aspect of Anderson's findings¹—that relating to nursing care. The main message, that patients evaluate their care in a multidimensional manner rather than focus on function and death, is in our view an important one with implications for research and clinical practice in stroke.

The other points raised by Ann Bisset and Rosemary Chesson are of little relevance in determining the methodological standard of qualitative research but are more important in quantitative work. Both quantitative methods and qualitative methods were used at different times as the stroke