The Interface between Western Health Care and Traditional Healing

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In a gripping book, Anne Fadiman (1997) describes the clash of two medical worldviews. Nao and Foua Kao, Hmong refugees from Laos living near Merced, California, had a child who went into convulsions. They were convinced this was *qug db peg*--when "the spirit catches you and you fall down," and, therefore, that she was a very special person who would grow up to be a shaman. Doctors in the Merced Community Medical Center diagnosed it as epilepsy cause by an electrochemical storm in her head, and did a spinal tap, a CT scan, an EEG, a chest X ray, and extensive blood work. Her parents were sure that the American doctors were draining away her blood and using their child as an experiment to test their ideas. The doctors were angry that her parents did not regularly administer the drugs they prescribed, or overdosed her to cure her faster. The parents saw the doctors as heartless technicians unconcerned about the spiritual and social well being of their doctor. The doctors saw the parents as obstreperous and unconcerned about the physical health of their daughter. Similar stories could be told a missions hospitals around the world, if only we knew how everyone viewed the cases being treated--the missionary doctor, the patients and their families, the community, and the local shamans, magicians, exorcists, witch doctors and other healers.

The book raises the complex problems inherent in introducing modern medical practices in traditional societies. It also shows that simply imposing allopathic treatments and rejecting other systems of medicine as superstition does not work. What are some of the lessons we can draw from examining such cross-cultural medical encounters not only for providing immediate medical care, but also for bring about lasting worldview transformations in traditional societies? Here we

will look briefly at some principles drawn from studies of intercultural medical ministries, and illustrate them drawing on a case study in Kenya.

Principles in Intercultural Medical Missions

Over the past century governments and non-governmental agencies have been deeply involved in introducing modern medical systems around the world. Despite the investment of billions of dollars, health problems remain center stage in much of the world. Studies of the cases involving intercultural medical ministries provide us some guidelines for Christian medical missions (Paul 1955, Niehoff 1966, Fadiman 1997). We will examine four principles that have become increasingly clear.

1. We must begin with people where they are and the community as it is, not where we think they should be.

Too often in medical ministries, we focus on where we think the people should be, not where they are (Paul 1955, 476). We come with our medical systems and assume that these are true, and that there is nothing in traditional practices on which to build. Confronted by shamans, witch-doctors, herbalists and medicine men, our normal response was to reject their beliefs as animistic 'superstitions,' and to try to stamp these practices out by ridicule or condemnation. John Pobee observes,

> All the historical churches by and large implemented the doctrine of the *tabula rasa*, i.e., the missionary doctrine that there is nothing in the non-Christian culture on which the Christian missionary can build and, therefore, every aspect of the traditional non-Christian culture had to be destroyed before Christianity could be built up (1982, 168).

This rejection of traditional practices has largely failed. Many people accepted western medicine as a means of last resort, but continued to turn first to their old ways when faced with

illnesses. Christians hid amulets under shirts to protect children from diseases, and do not admit to Christian doctors that they are also going to the village shaman. They know they dare not tell the missionary about their old ways lest they incur his or her anger. The result is 'split-level' Christianity in which people turn to the church and western medical systems on certain occasions, but remain in their traditional ways most of the time. Pobee writes,

> As one watches the daily lives and activities of the people and takes account of the rites connected with marriage, birth, death, widowhood, harvest and installation of traditional offices, one learns that a great deal of the normal communal activities of the converts lie outside their Christian activities, and that for all their influence, the Christian churches are still alien institutions, intruding upon, but not integrated with social institutions." (Pobee 1996, 2).

How can we introduce sustainable change in the medical worldviews of the people we serve? First, *we must study the people and their cultures in order to understand them*. It is important to remember in introducing cultural change that people can only move from where they are. They simply can not jump into a totally new way of thinking and behaving that make no sense to them. Medical systems are parts of larger cultures, and changes in the way people think about illness and healing affect profound changes throughout the whole of their culture. To be lasting, such changes must touch not only their beliefs and practices, but also the underlying worldview. Only when we understand, in some measure, where people are coming from can we begin to transform the worldview that shapes their beliefs and practices.

Second, *we must examine the worldviews we bring with us.* We take these so for granted that we fail to see how culturally shaped our beliefs and practices are. So long as we minister in our own cultures, we are largely unaware of our own basic assumptions because everyone shares them. Ministering in another culture changes all this. We are forced to confront other languages,

cultures and worldviews. We begin to realize that people live in different worlds, not the same world with different labels attached, and we must come deal with these differences.

Third, *we need to compare the two worldviews and develop bridges for mutual understanding.* Traditional societies vary greatly, and each must studied in its own terms. In several critical areas, however, most of them share assumptions radically different from modern medical presuppositions (figure 1). One area of difference is our views of disease. In the modern world worldview we focus on the disease and its causes, and make a sharp distinction between natural and supernatural realities. We assign physical and mental diseases to the former, and differentiate these from spiritual illnesses. Different explanations of illness are stacked in discrete layers. Spiritual sicknesses are the domain of ministers and priests, psychological disorders are assigned to psychiatrists and psychologists, and biophysical diseases are treated by doctors and surgeons. Within these domains, further specialities are developed. The result is a high degree of fragmentation, and the treatment of specific, narrow pathologies, not whole persons in their biological, social and spiritual contexts. In traditional societies, practitioners focus on the person and treat not only the biophysical symptoms and causes, but also the psychological, social and historical contexts in which the patient lives. The people often see modern doctors as secular technicians who repair bodies, not whole persons.

Figure 1
Contrasting Worldviews and Health Ministries

Western Worldview	Traditional Worldviews
- compartmentalized explanations	- wholistic explanations
- diseases explained in terms of natural laws	- diseases explained in terms of relationships
- focus on the individual	- focus on the group

A second difference is that modern medicine takes a mechanistic view of diseases. They are explained in terms of natural processes governed by the laws of nature. This view leads to an engineering mentality in which we believe we can cure diseases once we know the laws of nature. It also leads to compartmentalization, specialization, bureaucratic institutionalization and quantitative measurements that enable us to manage our world (Berger et. al. 1973, Ellul 1964). Most traditional societies, on the other hand, see illnesses as ultimately caused by broken relationships between people, ancestors, spirits and gods. Healing requires the restoration of the patient to right relationships in the universe.

A third difference between traditional and modern views of medicine has to do with the patient. In traditional societies, he or she is inextricably a part of a community, and for a person to be healed, the family and community must be involved. The patient can take prescribed medicines only when the head of the family or lineage agree. In the West, the doctor treats the patient, and largely ignores the community in which she or he lives.

2. <u>People take what we bring and adapt it to fit their cultural patterns</u>.

When we introduce modern medical beliefs and practices, we generally assume that they will adopt these in place of their old ways. In reality, they take our ideas piecemeal and reinterpret them within the framework of their old beliefs. This causes serious distortions of which we must be aware. In much of the world people want injections because they believe that these have magical power that pills and liquids do not. Many believe that modern doctors harm their patients by drawing blood, because the body has only so much blood and to remove some of it weakens the individual. In introducing cultural changes, we must always expect them to modify and adapt what we bring.

3. Sustainable change will occur only when the people own the process.

In medical missions we have see our goal as treating the sick. When we leave, however, we often leave little left of lasting value. Too often we are driven by the needs of the sick, and we forget that our ultimate goal in missions is to introduce medical transformations not only in the lives of patients, but also in the way the people view and respond to reality. As Niehoff points out (1966, 290), sometimes the longest way round is the shortest to the goal.

How do we introduce sustainable programs and lasting change? It is important to remember that these only occur when the people themselves own the process, and when community health becomes everybody's business (Niehoff 1966, 290) This requires full dialogue and partnership in every step of the process. Our major role as outsiders is to introduce new ideas, to model Christian ministry, and to empower the people to think and act on their own. It is more important to involve the people in learning to do the work than to do it and create dependencies. Our deeper goal is to help them respond to their illnesses, not to heal all the sick.

4. We need to study and learn from our experiences.

Doctors and nurses are taught to act in times of need, and the needs are endless, the time and resources are so short and ready answers are at hand. Why stop to study what we are doing? It takes time and energy, and above all vision to realize the value of careful research can help us to find bridges of communication and remove cultural barriers, and to develop models for cross-cultural medical ministries (Paul 1955, Niehoff 1966, Fadiman 1997).

Ministry and research must go together. Too often we do research and then minister. The danger is we end research too soon, and stop learning from our experiences, or we keep on doing

research and never get around to ministry. Initial research can help us learn to know the people we serve and plan our work, but it also opens up doors for relationships crucial to lasting ministry. Ministry, on the other hand, raises new questions that require further research. The two must continue side-by-side throughout our service.

We look now at a case of ministry in Kenya that illustrates these and other principles essential in effective cross-cultural medical missions.

Case Studies in Intercultural Medical Ministries

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