MEDICAL HISTORY TAKING AMONG THE BANTU TRIBES OF SOUTH AFRICA*

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Accurate elicitation of the history of an illness is a vital step for the ease and correctness of clinical diagnosis. The story should be precise, and must be completed with a minimum expenditure of time and effort for both practitioner and patient. It is, therefore, evident that the ideal setting obtains where patient and doctor speak a common language. Feeling and belief pervade the patient's complaints and the interpretation of his symptoms by the doctor and the patient himself. This focuses attention on the desirability of appreciating or knowing fully the cultural make-up of one's patients. It is the purpose of this article to highlight the need for such orientation.

Experience gained in practising in both rural and urban Bantu population forms the basis for the postulate that, for practical purposes, the indigenous people of South Africa are a uniform cultural unit. A large section of the African population is still markedly tainted with traditional cultural attitudes.

For some time to come, non-Bantu colleagues will provide the major or only medical personnel in private as well as official practice. It is hoped that these doctors do find the time to learn the language of their patients and acquaint themselves with the patient's culture. It is distressing to stand by and listen to an intern wasting valuable time obtaining history through a nurse. The inexperienced nurse is quite often a stranger to both the doctor's and the patient's way of thinking. She presses home with literal translations of English phrases which are correctly misunderstood by a patient who is ill and desperate to tell his own story without interruption. A simple question requiring the answer 'yes' or 'no' or 'I have been ill for two months', involves a protracted discourse which is unintelligible to the patiently waiting doctor; ultimately an answer is extracted and, to the doctor's surprise and probable disgust, the response has no bearing on the question posed. It has happened that a questioner wishing to know if dyspnoea has been experienced before, has been told that the patient has not menstruated for one year. These and many other mishaps can be obviated if the doctor speaks directly to the patient and is imbued with the patient's cultural outlook.

By major linguistic features, South African Bantu tribes can be regarded as consisting of (*a*) a Nguni group which includes Xhosas, Zulus, and Swazis; (*b*) a Sotho group comprising Shoeshoes, Tswanas, and Pedis; (*c*) Shangaan—Vendas; and (*d*) small intermediate groups such as Ndebeles, Digojas, and some tribes scattered in the Orange Free State.

During medical training the importance of systematic interrogation is stressed. The patient is assumed to be an intelligent witness. One must avoid so-called leading questions in order that the validity of the answers may not be prejudiced. Detailed accurate responses are needed and it is taken for granted that such will be forthcoming. The ensuing physical examination also follows a prescribed scheme. Either the history or the physical findings may solely be productive of the diagnosis or these two steps are complementary. Examples of predominantly historical diagnoses are angina, peptic ulcer, and peripheral vascular insufficiency, to name three. Cerebrovascular disorders (some), meningitis, malignant disease and complicated hypertension are some of the disorders in which the physical findings may be all-important. Most literate and educated persons tend to present early, so that the clinical features of disease are frequently subtle and unobtrusive. It is not uncommon for these patients to consult about trivial or harmless abnormalities, for which only reassurance suffices. It is important to appreciate the fact that in the western sense the doctor plays the role of both diagnostician and therapist.

Traditional Bantu medical practice is different. The patient's medical care is shared among a number of practitioners. The two primary groups comprise the diagnosticians (*sangoma, lethuhela*)† and the therapists (*inyanga, ngaka*). A combined diagnostician-therapist is rarely found. The therapists are again a body of specialists with differing special skills in the various aspects of the game. A diagnostician is aware of this set-up and has to refer patients accordingly. The diagnosticians themselves are specialists in various lines of the art. Insight and an unwritten code of ethics do exist; thus a patient who consults a man less skilled in a particular problem or problems is normally advised and referred. Christianity has added prophets and faith-healers to the profession without, however, clouding the main boundaries which

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†In the text one word each from an Nguni and a Sotho language is given, the former first throughout.

separate the members of this now multifaceted game. It is interesting to note that in the new phase, doctors (prophets), occupy a position of either ambiguous partnership or implied non-recognition with no open hostility.

Another characteristic of traditional practice is that a patient may on occasion be his own therapist. The diagnostician advises the ill where to find herbs and how to use them or what rituals to perform to rid himself of disease.

THE DOCTOR-PATIENT RELATIONSHIP

Basic to the whole scheme in the practice and crucial to the validity, reliability of opinion, and efficiency of the treatment, is the doctor-patient relationship. Unique and essential is the fact that the patient approaches the doctor without a word. Unannounced and mute he calls on the diagnostician. The doctor is not taken by surprise because by his special powers he will have anticipated the patient's arrival. Following a few preliminaries the doctor proceeds to disclose the symptoms which prompted the consultation and, of course, enumerates the causes of same. The patient or members of the entourage will corroborate in a defined manner the correct or near-correct diagnosis and ignore the irrelevant, the latter being by acceptance part of the skill of feeling for clues. There will also have been established without help who the patient is among the group, and the doctor also establishes rapport by disclosing whence the party came (cardinal point), approximately how far they had to travel and also their means of transport. The end is reached when enough of the possibilities have been mentioned to constitute a satisfactory and workable diagnosis.

Many African patients will exhibit a pattern of attitudes born of these traditional influences. Medical practitioners are credited with special skills and knowledge. Our patients do expect to obtain a medical appraisal without any help from their side, and may take unkindly to too much interrogation. Undue and often inappropriate optimism in one afflicted with a life-threatening condition, and the seeming naïveté not to bother with frivolous complaints are all rooted in a unique culture. Economic factors add their share by prescribing unnecessary dangerous procrastination. As long as simple but essential life activities are not interfered with, medical advice will be solicited only at the advanced stage of an illness. Priorities with regard to the seriousness of various symptoms are determined by both culture and socio-economic factors. For similar reasons, these people are an easy prey even to practitioners of questionable reputations. Thus two important factors stand out at this stage, which make a formal detailed history unnecessary or objectionable, namely, cultural prejudice and late presentation.

It is proposed that a great number of Bantu, by trying to conform to a foreign system, will unwittingly assume the role of a traditional diagnostician. The patient tells the story well, but may exasperate the doctor by explaining every one of his symptoms. This self-analysis and diagnosis is, however, a priceless account to the doctor. It is important to recognize this fact and utilize it. The manner in which the patient relates his story, his timed emphasis, all furnish information which may otherwise be hard to come by. The ill and anxious patient will be seriously offended should the doctor not show familiarity and knowlegdeability with the set-up. A doctor should not be surprised if a diabetic is preoccupied with sexual weakness and resents being asked to talk about wasting or polyuria. The doctor should show concern for the patient's haemoptysis, as he implores him to do so, and come last to the obvious oedema or dyspnoea. The doctor must obtrusively direct his attention to the backache and the back despite a large pelvic mass. Pleuritic chest pain (*ilihlaba, setlhabi*) for which there is effective and efficient treatment (*ukulmega, lomega*), may take second place to coughing of blood.

Multiple pathologies are commonplace. A heart failure case may, for example, be complicated by renal failure resulting from nephrotoxins prescribed by an *inyanga* for the cure of penile oedema. Such a problem being compounded further of multiple nutritional deficiencies and fulminant septicaemia introduced by the *ngaka's* skin incisions. There are many similar combinations. Added to any one hotch-potch, there may be an infinite variety of disturbances which can complicate the ill-advised deploy of patent medicines and legitimate western medications.

A doctor must be aware that the significance of certain symptoms is obscured by their presumed benefit or usefulness. Examples of this group are diarrhoea, vomiting, epistaxis, menorrhagia and skin rashes, to mention a few. Venereal disease equals the price and proof of masculinity.

A patient's beliefs, fears, and interpretation of some symptoms should be appreciated because the clue to his attitude will be found thereby. The kidneys are the all-important organs of sexual strength and of fertility. Harmful results can emanate from venereal disease. Mean and spiteful females may, by some complicated guise, inflict a whole gamut of maladies which will flourish in the substance of the kidneys.

The background to a patient's psychological and cultural outlook must provide the mirror through which the clinical picture is viewed. The success of the technique adopted for historical interviews depends on only a few simple hints. The patient should be spoken to in the language suited to his outlook and culture. It is most profitable to sit and listen all the time, without interruption, and allow the anxious patient to ventilate what is foremost in his troubled mind. Better results are obtained by employing direct questions. Through practice and experience and by an appreciation of the prevailing cultural motivation, validity of so-called leading questions can be maintained. Tribal terminology facilitates communication. The patient's confidence and co-operation are secured if the medical practitioner identifies himself with his patient by word as well as by action.

THE DOCTOR'S APPROACH

I should like to emphasize that many of our patients are, to a varying degree, imbued with the traditional doctor-patient relationship. This system prescribes that the doctor shall tell both the troublesome symptoms and in turn, the aetiology. The patient usually has a profusion of probabilities from which to choose the diagnosis that fits or nearly does so.

Questions such as, 'What is wrong with you'; 'What is the matter?'; or the sweetened 'What can I do for you?' will antagonize most patients. The practitioner presents

himself as lacking and unskilled at the outset. The seeds of despair and diffidence will have been sowed and the subsequent interrogation will be marred by a confused and haphazard history.

A frequently rewarding approach is to make a statement-question thus: 'You are ill, please tell me all about it or tell me how or when it all started' or 'I see you have been sick for a long/short time; I wish to know how it started'. It is amazing how easily the patient is disarmed and a detailed history flows. The revelation to the patient that his ailments are recognized at a glance, establishes that vital confidence in the doctor. The patient co-operates without realizing it, despite the fact that the doctor's manner goes against tradition. The patient assumes the role of the diagnostician and he explains his piece fully. The doctor must sit quietly and listen carefully throughout in order that maximum benefit be derived out of this scheme. The patient will intersperse the story with explanations. One observes that the historian is motivated by the belief that correct treatment can come only of a correct diagnosis and for the latter a story well told pays dividends.

Another fruitful starting step is to make a spot diagnosis and proceed immediately with the physical examination. The obvious striking signs are pointed out, and a patient will almost invariably take over to tell all. He may be provoked into relating the story by a gentle 'What else has been a part of this illness?' A spot diagnosis presents no obstacles in quite a large number of cases because many of these patients come very late for help.

Quite often the practitioner has no further questions to ask, and valuable time will have been saved. The patient's story is complete, and the doctor with sufficient experience in this method has little trouble sorting out the pertinent facts from the unwanted ones. At this stage, it is also immensely gratifying to talk to a patient, who, having ventilated his troubles, is most amenable to a short patch-up interrogation, should this be found necessary.

The patch-up questions must be simple, direct and specific. It is futile and a waste of time to avoid the use of leading questions and, besides, the validity of the answers is in no way prejudiced. It is realistic to ask the patient if he has a cough and if so, whether obvious blood, pus or other abnormality, has been noticed. This applies to all symptoms about which a doctor may want to inquire. Similarly, direct questions should be employed in seeking additional definition of a symptom or sign. Time relationships must be offered in exact terms by the doctor, either empirically to 'set' the patient, or on the basis of some surmise. One must not omit to ask about induced symptoms such as diarrhoea, vomiting and haematuria and inquire into the reasons for self-medication. Some symptoms such as chronic cough, menorrhagia or a skin rash may be regarded by the patient as normal or may not be mentioned because he is reserving them for the next doctor; these are likely to be missed by the doctor unless somehow slipped in.

Attitudes to Illness

It is desirable to know specific traditional terminology which is used for the description of isolated signs or symptoms, or in some few cases, certain diseases. The utility of this knowledge lies in the fact that the causes and, possibly, the appropriate remedy, may be deduced from the tribal vocabulary. A doctor who displays relevant erudition in this manner, derives maximum patient confidence, besides.

We should appreciate the varying attitudes of our patients to their illnesses. Some complaints are serious, others are minor nuisances, while some others, though needing a doctor's attention, are regarded in a light vein.

It is noteworthy also that the Bantu patient categorizes his ailments. Some symptoms will be presented eagerly for the 'white' type of practitioner, while a certain group of complaints is reserved for the traditional doctor or a prophet. There is, however, no consistent or specific scheme whereby the patient determines this division of medical labour. A diabetic sufferer may elect to seek help from a 'western' doctor for weight loss and recurrent infections and reserve distressing impotence for the *inyanga*. In another situation a 'western' doctor may be consulted for penile oedema by a patient with advanced congestive cardiac failure who intends taking his dyspnoea to an *inyanga*.

Priorities of symptoms and signs have a complex but interesting treatment. A patient with gonorrhoea will give undue prominence to backache and not mention penile discharge, the reason being that the damage may have been inflicted on the kidney, which is an important organ of potency and masculinity. Another example is in regard to haemoptysis and chest pain. The former symptom prompts early consultation, while pain alone will be ignored or tolerated for as long as life is not interfered with.

It is interesting that the 'western' type doctors are also frequently credited with special skills in various aspects of the art. If an abnormal feature is not disclosed, it may be that it will be taken to a colleague down the street.

TRIBAL TERMINOLOGY

Knowledge of tribal terminoloy has indeed much to recommend it, especially when facility and finesse are vital tools to a hardworked, understaffed personnel. The problem is pinpointed quickly, the patient is saved frustration, and mutual confidence is readily fostered.

Cardiorespiratory Disorders

Umkhohlwane/mokhohlwane has two meanings, namely a mild general illness or just a chest cold. A cough (*ukukhohlela/gogthlela*), if mentioned specifically, usually implies that the sickness is much more serious. Pleuritic pain (*ilihlaba/sethlabi*) is nearly always treated by traditional methods first. A patient will reply 'no' to a question as to whether he has a pain in his chest, if the generic pain word (*buhlungu/bothloko*) is used. The pleuritic pain will be brought for relief only after *inyanga* treatment has failed or if the pain is associated with a more serious disorder presumed to affect internal organs. Coughing blood will be described as such. This is frequently a good sign because the patient gets rid of disease that way. This explains why it may be omitted in the complaint. If pus is noted in the sputum, the complaint will be that there are sores (*ilonda/dintho*) in the chest or lungs. The tribal term for pus is *ubomvu/boladu*. It saves time to inquire directly for abnormal features of sputum

rather than wait for the patient to volunteer such.

Isifuba/sehuba, which literally means chest, is another word that will direct the doctor's attention to the cardio-respiratory system.

Pulmonary tuberculosis is called *isidliso/sejeso* and vomiting is a popular form of treatment. It is interesting that it is seldom mistaken for *umkhohlwane*. It is misleading to describe dyspnoea as the literally translated 'shortness of breath'. Asthma is more commonly described in the latter term. An appropriate word for true dyspnoea is *iphika/letsoeha*. The circumstances under which the symptoms occur may be asked for in the usual manner. *Ukufuthelana/hofupelwa*, meaning suffocation, is also used to describe difficulty with breathing in a non-specific way. Palpitations, angina and paroxysmal dyspnoeic attacks will have to be described to the patient in the clearest of terms.

Pain Description

It is meaningless and misleading to simply ask if the patient has pain. Pains at various sites are referred to by terms which imply organ origin and suggest a form of treatment. We have learnt that *ilihlaba/setlhabi* refers to pleuritic pain, and that this type of pain is frequently treated at home. Blood-sucking is a popular method of doctoring. Headache is *inhloko/tlhogo*, literally meaning 'head'. Abdominal pain (*isiso/mala*) is a minor disorder amenable to purgation or self-induced vomiting. Backache is not the literal pain in the back, but *iqolo/segologolo*. *Isibeleto/popelo* (womb), *isinya/senya* (bladder) are used to direct attention to pain in the lower abdomen. Throbbing pain (*futha/opa*), colic (*sika/sega*), *izinso/diphiyo* (kidneys), are pain syndromes enjoying a specific description. The generic term for pain (*buhlungu/bothloko*) may refer to diffuse non-localizable pain. If this word is employed to inquire for pain as such, the answer can for example be: 'No. I have no pain, but I have *isiso*'—a confusing contradiction in terms. The practitioner may obtain further characterization of pain through the use of other words translated as such; for example, cutting, pulling, stabbing, pressing or any other. The procedure is cumbersome but will produce results in the appropriate case. The pain inquired for must be labelled with the above-mentioned terms, of course.

Gastro-intestinal Diseases

Symptoms can be difficult to evaluate because many of them can be purposely induced. The doctor should always ask if diarrhoea (*ukusheka/letsollo*) or vomiting (*hlanza/thlatsa*) are spontaneous or induced. One must also ask directly if the stool contains obvious blood or pus. Melaena must be described fully to the patient as black foul-smelling stool noticed when no medicaments had been ingested for at least a week previously and that the patient had had a regular bowel up to then.

Nervous System Diseases

Epilepsy (*sithuthulwana/sethwathwa*) should not be called 'falling sickness'. *Ukucaleka/goakgega* (a simple faint), *mafofonyane* (hysteria), *ukuhlanya/gothlanya* (psychosis) are examples of relevant terms. The treatment for epilepsy and hysteria is nearly always by an *inyanga* or prophet, the 'western' doctor being consulted only for temporary control. Paralysis, tremors or other abnormal movements, paraesthesiae, and disorders of special senses, etc., must again unfortunately be fully explained when questioning the patient.

Urinary System

Symptoms referable to the urinary system enjoy no special terminology. Diuresis and haematuria are some abnormalities which may not be volunteered. The latter is frequently the result of self-medication or regarded as a good process. Venereal disease enjoys both the traditional and western forms of treatment. Gonorrhoea is known by many words such as *ukusha/golongwa* (to burn or to be be bitten), *ukuvusa/godutla* (leaking), 'drop', and many others. Syphilis (*silonda/mokaola*) (also cauliflower) may be treated by circumcision. Sexual weakness is most worrying to the men. The descriptive words or sentences are many, e.g. *ukungachame/gosa rote* (not micturating), *phelelwa'a mandla/go fellwa ke matla* (weakness) and others. The actual complaint, if analysed, may be found to mean excessive potency by accepted standards! Venereal disease may leave a legacy of kidney (backache) or bladder poison or impotence, for which an injection is mandatory.

To ask for the duration of illness, it expedites the process to offer definite periods such as so many weeks or months. The answer to: 'How long?' is frequently 'very long' or, equally ambiguous, 'not long', and a whole train of digressions are likely to creep in, compounded of misunderstanding, a desire to explain that the gravity of the ailments outweighs the duration, frustration at being asked about a minor illness (in the patient's mind) and so on.

Relevant to aetiology and to obviate offending, customary practices should be known and asked for. The nature of the treatment and the reasons for it should be inquired after. A number of diseases can be mimicked by self-induced disorders or natural illnesses can be vitiated by traditional methods of treatment. One could mention diarrhoea, vomiting, bleeding from the gut or urinary tract and consequent anaemia, tetanus, foreign bodies in various natural orifices, perforated bowel, septicaemia, liver disease, bowel strictures, neurotoxicity and so on, as examples.

In regard to past history one must guard against accepting unconfirmed diagnoses. It will be found difficult to avoid having to describe the full clinical picture of a particular disease and, in some cases, the laboratory investigations usually gone into. This applies equally to family history.

SUMMARY

It is essential to adapt medical history taking to Bantu culture. A great deal of time and effort will be saved and both practitioner and patient will derive satisfaction out of such a scheme. A medical vocabulary does exist for the indigenous peoples. It behoves every doctor, who has to practise among Bantu to learn their culture and their language.

For a large number of diseases and symptoms which lack tribal equivalents, a brief but clear-cut description will be necessary. The specific tribal terminology offers the advantages of understanding, simplicity and facility of quick communication.

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