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HISTORY OF PLURALISTIC MEDICAL SYSTEMS: A SOCIOLOGICAL ANALYSIS OF THE GHANAIAN CASE

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INTRODUCTION

This paper addresses itself to the history of pluralistic medical systems in Ghana. Case studies of the systems (traditional and modern-scientific) as evolving traditions with unique premises and techniques will be discussed. Modes of medical institutionalization, recruitment, training, and allocation of resources will be explained. Finally, this paper will attempt to explain the nature of the interrelationship between the two medical orientations in terms of their consequences in health care. The essay will focus on how medical systems are used by consumers and how medical systems are created, maintained, and reformed by professional authorities.

THEORETICAL ORIENTATION

The topic will be treated as a case of conflict between different cultural systems. Writing about conflict, Lewis Mumford had this to say: "Patrick Geddes sought to demonstrate the necessity for a constant interplay of ideas, forces, functions, groups and institutions" (L. Mumford 1968, pp. 81-83). Geddes' position is that whenever two institutions performing similar roles exist independently in a sociocultural system, problems of conflict arise. He rejected the coexistence of mutually independent institutions.

Medical systems we know have broad-ranging ties to cosmology and the way of life of a people. A study of medical systems will provide us with an excellent contextual basis for the understanding of the society. The proposed manner of considering the issue can be linked to Thomas Kuhn's theory of consecutive paradigms in the history of scientific revolutions (Thomas Kuhn, 1962). From Kuhn's perspective, we reject the notion that "truths" are held as permanent in the face of new knowledge, that is, when research is conducted, other paradigms may be considered either out of date or inadequate to the understanding of the present social reality.

In Ghana, scientific and traditional medical paradigms exist contemporaneously, but in a mutually independent context with little prospect of one displacing and/or fusing with the other. The common man is the unsuspecting victim (although occasionally the double beneficiary of the contradictions that emerge in the medical orientations).

As an institution, a medical system is a cultural universal, common to all societies, and it deals with some of the basic, universal problems of ordered social life. Three basic orientations are emphasized in institutional theory (J. O. Hertizer, 1964). First, patterns of behavior are regulated by institutions. Second, institutions involve the regulations of behavior of individuals in society, according to some definite norms and values. Third, patterned ways of life involve a definite normative ordering and regulation. Institutions, then, arise to meet the needs of men, and societal, cultural, and material circumstances determine the nature and type of the institution.

History tells us that social reality is a process in a state of becoming. History is phylogenetic. Its interest lies in the sequence of adaptive changes. The idea of progress is that institutions have the potentiality throughout history to rise to higher forms. Historical progress is measured in terms of how the societal institutions are nurtured to meet the needs of the society.

My conception of social reality and, for that matter, social institutions is that they must respond to adaptive changes in the system because they are not static entities. To hold onto traditional institutions rigidly in the face of changing cultural material is dysfunctional. The point, then, is to examine critically and continuously the needs of a given society, its cultural material, and resource potential, in building a viable medical system.

Ghanaian society can be described as traditional, using Max Weber’s model of traditionalism. The norms are enshrined in tradition. The best way to act is the way the ancestors have ordained; that which is legitimate is that which had been prescribed in the past. The social organization of the people revolves around kinship; it is an elder-oriented society in which the head of the lineage occupies an important place. He is the custodian of the land and what is deemed proper.

Ghana, today, is a traditionally-oriented society. According to the recent census figures, 71 percent of its people live in rural and outlying areas. They share traditional institutions, and kinship plays a very important part in their social relationships. It is also important to note that the modern sector is inhabited by only 29 percent of the people. There is, however, an interesting interplay between rural and urban systems. Therefore, in understanding the present Ghanaian society, it may be relevant to look at the Parsonian pattern variables.

Parsons distinguishes five analytical variables (T. Parsons, 1958), of which three are immediately applicable to our analyses of the Ghanaian situation. He mentions the choice between modalities of the social object. In traditional systems, the ascriptive norm is valued; in the modern sector, the achievement norm is preferred. The second alternative is the distinction made between universalism and particularism. This is the choice between types of value orientation standards and the definition of the scope of interest in the social object. The third variable is the difference between specificity and diffuseness. In modern society, job description is functionally specific. The "jack of all trades” phenomenon, mainly
characteristic of traditional models (diffuseness), is de-emphasized. People are fitted into job positions because of their achievement potential.

In applying these pattern variables to the distinction between traditional and modern societies, we can observe that traditional systems usually (though not always) show a lack of reliance on achievement as a norm for acquiring economic goods and services. This is not to say that in such societies achievement as a behavioral practice is wholly excluded, but that it is limited in the ideal-type case. Achievement is the norm for assigning people in modern systems. Another characteristic that needs elaboration here is the prevalence of particularism in the distribution of work. In modern systems, universalism prevails in the practice and distribution of tasks.

The observation that ascriptive norms and a fairly high frequency of particularistic social relations are commonly associated with traditional societies is not new. Sir Henry Maine wrote that: “the movement of societies has hitherto been a movement from status to contract” (Sir Henry Maine, 1906). This is an expression, in different words, of the point made by Parsons that with socioeconomic growth, the ascriptive norm in a highly particularistic society is transferred to the achievement norm.

One of the orientations that is generally accepted as valid by social scientists, at least since Adam Smith, is the idea that socioeconomic development is associated with an increasing degree of social division of labor. This means that modern economic progress leads to gradual prevalence of specificity in functional jobs. If a certain job in production requires specialized intellectual or manual skills, it can only be filled effectively by a person who possesses the specific attributes. Competition to fill the position becomes open to all those who possess the required attributes, rather than to those who occupy certain ascribed status in society.

Summarizing the analysis of the Parsonian attributes, we may say that we would expect modern scientific medicine in Ghana to show predominantly different norms and values from the existing Ghanaian societal norms and values. Roles are functionally specific and universalistic in outlook, the predominant norms are based on the principle of achievement, and the holders of office are expected to maintain collectivity-oriented relations and bureaucracy in orientation. Whereas in traditional medicine, particularism (the "we" feeling), ascriptive norms, and functional diffuseness are the value orientations that are typical, and these variables are part of the cultural experience of the people.

TRADITIONAL MEDICINE: 
THE GHANAIAN EXPERIENCE

We use the term traditional medicine as a generic concept. Various healers—the herbalist, fetish priests, and psychic healers—can be grouped under this term. The essential feature about them is that they use magico-religious concepts, acts, and symbolism in their healing practices (Tiwumasi, 1975). This is not to say that the practitioners of traditional medicine have no notions of physical cures and treatment. They have a stock of remedies with which to treat ills, and some have scientific validity (Oku Ampofo, 1977). For example, wounds are bandaged and broken bones set and bound. Stimulants and sedatives are also found in the traditional medicine chest. Most treatments, however, are regarded as aspects of a total treatment that includes magico-religious ingredients.

The institution of traditional medicine, we must emphasize, emerged from the cultural material of Ghanaian society. As opined by Bronislaw Malinowski, social institutions arise fundamentally to meet social needs. Therefore, human behavior and, hence, the institutions that organize the behavior of its members into meaningful patterned activities arise from the culture of the people. In every traditional community studied by trustworthy and competent observers, medical practices were in evidence. This observation is confirmed by researchers in physical anthropology and archaeology, drawing our attention to prehistoric medicine.

Colonial dogma inflicted damage upon traditional medical institutions. For example, a colonial anthropologist, Professor Levy-Bruhl, tells us that primitive man has no sober moods at all and is hopelessly and completely immersed in mysticism. He is incapable of scientific thought and procedures of science and consistent observation without obstruction. Levy-Bruhl goes on to say that primitive man is hampered by “a decided aversion towards reasoning” (Levy-Bruhl 1923, p. 26). According to Levy-Bruhl’s thinking, primitive man is unable to benefit from his experience and unable to construct or understand even the most elementary laws of nature. “For minds thus oriented there is no fact purely physical” (Levy-Bruhl, 1923, 76). He believes that primitive man has no clear vision of substance and attribute and does not relate to issues in terms of causes and effect. To Levy-Bruhl’s colonial mind, primitive man’s outlook was that of confused superstition, prelogical mode of mystic participation, and exclusions (Levy-Bruhl, 1923, p. 76).

We can reject Levy-Bruhl’s ideas about the prelogical thought system of primitive man. What we cannot easily forget is that he did considerable damage to traditional attempts to build viable medical systems. Levy-Bruhl’s line of thought persisted in the minds of other colonial anthropologists. The whole argument in the colonial experience about the nonexistence of science and technology in primitive societies boils down to the fact that the proponents of colonialism used the evolution theory to look at nonwestern institutions.

Social historians in Ghana had observed that traditional medicine men worked with skills, techniques, and a body of knowledge. The social causation theory featured prominently in their search for cures and treatments. According to this view, disordered social relations can bring ills to the group.

The individual in such a setting is dependent upon other members of his kin group and upon the various supernatural agencies. He knows that deviant behavior may be subjected to sanctions from the spiritual world; ill-health is one of the devices that may be inflicted upon the traditional deviant. In such an integrated setting, a breach in social relations almost threatens the survival of the group. Relatives almost always interact with kinsmen in their day-to-day activities. In such a setting, when ill feelings develop and when they are accompanied, as they often were in the past, by certain kinds of prolonged illness and uncertainty, it seems obvious for the members of the group to trace them to the social causation theory. To enjoy good health and prosperity, therefore, members of the society must remain in good standing with relatives.
In the medical institution, sons and relatives of practitioners are usually recruited into the profession. Other trainees may be recommended by relatives or friends of the practitioners. They must have certain desirable qualities suitable to the norms of the institution. They must be quiet people, who wish to learn from the supernatural world.

The trainees undergo a period of orientation that may last for about one year. Then, after assessment that the trainee will become a good practitioner, he is introduced to the art of curing. He learns the names of trees and the curative potential of certain herbs, and he observes the curative practices of his master. Then, he is introduced to psychological techniques—how to deal with people, how to extract information from his clients and relatives. If he is to become a fetish priest, he must now learn the arts of divination, possession, and dancing (Twumasi 1975).

Let us briefly look at the three main types of traditional healers operating in Ghana today.

(1) The herbalist. He is usually an elderly person of about forty-five, who learned the trade from a relative or friend. In many instances, he combines this trade with another job, such as farming and fishing. He learns the medicinal potentiality of many herbs, which he collects from trees and plants. The juices from these preparations are extracted and stored in the medicinal containers of the herbalist. His success is measured by his ability to satisfy clients. At times, he may perform an experiment by applying some medicinal preparation to a sick animal or bird. He becomes a keen observer of the process of healing. Herbalists believe that certain supernatural powers help them to find a particular herb and that they are only passive mediums in the whole therapeutic relationship. Their practice is located mainly in the rural and outlying areas, but it is not uncommon to find herbalists in urban area.

(2) The spiritual or psychic healer. Many traditionally oriented churches are fast becoming second hospitals. The healers may be Muslims or Christians. They obtain clients from their members. They deal mainly with psychosomatic diseases (such as impotency, infertility, and mental illness), which the regular hospitals neglect. They may also give charms and talismen to protect their clients.

(3) The fetish priest and priestess. They occupy a fundamental position in the institution of traditional medicine because of their numbers and their role in society. Last year (1977), I concluded a three-year field research project in the Ashanti region of Ghana on the social structure of the fetish priesthood. Throughout his training, the novice who enters the profession would say that he selected it because he has experienced possession by some spirit influence. He may have been going about his ordinary daily duties, but more often was attending some religious ceremony, when suddenly, without warning, he heard "a voice." His relatives may call in a qualified healer to interpret the episode. The latter might say that it is the spirit of a particular god in the lineage who wishes the possessed individual to enter into the practice of the fetish priesthood. However, the final decision to permit the person to enter into training is left to his relatives.

The aspiring novice starts his medical socialization within a particular fetish priesthood. Throughout his training, the institution provides him with his professional knowledge, skills, and identity, so that at the end of his training, he is expected to think, act, and feel like a full fledged fetish priest. The whole training ground is a complete supernatural organization in which the essential ingredients are centered around inanimate objects—fetishes, shrines, and ritual symbolisms. These ancillary objects play a great part in the everyday life of the traditional people.

Diagnosis of illness is deeply imbedded in the magico-religious system. The healer—working with the strength of his own personality and the magico-religious rituals of society—performs acts which give the sick inspiration and restore confidence. In other words, the whole community—its religion, myths, history, and spirit—enters into the therapeutic relationship. This method of diagnosis and treatment of disease follows directly from the healer's beliefs about the cause of disease, and this is understood by the general public.

**SCIENTIFIC MEDICINE: THE GHANAIAN EXPERIENCE**

The history of the Ghana scientific medical service dates back to the colonization of the country by Britain in 1844, when British medical officers were posted to the Gold Coast...
to take care of the colonial administrators. The medical officers were given responsibility for the health needs of the senior administrative officers working in the civil service of the colonial government.

As time went on, the various missions in the country also brought in medical officers. The mission hospitals (owned by the churches—mainly the Catholic church and the Presbyterian church) were established in various centers in the rural areas. They established dispensaries that were sporadically spread throughout their area of influence. By 1878, the missions and colonial medical officers had enlisted the help of male orderlies to bathe and feed the sick, to dress wounds, and to administer drugs to the local population under their medical supervision (Kisseih 1968). It is recorded, however, that formal medical work started in Accra after 1878 and spread slowly thereafter to the main trading centers in the country.

The methodology of scientific medicine calls for a certain type of environment and a particular social organization. It operates largely on the germ theory of disease; medical personnel must look for causes of diseases through laboratory investigation. X-ray equipment is needed, and laboratory work necessitates the use of electricity. The proponents of scientific medicine operate as if they are in an industrial socioeconomic system, although they know the social condition of Ghanaian traditional society. Scientific medicine operates within a formal institutional context, with its bureaucratic norms and procedures. However, Ghana is a society in which informal relationships take precedence.

Scientific medical practice did not have a smooth beginning. As with any new idea, there was initial opposition from the indigenous population. There were obvious difficulties. The traditional social system had not yet been prepared to support the new institution. In terms of recruitment, there were not many job seekers who came forward to be trained as medical personnel. The recruits needed basic formal education in order to understand the structure of scientific medicine. Traditional cosmology, which was opposed to the scientific explanation of disease, supported the view of the supernatural or social causation of disease, where causal factors between events are not of the natural world. Experimentation was unnecessary because supernatural laws were immutable and were known. Society was permeated by a vast body of beliefs held by both the medicine men and the general population. The structural conditions were effective in supporting traditional medical practice. Certain changes in the cosmological pattern were necessary in order to establish a new medical practice.

The health problems during this period were mainly environmental (such as malnutrition and poor sanitation) and contributed to the spread of various tropical infections (such as malaria, worm infestation, bilharzia—to name only a few). Scientific medicine has now developed the technology to deal with most of these tropical diseases in the curative sense, but the eradication of most of these tropical ills requires preventive emphasis.

The Ministry of Health in Ghana is responsible for providing integrated services in the country. The constraints under which health care is provided have two major consequences for the organizational design of scientific health services. In the first place, health programs must reach the distant rural communities if they are to solve the problem of overcoming distance and to effect change in human behavior and the physical environment. Secondly, the constraints of numbers and distances mean that professional personnel at all levels cannot be resident at the local level. Rather, paramedical or auxiliary personnel must provide primary care for both individuals and their communities. If the principle of delegating responsibility to other paramedical personnel, including traditional healers, is not accepted, scientific medical practice will not be able to reach more than a small proportion of the people in rural Ghana. On the other hand, accepting the principle of delegating responsibility to paramedical personnel and to traditional healers (as an open legitimate practice) allows the flexibility that is essential for designing the system of scientific medical practice.

COMPETING MEDICAL SYSTEMS

As of 1975, there were 939 doctors on the Ghanaian medical register. At the same time, the Ghanaian population, according to estimates from the recent census, was nine million. Roughly, this represents one doctor per 10,700 people, supported by a cadre of nurses, pharmacists, and other paramedical personnel. These data indicate the need for more doctors. The urgency of this need is further indicated by the fact that the rate of population increase per annum is now 2.5 percent, which, in raw numbers, is an increase of about 212,500 every year. Another aspect of the problem is that the bed state is grossly inadequate to the growing needs of the population.

When one looks at the developed countries for comparative purposes, one sees that the social and economic development of Ghana is different in terms of its standard of living, economic and social resources, and cultural institutions. The difference is very noticeable if one applies western standards to the current state of scientific medicine in Ghana. The Ghanaian medical structure reinforces western influence by rewarding the practitioners of scientific medicine. Hence, traditional medical practice has been pushed into the background. Scientific medicine has a built-in bias. It is urban oriented and operates most effectively in a modern urban setting. This built-in bias is a handicap in meeting the needs of rural people. It is true that the urban population has been growing at a rapid pace, and, therefore, it is not illogical to find that hospitals and other major medical services tend to concentrate in the urban centers. It is also not unreasonable to find that scientific medical personnel are attracted to the urban areas because of the availability of supporting services and facilities. An indication of this urban attraction of medical personnel is that although only 29 percent of the Ghanaian population live in the urban centers, about 76 percent of the scientific medical personnel work in the cities and large towns. Although medical services in Ghana are relatively well distributed in relation to the urban population, there is still a need for more scientific medical personnel in rural Ghana.

Preventive medicine is still not considered the most prestigious medical specialty because it does not focus on the dramatic curative aspects of healing. Therefore, the physical environment of the rural areas has been neglected. Health affects socioeconomic factors and is itself affected by the socioeconomic environment. A person’s ability to take full advantage of the health care program is related to his socioeconomic standing.
The point that we need to stress is that limited resources strongly influence health services. Before these limitations become appropriate determinants of health planning and design, it must be decided who should receive health care. Everyone should receive health care. But this point of view is seldom implemented. The areas of greatest need in Ghana are the rural areas where the bulk of the people reside. These areas are the most difficult to reach with supplies, transport, and personnel. The pressures favor the urban areas. Scientific health personnel would like to remain in the cities. These demands have professional strength behind them.

There is yet another factor that is pertinent to our analysis. It is difficult to estimate how much understanding exists between the scientific medical personnel and the indigenous rural population. Medical sociologists have discovered that different cultural orientations tend to color the essence of therapeutic relationships existing between medical personnel and patients. Many medical social scientists argue that medical practitioners find it most helpful when the patient reveals enough of his beliefs and attitudes to enable the practitioner to formulate properly a professional or rational explanation of disease. On the other hand, medical practitioners find it frustrating when a patient cannot understand or accept medical explanations or instructions because they are inconsistent with the patient’s beliefs and attitudes.

In modern systems, disease and illness are most often seen as natural phenomena and, hence, subject to investigation and study by scientific methods. Consequently, beliefs about causes of various diseases require scientific proof for substantiation. Thus, answers to the questions of etiology are sought in the laboratory and in the clinic under controlled conditions. In the traditional Ghanaian setting, many, if not most, diseases are seen as manifestations of supernatural powers; thus, causal explanations take on a magico-religious tenor. The doctor needs to understand this predicament of the traditional people.

There is another problem. In the rural areas, it is difficult to get aid for the ill from a scientific medical specialist at a relatively low cost because specialist services are located in towns and cities. So, as a result of specialization of functions and staff specialization, scientific medicine, in a developing economy, has become a rare commodity, difficult for the poor person to purchase, particularly in terms of time and transportation.

In the fields of psychiatry, the facilities are grossly inadequate. Consequently, the traditional healing agencies are performing important social functions. A dialogue is necessary between the two medical orientations to find out what really could be the contribution of each therapeutic orientation. We suggest interdisciplinary research into the area of traditional medicine to find out some of the therapeutic claims made by its practitioners. In cases where it is found necessary to send a patient to a scientific medical institution, is it also necessary to subject him to the sort of regime that may apply in the industrialized world generally? Is there not a case for employing the principles related to the Ghanaian situation in treating ills?

This author calls for a change from a health care delivery system dominated by scientific principles to a network of shared responsibilities, in which traditional medicine also becomes a functionary in the provision of a legally approved health care system.

Let us remind ourselves that practitioners of scientific medicine—though long blinded to such things by the success of the germ theory of disease—have come to realize more and more that disturbances in an individual’s social relations may, in fact, contribute to a whole series of illnesses, ranging from those commonly assured to be of psychosomatic origin to primary organic diseases. In making this rediscovery, however, the scientific medical men, especially in the field of psychiatry, have tended to relate it to the so-called “pressures of modern living,” imagining traditional societies to be psychological paradises in which psychosomatic diseases were thought to be scarce. This viewpoint has never been adequately tested.

In the Ghanaian situation, scientific medical practice has a firm power base. It is an open, legitimate activity. The practitioners of scientific medicine have a strong base in the negotiation process. A hard core of the inner fraternity of doctors would wish to have nothing to do with the traditional healers. Part of the reason for this continued isolation is economic. If traditional medicine is accepted as an open practice, the prestige and economic position of the medical doctors will be threatened. Therefore, they have built a wall around the practice and, in that relationship, have acquired a firm power base in the bargaining process. A governmental policy may help to break through this wall.

Historical studies in Europe and America confirm the extent to which medicine has been shaped by the dominant economic institutions and values of time. The argument is that the rise of scientific medicine, technologically equipped, in the developing countries is costly. In the developed nations, rising standards of living, technological development, and mass literacy have led to patterns of behavior that support the system. It is also clear that in the field of psychosomatic ills, there is benign neglect. At this point, there is ambivalence regarding modern medicine’s complexity, impersonality, and cost function. Modern medicine is technologically based and tends to be elitist and hierarchically oriented. Great power is placed in the hands of the specialist. And its curative emphasis means the building of medical cathedrals, or what the Director General of WHO terms “disease palaces.”

Traditional medicine, by contrast (although its forms are many and it is often hard to generalize), tends to be built upon accumulated understanding of the people and reaches the grassroots level in terms of its coverage and methodology. It receives social support and is relatively inexpensive.

The people would benefit from the merger of the two systems. In our setting, a good beginning is seen in the establishment of the Institute of Scientific Research into Plant Medicine. This institute is encouraging research and teaching on medicinal plants and the curative practices of traditional healers. This research is also intended to aid in the compilation of a materia medica on African herbal plants. Continuous efforts are being made to encourage the Ghana Medical School to establish a unit or department for the study of traditional healing. Knowledge obtained from the Danfa Project (University of Ghana and University of California, Los Angeles Rural Health Project) indicates that traditional healers are willing to be trained in hygienic practices to improve their delivery system. The Kintampo Project (WHO-Ghana project) is looking at the specific ways and means of involving local people in the planning and delivery of health services.

The point we need to stress in proposing an integrating model is that each medical system has its own merits and
limitations. Incorporation of the merits of each system can help to improve the health delivery system.

SUGGESTIONS AND CONCLUSIONS

(1) People should not be instructed to discard previously adopted health measures unless it can be shown that under existing resource constraints, the alternative technology will yield significantly greater benefits to them; (2) Community participation and involvement should be considered an integral part of any viable medical system; (3) The promotion of an institutional environment that will foster a coordinated approach between traditional and scientific healers should be encouraged; (4) The health plan urgently needs a team approach with greater cooperation, public health services, the agricultural sector, nutritional specialists, and town/village planning and local government agencies.

In conclusion, may I say that our only claim to integrity is to be patient and humble and to listen to what the traditional healers are saying, because it is a mistake to reject out of hand an indigenous approach to medical practice.

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