Physiotherapy in Relation to the Treatment of Non-European Patients

Paper read by MISS LOIS DYER, M.C.S.P.

THE problem of giving Medical Services to the non-Europeans in South Africa, in view of the fact that they constitute approximately 80 per cent. of the population and are a constant source of difficulty and infection, is of paramount importance and could be discussed endlessly. All the difficulties and fundamental differences find their counterpart, though perhaps to a lesser degree, in the application of Physiotherapy to this group of people.

The non-Europeans in South Africa comprise, the Bantu or native, the Coloureds, who are those of any mixed blood, the Indians, Malay and Chinese—in fact, anyone whose skin is not white. The Bantu form the largest group and it is about them that I am going to talk.

One's approach to the Bantu race is of necessity different from that used for the Europeans. It is a largely primitive race which does not understand European methods of medical treatment, and even among the urbanised group, with which I have had most experience, at least 60 per cent. of the non-Europeans have treatment by their own people before attending Hospital.

They are used to the methods of their witch-doctors who spend four fifths of the time after a spot diagnosis, discussing what they consider is the pathology of the condition, and then prescribe their various herbs as remedies for this, that and the other symptom. The belief is still firmly held that illness is caused by evil spirits of their dead relatives and acquaintances, and this tends towards a certain fatalistic acceptance of illness.

I must quote an example to give you some idea of the superstition and mistrust against which medicine has to battle. An African Staff Nurse who was trained at one of the non-European Hospitals in Johannesburg, and who was a good nurse, decided to get married a couple of years after the completion of her training. This she did, and shortly afterwards she had a baby. The baby became ill, and this Staff Nurse first took her child to the witch-doctor, and only when its condition deteriorated did she bring it to the hospital. If that is the attitude of what was a reasonably intelligent native woman with a medical training, it is easy to imagine what the actions of the lay African public are. Time and again one has first to undo the damage done physically and psychologically by the witch-doctor, before progressing to the routine scientific treatment of the patient.

The language difficulty is of course a major one, and even with the use of intelligent interpreters, it is not easy to establish the relationship with the patient which one does when speaking the same tongue.

The African has no idea of prophylactic medicine and indeed usually does not come to the hospital unless his condition is very painful, or is sufficiently incapacitating to prevent his working.

Apart from the psychological factor which has to be combatted no matter what form of medicine the patient is to receive, there are very real difficulties encountered physically and economically, and I would like to try and give you a picture of some of them as met with in the Physiotherapy Department.

Firstly, the native does not understand the need for physiotherapy, and would usually far rather be given a bottle of medicine to help his broken leg and would be better pleased with it, no matter how vile the taste. We all know how difficult it is to explain to some Europeans why they are being made to use their muscles, and why they must be given breathing exercises when they complain bitterly that it is an operation on their knee that they are going to have! With the Africans, it is worth trying to explain simply what one is doing, but even though they smile and co-operate quite well while one is with them, it is obvious that they think this is another of the white man's idiocies to be accepted, not questioned and certainly not understood.

The high incidences of tuberculosis, venereal disease and malnutrition manifested in many forms, tends to lower the resistance of the Africans to general infection, although it is amazing considering their living conditions and complete lack of hygiene and knowledge of food values, that it is not even lower. Their constant exposure to disease and conditions of sepseis must stimulate the formation of vast numbers of antibodies and create a certain immunity.

Again, it is astonishing to see a patient who has perhaps been immobilised for six months with a fractured femur, the callus formation often being slow because of the low calcium production, come out of traction and within two or three weeks have full knee flexion. This is probably due to the fact that the primitive native still tends to use his joints naturally and has not had to undergo the abuses of joint function which our modern civilisation demands.

Most cases sent for treatment are due to trauma, since the African is exposed to many industrial hazards apart from the common causes of accidents among Europeans. There are many cases of assault, chiefly stab wounds and injuries caused by hitting each other with sticks and pieces of iron. This seems to be a favourite pastime particularly at the week-ends when many of them do not work, and drunkenness is common. Then one has the usual medical conditions to treat, plus an enormous number of sepsics. Burns are very common, primarily due to the primitive methods of cooking and heating which they employ.

I have rarely seen a case of fibrositis, and very few rheumatoids. The reason for this is probably due to the much higher incidence of rheumatoids. The Bantu, however, appears to be more prone to osteoarthritis than the European, although it is interesting to note with this particular disease that the joints most commonly affected are quite different in the two races. Definite anatomical differences in the knee joints of the Bantu and European seem to account for the fact that medial meniscus injuries are extremely rare in the Bantu. It is only in the last few years, since so many have adopted the European dietary habits, together with the strain of city life, that one has seen cases of appendicitis, gastric ulcers and a certain evidence of psychological and functional illnesses.

Lead swinging was practically unknown until the last War, when the habit seemed to have been picked up in the Army. However, one sees very little of it, chiefly because when an African is ill, he has no means of earning, since very few are entitled to unemployment benefits. He either has to get better quickly and return to full earning capacity, or he and his wife and children starve. This makes life much easier for the physiotherapist since the patients have a definite will to get better and co-operate well.

They are usually prepared to tolerate more pain than the European, and it seems that the pain threshold is much higher. They are renowned for their stoicism and unending patience.

Treatment in classes is very popular, as is work involving apparatus, and competition is keen, rather as it is with...
October, 1953.

PHYSIOTHERAPY

Page Three

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