William Osler once remarked:1 ‘the only thing that distinguishes man from lower animals is his desire to take drugs’. The use of plants as healing agents is depicted in paintings in the Lascaux caves in France, radiodated to 25 000–13 000 BCE.2 From the earliest times, the healing arts were not confined to the physical realm but were part of spiritual communication and restoration. Their practitioners frequently came from priestly castes, a tradition that persisted well into medieval Europe and continues today in the form of shamans in different parts of the world, including our own.

The ancient Greeks were perhaps the first systematically to detach healing from its spiritual origins and to apply rational intelligence and methodical speculation to illness.3 Other traditions also developed systems of medical practice, which were often linked to specific cultural or religious beliefs. While observation was a significant part of the canon, the medical arts first approached the level of ‘true science’ with the Enlightenment and its discoveries, initially in the physical and chemical sciences and later in biology. The long evolution of medicine was accompanied by the creation of various professional bodies or guilds alongside unregulated folk practitioners and charlatans. Nevertheless, it was the evidence-based medicine movement,4 controversially thought5 to have been initiated by Austin Bradford Hill in 1948, that brought statistics into issues of therapeutic choice through the application of randomized, double-blind, placebo-controlled clinical trials and sophisticated methods of analysis. The movement came to fruition in the 1970s owing to the initiatives of Archie Cochrane.

Modern scientific medicine is now a thoroughly secularized profession, conducted by registered practitioners according to clear ethical principles and supported by a vast body of knowledge, skills and concepts. It has achieved astounding successes and promises more of the same. Yet, despite this record, large numbers of people use various folk modalities to prevent or treat illness. In Western Europe and Australia, 20–70% of their populations regularly use complementary, or alternative, medicines.6 In the United States, the figures range from one-third to two-thirds of the population, depending on precisely what question is being asked.7–9 In Africa the figures are often higher and the proportion of traditional healers, at 1 per 500 of the general population, may be 100–200-fold greater than that of orthodox scientific practitioners.10 The persistence of traditional healers or complementary—alternative medical practitioners has its roots in psychology, culture and simple economics. Can and should these two healing cultures be reconciled?

The answer depends on the personal orientation of the respondent, but also upon circumstances. In addition, part of the problem lies in applying a set of poorly defined and overlapping terms, like ‘alternative’, ‘traditional’, ‘complementary’ and ‘folk’ medicine, to a many very different therapeutic modalities carried out in quite different settings.

While not entirely satisfactory, ‘folk’ is used here as an umbrella term to cover all forms of medicine other than the orthodox. Can and should we differentiate between the 100 and more forms of unconventional therapeutic and prophylactic systems — some practised in remote African villages, others in Western urban health shops or in alternative health spas catering for the wealthy, and still others within the confines of scientific medical centres?

A blanket response to such a variety of forms and motivations does not seem possible. Many argue that it is not worth trying to achieve a rapprochement between scientific medicine and this Pandora’s box of pre-scientific competitors and outright quacks.

There is some justification for a rejectionist attitude. The harm inflicted by poorly regulated, ill-defined, unhygienic and unsubstantiated therapies has been well documented.11–12 Even when these interventions do not actively cause morbidity or mortality, they can impair the therapeutic efficacy of concurrently administered conventional medicines or seduce patients away from potentially life-saving measures available from orthodox, scientific medicine. Furthermore, the two forms of medical practice are separated by a vast epistemological divide.13–14 Accepting such forms of medical practice also puts us in danger of condoning anti-scientific thinking and superstition. The guiding principle of ‘primum non nocere’, or ‘first do no harm’, surely compels rejection of all forms of medicine falling outside the purview of the orthodox, scientific establishment.

Such a position, whatever its merits, fails to deal with certain important realities:

- Since folk medicine is unlikely to disappear, it is sensible to exert a constructive influence, which necessitates some form of dialogue and cooperation.

- Folk medicine can yield novel sources of genuine therapeutic efficacy, either from the careful study of natural products or from such modalities as chiropractic, acupuncture or mind–body therapies. But without the application of the scientific method, the latent value in such forms of therapy is unlikely to be extracted.12

- In theory, folk practitioners can be incorporated into systems of primary health care, especially within the African context, and simultaneously educated in the attitudes and skills of modern medicine.14,15

- Modern scientific medicine is not free of error and failings: too sanctimonious a stance is unbecoming and alienating.

- Finally, dialogue with alternative views of reality make it possible to identify and strengthen the values of scientific medical practice and simultaneously eliminate those that alienate patients and reduce therapeutic efficacy.

Many studies have considered the most appropriate ways in which scientific and folk medicine can interact.14,15 All agree that this must sacrifice neither the patient’s welfare nor the scientific principles that inform modern medical practice. Optimally, the interaction will cause folk medicine increasingly to take up the concepts and methods or modern science even as it enriches orthodox medicine through novel perspectives and humanistic orientations.

Subversion of such good intentions is not impossible, however, as is clear from certain confusing and unscientific messages coming from South Africa’s Department of Health and other government organs. A perusal of the Traditional Health Practitioners Act of 2004,16 which is intended to establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners,
students and specified categories in the traditional health practitioners profession; and to provide formatters connected therewith. yields considerable grounds for misgiving.

To mention just two. First, the regulations governing membership of the Traditional Health Practitioners Council of South Africa require 10 traditional health practitioners, one to serve as chair, in addition to a representative from each of the traditional healer categories. In contrast to this overwhelming representation from the traditional sector, the Act provides for the appointment of only one orthodox medical practitioner. Second, while the document is long on rules and procedures it is extremely short on substantive statements that set out standards of skill, knowledge and training, or that address the safety and efficacy specifications required of materials and methods used in the practice of traditional medicine. Given the composition of the council and the absence of mandated academic, scientific expertise, it will be a miracle if the regulations that ultimately emerge will meet the scientific and ethical concerns of medical science and modern standards of patient care.

These concerns are echoed in a discussion document prepared for the Treatment Action Campaign and AIDS Law Project, which points out that South Africa lags behind other African countries in creating a proper regulatory framework for incorporating traditional medicine into its health services. I am not aware of any substantive report or action from the interim council that addresses the complex integration of such vastly different systems of health care.

The need for such action is highlighted by the paper from Sharlene Govender and her colleagues published in this issue. In a study on the hygienic standards of traditional medicines sold in the Nelson Mandela Metropole, the researchers found that a considerable proportion failed to meet the specifications set by regulatory agencies abroad and by South African microbiological regulations for food products. Furthermore, the kinds of contamination found placed unsuspecting users of traditional health products at significant risk of serious illness. Although the paper does not comment explicitly on the matter, it also highlights the variable standards among different regulatory agencies.

Integrating traditional medicine into South Africa’s health-care system is a complex undertaking. Whereas a case can be made for such integration, it is clear that without the appropriate regulation and oversight of this process, considerable harm can ensue. The government’s response fails to reassure that the magnitude and significance of the challenge is appreciated. In the absence of strong and informed leadership, the process is in danger of being given over to special-interest groups and political manipulation, with serious damage to our health-care system and our reputation. The scientific establishment has a duty to make known its concerns.

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