Traditional beliefs and practices affecting medical care in Malaysian Chinese Communities

F.L.Dunn
M.D., Ph.D., D.T.M. & H.
University of California ICMR,
Institute for Medical Research
Kuala Lumpur.

Introduction

In this paper, focussed on medical care in the Chinese communities of Peninsular Malaysia, I offer a preliminary view of what is known of traditional Malaysian Chinese medical beliefs, practices, and personal health-related behaviour (Dunn, in press). I should also like to offer some thoughts on the implications of these facts for physicians and surgeons whose professional training and experience has been very largely within a medical tradition that we usually designate as scientific, modern, or Western, i.e. the system that I prefer to call cosmopolitan medicine.

Peninsular Malaysia is a land of considerable ecological and cultural diversity. In its ethnic heterogeneity, and in the history of immigration that has led to this modern diversity, there are many resemblances to the American experience and to modern American heterogeneity although, of course, ethnic composition is very different in the two nations. Malaysian ethnic diversity has led to some of the same problems, and challenges, that face the United States; and this applies with special force to the delivery of health care. Although there are obvious medical ecological differences between tropical Malaysia and the largely temperate United States, the distribution of diseases and disorders in Malaysia's population is coming to resemble that of America more closely every year, and the problems of health care delivery, especially to rural and to economically deprived segments of the populations, are broadly similar. Thus I have found that my work in Malaysia is in many ways relevant to American conditions as well, and vice versa.

An important element in assessing needs and priorities, and in providing cosmopolitan medical care, through both public and private channels, is a clear appreciation of the significance of what Dr. Paul Chen (1974) calls 'sociocultural factors' and I refer to as 'traditional beliefs and practices' in the titles of our papers for this issue of the Journal. Reflecting its ethnic diversity and immigration history Malaysia has acquired a wide range of traditional beliefs and approaches to medical care (traditional medical systems). But in this country, as in the United States and in most other countries, research on traditional medicine has thus far been very limited in scope. It is generally true, in my country as elsewhere, that medical students and young physicians complete their formal training with little awareness or understanding of the alternative modes of medical practice and the range of beliefs about health and disease that exist in their own communities. A consequence of this is that inevitable sociocultural barriers between physicians and patients often remain unrecognized as such, or if recognized remain impenetrable or insurmountable. These barriers can cripple effective delivery of medical care. A second consequence is that physicians and allied health workers in the cosmopolitan system, on the one hand, and practitioners of traditional medicine, on the other, have little common ground of understanding. This is almost a world-wide problem. On both sides there tend to be elements of suspicion and unnecessary competition, when there could be recognition that these forms of care are complementary rather than competitive; and that it is through cooperative action amongst all who are concerned with

medical care that the best progress can be made toward the enhancement of human health.

Personal Health Behaviour

Let us now consider some of the forms of traditional medicine and health behavour that are prominent in Malaysian Chinese communities today. I shall begin with what can best be classified as forms of personal health behaviour – and each of these I shall mention only briefly. Each item of behaviour is in one sense an 'indicator' in that the extent of its practice reflects adherance to tradition and perpetuation of a Chinese cultural heritage within the broader frame of Malaysian national cultural identity.

An obvious example of what I am talking about is T'ai Chi Chuan, those calisthenics that are perhaps the most conspicuous expression of one's personal commitment as a Chinese to health maintenance through preventive behaviour. Although these exercises are often associated with 'self-defense' it is only the advanced student, in command of all the classic movements, who can make full use of the art for such purposes. For most people the basic movements simply provide good exercise with emphasis on relaxation and control, in the interest of continued good health. T'ai Chi is widely practiced in Malaysia, and devotion to the art is growing. A school recently established in Kuala Lumpur, for example, now has some 300 students of all ages and both sexes. Instruction in Chinese medicine is considered a normal part of the training to become a T'ai Chi instructor, and many instructors are said to be skilled in the treatment of sprains and strains. One of the most famous instructors in Kuala Lumpur is also locally renowned as a bonesetter. It is indeed difficult to draw a line between T'ai Chi Chuan and preventive (or even curative) medicine.

Cuisine is another important and obvious expression of the preventive element in Chinese philosophy for the balanced and considerate use of foods is seen as essential to maintenance of good health. The arts of cooking and dining are intimately tied to concepts of biological and social health; and personal food behaviour is subject to important modifications – still widely recognized among Malaysian Chinese – at certain points in the life cycle. In traditional Chinese medical practice too, the practitioner gives his patient's food habits special attention, and often recommends temporary or permanent modifications in diet. Without doubt many Malaysian Chinese see food behaviour and health as closely linked: this attitude is manifest in ideas about 'balance' in cuisine; in concepts of 'hot' or 'heating' versus 'cold' or 'cooling' foods; in wide recognition of the need to observe certain food taboos during confinement; and in the general use of medicinal teas and herbal remedies that border on being 'foods.'

A book could be written solely on the subject of Malaysian Chinese medicinal teas. In old Kuala Lumpur, for example in the vicinity of Petaling Street, one can find more than 20 medicinal tea stalls, patronized with regularity by the residents of the neighbourhood and by visitors to the evening street markets of the area. The stalls are located in traditional street-side spots, and ownership is usually handed on from parent to child. At one such stall four varieties of tea are dispensed: sugarcane and lallang root extract as a 'cooling' tonic; chrysanthemum tea, also 'cooling;' wong loh khat, a popular dark and bitter tea taken as a preventive tonic; and Korean ginseng flower tea, used especially for sore throat. Hundreds of passersby purchase these and similar teas every day, not only at this site but in many such localities up and down the length of Peninsular Malaysia. The popularity of these teas – together with many other kinds of self-medication, especially in the form of ointments and tonics – is still another measure of personal adherance to Chinese medical tradition.

Confinement behaviour in the Chinese communities also illustrates the continuity of traditional belief and practice in Malaysia. Food taboos, seclusion practices, and post-confinement ritual are interwoven with ideas about protection of the mother, the infant, and the household from misfortune, and especially from disease. Many of the customs may indeed be protective, e.g. against such hazards as staphylococcal infection of the newborn and maternal mastitis. According to my informants, traditional confinement practices continue to be widely observed in Malaysia and are unlikely to fade away. The guardians of these traditions are the mothers and grandmothers; their daughters, however non-traditional their views, will generally accede to their elders' wishes at the time of confinement, and so the traditions are maintained. Delivery itself is generally accomplished in a hospital or maternity home, even in the most traditional Chinese families in rural areas or new villages. Thus delivery and confinement practices constitute a blend of modernity and tradition, a good example of the interface between cosmopolitan and traditional medicine where cooperation and understanding are truly essential.

Another major category of personal health behaviour is that relating to the use of charms and talismans, and to consultation with fortune tellers or spirit mediums. This is the only part of Malaysian and Singaporean Chinese medical behaviour that has received much scholarly attention in years past. It is impossible to measure the importance of such beliefs and practices either in terms of physical or psychosocial health, but it is clear nonetheless that many people believe in and resort to these practices at times of stress in their lives. In a broad view of

health and medical care in Malaysia we must, I think, accept the notion that even the temple spirit medium plays an important role (for certain people), and that on occasion the sidewalk fortune teller may, in fact, assume a psychiatric role as dispassionate listener and advisor. Again I must note that in all societies, in all parts of the world – and in all Malaysian ethnic communities – there are counterparts to these Chinese practices, beliefs, and health-supporting personnel.

Traditional Medical Practice

Let us now give some attention to Chinese medicine itself, to a strong tradition in Malaysia that continues to grow stronger each year. Many Malaysians, Chinese and others, support and patronize Chinese medical practitioners, at least for selected medical complaints. In the Peninsula today it is estimated that there are about 1,000 practitioners of Chinese medicine. Of these about 500 are members of Chinese medical practitioners associations who received formal training in Institutes. Most of the rest entered practice on their own, often after completing apprenticeships. Only a few continue in practice of those who came to Malaya before the second world war, after completing their training in China. Most with Institute training have attended courses in Kuala Lumpur, Penang, Ipoh, or Singapore. Since its opening in 1955 the Chinese Medical Training Institute in Kuala Lumpur has graduated about 200 practitioners, and a new class of some 50 students (selected from about 80 applicants) began coursework in January of this year. (It is estimated that there are about 130 students in Malaysia's three Institutes at this time.) The Institute course in Kuala Lumpur extends over a four year period, with three terms per year. Instruction is carried on in the evening since most students have to support themselves in jobs during the day. Instruction stresses Chinese medical theory, diagnosis, and herbal, acupuncture and moxibustion therapy. Instruction is also provided in Western medical theory and therapeutic principles; and diseases are considered from both the traditional Chinese and Western perspectives. Thus the graduates have the potential training for some forms of cooperative work with cosmopolitan-trained physicians. At the end of each year the Kuala Lumpur students take a series of examinations, and upon graduation they receive certificates that are recognized by the various Malaysian associations of Chinese medical practitioners although not by the Government.

Patterns of practice are varied. Many practitioners work in association with medical halls (herbal medicine shops); others maintain Western-style offices, in group or solo practice. Still others support themselves in non-medical fields and practice part-time as volunteers, e.g. at the Free Clinic associated with the training Institute in Kuala Lumpur. Several, again in Kuala Lumpur, practice as employees of the Tung Shin Hospital. Typically the practitioner associated with a medical hall holds office hours thoughout the day when the shop is open. He provides herbal and other prescriptions which the patient can fill immediately in the shop, and he may employ acupuncture-moxibustion. He may also assist the patient by advising on diet and exercise, and by provision of informal psychological support. Often he will recommend that a patient see a physician or go to a government hospital. Most Chinese traditional practitioners with whom I have talked in Kuala Lumpur are agreed that about 20 to 25% of their patients are non-Chinese. This is also the approximate percentage of non-Chinese customers reported by some of the proprietors of herbal medicine shops in the city. It has been difficult to collect data on the medical halls; a comprehensive survey is clearly needed. Certainly they can be found in every Malaysian town and in great numbers in the cities. According to best estimates there may be 200 such shops in Kuala Lumpur alone, and more than 1,000 in Peninsular Malaysia. The traditional shop carries a formidable inventory of crude herbs and other preparations. An inventory in medical halls in Singapore once recorded 456 drugs – 415 of plant origin, 29 from animal sources, and 12 minerals (Hooper, 1929). Many shops today carry similar arrays of drugs, supplemented by scores of patent medicines.

To sum up this brief description: I am convinced of the continuing strength of Malaysian Chinese traditional medicine and am impressed as well by the persistence of many traditional forms of personal health behaviour. The strength of Chinese medicine, as such, is attested to by the vigour of the medical practitioners' associations and training institutes, and by the abundance and heavy patronage of the herbal medicine shops.

Implications

Let us now consider some implications of these observations for cosmopolitan or Western medicine in Malaysia. The first point to stress is, of course, that in Malaysian society it is the health care consumer who makes the choice of kind of medical care, and his (or her) choice depends upon his perception of a health problem. (What kind of problem is it, and how severe as measured by anxiety, by pain, by disability, by inability to go to work?) His choice also depends upon his view of the options for appropriate medical care. The most important point to emphasize in discussing the Malaysian Chinese is just this: that the perceived range of options for care appears to be very broad. Thus, depending upon the

health problem, the "patient" may resort to self-medication, perhaps by visiting a tea stall; may visit a private physician; may consult with a temple spirit medium; may attend the nearest government hospital or clinic; may consult a practitioner of Chinese medicine – a sinseh – at a medical hall; and so forth.

Among my informants, however, there is substantial agreement that there has been a shift in attitude in favour of cosmopolitan medicine in the Chinese community since about 1950. Prior to that time it is said that many Malaysian Chinese turned to cosmopolitan medicine – and especially to hospitalization – only as a last resort. In recent years more and more people seem to have reversed their choice, especially for acute physical diseases and disorders. Thus today it appears that cosmopolitan, Western-trained physicians see much of the infectious disease and the other acute and severe complaints of Malaysian Chinese. However the stubborn problems of old age, the chronic disorders such as arthritis, the incurable diseases in general continue to receive the supportive care of Chinese practitioners in many instances.

This brings me to a series of questions for future research in Malaysia. These questions apply to all Malaysians. What are the actual and perceived spectra of options for medical care in each of Malaysia's health sectors? What therapeutic alternatives do people actually consider when confronted with threats to health of various kinds? What actions do they finally take, and in what sequence if several types of practitioners, and physicians, are consulted? Little information is available on the behaviour of Malaysia's health care "consumers," and much is needed. Also demanding of research are several questions about practitioners of traditional medicine and their behaviour. Who enters such practice, and how, and with what motives and values? What kinds of relationships exist between practitioners of different traditions and schools, as well as with the physicians of cosmopolitan medicine? How do these relationships, or their absence, influence patient access to care? To generalize these questions: how does the traditional practitioner fit within the broader system of Malaysian national health and medical care?

It does seem obvious to me that traditional medicine – Chinese, Malay, Ayurvedic, and other – is not likely to disappear or sharply diminish in strength in this country in the decades ahead. What does the future hold then? Will some form of blending or merging of some of Malaysia's diverse forms of medical care emerge? Will traditional practitioners come to be seen as allied ("paramedical") health workers within the broader national programme of health care? In my view these are essential research topics for the future as a part of the development of Malaysian research in comparative medical systems and community health.

In conclusion two points deserve to be stressed: first that we, as physicians, ought to keep in mind that our medical school-ingrained definitions of medicine may be very different from – and perhaps narrower than – the definitions of medicine in the minds of our patients; and second, following from this, that we need to increase our awareness of the breadth of options for medical care that exist in people's minds. Among these options cosmopolitan (Western) care may be only one, and one to be called upon for relief of only a limited range of disorders and diseases.

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