The ancestors have caused this: isiZulu-speaking nurses' understandings of illness and patient care

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Abstract
This paper takes an ethnographic and participant observational approach to exploring how a particular group of isiZulu speaking nurses' understanding(s) and assembled constructions of illnesses and health shape their approach to patient care within the hospital setting. The paper probes how African isiZulu-speaking nurses observe and "group" patient's illness according to personal understandings of illness and looks at how these understandings contribute to their clinical decision-making and practice. Findings reveal that the nurses appear to operate in a dual system that is oftentimes fraught and conflicted between what their biomedical training dictates, and what their culturally and cosmologically embedded upbringing and Pan African worldview of ancestors and bewitchment compels.

KEYWORDS: biomedicine, culture, clinical decision making, ancestors

Introduction
Response(s) to patients' illnesses involve a variety of decisions by nurses and other health care practitioners, which can be termed "clinical judgement".[1] This paper takes an ethnographic and participant observational approach to exploring how a particular group of nurses' understanding(s) of illnesses and health shape their approach to patient care (clinical decision) within the hospital. The paper probes how African isiZulu-speaking nurses can observe and "group" patient's illness according to personal understandings of illness and looks at how these understandings contribute to their clinical decision-making.

[1] The term clinical judgment is used interchangeably with clinical decision. Clinical judgment is defined by Tanner (2006: 204) as 'an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response.'

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Nursing, has been described as a profession that makes constant use of clinical judgement (Royal College of Nursing 2003), and involves the use of one's knowledge, experience and conscience in taking actions in any clinical setting. This means that the goals of clinical decisions taken (by a nurse in this context) are not only important in themselves but in the manner that they contribute to the wellbeing of patients. The result is meant to promote a "better state" of patients' health.

The decisions taken by nurses are in turn shaped collectively by their educational training, nursing experience, life experiences and, most importantly *their personal beliefs*. IsiZulu-speaking nurses have a wide understanding of illness, in part shaped by their cultural upbringing, thereby giving them particular cultural understandings of health and illness. Thus, understanding the context in which the African isiZulu-speaking nurses carry out their decisions and what shapes such decisions, is critical. Arriving at any stage of clinical judgement sometimes requires a rigorous, and sometimes a quick process of reasoning; a critical response to a medical "situation" that presents. Tanner (2006: 204) asserts that this process includes the 'deliberate' process of creating alternatives, weighing them in comparison to any available evidence, and in the end making a choice (immediate or more calculated as the circumstances demands) that will be considered most appropriate. This paper in turn probes how isiZulu-speaking nurses' cultural conditioning may shape particular responses to patients[2] and particular patient care approaches.

Methodology

The study was conducted in a non-profit based private hospital in Durban, in the Province of KwaZulu-Natal, South Africa. The hospital was chosen because most patients who patronise the hospital were African isiZulu-speaking. Most of the nurses were also African isiZulu-speaking.

Initially, three participants were recruited through purposive sampling and afterwards allowing the three participants to identify another 17 participants through snowball sampling. In purposive sampling, a researcher intentionally recruits certain people whom he or she considers to be of relevance to his or her study (Sarantakos 2005). Snowballing has been defined by Frank and Snijders (1994: 53) as 'a way of having initially sampled individuals lead you to other members of the hidden population, which in turn could lead to further members.' All participants in the study were isiZulu-speaking professionally trained nurses of mixed gender, from the age of 22 above, and were staff members. "Sr." refers to female Sister/Nurse, while "Sir" refers to a male nurse. This is how they are customarily addressed in the hospital.

The researcher gathered data mainly through participant observation and semi-structured interviews. With each participant, the researcher conducted at least three formal interviews in which an electronic recorder was used with the participants' permis-

[2] It bears noting that in this instance both the nurses and the patients subscribe to the same or similar pan-African worldview. Thus although not all the patients may be "ethnically" isiZulu-speaking, they are all Black African, with the majority professing and following traditional and cultural African practices, including belief in ancestors, witchcraft and bewitchment.

sion. Each interview lasted for about 45 minutes, depending on the availability of the participant. Most of the interviews were conducted within the hospital space and a few at the participants' homes.

Corbin and Strauss (2008: 46) remind us that in carrying out research, a researcher has to, at some point, 'do something' with the data he or she has gathered. The "doing something" with the data the researcher meant processing and analysing the collected data in order to make sense of the collected data. Accordingly, the electronic data was transcribed, all field notes collected and arranged based on themes. The transcribed data was also arranged based on the dominant emergent themes from the study. This thematic 'mapping' enabled a microanalysis of the data, bringing a critical gaze to each of the themes that emerged, their relation to the study, and their impact on the overall understanding of the studied phenomena, which was patient care. Microanalysis has been regarded by Corbin and Strauss (2008: 58–9) as a detailed form of coding data which enables a researcher to 'break open the data to consider all possible meanings.' In analysing the data, however, the researcher was aware of the possibility that the researcher's personal understanding and views of patient care or cultural understandings of illness could also influence how the researcher interpreted the collected data. This required a measure of self-reflexivity. According to Rosaldo (2003: 583), 'one cannot totally take away his/her personal feelings and experiences from how he/she interprets what he/she observes or hears.' However, reflexivity assists in keeping that in check. Thus, a conscious awareness of such a possibility enabled identifying observed phenomena without allowing the researcher's understandings to "meddle" with that of the participants. Extended "thick" (à laGeertz) narratives are presented in the paper so that the reader can obtain an emic perspective of the participants' experiences.

How nurses group patterns of patients' illnesses

> I have a child who is now three years. After his birth, he was just normal, and then at the age of 18 months, I found out that the 'top of skull' is still opened. So I went to the doctor, and he was scanned. The results came out, and it was declared hydrocephalous, but they said it was non-communicative hydrocephalous [sic]. Then I told my in-laws, and they said no, this is not hydrocephalous. It being hydrocephalous means he needs to be taken for an operation to put up a shunt. The family said no I do not have to go for an operation. That this is normally what happens in the family. There are some kids in the family who had the same problem, and you have to consult an *isangoma*[3] first before you even go and do whatever operation you want to do. So we went, and we did all the cultural things that I needed to do because I had to clear my conscience and be sure of what I was doing. After they had finished, I went back to consult the neurologist and was booked for an operation. But when we went for the operation, the child was sedated, and

[3] Traditional Zulu healers use divination, mediumship, and what might be termed "psychic healing" to assist their clients.

> whenever they wanted to start the operation, he just wakes up and sits there for the whole day. That happened on two more visits even when he was given a stronger sedation. Then we went back home, and the family said, 'No way'. This shows that there is something more that needed to be done as a family. So I had to do what the family wanted to clear my conscience. Now we are doing all the rituals, the Zulu rituals ... As a healthcare professional, I know I have been treating these children with hydrocephalous [sic] and you can see their progress. But with my child it was unusual because the fluid was not growing. It is there, and if you look at my child, he looks normal, but when you talk to him, that is when you realise that there is a problem and that he is hyperactive. So when I see a patient with something similar to that, I take my time to really know what could be wrong as it can be something to do with the ancestors like in my child's case (Sr. Andiswa).

As mentioned, nurses' understandings of illnesses are shaped by multiple factors. Sr. Andiswa was not directly responsible for treating her child when he was ill. Nonetheless, she claims that her observation of her child's treatment progress and that of other patients helps her to better interpret illnesses. As Tanner (2006: 206) states, 'sound clinical judgement rests to some degree on knowing the patient and being aware of his or her typical pattern of responses, as well as an engagement with the patient and his or her concerns.' This *knowing* is usually derived from working with the patients and hearing their experiences and is also known as "life history" in the clinical setting. Thus, the experience Sr. Andiswa had with her child and her knowledge as a nurse contributed to how she observed patterns of illness amongst patients:

> There was this child who was presented with pneumonia and was treated for it, but nothing happened, then we commenced treatment for pulmonary TB for six months, and the patient was discharged. Then after a short while he was brought back for the same issues he had earlier. Then the aunt who was staying with him said she also had the same problem. That she has been treated for pneumonia and for TB, but nothing has improved. They were not even diagnosed as having TB from the chest X-Ray. Just that it is pneumonia that is not responding to any antibiotics, that was why we tried the TB treatment. The condition subsided for two to three months then they came back again. I suspected that something else must be wrong her. So I spoke to the aunt and that was when she told me that she thinks it is some *idliso* (food poison) that had been put in her food, which she ate with the child (Sr. Andiswa).

This narrative reveals Sr. Andiswa first diagnosing TB, but later "realising" an illness related to "traditional" poisoning. Aside from her 12 years of professional nursing training, the experience she had with her child, her belief in the cultural influence of ancestors on humans also contributed to how she could "identify" and group the illnesses suffered by patients. As research has shown (see Benner 2004; Benner, Tanner & Chesla 1996; Peden-McAlpine & Clark 2002; Tanner 2006), clinical judgment can be greatly

influenced by the personal experience and exposure of the nurses than just the "objective" data of the situation. In the second story of the suspected TB patient, her suspicion of the patient's illness was solidified by the patient's aunt who told Sr. Andiswa that the patient had eaten some idliso (poison understood in a traditional sense):

> When a person comes to the hospital, initially the person may be seeking help as offered in the hospital. But as a traditional healer as well as a nurse,[4] I will try to find out more history from the person. Firstly, I will treat them medically. While I am treating them medically, I will try to find out from the person his or her personal history and all that. I will try and link what could be the cause. Because mostly, people come to the hospital thinking that they are sick. Mostly the patient might be getting fits at night and all that and they will think that the patient is having epilepsy. Meanwhile, his or her ancestors are trying to communicate with him or her. So the patient will be having a severe headache and fits all because the ancestors are trying to communicate with him or her. So I as a traditional healer, I know all the signs when a person is being visited by their ancestors, and he is not sick. It is just that he needs to accommodate his ancestors through some rituals and other rites. So we will give the person the medication here in the hospital, we do x-rays, and we do all the test but we will find that the person is NAD, which means 'no abnormalities detected' because she is not sick,. So in that situation, I need like a special place to sit down and talk to him or her explaining what is happening. Sometimes the patient knows that problem but she or he will try to run away from it. Especially this people who say they are 'born-again Christians'; they really run away from their tradition. But sometimes the person doesn't know, and then I will make them aware. The patient will go home and do all those procedures I would have told to do, and sometimes they will come back and thank me, saying 'You have saved my life' (Sr. Nelisiwe).

While Sr. Andiswa depended on her professional *know how and* her cultural knowledge of illnesses, Sr. Nelisiwe seems to have in the first instance, a more culturally rooted ability to read what illness a patient may be suffering from. Being a cultural healer, gifted as an *isangoma* and an *inyanga*,[5] coupled with her 23 years of experience as a senior nurse, she said she could see beyond what the patients even knew about their illness. Cioffi (2000) tells us that 'when the experienced nurse encounters a familiar situation, the needed knowledge is readily solicited; the nurse is able to respond intuitively, based on an immediate clinical grasp and just "knowing what to do".' McCarthy (2003b) in her study showed how profound the influence of nurses' knowledge and experience was towards clinical judgement. She showed how a variation in nurses' ability to read patients' illness was based on how knowledgeable and experienced each nurse is. This notion of clinical thinking and judgment is strongly aligned to Hammon's (1981) Cognitive Continuum

[4] This dual positioning of some nurses, as both professionally trained nurses and African traditional healers, is examined in another study.

[5] Traditional Zulu healers who specialise in herbal medicines and potions.

theory.[6] As the theoretical lens allows us to see, each nurse possesses a level of intuition based on her level of exposure and experience with similar patterns of illness.[7] The most experienced nurses can immediately identify, without much difficulty, a pattern of illness that they have encountered over the years, while the less experienced nurses depend mainly on theoretical interpretations:

> … we have also had situations whereby after all sorts of tests and scans had been done, we were not able to detect what is wrong with the patient ... like we had that patient who had a swollen face and neck. Many tests were done such as TB, lumber puncture, blood tests and it did not bring out anything that could be linked to the symptoms the patient presented. So I was aware that it could have been some *muti*[8] that had been used on the person, and there is nothing that can be done medically for him and the patient ended up dying in the end. Even the family was aware that it was muti, and they wanted to take him to the traditional healer. Unfortunately, it was too late (Sir Jabulani).

Sir Jabulani was convinced of the patient's condition as being bewitched using muti based on his experience of similar incidences in his community. He said he was told by the patient's family that the patient had just been promoted at work, and because of the 'jealousy that is amongst the Zulus [sic], someone must have used traditional medicine to attack him,' he said.

Aside from participants like Sr. Andiswa, Sr. Nelisiwe and Sir Jabulani had a strong conviction in their ability to know and diagnose when a person had an illness linked to a particlar cultural practice:

> … we do have some patients although, that after all kinds of tests we still do not know what is wrong with them, or it might be the wrong diagnosis. There is one in my department presently, we did everything and we found a certain condition and have been treating her for that condition, normally she should be getting better but she is not. Instead, she is getting worse day by day. So, now I wonder if we got the right diagnose or maybe something else might be involved in this (Sir Siyanda).

Another participant also referred to the possibility of misdiagnosis and the discovery of traditional herbs in the patient's system as how they can notice or group what a patient is going through:

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[6] This is a 'descriptive theory that illustrates how judgment situations or tasks relate to cognition' (Standing 2008: 124). The Cognitive Continuum Theory places focus on judgment and decision-making. Although the theory was originally initiated for use within the scope of cognitive psychology, it has proven to be useful within clinical nursing settings (see Cader, Campbell and Watson 2005: 398; Harbison 2001: 126; Lamond and Thompson 2000: 211; Thompson, Cullum, McCaughan, Sheldon, and Raynor 2004: 68).

[7] The use of intuition in nursing has been discussed extensively by many writers (see Benner et al. 1996; Schraeder & Fischer 1987; Leners 1993; Tenner 2006: 206–7). In most of these studies, intuition is regarded as the prompt apprehension of any clinical situation that nurses would have had similar experiences of.

[8] Traditional medicine.

> There are so many tests, and surely a person will be found with one thing or the other. X-ray, urine and electrolytes, FBC (full blood count) to detect the HB haemoglobin as well as the platelets of the patient, thrombocytes, INR (International Normalised Ratio), BSR, surely there will be one thing found. Even when a person is presenting different symptoms from what we diagnosed them with, it could be that the person has been misdiagnosed. Sometimes, they end up taking traditional herbs that they have been given by the healer, and we can know this from the black or greenish watery stool. They are usually given that in a drink or enema by family members when they visit them in the hospital … Mostly, all those that take *isihlambezo*[9] have adverse effects. You only see that a person has taken isihlambezo from the effects and when you ask they will tell you 'Yes, I took isihlambezo' (Sr. Phindile).

The patterns of illnesses narrated by the nurses are either illnesses that seem not to have any "cure" within the hospital, or an illness for which the patients have "consulted" a traditional healer. Although the nurses were technically trained in specific (biomedical) approaches to all illness presented in the hospital, the nurses took decisions that would be considered "not in line" with the hospital's practices. As Tanner (2006: 205) asserts, 'clinical judgement requires a flexible and nuanced ability to recognise salient aspects of a (seemingly) indefinable clinical situation, interpret their meanings, and respond appropriately.' In this case, the interpretations of some of the illnesses were not only based on the nurses' biomedical training and clinical experience, but also on their cultural understandings of illness and clinical "critical thinking".[10]

Nurses' understanding of patients' response to hospital treatment

> We have patients here that their parents feel they want to take them away. Just like the patients whose file is in front of me now, his parents brought him here and he was diagnosed with diarrhoea and dehydration, and we were still treating diarrhoea when we found out that the child also has dysentery with blood in the stool. On the same day when we got the results of dysentery, the parents came asking to take the child home. We advised them not to take the child as the child was still sick. We tried to explain to them, but they said the grandmother of this child wants to remove inyoni. They said the child is not sick; that it was inyoini (meaning the person was stroke by a bird –inyoni). We asked them to just wait for the treatment before leaving and they can even sign RHT (Refusal of Hospital Treatment form) and go home but continue with the medication or do whatever they want to do

[9] Traditional concoctions.

[10] Critical thinking within the clinical environment has been defined by Facione (1990: 315) as 'purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as the explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment was based'.

> afterwards. But while we were busy with doctor's rounds, they ran away with the child. We phoned them and begged them to come and just take the medicine because we were worried about the child. They said they were coming. We waited and until today they never came (Sr. Anele).
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> We also have situations where patients or their family members say they will want to take the patient to the traditional healer for help because the person has been bewitched (Sir Siyanda).

Here we see narratives of how nurses said patients were sometimes taken away from the hospital by their relatives. In sharing her narrative, Sr. Andiswa appeared sad that parents sometimes mistake what she referred to as "normal" illnesses associated with children, (like flu and cough, etc. in her understanding) for illnesses that are related to their cultural practices. She said she had seen many such cases in the children's ward. Sir Siyanda also shared how patients are taken away, either by their personal choice, or by their family members' decision. He said that sometimes the patients asked for a "pass out", claiming they needed to attend a family ceremony, whereas, they are trying to simply leave the hospital to consult with a traditional healer:

> … there was a middle-aged woman who was diabetic, and I was supposed to give her antibiotics and injection. She passed out immediately, but before passing out she said 'You have just killed me'. At that point, I didn't know what that meant or why she was saying that because for me I was only trying to help. I thought she was just joking, but when she passed out, I got scared. I called for help, and the doctors tried to resuscitate her. I was so scared that she was going to die knowing that she said I was killing her just after injecting her. When I came back the following day, I went back to her to ask what really happened. She said after I gave her the injection she could feel that something was wrong. Then we later found out that in her cupboard, there was a bottle with some herbs that she had taken. So using that herbs and the hospital medication almost cost her life (Sr. Nosipho).

According to the nurses, patients try to *mix* the hospital's medications with the medications they would have received from the traditional healer. While Sr. Nosipho said she understood why the patients still wanted to make use of their traditional medicine, even while in the hospital, she felt that mixing the medication can cause much harm. The challenge faced by nurses here is knowing whether they should allow the patients to mix the medication or not, whether they should recommend the patients to visit a cultural healer or not, all based on their judgment of the patient's illness and its condition and, of course, their own culturally constructed understandings of illness and health:

> Although traditional medicine works, it is dangerous when you try to mix it with the hospital treatment especially amongst children with diarrhoea. It causes more dehydration, and sometimes it delays the treatment of the child (Sir Wandile).

> I am not sure if the traditional medicine works, and we are not sure of the strength of the traditional medicine they use because some of it can cause renal failure and affect the kidneys, too. That is why we discourage them from using traditional medication. We had one case whereby a patient was given traditional medication by relatives. … they called us when the patient started vomiting. ... the patient died in a short space of time. We told the lady that look, your mother was sick, but she is now dead, and we do not know what the cause is but we have been told that you gave her some herbs. So you see, I surely cannot allow someone to take those things when we do not know what implication that might have (Sr. Sindiswa).

In the narratives, we are presented with critical realities where nurses curtailed how much they support any form of "cultural medication" due to the accidents (sometimes morbidity) they said were potentially caused by the use of cultural medications. Although some patients may have attempted combining herbal and allopathic medication, nurses frowned at such practice due to the possible complications that may arise: 'Some traditional medicines are good while some are bad because their effects can actually cause more harm to the patients' (Sir Thabiso).

Nurses' view on why patients handle their illnesses as they do

> It is just that their beliefs and their minds have been set that they are traditional people and if they do not receive that traditional treatment they will not be well because they believe that that is who they are. … It is because according to our understanding as Zulus [sic], there are those illnesses that people believe that can be treated in the hospital, but this another is considered as a Zulu thing or patients may believe that they have been bewitched, and it needs a traditional healer. So when they come to the hospital, they would have thought that they can be helped here, but if they are not getting better they will say no it is a Zulu thing, and we need to go (Sir Thabiso).

The use and belief in traditional medicine and practice are pervasive in many African countries despite the expectations that came with the advent of the so-called "civilisation" and the hegemony of biomedical practices. As stated by Sir Jabulani, the patients have 'their beliefs and their minds have been set that they are traditional people and if they do not receive that traditional treatment they will not be well because they believe that that is who they are.'

Aside from the personal belief and adherence to traditional medicine being the cause of patients leaving the hospital, there were also issues of distrust of biomedicine and its personnel as raised by the research participants:

> Maybe they criticise us, and they suggest that we are not happy about one, two, three things. Then they suggest what they want to see being done. When they offer the suggestion box, you find out that they are suggesting

> something and saying instead of this, I prefer you do this and this, saying they are happy with this or that (Sr. Khanyisile).
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> So those who want to go to traditional healers even when they are in the hospital it is because of lack of knowledge, their beliefs, or culture. Some of them do not trust nurses and doctors. They believe that they have *izangoma*, and the izangoma will help them (Sir Siyanda).

It also emerged that sometimes, due to a people's belief that certain illnesses can and should only be treated traditionally, patients dismissed the use of the hospital's medication due to their lack of trust in the medicine or the personnel. Golooba-Mutebi and Tollman (2007: 72) stated that in such sceptical moments, 'people choose traditional rather than allopathic treatment because witchcraft-related afflictions are generally considered incompatible with allopathic treatment, as are those linked to ritual pollution or violation of taboos.' Scheper-Hughes (1992: 42) in her study, *The Violence of Everyday Life in Brazil* reminds us that 'when allopathic therapists are not reassuring, people look to traditional practitioners for treatment and explanations that lessen fear and anxiety'. Writing in another context, Naidu's (2012) study of cancer patients showed how patients felt that the health care practitioners ignored other aspects of their humanity and only focussed on the sickness, stating that the doctors seemed to treat the cancer and not the patients (Naidu 2012: 77). Although cancer and its understanding is not culturally peculiar to only isiZulu-speaking people or their nurses, the study shows how patients sometimes deride the approaches used by biomedicine. Hence, 'although bio-medical approaches are recognised and even understood' as stated by Gumede (2009: 55), 'they may still be regarded with suspicion':

> So when I notice that a person is suffering from something other than what the hospital thinks he or she is suffering from, I need to intervene. I will go to her, make a special prayer, but I cannot burn my imphempo, the incense we burn because we are in the hospital. But since I am gifted as an isangoma and an inyanga, then I can pray and talk to God or talk to her ancestors at the same time then they will show me what is wrong with the person. Like even if a person is hiding something from me I can know that you are hiding something from me (Sr. Nelisiwe).

Unlike Sr. Nelisiwe who, although she could not carry out all her cultural practices in the hospital still enjoyed some level of freedom, other participants felt they have to 'hide' whenever they want to suggest any form of treatment to patients aside from the hospital's treatment:

> When we did our nursing studies, we were told that we must never introduce traditional medicine to our patients, so I cannot do that. Even when I see that a patient really needs it, I am forbidden by the South African Nursing Council rules. I may tell the person, can I see you later on, and then I give them my number so that automatically it becomes a private talk. It will not be a hospital kind of thing. So, no one can say to me the person was in the

> hospital then I told them to leave the hospital and come and see me (Sr. Thabile).

Despite also being an *isangoma* and known by the hospital as Sr. Nelisiwe, Sr. Thabile stressed how (according to her), she did all she could to abide by the regulations that prevented her from introducing any non-biomedical treatment to patients:

> Because I am concerned about the health of the patient and being a Zulu person, I know that some traditional medicine helps and some don't help. But that doesn't mean that the traditional medicine doesn't work, it does work. So there were times when I see that medically we cannot help a person, I ask them to maybe go and see someone who can help them. We make sure that we do not allow them to mix traditional medication and that of the hospital; they do not work together (Sir Jabulani).

> If I am to meet something like that here in the hospital, I will make sure we first do all the tests to check if there is something wrong and if it comes back to say there is nothing, sometimes I will say 'Rather check on the side of your culture.' Although the hospital will not be happy if we allow the patients, but we as nurses, we are in close contact with the patients, we talk a lot and in that way we are able to relate more and know more about what should be done. So, we can talk to them as a nurse and a patient, but afterwards she will come to me at the side and say 'Sister, I understand what you told me, but now, let us look at this thing in the reality of our culture.' I have to do that though not in front of the hospital management because I think their reaction will not be positive to what I have said to the patient. So what I advise patients to do is to use one thing at a time and not mix it. Being a Zulu person, I know that Zulu medicine works and when a person insists on using it even when they are suffering from what we can treat, I do not really fuss (Sr. Nosipho).

> What I normally do is to say, 'Okay, maybe something is wrong between you and your ancestors, so go to an isangoma and find out what is wrong with you' … I do suggest and sometimes even while we are treating the child, a person can go and consult the isangoma. If it is something that can be done, let it be done, because sometimes you do not even have to give herbal medication. Sometimes you just have to slaughter a goat at home, and the illness will be gone. The incident with my child was an eye opener in this, and I do not just take things for granted. So I do suggest that. But even if I will say it will make sure I don't do it in from of any senior member of the hospital board (Sr. Thabile).

While Srs. Nelisiwe, Thabile, Nosipho and Sir Jabulani felt confident when suggesting to patients other forms of treatment aside from the hospital treatment, other participants strongly felt that it will depend on the sickness the patient is suffering from:

> … so it depends on what illness or circumstances the person is suffering from. While for some I will not hesitate to suggest to the patients to go see an isangoma especially when the patients have been told by the traditional healer that the ancestors are not happy with him or her because he or she failed to perform a certain ceremony, they can suffer for it. So, because we are also Zulus [sic] and we are cultural, we might as well advise them to go for the traditional help when we are not able to help them here. But for some illnesses, I know that they can and should be treated biomedically (Sir Jabulani).

> Like I have a file, then I see that they are HIV positive, and then I will direct them in a way that they will take their treatment even when they feel they need traditional medicine to supplement. But I also do not want to invade in their thinking that they have been cursed or what. So it depends on the illness. Although the hospital will allow me to recommend in whatever condition because it treats patients in the Western way when I think it is necessary, I will do it. And it is not easy to do that knowing that we are in the hospital. Say in this case of the patient who tried to commit suicide and with other patients who might be HIV positive, do you think that there is any way that the hospital can accommodate their beliefs and traditional practices? So whatever I will say to the person will depend on the type of illness (Sr. Nontokozo).

Conclusion

The rich narratives presented in the paper portray some of the dilemmas faced by nurses in carrying out clinical decisions. While some nurses felt they should never recommend a patient to seek any form of "cultural help", others seem to suggest that they should and *would* do so. However, as stated by participants such as Sir Siyanda and Sr. Andiswa, they do so at their own peril, because if they are caught, they stand the chance of losing their jobs. The difficulty in deciding what to do in such situations can be said to exist due to the "imagined" and sometimes real disparities that exists between the isiZulu-speaking nurses' constructed understanding of illness and the expected biomedical understanding of illnesses. Within the biomedical approach to illness, culturally constructed diagnoses are given little or no room in understanding and treating patients' illnesses. However, 'cultural factors are imperative to diagnosis, treatment, and patient care' (Kleinman & Benson 2006: 1673), as they contribute in shaping nurses' health-related beliefs, behaviours and values. As such, nurses, can possibly be caught up:

> … between two worlds: the world of technological medicine, that symbolizes modernism, and the realities of a developing nation whose patients and doctors hold traditional and popular understanding of illness that requires simple technologies to alleviate the most prevalent diseases (Finkler 2004: 2048).

Thus, 'an understanding of not only the pathophysiological and diagnostic aspect of a patient's clinical presentations and disease, but also the *actual* illness experience

of both the patient and family and their physical, social …' (Tenner 2006: 2005), needs are to be taken into consideration in order to assist nurses carry out "good" clinical judgment. In doing such, the nurse will become more and more a "critical thinker".

The narratives shared by the nurses reveal how their understanding of illnesses and health shape their approach to patients and patient care within the hospital. Carrying out clinical judgment involves the use of critical thinking. The paper showed how nurses not only rely on their (important) biomedical training in reading illnesses, but also on their wealth of experience in nursing *and on their cultural beliefs and understandings of illness*. This ability to critically 'read' a patient is what makes the nurse a 'critical thinker', says Facione (1990: 315).

This paper has shown that the nurses in this study had a general belief that illnesses are treatable by both cultural and allopathic therapy. However, while they believed that some illnesses can be treated by both means, they felt that "other illnesses" can only be treated culturally. The narratives shared reveal that the decision on which approach to use is in turn, often fraught.

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Povzetek

Prispevek temelji na etnografski metodi opazovanja z udeležbo in proučuje, kako skupina medicinskih sester, ki govorijo isiZulu razumevajo in konstruirajo bolezni in zdravje in kako to oblikuje njihov pristop k oskrbi bolnikov v bolnišničnem okolju. V analizi proučujemo, kako afriške isiZulu govoreče sestre zanavajo in "razvrščajo" zdravstvene težave bolnikov glede na osebna razumevanja bolezni in kako ta razumevanja vplivajo na njihovo klinično odločanje v praksi. Ugotovitve nakazujejo, da medicinske setre delujejo v dvojnem sistemu, ki jih pogosto preobremenjuje in v medsebojni konflikt postavlja njihovo biomedicinsko usposabljanje ter njihovo kulturno, na kozmologiji temelječo vzgojo ter pan-afriški pogled na prednike in magijo.

KLJUČNE BESEDE: biomedicina, kultura, klinično odločanje, predniki

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