

Medical Pluralism in Action? A Case Study of Community Pharmacies in Johannesburg, South Africa

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ABSTRACT

Objectives: The main aim of this study was to examine whether, and to what extent, community pharmacies have become sites for the practice of complementary and alternative medicine (CAM) as an example of “medical pluralism.”

Methods: Qualitative as well as quantitative methods such as a telephone survey of all pharmacies in Johannesburg, observations, and in-depth interviews with pharmacists and CAM healers were used.

Results: The evidence presented in this paper, although based on a study of community pharmacies in Johannesburg only, can be interpreted as an indication of a general trend in urban areas in South Africa, that of involvement with CAM in the form of dispensing and sales of CAM products, provision of advice, and, in a few cases, employment of CAM practitioners to consult on their premises. Thus the two systems of CAM and allopathic medicine are being practiced within the same premises. However, the manner in which they operate, as portrayed in this study, is that of two separate systems existing in relative harmony side-by-side.

Conclusion: Because of the constraints of the study, it is difficult to ascertain to what extent this is a first step toward the development of a more meaningful integration between the systems. It is much easier to demonstrate that this growth is driven by the pharmacists’ response to the growing demand from the public and their readiness to seize the opportunity to expand their responsibilities and increase their profits. This is supported by the willingness of CAM healers to participate in the endeavor.

INTRODUCTION

There is no doubt that complementary and alternative medicine (CAM) has gained greater recognition and its use by the public has grown in the last decade (Cant and Sharma, 1999; Ernst, 1997; Kelner and Wellman, 2003). The resultant effect of this increase in popularity has been the public’s demand for its services and accessibility. Studies indicate that one third of all Americans rely on CAM (Eisenberg et al., 1998; Kupferberg, 1994). In Britain, it is estimated that between one fifth to one third of the population have been using alternative medicine (Fulder, 1996) a similar proportion to that of the United States and Europe (Eisenberg et al., 1993; Fisher and Ward, 1994).

This has been accompanied by a cautious but growing ac-

knowledgment by agents of the professional allopathic system such as doctors, nurses, and pharmacists (Shuval, 1999). An increasing number of doctors and other health professionals are also practicing alternative therapies (Easthope et al., 2000, 2001; Eastwood, 2002; Saks, 1994). Turner (1990) notes that the hierarchal division between scientific medicine and CAM is collapsing. This, in turn, leads to the deregulation of health care, in which licenses to practice become increasingly irrelevant in the marketplace of hyperconsumption (Saks, 1998). Cant and Sharma (1996) claim that this helps to explain why the British Medical Association has replaced its tendency to discredit alternative medicine as unscientific with a less prescriptive guide to patients in choosing their therapies from the broad range of orthodox and unorthodox approaches on offer.

It seems that because of the peculiar position in which community pharmacists find themselves, where they are constantly striving toward an expansion of their diminishing traditional role (Gilbert, 1998a),* they are eager to accept the merits of CAM and embrace it within their pharmacies. This is aided by the fact that the setting of a community pharmacy is easily accessible to the general public.*

Community pharmacy as a profession has been in transition, accompanied by changes in the definition of its role and general philosophy. It is constantly adapting to changes in consumer demands due to its ambiguous position as a business orientated-profession.* One of the characteristics of the adaptation process is its thrust toward the adoption of an extended and more meaningful role. The attempts to achieve additional powers to prescribe medications have, however, been thwarted by the medical profession, although, the initiative to engage in a wider range of activities has been more successful. It seems that the shift toward embracing additional professional tasks within the pharmacy, either by the pharmacist or with the assistance of a nurse, is relatively smooth and is gaining momentum, with no serious resistance from the medical profession (Gilbert, 1997a, 1997b, 1999).

Against this background, it is of interest to explore to what extent community pharmacies are extending their traditional functions beyond the boundaries of allopathic medicine and health promotion in the conventional sense and what the nature of this expansion is. Is the community pharmacy a site of integration of healing systems or is it economic opportunism of a profession with diminishing functions and decreasing income?

If “mechanical pluralism” is the coexistence and availability of different ways of perceiving, explaining, and treating illness (Gilbert et al., 2002), then the community pharmacy becomes a microcosm of where it can be observed and studied “in action.”

Although CAM has been the subject of an increasing volume of research in the last 10 years, it has not been studied significantly in the context of community pharmacy. Thus, the linkages between the issues outlined above have not been explored extensively.

METHODOLOGY

The main aim of this study was to examine whether and to what extent community pharmacies have become sites for the practice of complementary and alternative medicine (CAM) as an example of medical pluralism. For practical

reasons, this study focused only on community pharmacies in and around Johannesburg.† Because the study’s objectives included attempts to establish general trends as well as to understand specific aspects in more depth, it called for a combined methodology. For this reason the following quantitative as well as qualitative methods were used:

A telephone survey‡ of all pharmacies listed in the Johannesburg area to establish whether they stock alternative medicines, provide consultation in this regard, and whether they have a consulting CAM practitioner.

The results of the telephonic survey provided the sampling frame for the targeted pharmacies where some form of CAM takes place. Fifty (50) community pharmacies indicated the existence of activities related to CAM and were therefore chosen to be included in the second stage where the following took place:

- Observation of the nature and magnitude of “what takes place”
- In-depth interviews with the pharmacists and CAM healers.

The quantitative data were analyzed using SPSS 11.0 (SPSS, Inc., Chicago, IL) while the qualitative data were analyzed according to relevant themes or concepts identified in the process.

RESULTS

CAM products

Because the purpose of the telephone survey was to find out to what extent pharmacies are engaged in CAM, the first step was to examine whether CAM products (as defined by the pharmacists themselves) were stocked and sold by the pharmacies.§ Not all pharmacies stock and sell what, according to them, can be classified as CAM products, as shown in Table 1. What is clear, however, is that a majority of them do keep at least a limited range and as much as 40% keep a wide range of products. The questions to be asked here are: what other characteristics of the pharmacy are linked to the engagement with CAM? Cross-tabulation by the location of pharmacy reveals an interesting scenario. Fifteen percent (15%) of all pharmacies do not stock alternative medicine products. This is highest in the Central Business District (CBD) (30.3%) and black areas (28.6%), which are relatively disadvantaged locations. In higher-income areas, 71.4% of pharmacies in residential areas and 93.8% in shopping centers stock a wide range of CAM products, com-

†This was done according to available records at the Pharmacy Council.

‡For more details about this part of the study, see Gilbert, 2002.

§It should be noted that pharmacists are allowed to stock and sell only registered products in South Africa.

*Gilbert L. The Present and Future Role of Community Pharmacy in South Africa [dissertation]. Johannesburg: University of the Witwatersrand, 1997.

TABLE 1. ALTERNATIVE MEDICINE PRODUCTS BY LOCATION OF PHARMACY (%)

CAM products	Location of pharmacy						Total
	Residential area—middle/higher income	Residential area—lower income	Shopping center—higher income	Shopping center—lower income	CBD/inner city	Black	
No	5.7%	15.0%			30.3%	28.6%	15.0%
Yes, limited range	22.9%	55.0%	6.3%	66.7%	45.5%	64.3%	44.4%
Yes, big variety	71.4%	30.0%	93.8%	33.3%	24.2%		40.1%
No CAM but African medicine						7.1%	0.5%
Total	100%	100%	100%	100%	100%	100%	100%

CAM, complementary and alternative medicine; CBD, commercial business district.

pared to 30% and 66.7%, respectively, in areas of lower income.

The most important reason for stocking CAM, as articulated by the pharmacists, is a response to the demand by the public (95%). The reality that it is also quite profitable (29%) and the pharmacists believe in its effectiveness (43%) contributes to its popularity. These findings are consistent with those reported in the literature with regard to the growing public demand for CAM and its use (Eisenberg et al., 1998; Goldstein, 2002).

Ten percent (10%) of the pharmacists mentioned that there is a request from doctors for CAM. Although this is not a significant percentage, it is an indication of an emerging reality in South Africa that is likely to follow a trend already identified in other Western countries (Astin et al., 1998; Berman, 2001; Boozang, 1998; Borkan et al., 1994; Cant & Sharma, 2000; Easthope et al., 2001; Eisenberg et al., 1998; Sullivan, 1996). The fact that “a local complementary medical association (South African Complementary Medical Association) has recently been established” and that “the medical association (Medical Association of South Africa) is taking a fresh look at alternative medicine with a view to possible recognition” (Pantanowitz, 1994) are just such examples. If this trend is to be further developed, it will in turn add another significant motivation to the increased incorporation of CAM into the community pharmacy. However, in an interesting way it will continue to perpetuate the traditional relationship between pharmacists and doctors, whereas the venture by pharmacists into CAM can be seen as an emancipating move on behalf of individual enterprising pharmacists toward an autonomous practice devoid of the traditional constraints (Gilbert, 1998a).

Mode of operation—choice of products by customers

Documenting the way that CAM is being practiced within the community pharmacy was one of the aims of the study. Some of the questions raised were: What is the most common scenario in the pharmacy with regard to CAM? How

do customers choose the products? What is the involvement of the personnel in this process and what role do they play? Table 2 presents a summary of the various scenarios as reported by the pharmacists. It seems that the dominant mode of operation is an independent “well-informed” customer choosing a suitable product according to their perceived needs without any intervention from the personnel in the pharmacy (91%)—this is not dissimilar from “self-medication” with over-the-counter (OTC) conventional drugs—a widely acknowledged phenomenon with regard to peoples’ “health & illness behavior” (Beckerleg et al., 1999; Cocks and Dold, 2000). An additional scenario is one in which the pharmacist is the first port of call for advice with regard to CAM products (86%). Again, this corresponds with people’s behavior with regard to conventional OTC medications (Beckerleg et al., 1999).*

Taking into account these main modes of operation, it is clear that the use of CAM products within the pharmacy has been incorporated into peoples’ traditional patterns of behavior with allopathic medicines (Thorne et al., 2002b). In 28% of the cases the CAM healer is the one approached—this obviously happens only in those pharmacies where this option is available. There is no doubt that we are witnessing a new phenomenon: that of the use of a pharmacist (trained in allopathic medicine) as a source of advice and

TABLE 2. SUMMARY OF SCENARIOS OF USE OF CAM IN THE COMMUNITY PHARMACY

Customers choose products on their own	91%
Customers approach pharmacist for help	86%
Customers approach assistant for help	33%
Customers come with prescriptions/instructions	31%
Customers approach healer on the premises	28%
Customers are approached by a “special CAM assistant”	19%
Staff advise	17%
Customers come with “lay recommendations”	15%
Customers respond to an advert	7%

CAM, complementary and alternative medicine.

information with regard to CAM. This raises additional issues and requires further explanations with regard to the patterns and motives of the use of CAM, which this study only begins to explore. The interviews conducted with CAM healers confirm this general pattern; most of them stressed the customers' familiarity with the products and their reliance on the pharmacist for additional advice.

CAM customers' profile

As indicated earlier, data from the telephone survey clearly showed that CAM is used in community pharmacies mostly located in traditionally white-affluent areas (Gilbert, 2002). The interviews with pharmacists in these pharmacies confirm that the typical customer in search of CAM is "mostly female" (59%); "mostly white" (56%) middle class or "well-off" (89%) in a broad and varied age range (43%). Comments were also made about these customers being "well educated" with the implication that they are also well informed about the nature of these products. This notion can be supported when examining the dominant mode of operation in which the customers choose their own products, as discussed earlier. According to Goldstein (2002) a number of studies have found that CAM use is associated with demographic factors. Women (MacLennan et al., 1996), whites, and the more highly educated (Astin, 2003; Bernstein and Shuval, 1997) are all overrepresented in most studies (Eisenberg et al., 1993, 1998; Kelner and Wellman, 1997; Menges, 1994).

A more nuanced analysis of these findings points to that of an emerging different trend of "mostly African" (10%) users of CAM; needless to say that this is the case in pharmacies where most of the customers are African (Gilbert, 1997c, 1998b). The pharmacists in these pharmacies claim that the Africans have always used alternative sources of healing, thus the use of CAM "is natural," however, the validity of this cannot be verified in this study. Because Africans in the urban population rely to a large extent on

the community pharmacy as a site for health care (Gilbert, 1997c, 1998b), it is quite likely to emerge that CAM is easily adopted as a "product" allied to the community pharmacy in addition to traditional-indigenous medicine already being practiced by this population (Cocks and Dold, 2000). Although it has not been developed further in this study, existing literature dealing with the practice and adoption of a variety of healing systems in developing countries provides the needed evidence that it might be a topic worthy of further exploration (Cant and Sharma, 1999; Hyma and Ramesh, 1994; Janes, 1999; Kleinman, 1984; Yankauer, 1997).

CAM consultations

Pharmacists were asked whether any CAM consultations take place in their pharmacies. The distribution of pharmacies with CAM consultations (Table 3) is quite even, while more than a third of the pharmacies (35.3%) do not have CAM consultations, two thirds do so. Nearly 37% offer consultation only in relation to minor or self-limiting conditions such as colds, flu, et cetera. Special mention was made here that no consultation is taking place where chronic or more serious conditions are concerned. This comment should indicate a cautious approach on behalf of these pharmacists. What are the reasons that they do not consult when it comes to chronic or more serious conditions? Is it because they do not believe in CAM and its efficacy? Is it only appropriate for minor ailments because it will not make any difference, but they do not want to touch it when it comes to the rest? Or do they feel that they do not know enough? These questions were further probed in the interviews, where a fair degree of uncertainty was expressed by the pharmacists interviewed. The fact that the answers are not clearcut, and the evidence inconclusive are indications that giving advice about CAM in the community pharmacy is accompanied by a certain degree of caution. There is a feeling that because of the high demand that was mentioned by all, there is grow-

TABLE 3. CAM CONSULTATION BY LOCATION OF PHARMACY (%)

<i>CAM consultation</i>	<i>Location of pharmacy</i>						<i>Total</i>
	<i>Residential area—middle/higher income</i>	<i>Residential area—lower income</i>	<i>Shopping center—higher income</i>	<i>Shopping center—lower income</i>	<i>CBD/inner city</i>	<i>Black</i>	
No	17.1%	38.8%	12.5%	11.1%	48.5%	71.4%	35.3%
Yes for minor ailments	31.4%	41.3%	37.5%	55.6%	30.3%	28.6%	36.9%
Yes for more serious problems	2.9%	3.8%	6.3%	22.2%	3.0%		4.3%
Yes for everything	48.6%	16.3%	43.8%	11.1%	18.2%		23.5%
Total	100%	100%	100%	100%	100%	100%	100%

CAM, complementary and alternative medicine; CBD, commercial business district.

ing pressure—mainly financial, but not articulated as such—to get involved in CAM or to “get on to the bandwagon.” For this reason, those involved in it try to play it safe. As an example, helping patients with weight loss by using CAM was mentioned: “because it does not matter whether it helps or not; it cannot do much damage.” This is obviously incorrect but reflects the pharmacists’ perception, which is similar to that of the general population that CAM has no harmful side-effects (Ernst, 1996).

In 27.8% of the pharmacies CAM consultations take place for more serious ailments as well or for “anything the customer asks for.” This is done not only in pharmacies where there is a healer on the premises or somebody officially trained in CAM. Needless to say that this cannot be fully verified and substantiated. Nevertheless, it raises the question of necessary training for pharmacists and others offering advice about CAM.

In relation to the location of the pharmacy, a pattern similar to the previous one repeats itself here: More CAM consultations take place in pharmacies in residential areas as well as shopping centers in middle or higher-income areas (48.6% compared to 16.3% in residential pharmacies and 43.8% compared to 11.1% in shopping centers). CAM consultations for minor ailments take place in 36.9% of all pharmacies. Generally there are more CAM consultations in pharmacies located in shopping centres. However, it should be noted that in 38.8% of residential areas-lower-income pharmacies, 48.5% of CBD pharmacies and 71.4% of pharmacies in “black” areas, there are no CAM consultations at all although they do stock and sell CAM products.

Nature of consultation

This is a theme explored in the in-depth interviews. What emerges quite clearly is that the bulk of CAM consultations sought in the community pharmacy are for common, self-limiting conditions such as colds and flue (65%) and related symptoms such as sinusitis (30%). These findings compare favorably with results from studies dealing with conditions treated with OTC medications (Beckerleg et al., 1999), introducing, once again, the “lay pattern” of consumption of medication (Thorne et al., 2002b; Van Zyl-Schalekamp, 1993).

The perception is that there is no danger that these conditions will worsen without any intervention. Thus, as long as the intervention—in this case OTC or CAM—does not cause any harm, it is immaterial, and the pharmacist is aware of it. Weight loss and muscular pain will also fall into this category. A local study found that, in the Eastern Cape, “African Chemists” or *Amayeza* stores were used in a comparable manner for similar ailments as part of the process of self-medication (Cocks and Dold, 2000).

However, it is worthwhile noting that 43% of the pharmacists mentioned that CAM consultations are requested in menopause-related cases, which raises a few relevant questions. Is it so high because of the profile of the users? Or,

is this a representation of a new trend for more “natural” products used for “natural” processes?

Related to the last point is the finding that 35% mentioned the use of CAM for the promotion of general health as mentioned by others (Angell, 1998). These findings are in line with the mainstream thinking that links the growth of CAM to, among others, the “culture of fitness” (Goldstein, 2003).

Depression (15%) and stress, and anxiety (23%), when combined, represent a significant proportion of the consultations. This raises questions that it might be related to the growing rates of these conditions in the general population and the inadequacy of the existing health care system to care for the arising needs. It can also be interpreted as disillusionment with allopathic medicine and its inability to help with these conditions. The answer probably lies in a complex combination of all these factors.

Here, arthritis (30%) probably represents one of these chronic conditions that are “vulnerable” to “abuse” as a result of missing its commonality and complicated treatment regimens. It also features quite prominently in the literature dealing with the effectiveness of CAM (Boisset and Fitzcharles, 1994; Brown, 1998; Ernst, 1998).

CAM healers

As mentioned in the methodology, the interviews were conducted only in the pharmacies that indicated in the telephone survey that there is some sort of CAM-related activity on the premises. In 45% of these pharmacies, a CAM healer was available for consultation.—This varied in frequency from daily (64%), half weekly (21%), to 1 day (7%) or weekends only (7%). Needless to say that this is based mostly on demand and availability of the healer.

Homeopaths (56%) were the majority among the CAM healers present in the community pharmacy, followed by iridologists (23%) and pharmacists trained as homeopaths (11%). The last result, although too early to predict, seems to indicate a new trend based on literature from other countries and the pharmacists’ comments.

The consultation with the healer took place in a “separate room in 62% of the cases with (39%) or without (23%) a booked appointment.” Those consultations outside a separate room were described as “rapid consultation in the pharmacy” (23%) or “work the floor and give advice” (14%). These *ad hoc* practices raise legal questions related to the acceptable arrangements between these two professional bodies.

An issue that complicates matters is that according to the Allied Health Professions Act of 1982 (previously known as the Chiropractors, Homeopaths and Allied Health Service Professions Act), practitioners registered according to the council above are not allowed to practice from within a retail outlet—which a community pharmacy is—unless there is a special room with a separate entrance. Pharmacists on the other hand need to obtain permission from the South African Pharmacy Council for the employment of a CAM

healer because any other professionals operating from their premises must be employed by them. According to the South African Pharmacy Council, granting these permits does not present a problem as long as they comply with the regulations.

Relationship between pharmacists and CAM healers

The argument has been made that this trend is relatively new in South Africa: and is confirmed by the findings of this study. Only one CAM healer was involved in the community pharmacy for more than 10 years. The majority were there for less than 3 years (65%). It was thus important to find out what the prevalent attitudes are toward this new phenomenon. How do the pharmacists perceive the associated benefits? Based on their answers, it seems that they are in-line with the general motives behind the incorporation of CAM into the community pharmacy. They are associated mainly with the capacity to increase customers and profits with some elements based on the positive belief in the therapeutic powers of CAM.

Seventy-six percent (76%) of pharmacists stated that they served the same customers as the CAM healers. This points toward the potential complementary nature of the two healing systems. The rest of the answers, however, indicate a separate and detached mode of operation in which completely separate functions are performed. Often, the pharmacist follows a prescription written by a CAM healer. The general impression based on the observations and interviews with CAM healers is that they are operating side-by-side rather than in tandem. Although when asked directly, the pharmacists categorically state that they “work together to a great extent” (50%) or at least that they “work together to some extent” (50%). This most likely refers mainly to the established referral system in which the pharmacist tends to refer customers to CAM healers (50%).

In the pharmacies in which CAM consultations took place without the presence of a qualified healer, it was justified on grounds that “there is not enough demand to justify a CAM healer on the premises” (58%) or that the “pharmacist is well studied and read.”

Pharmacists' attitudes toward CAM

There is no dispute that the guiding principles of CAM differ widely from those of allopathic medicine (Angell, 1998; Barnes, 1998; Pantanowitz, 2002).^{||} The pharmacists in this study—who have all been trained in the allopathic medicine tradition—were involved to a certain degree with CAM practices, regardless of whether a CAM healer was

present on the premises or not. Therefore, it was important to establish whether they found any conflicts between these practices and their professional training. It is of interest to note that only 14% of the pharmacists identified the apparent conflict between the two different approaches. The rest (72%) insisted that there was no conflict using justifications such as: “There is no reason for conflict because CAM complements allopathic medicine and does not contradict it.”

So, within this amicable atmosphere, what is the pharmacists' opinion of CAM generally? It is not surprising that the opinions here vary from “CAM is holistic with no side effects and should be mostly used” (22%) to “CAM has a place but is not adequate for all symptoms” (15%) or “there is a need to use CAM together with allopathic medicine” (15%). There is an evident caution to be read between the lines that “CAM needs to be practiced professionally” and “specialized knowledge is required.”

Seventy-three percent (73%) believe that CAM therapies are effective, while 24% believe that they are effective only to “some extent” and only 2% doubt its effectiveness. One wonders what the evidence is on which these responses are based or perhaps it just a way to justify the already established practice? There is no doubt that these questions require further investigation, which is beyond the scope of this study.

Following this relatively consistent pattern, based on further probing, it is not unexpected that 75% of the pharmacists feel that CAM truly complements allopathic medicine as opposed to 8% who feel that it conflicts with it. An insightful response came from 18% who feel that “CAM both conflicts and complements allopathic medicine,” thus highlighting the built-in ambiguity of their situation. Similar concerns have been reported in the literature (Thorne et al., 2002a).

Fifty-five percent (55%) of the pharmacists predicted that, as a result of public demand and growing awareness as well as global trends, the future of CAM in the community pharmacy in South Africa is likely to develop and grow further. They also offered suggestions on how to stimulate this growth, as presented in Table 4.

It is of interest to note that only 2% think that incorporating a CAM healer into the pharmacy practice is likely to

TABLE 4. SUGGESTIONS TO INCREASE THE GROWTH OF CAM IN THE COMMUNITY PHARMACY

Educate all	44%
Educate medical practitioners	39%
More advertising	34%
Educate public	29%
More training of pharmacists	17%
More open mindedness/awareness	15%
CAM should be regulated/professional body	10%
Have CAM healer on pharmacy premises	2%

CAM, complementary and alternative medicine.

^{||}Greyling E. A Sociological Investigation of the Professional Institutionalisation of Alternative Medicine in South Africa [unpublished master's thesis], University of Port Elizabeth, South Africa, 1991.

contribute to its future growth. Instead the emphasis is on educating the public (29%), medical practitioners (39%), as well as general education (44%) and increased advertising (34%). These efforts are meant to increase the already growing demand from the public and will, no doubt, position the community pharmacy at the center of this growth as an already established entity with the appropriate legitimization of allopathic medicine. Thus the pharmacists are likely to be the major beneficiaries of profits associated with CAM without the need and the complexity of having to incorporate CAM practitioners as well.

Pharmacists' training in CAM

In light of the findings so far, where there seems to be a substantial incorporation of CAM into the daily practice of the pharmacy as well as that of the pharmacist, with a forecast for growth.—A question that begs an answer is: What is the current level of training of the pharmacy personnel that is likely to equip them with the knowledge and skills to practice effective and responsible CAM? Table 5 is an attempt to answer this question.

Of major concern is that only 18% have some sort of official certificate or diploma in CAM, while the rest rely on partial (15%) or short and insignificant training (39%). Needless to mention that the fact that 28% have no training at all has to be seriously considered by all those interested in the welfare of health care users. This, it seems, is not an isolated finding because the need for adequate training of health personnel such as nurses, doctors, and pharmacists in CAM features prominently in the literature on this topic (Al-Shahib et al., 2000; Cant and Sharma, 2002; Das et al., 1997).

Note should also be taken of the fact that only 17% of the pharmacists suggested the need for more training (Table 4) in order to increase CAM activities in the community pharmacy. Thus, the perception is that this is not a major requirement for this growth, which adds to the concerns already mentioned.

Inevitably, the question of whether training in CAM should be part of the curriculum of pharmacy training had to be put forward. An unequivocal majority (93%) responded in the affirmative. The aim of this training is expressed mainly as to “increase general understanding of CAM” (79%). While the envisaged format in the curriculum ranges from “basic training in CAM” (46%) to a “general overview” (18%) including additional minor sugges-

tions with no significant implications. There is definitely no vision of a major curriculum restructuring to accommodate the new development. Once again the findings of this study reveal similar views to those expressed in other studies (Al-Shahib et al., 2000).

DISCUSSION AND CONCLUSIONS

This study set out to examine whether and to what extent community pharmacies in Johannesburg, South Africa, have become sites for the practice of CAM.

The study of community pharmacy as a profession on the one hand and CAM on the other are both linked to the general themes of professional authority and medical dominance (Turner, 1990). The marginality of community pharmacy and CAM in relation to the medical profession has been discussed, among others, by Saks (1998), Gilbert,* and Daniel (1998). One could argue that, because of the unique position in which community pharmacists find themselves—where their traditional functions have been eroded and they are engaged in efforts to replace the loss with new ones—they are eager to accept the merits of CAM and embrace it within their pharmacies, without giving serious consideration to the possible implications such as lack of training and conflicting paradigms.

The evidence presented in this paper, although based on a study of community pharmacies in Johannesburg only, can be interpreted as an indication of a general trend in urban areas in South Africa, that of involvement with CAM in the form of dispensing and sales of CAM products, provision of advice, and, in a few cases, employment of CAM practitioners to consult on their premises. Thus, the two systems of CAM and allopathic medicine are being practiced within the same premises. However, the manner in which they operate, as portrayed in this study is that of two separate systems existing in harmony side-by-side.

Because of the constrains of the study, it is difficult to ascertain whether this phenomenon is a first step toward the development of a more meaningful integration between the systems. It is much easier to demonstrate that this growth is driven by the pharmacists' response to the growing demand from the public and their readiness to seize the opportunity to expand their responsibilities and increase their profits. It seems that the pharmacists are not the only ones who, in this case, respond to public demand. From the CAM healers' responses it is clear that this is the main reason for their consultation within the community pharmacy. The perceived “great demand from the public” and the opportunity that the community pharmacy affords “access to more people” are without doubt the motivating forces behind this new trend. Additional motives such as a drive to “promote CAM” and the fact that it is “complementary and holistic” as well as personal drives such as “to gain experience” and a “big profit margin” complete the picture.

TABLE 5. FORMS OF CAM TRAINING

None—not even reading	8%
No special training—just reading et cetera	20%
Short training—a couple of lectures/short courses	39%
Substantial training over a period of time	15%
Official certificate/diploma in CAM	18%

CAM, complementary and alternative medicine.

Notwithstanding the debate with regard to the nature of the "integration," the convergence of the various healing practices within the premises of the community pharmacy is symptomatic of a perceived benefit to all. On the one hand, this has an understandable appeal for CAM, because practicing it within the confines of a "community pharmacy" situates it within the bounds of the "legitimate" allopathic medicine, increases its accessibility to the public and makes it seem part of the official health care system. On the other hand, the perceived emphasis on prevention and the individuals' responsibility for their own health fits in with the desired "new image" of the community pharmacy as a health-promoting center and has the added advantage of a potentially financially profitable move by pharmacists. One of the pharmacists interviewed articulated it in terms of professional survival: "If pharmacists don't change to alternative medicine, they are going to die." This might explain the lack of concern with regard to inadequate training and co-existence of potentially conflicting paradigms.

Although some of the issues emerging here are beyond the scope of this paper, they should point the way for further research, because they have the potential to add to our understanding of medical pluralism in general, and to "health care pluralism" in South Africa in particular.

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