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MAPPING OUT THE GROUNDS FOR AFRICAN PHILOSOPHY OF MEDICINE AND BIOETHICS

By

Okwenna, Chrysogonus M.

Abstract

In this paper, I open an inquiry that provides a catalyst for the inauguration of African Philosophy of Medicine and Bioethics (APMB) as a full-fledged academic pursuit. I situate this inquiry within the quest of early professional African philosophers for a stirring of the course of contemporary African philosophy along the path of critically retrieving, clarifying, and articulating aspects of traditional African culture and practices in the light of social pluralism and modernization. The case I make for the establishment of this discipline and my effort to delineate its nature, scope, and method hinge on three important realities: (i) The existence of African Traditional Medicine (ATM); (ii) the existence of philosophical puzzles in ATM that require conceptual, metaphysical, epistemological, ethical, and socio-political analyses; and (iii) the need to carry out this analysis in the context of the twenty-first-century reality of medical pluralism and globalization. Solidifying my effort to map out the landscape of this new enterprise, in the concluding part of this paper, I make recommendations on the direction the discipline is to take if it must fulfil its goal of providing a framework for the improvement of medical knowledge and practice in contemporary Africa.

Keywords: African Medicine, African Philosophy, Bioethics, Globalization, Western Medicine

Introduction

African Traditional Medicine (ATM) enjoyed a monopoly of attention in traditional African societies. Millions of Africans relied on ATM for their health and well-being. This monopoly was cut short by the introduction of Western Medicine (WM). In some quarters, efforts were made to suppress ATM; it was condemned as fetish, primitive, and unscientific (Ashu and Sudeshni, 134-138; Onah and Eyong, 1). This unfavorable appraisal of ATM has not completely changed. However, in recent times, efforts abound in the area of integrating ATM with WM. These efforts have often barely scratched the surface of the philosophical issues that arise in the practice of ATM.

With the inception of the Philosophy of Medicine and Bioethics (PMB) over 45 years ago, an avenue was created where scientifically minded philosophers and philosophically minded scientists could critically reflect and engage in systematic dialogue on philosophical puzzles that arise in the medical sciences (Tristram, 13). Unfortunately, reflections in this discipline have targeted philosophical issues in WM and other medical traditions only insofar as they contribute to its improvement (Tristram, 13). This approach is inadequate and has often eclipsed significant issues in other medical traditions or health-care systems. The institution of specific and special inquiries into these other medical traditions is of utmost importance because despite the prevalence of WM, very many people still subscribe to these alternatives and thus making them relevant in this contemporary era as far as recourse is made to them. Hence, in this paper, I launch a campaign for the inauguration of African Philosophy of Medicine and Bioethics (APMB).

Consequently, my goal in this paper is fourfold: (i) to argue for the necessity of APMB; (ii) to delineate its subject matter, nature, scope, and method; (iii) to initiate

preliminary reflections on some themes that are of importance to APMB; and (iv) to make recommendations for the concrete establishment and development of APMB.

African Traditional Medicine

Is ATM distinctive? If so, in what way? Is it in some way second-rate in comparison with WM? Can we rely on its explanations and methods? If it is not distinctive, and all medicine is WM, to what end do we engage in this inquiry?

Different societies world-over have evolved different forms of indigenous healing methods (Abdullahi, 116). These methods are often captured under the broad concept of Traditional Medicine (TM), indigenous medicine, ethno-medicine, folk medicine, complementary, and alternative medicine (Abdullahi, 115).The World Health Organization (WHO) provides one of the most accepted definitions of TM. According to WHO, TM is "the sum-total of the knowledge, skills, and practices based on the theories, beliefs, and experience indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses"(WHO, 1).S Hence, TM constitutes an ancient and culture-bound method of healing that humans have used to cope and deal with various diseases that have threatened their existence(Abdullahi, 115). ATM is one of these methods or traditions.

ATM therefore refers to the cumulative knowledge and practices among Africans, whether explicable or not, used in the diagnosis, prevention, and elimination of physical, mental, or social imbalance, and the restoration of health and wellness. By ATM, I do not suggest that there exists a seamless uniformity in medical practices across Africa such that what is said of one ethnic group in Africa is true of all others. It is only reasonable to say that ATM is representative of what medical practice is in most of Africa. Hence, ATM designates medical explanations and methods that pervade most of Africa. Having said that, ATM is based on knowledge, practical experience and observations handed down from generation to generation, either verbally or in written form, from African forebears. Just like the Asians, Africans had genuine medical theoretical systems whose purpose was to provide models of explanation, predictions, and controls that would allow them to link events in the world of everyday life with causal forces that either transcend or underpin that world (Hallen, 18). They had their unique perception of issues of health, wholeness, illness, and death; what they believed to be the cause of disease and disharmony, how they approached the promotion of health and harmony; what therapeutic solution they sought and the places they sought these therapies. These were determined by their culture.

ATM as well as TM has been distinguished from what we commonly refer to as Western, orthodox, scientific, or allopathic medicine (Samuel and Eugenia, 82). As regards medical explanations and methods, ATM has employed approaches different from WM. ATM usually takes a holistic approach. This approach is such that it seeks to explain instances of illnesses and diseases from multiple dimensions: spiritual, physical, and social. Hence, in healing, traditional healers try to balance these dimensions to preserve lives(WHO, 11).The importance of this healing systēm does not just lie in the ability to heal disease but its intent to holistically preserve the society through its social interactions, religious sacredness, and conservation of the environment (Adu-Gyamfi and Anderson, 95-96). Thus, ATM does not regard man as a purely physical entity but also takes into consideration the social and spiritual (God, gods, and ancestors) dimensions of the universe(Ester, 2). ATM covers both natural healing agencies such as leaves, roots, herbs; and the invocation of ritual or spiritual influences that are thought to be associated with them(Onah and Usang, 2). Hence, therapeutic methods used by traditional healers include herbalism, psychotherapy, simple surgical procedures, rituals, and symbolism (Agbor and Naidoo).

On the other hand, WM takes a reductionist approach. It sees illness and disease from a biological or physical dimension. It isolates the physical human body from social processes and treats it based on laid down scientific principles. This is why WM is characterized as scientific anthropocentric, individualistic, and mechanistic. Foster Opoku-Mensah distinguishes WM from ATM when he describes WM as any medical system that is based on sound biomedical research and is considered foreign to African culture (Foster, 10). WM is based on the principles of science, technological knowledge, and clinical analysis developed in North America and Europe. Hospitals, clinics, dispensaries, health posts, or their equivalents where the sick could be attended to form the outward expressions of this system.

African Philosophy of Medicine and Bioethics

The relatively recent field of study within the philosophy of science known as "Philosophy of Medicine and Bioethics" does indeed exist as a field of inquiry' (Adu-Gyamfi and Anderson, 95-96). However, African Philosophy of Medicine and Bioethics (APMB) does not yet exist as a discipline. The available scholarly publications on ATM or advocacies for its integration with WM only provide materials for reflection in APMB. The establishment and development of APMB are premised on: (i) the fact that the discipline of Philosophy of Medicine and Bioethics does not explore the depths of ATM since ATM exceeds its scope; and (ii) the fact that a culture or context-specific discipline—as evidenced by contemporary African philosophical discourses—promises to penetrate these depths. An inquiry of this sort is important because the categories of race, culture, and nationality continue to actively influence our attitudes, the methods we adopt, the choice of questions we ask, and the answers we give to those questions (Imbo, 1).

The answers that ATM gives to questions ought to be assessed. They must never be accepted simplistically, but must always be interrogated and evaluated to ascertain their correctness, validity, and suitability; and ground them on more plausible, truer, and formidable foundations. A field such as APMB simply seeks to carry out this important task for ATM. Hence, ATM is the subject matter of APMB; its conceptual, metaphysical, epistemological, and socio-political presuppositions provide the basis on which APMB thrives.

Consequently, the proper pursuit of APMB is the critical reflection on the theory and practice of ATM; the examination of philosophical problems and issues that arise specifically and frequently within ATM; the setting up of a framework for dialogue and interaction between ATM and other medical traditions. In carrying these tasks, an African philosopher of medicine and bioethics is to apply a critical and dialectical method; this method guarantees that while APMB preserves the "goods" in ATM, it remains focused on our universal commitment to truth, practicability, and logic. The method also ensures that the "goods" present in WM and other medical traditions are adequately incorporated. This does not make the outcome of this inquiry—contemporary African medicine—any less African. Kwasi Wiredu's proposal for intercultural interaction in an era of globalization is highly recommended in APMB (Wiredu, 64). Hence, while preserving certain aspects of ATM, APMB must emphasize the openness of ATM to the incorporation of truths, methods, and technologies from other medical traditions. It would be very unwise to ignore developments in other medical traditions in the name of preserving "tradition" in ATM.

It is important to add that in APMB, there is no separate inquiry into the medical issues distinct from the bioethical issues in ATM such that "African Philosophy of Medicine" is distinct from "African Bioethics." The distinction between philosophy of medicine and bioethics only succeeds conceptually (Engelhardt,4). Philosophy of medicine and bioethics essentially functions as one general field of investigation with areas of special focus (Paul, 5). While the philosophy of medicine is said to focus largely on epistemological and metaphysical in medicine, bioethics focuses on the ethical. However, there is a deep overlap between these aspects of medicine (Tristram, 99).

Hence, I see APMB as a single discipline that interrogates the metaphysical, epistemological, ethical as well as conceptual and socio-political problems in ATM.

Some Reflections in African Philosophy of Medicine and Bioethics

African Philosophy of Medicine and Bioethics is not simply descriptive, but thoroughly normative. It does not only seek explanations for what ATM is but also spells out what it ought to be, especially in terms of the assumptions upon which it is based. It is with this in mind, that I initiate model discussions in APMB. This reflection features the conceptual, metaphysical, epistemological, ethical, and socio-political questions that arise in the practice of ATM.

Conceptual Questions

APMB seeks to understand and define the conceptual *substrata* of ATM. Doing this requires insight into the understanding of concepts like health, medicine, disease, suffering, and death in ATM. Here, health and medicine are briefly surveyed.

In the traditional African conceptual framework, health entails a state of balance or equilibrium that an individual has established within himself and between himself, the spiritual, and his social and physical environment. It is a social phenomenon far more than an absence of disease. It entails virtually all facets of human life. In ATM, the belief in the existence of a supreme being and supernatural forces greatly influence the conception of health. Hence, healing becomes a part of the complex religious attempt to bring the spiritual and physical aspects of the universe as well as man who lives in it, into a harmonious unity and wholeness. This is why treatment often involves the use of both material substances (including plant remedies) and resources drawn from the cosmic world. On another note, in ATM, 'medicine' includes all herbal as well as psychotherapeutically and spiritual technique-herbal mixtures, ritual objects, incantations, and rites capable of changing the human condition for better or for worse. Hence, it may either be good or bad; it is good if it cures and heals, and it is bad if it is used to cause harm.

Now, it is the task of the African philosopher of medicine and bioethics to interrogate these concepts. S/he ought to be concerned about questions like the following: Is the ATM concept of health consistent with reality? Should it be retained or adjusted? How about models that view health simply as the absence of disease or ailment (as in WM)? How about those that conceive it as a state that allows the individual to adequately cope with all demands of daily life? Is there an all-embracing conception of health like the bio-psychosocial? (Onah and Usang, 2).How about ATM's conception of medicine? Should the concept of medicine include elements capable of causing harm? Are there other traditions whose description of medicine is more consistent with the "essence of medicine"?

Metaphysical Questions

It is the role of APMB to clarify the metaphysical foundations of ATM. This is because people's metaphysical worldviews profoundly affect their medical knowledge and practice. Consequently, the African philosopher of medicine and bioethics ought to interrogate the metaphysical presupposition(s) of ATM. An interrogation of this sort is sure to raise further metaphysical questions such as those on personhood and causality.

The metaphysical outlook of ATM has been described as eco-bio-communitarian or holism (Tangwa, 389). This shows the belief in the interdependence and harmony between earth, plants, animals, and humans. The communitarian dimension implicates the supernatural forces (both benevolent and malevolent). Consequently, illness is said to be caused by the breach of natural laws or the infraction of totemic principles or from forces directed by witches, wizards, sorcerers, evil spirits, or angered ancestors(Onah and Usang, 3-4). It is believed that people do not just suffer illness by chance or coincidence.

The supernatural cause of an illness is taken even more seriously. Hence, the restoration of health would require such acts as confession, and the performance of rituals. Within this metaphysical framework, a person is never understood only in terms of the material; he is seen as composed of constantly interacting material (biological), social and spiritual elements (Marcum, 7).

In the face of medical pluralism and globalization, many Africans today believe in the possibility of natural and supernatural causes of illness. While they have little or no difficulty in accepting biomedical explanations based on the presence of viruses, bacteria, parasites, cancer, or high blood pressure, they find it difficult to completely rule out the supernatural.

Hence, the African philosopher of medicine and bioethics is provoked to reflect on such questions as the following: Why are supernatural causes always implicated? Is there any advantage in seeking joint-help from traditional healers and medical doctors? What are the chances that WM's failure to treat some illnesses in Africa is a result of its neglect of the supernatural? Is the understanding of the human person in ATM more in tandem with reality? What must we retain, modify, or change as regards the metaphysical presupposition(s) of ATM?

Epistemological Questions

Questions on the nature, source, and method of acquiring medical knowledge in ATM are of great significance to the APMB. Questions of this nature seek to address the methodological issues involved in the practice of ATM. The activities of traditional healers are the reference point here. Traditional healers are believed to be intermediaries between the visible and invisible worlds. Their task is essentially the determination of the specific cause or causes of illness and the provision of medicines capable of restoring the individual. They carry out this task using methods such as divination, magic, witchcraft, and sorcery.

In contemporary African societies, ATM is faced with the huge demands posed by Evidence-Based Medicine (EBM) which is the dominant approach in WM. EBM which is put forth as the "gold standard" for clinical decision-making seeks to ensure that medical knowledge and practices are products of or subject to the rigors of scientific testing and verification. With EBM, health care professionals are required to base their health care decisions on the best available evidence. Proponents of EBM rely less on traditional medical authority and more on systematic clinical and laboratory observations and data, especially obtained from randomized clinical trials (RCTs) and interpretation of that evidence through meta-analysis (Stegenga, 12). According to EBM advocates, best evidence represents results from RCTs and meta-analysis of those trials (Stegenga, 7). They argue that EBM is essential for identifying and improving good health practices and eliminating bad ones (Adu-Gyamfi and Anderson, 82-83).

According to Maynard K., although ATM uses non-biomedical diagnoses and therapies that reflect cultural values and mores, it has always been based on careful observation and testing of remedies over time (136). Adu-Gyamfi and Anderson corroborate this when they say that ATM functions "due to centuries of practice, evolution, and experimentation, well established traditional doctors have a unique understanding of physiology, pathogenesis, pharmacology, and pharmaceuticals, which are different from western biomedicine"(82-83). Accordingly, forms of treatment in ATM have always included but are not limited to surgical procedures, dietary therapy, herbalism, and psychotherapy. These claims are of interest to the African philosopher of medicine and bioethics.

Also, the African philosopher of medicine and bioethics should ask the following questions: Can medical knowledge be based on supernatural causation? Do the principles of secrecy and mystery fare well in medicine? Is it possible to design a research study that is comprehensive for all ATM given its diverse forms, insufficient statistical power, and the

likes? How can medical knowledge in ATM be available or replicated in other circumstances? Should all medicine be evidence-based? Is ATM completely non-evidence based? Is there any logical coherence in the epistemic claims made in ATM? Is EBM in any way deficient or merely controversial? Should we go in search of new epistemological approaches other than EBM (Miriam, 1)?.

Ethical Questions

Medicine is moral. It is moral because the defining element of its practice is the patient-physician relationship; and that relationship is profoundly principled and often based upon ethical rules and duties. It is also moral because the physician's behaviour and not just his medical knowledge is critical for the patient's wellbeing and possible healing. It is again moral because the ethical mandate of medicine, concerning the physician's action, is to help—and not to harm—the patient. To harm the patient, either intentionally or unintentionally, is to fail at medicine's primary ethical mandate (Marcum, vii). This fundamental quality of medicine gives rise to different moral issues in medicine that dominate bioethics or medical ethical reflections today.

Western biomedical research and practice embrace at least two broad categories of moral questions. The first has to do with the patient-physician relationship, the conduct of the healing relationship, and the obligation of physicians to those who seek their help (Pellegrino, 1). Questions in this category include those on patient confidentiality or autonomy, informed consent, and acknowledgment of social obligation. The second comprises the whole range of "bioethical" and "biomedical" ethical issues such as abortion, surrogate motherhood, transplantation of human organs, experimentation on a human subject, euthanasia, artificial insemination, in vitro fertilization, embryo research, and eugenically motivated genetics, acquisition and use of genetic information, creation and release of genetically modified organisms, animal cloning, and human cloning, and issues on research publication(73). Although some issues in the second category of moral questions have not always been of direct concern in ATM, the first category which concerns the patient-physician relationship has been part and parcel of ATM.

ATM is embedded in tradition, culture, norms, and taboos. Traditional health care services are practiced following *Ubuntu* philosophy (an African ethical or humanist philosophy focusing on people's allegiances and relations with each other). A human being is holistic yet corporate, in terms of the family, clan, and whole ethnic group. Therefore, it is required never to harm the patient unless it is in his/her best interest of the community because if s/he suffers, s/he does not suffer alone but with his corporate group: when s/he rejoices, s/he is not alone but with his/her kinsmen, neighbors, and relatives (Innocent, 2). In this way, *Ubuntu* philosophy in ATM presents a twist to the traditional patient-physician relationship. Its model is more of a "patient-community-physician relationship." In some vital ways, the community comes in whenever the health of an individual is at stake. In fact, the community aspect of this relationship cannot be overemphasized. The community, often seen as bedside healers play a very crucial role in the restoration of a community member's health. Accordingly, this model is to be interrogated by African philosophers so that it can feature in contemporary health-care practices in Africa. Also, the fact that in most cases, traditional healers share a patient's language or dialect, idioms, and other communication signals, both verbal and nonverbal has fostered the patient-physician relationship in ATM.

Furthermore, besides considering other issues in bioethics that are recently gaining grounds in Africa, the African philosopher of medicine and bioethics must be concerned with issues in ATM resulting in exposure to blood: practices involving the use of shared instruments (ritual scarification, group circumcision, genital tattooing, Female Gentile Mutilation (FGM), etc.) (Agbor ang Naidoo, 137). S/he should be concerned with how traditional values influence research methodology or medical knowledge. APMB ought to consider the challenges of moral and social pluralism that beset bioethics since different

moral convictions exist and make for moral complexity in healthcare (Henk, 105). FGM is one such area of concern. In sum, APMB must interrogate the moral justifiability of "bad medicine" considering medicine's ethical mandate to assist a patient.

Socio-Political Questions

Medicine is a significant part of society; it is never practiced in isolation (Have, 7). It is always practiced within a specific socio-political climate. This climate influences the direction it takes. In the present nation-states arrangement, societies make policies that regulate medical practices. Depending on the nature of these policies, medical practices can either be improved or stifled. Hence, for the philosophy of medicine and bioethics, to scrutinize medical practices effectively, it has to take socio-political structures into account. Therefore, APMB must make forays into the social and political dimensions of ATM.

In some parts of Africa, the earliest reactions to ATM upon the introduction of WM was very negative. ATM was largely subjugated; it was even banned in some African countries. In recent times, however, efforts have been locally initiated to challenge the condemnation and stigmatization of ATM and to give it the recognition and acceptance it deserves. There are ongoing attempts to integrate ATM into formal health care systems (Abdullahi, 115-116). African countries such as Ghana have managed to integrate ATM products in the National Essential Medicine List while South Africa, Sierra Leone, and Tanzania have ATM products sold over the counters due to the availability of education training programs facilitated by research (Innocent, 2). In Nigeria, the Federal Government through the ministry of health encouraged and authorized the University of Ibadan in 1966 to research into the medicinal properties of local herbs to standardize and regulate ATM (Abdullahi,116). In 2000, Nigeria was the first to promote plant medicine for the treatment of HIV/AIDS (Adu-Gyamfi and Anderson, 82-83).

APMB must examine the above efforts and ensure that they are in the right direction. It must seek to reflect on present health-care policies, and influence the framing of future policies. It must assess the reasons presented for its rejection in some African communities.

Recommendations

To concretely establish and develop APMB and to ensure it remains committed to its goal, I make the following recommendations.

1. I recommend that a conference on APMB be held. This conference may be hosted by the International Society for African Philosophy and Studies (ISAPS). It is to attract African philosophers, traditional healers, Africans trained in the Western medical tradition, and academics in the sciences and humanities who are genuinely interested in ATM. The goal of this conference is to inaugurate a formal discipline that will critically reflect on ATM and work towards its improvement in modern African societies. The maiden version of an African Philosophy of Medicine and Bioethics Journal should follow this conference.
2. I recommend that reflections on ATM be as critical as possible and APMB should focus on: (i) what has been; (ii) what is, and; (iii) what should be. The normative aspect of the discipline— "what should be"—should always be highlighted. More so, in being critical, APMB must avoid the temptation of viewing ATM as "second-rate." The present understanding of ATM as "alternative medicine" should be interrogated (Agbor and Naidoo, 133-134). ATM ought to be conceived in terms of one of many competing health traditions in a globalized world (Solomon, 19). The tendency to view dominant practices in WM as standards should also be watched closely. As deeper reflections will show, some theories and practices in WM which are often presented as foolproof have fallen to many criticisms today (Solomon, 3 and 13).
3. I recommend that the logical foundations of ATM should also be taken into consideration while interrogating its metaphysical and epistemological foundations.

This is important because explanations abound as to why certain practices are employed in ATM. For example, traditional reasons given for FGM such as its religious and social significance, its promotion of health, hygiene and continence, etc. must be interrogated with surveys, studies, and evidence that link FGM with infertility, infections, maternal-fetal complications, and protracted labour to ascertain their scientific or logical basis.

4. I recommend that the religious affinities of ATM be carefully examined. It is not our desire that the spiritual dimension of ATM is completely obliterated. However, if they obscure explanations and make medical practices clandestine, their import should be examined and questioned. In cases where they do not serve any relevant purpose, they may be discarded.
5. I recommend that special attention be given to practices in ATM that have recorded enormous success and stood the test of time, especially in comparison with parallels in Western Medicine. Some examples are the medical practices of traditional birth attendants with low rates (or absence) of delivery through cesarean sections and the practices of bonesetters whose cases hardly result in amputation of gangrenous limbs, and who have handled referral cases from orthodox hospitals effectively.
6. I recommend that the African philosopher of medicine and bioethics should promote intra-African and Intercontinental reflections that are much needed in an era of medical pluralism and globalization. S/he must avoid the temptation of overgeneralization, but pay attention to the nuances in medical practices across cultures in Africa.

Conclusion

There are strong indications that ATM is still in use by the majority of people in Africa. It is argued that this is as a result of its accessibility, availability, affordability, tenacity, and effectiveness. These impressive qualities of ATM have brought about increased interest in ATM, even with the advancements in WM. This has led to publications on various aspects of ATM and efforts to integrate it into the mainstream health-care system of many African countries. The actual practice of ATM, these publications, and the efforts at integration have raised serious questions. These questions are often of a philosophical sort since they are not empirically resolvable and there are often competing and compelling views on them. They require thoroughgoing philosophical analysis. The African philosophy of medicine and bioethics sets the arena for this analysis, leading conversations towards the resolution of these questions. Its *telos* is to provide a basis for the improvement of ATM that will reach the status of contemporary African medicine, competitive with other medical traditions in twenty-first-century Africa. African philosophers, medical practitioners, and those interested in ATM are invited to direct their critical powers in the direction of inaugurating and developing this field of inquiry.

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