An African response to the Philosophical Crises in Medicine: Towards an African Philosophy of Medicine and Bioethics

https://dx.doi.org/10.4314/ft.v10i2.1
Submission: April 21, 2021 Acceptance: September 5, 2021

Chrysogonus M. OKWENNA
Simon Fraser University, British Columbia
Email: chrysogonusokwenna@gmail.com
ORCID: 0000-0002-3073-2232

Abstract
In this paper, I identify two major philosophical crises confronting medicine as a global phenomenon. The first crisis is the epistemological crisis of adopting an epistemic attitude, adequate for improving medical knowledge and practice. The second is the ethical crisis, also known as the "quality-of-care crisis," arising from the traditional patient-physician dyad. I acknowledge the different proposals put forward in the quest for solutions to these crises. However, I observe that most of these proposals remain inadequate given their over-reliance on the Western biomedical tradition (WBT) and the medical hegemony that underpins the proposals themselves. Contrary to the approach employed in these proposals, I propose medical pluralism as a viable platform for resolving the philosophic crises in medicine, by critically engaging non-Western medical traditions (NMTs) and thought systems. Ultimately, I make a push for the deliberate inauguration of an African philosophy of medicine and bioethics (APMB) and other context-specific or indigenous philosophies of medicine and bioethics that will ensure continuous investigations into NMTs and their contribution to global medical issues.
Keywords: African Traditional Medicine, Bioethics, Epistemology, Ethics, Medical Pluralism.

Introduction

Over 45 years have passed since the inception of the philosophy of medicine and bioethics (PMB), as a full-fledged academic discipline (ENGELHARDT 2002; STEGENGA 2018; GIFFORD 2011). The goal of this discipline has been to inquire into and resolve philosophical puzzles arising in as well as from medical practices. Over the years, philosophers of medicine and bioethics have reflected on epistemological, metaphysical, and ethical issues in medicine. For their task, they, occasionally foray into historical and socio-political questions arising therefrom. Although their efforts have been impressive, they remain inadequate. In my view, this inadequacy is the result of a defect in the epistemic disposition of most of these thinkers. A majority of these thinkers set out with the assumption that medicine is monolithic and that the Western biomedical tradition (WBT, hereafter) is the standard medical paradigm within which medical issues are to be ultimately

addressed and resolved. With this epistemic discrimination, non-Western medical traditions (NMTs, hereafter) are scarcely given any attention. This disposition is hegemonic, hubristic, narrow, and of course, ineffective. A disposition of this sort is sure to reap only lean benefits especially in this era of globalization where solutions to many problems are arrived at through critical conversations, interactions, or dialogue between and among divergent thought systems and traditions.

The ineffectiveness of this disposition, as well as the inadequacy of the proposals it gives rise to, are evident in the recurrence of two major crises in medicine. The first is the epistemological crisis of adopting an epistemic approach to medicine that guarantees consistent improvement in medical knowledge and practice. The second is the ethical crisis that arises from the interaction between patients and physicians in terms of the quality of care given to patients by physicians.

While Evidence-Based Medicine (EBM, hereafter) with its insistence on basing medical research and interventions on the best available evidence dominates the proposed solutions for resolving the epistemological crisis, the proposal of a patient-centered care (PCC, hereafter) with its various ways of emphasizing the dignity, rights, and autonomy of patients dominates the responses to the ethical crisis. No doubt, these proposals or responses emergent from the medical and intellectual tradition that grounds WBT, as it will be argued herein, are fraught with great difficulties. Some of these difficulties will only be overcome once thinkers break free from the medical hegemony that influences their proposals and approaches to resolving philosophical issues in medicine. A flexible but critical approach which allows the exploration of all medical traditions remains crucial for any inquiry that seeks to provide comprehensive solutions to the crises in medicine.

Hence, in what follows, I deviate from the status quo and attempt to resolve the highlighted epistemological and ethical crises in medicine by critically engaging African Traditional Medicine (ATM, after) and the philosophy that pervades it. To do this effectively, I explore some of the proposed solutions to these crises, especially EBM and PCC, to uncover their shortcomings. I emphasize the reality of medical pluralism and introduce the criteria of medical equality and efficacy as ideal standards for investigating all medical traditions. With the criterion of medical equality and efficacy, I initiate a critical investigation into ATM and its underlying philosophy. I articulate and present the multi-evidential (ME, hereafter) approach in ATM and the virtue of epistemic flexibility that undergirds it, and the notion of the human person with its communitarian underpinnings as plausible responses to the epistemological and ethical crises in medicine respectively. Finally, I argue for the establishment of indigenous philosophies of medicine and bioethics and attempt to map out the landscape for an African philosophy of medicine and bioethics (APMB).

Epistemological and Ethical Crises in Medicine

The epistemological crisis of adopting a suitable epistemic attitude in medicine became more evident when it became increasingly difficult to appraise medical knowledge, methods, explanatory models and interventions. Beginning in the 1970s, Medical Consensus Conferences (MCC, hereafter) were organised to respond to this fundamental challenge. These conferences provided a platform where experts meet to address and resolve controversies in public health. However, MCC failed to resolve the crisis since it became a mere epistemic and political ritual favoring the appearance of objectivity, fairness, democracy, and expert testimony over the efficacy of medical interventions and the freedom from bias (SOLOMON 2015, 2).

In the mid-1990s, EBM was proposed to address the limitations and excesses of MCC. (THOMPSON AND UPSHUR 2018, preface). According to the advocates of EBM, medical knowledge and practices must be products of or subject to the rigors of scientific testing and verification (THOMPSON AND UPSHUR 2018, preface). With EBM, health care professionals are required to base their health-care decisions on the best available evidence. Proponents of EBM argue that we must rely less on traditional medical authority and more on systematic clinical and laboratory observations and data, especially obtained from randomized clinical trials (RCTs, hereafter) and interpretation of that evidence through meta-analysis (that is, analysis of the evidence already given) (STEGENGA 2018).

Furthermore, for EBM advocates, the best evidence represents results from RCTs and meta-analysis of those trials (STEGENGA 2018, chapter 7: Summary). They argue that EBM is essential for identifying and improving good health practices and eliminating bad ones (ADU-GYAMFI and ANDERSON 2019, 82-83) Today, EBM is widely accepted and has become a "gold standard" or "the epistemic attitude" for medical research and practice.

Although EBM responds considerably well to the epistemological crisis in medicine, it also falls short. This is because it pays little or no attention to local knowledge and less formal methods in the initial stages of research development. It leads only to conservative innovation and is limited to only interventions ready to go into clinical trials (SOLOMON 2015, 3). EBM's huge demand for and narrow view of what counts as quality-of-evidence creates room for an intellectual hegemony that discourages investigations into NMTs. Hence, in my opinion, EBM also requires revision and "broadening," for unjustifiably glossing over or even silencing other medical traditions that are very important to so many peoples. A move that can be best described and at once be decried as epistemic injustice.

Translational Medicine (TM, hereafter) and Narrative Medicine (NM, hereafter) are two other approaches that set out to make up for the setbacks of EBM. While TM, (though not completely new, given its roots in case-based reasoning, clinical judgment, and general causal reasoning), seeks to make up for the methodological limitations of EBM, NM, which is a more expansive response,

employs a humanistic methodology and seeks to correct the reductionistic excesses of EBM (SOLOMON 2015, 12). Again, these approaches fail to address the assumption that medical knowledge is one-directional and fixed; they do not deal with the medical cum epistemic hegemony that underlie MCC and EBM. It is, therefore, instructive to look at other medical traditions and thought systems for better approaches and possible solutions to the epistemological crisis in medicine.

On the other hand, the ethical crisis expressed in terms of the tensions in the patient-physician relationship has become an area of great concern. Its beginning is traced to a time when patients began to express dissatisfaction regarding the quality of care received from medical professionals and to question the status of a patient in medicine and the moral obligation of physicians to patients (SOLOMON 2015, 1-2). There was a visible objectification of the human body in clinical practice as patients were understood and reduced to bodies of specimens. In medical interventions, there was more emphasis on technical cure and management of disease over human care and compassion. Although the root of this crisis is traceable to the naturalistic, reductionistic, and mechanistic principles that underpin WBT, it is directly fueled by the traditional paternalistic approach to the patient-physician relationship which was dominant until the 1960s. This approach invested medical professionals with the power to make medical decisions on behalf of a patient and in the patient's interest. The patient relies on the expertise of the physician and is expected to cooperate (AMZAT and RAZUM 2014, 200).

The paternalistic approach is heavily criticized for undermining the values, freedom, and autonomy of the patient, and promoting the arbitrary use of power by the physician. Three new approaches that emphasize patient-centered care (PCC) are put forward to address the challenges posed by the paternalistic approach. The first is the informative approach, the second is the interpretive approach, and the third is the deliberative approach.

According to the informative approach, the patient exercises control over medical care and makes medical decisions upon receiving relevant information concerning his medical condition. The physician only cooperates with the patient by carrying out the decisions made. For the interpretive approach, the physician ensures that medical interventions conform to the values and aspirations of the patient. S/he relates to the patient the nature of his/her condition, the risks, and benefits of possible medical interventions, listens and interprets the values and aspirations related by the patient, and provides the medical intervention that suits the patient (AMZAT and RAZUM 2014, 202). With the deliberative approach, the patient and the physician discuss various aspects of the medical condition, ensure mutual understanding of values and priorities, and make a choice on the best medical intervention based on their deliberation (AMZAT and RAZUM 2014, 201-202).

The above patient-centered approaches to the quality-of-care crisis in medicine resolve certain aspects of the crisis. While the informative approach satisfies the issues with informed consent, the interpretive approach ensures that the patient's values and aspirations are considered in medical interventions, and the deliberative approach, based on its interactional nature, ensures that there are adequate involvement and input from the patient as well as the physician and such allows the development and revision of views and values through deliberation. Nonetheless, these approaches also fail in some regards.

The informative approach undermines the role of the physician and wrongly assumes that a patient can make good medical decisions for him/herself. The interpretive approach places a huge demand for cultural competence on the physician such that in a multi-cultural society, the physician would have to be familiar with multiple cultures to function effectively. The deliberative approach fails in emergencies as it is time-consuming.

Generally, these approaches appreciably strive to reach a level where care is not compromised and the rights of the patient (as well as the physician) are not infringed on. However, they remain unsatisfactory since they only treat the superficial effects of the crisis. They fail to address the important question of the moral status of the patient in medicine. An approach or inquiry that seeks to sufficiently resolve this crisis ought to have at its core and starting point, the interrogation of the dominant conception of a person or patient in medicine, and the articulation of a more humane concept that guarantees that a patient is treated accordingly.

Medical Pluralism and the Criteria of Equality and Efficacy

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 1998; NAPOLI 2011, introduction). Although medicine is a universal phenomenon, the direction it takes is greatly influenced by the different socio-political and cultural climates where it is practiced (HAVE 2002; MARCUM 2012). This is why we have different medical traditions. These medical traditions evolve from attempts by various cultures or societies to deal with universal problems associated with health and disease that threaten their existence (ABDULLAHI 2011, 115). The widespread medical tradition, also known as Western biomedicine (WBT), mainstream medicine, orthodox, modern medicine, conventional, and allopathic medicine, largely evolved from Europe and North America (ADU-GYAMFI and ANDERSON 2019, 83; RICHTER 2003, 7). Many other popular medical traditions have their origins in China, India, Korea, Arabia, and Africa. These medical traditions, outside what is considered "mainstream medicine," are often captured under the broad concept of Traditional Medicine (TM) and are similarly referred to as non-Western medical tradition (NMT), indigenous medicine, ethno-medicine, folk medicine, complementary, and alternative medicine (ABDULLAHI 2011, 115).

Medical pluralism attests to the existence, use, or integration of these different medical traditions, often grounded in different principles or based on different world-views within societies. With globalization, medical pluralism became a common phenomenon in many modern societies. From observation, medical traditions often relate or exist in any of the following three ways: complementary, competitive, and conflicting. In societies where a complementary relationship exists, indigenous medical traditions complement WBT or vice-versa, in which case, different medical traditions are recognized and incorporated in the general health care system of the society. Where the relationship is competitive, different medical traditions lay claim to expertise on various illness conditions and try to prove their effectiveness. Where the relationship is conflicting, tension exists between different medical traditions. Unfortunately, in cases of conflict, a rival medical tradition may be subjugated, condemned, or even banned. Consistent with this pattern, in many countries, WBT exerts dominance over NMTs. According to Amzat & Razum (2014, 209) and Adu-Gyamfi & Anderson (2019, 82-83), in favour of WBT, some individuals reject or dismiss NMTs as quackery or "second rate." They criticize these traditions as non-scientific, not amenable to science, non-susceptibility to empirical investigation, less advanced, and non-evidence-based with non-reliable methods and explanations

In spite of the foregoing observation, it needs to be disclosed that many people still seek help from NMTs. NMTs continue to enjoy serious patronage. Some argue that this is the case because of their affordability, accessibility, availability, tenacity, and conformity to the belief systems of indigenous communities. Although this is true, there is more to this. Many NMTs have proven themselves to be practically effective. They provide different practices, measures, explanations, and procedures for the maintenance of health as well as the prevention, diagnosis, improvement, or treatment of physical and mental illness (WHO 1976, 2-4; WHO 2000, 1). Some practices in these traditions have recorded enormous success. Examples include low rates (or absence) of delivery through Caesarean sections among traditional birth attendants and low cases of amputation of gangrenous limbs in the activities of bonesetters (ONAH AND USANG 2018, 3-4). NMTs have handled referral cases from WBT practitioners effectively. More so, since traditional health practitioners understand the socio-cultural background, historical events, language, and beliefs of patients and the implications of these categories for health and well-being, they handle the care of the sick very effectively.

Although WBT may legitimately lay claims to sophistication since it has championed several medical breakthroughs. However, just like other medical traditions, it has not sufficiently responded to all medical challenges or health problems (WEBER 2006, 2). No single medical tradition has all the answers to the rising problems in medicine. This truth and the fact of the effectiveness of NMTs calls for a disposition of medical equality or epistemic equality in which case every medical tradition is given a fair hearing; the knowledge claims of different medical traditions are equally taken seriously (at least, at the beginning of every inquiry). Hence, medical equality shuns the attitude of focusing only on a particular medical tradition and hurriedly dismissing solutions proffered by others.

It must, however, be noted that my insistence on medical equality is not an invitation to tolerate, legitimize, validate, or sanction every medical intervention proposed by any medical tradition. This unbridled medical relativism must be avoided. With medical equality, I recognize the potentials in every medical tradition to respond to certain difficult questions in medicine. However, responses provided by every medical tradition must be equally scrutinized according to the criterion of efficacy. Similarly, according to Weber (2006, 1), the criterion of efficacy comes as a standard or principle for ascertaining the effectiveness of medical interventions. According to this criterion, to accept any medical intervention proposed by a medical tradition, such an intervention must fulfil two conditions, that is, the conditions of efficacy. While the first condition is the condition of practical effectiveness, the second condition is that of theoretical effectiveness. With the first condition, a viable medical intervention must have or promise to have practical success in which case it must possess the ability to resolve a given health problem, crisis, or illness. With the second condition, a viable medical intervention must register or promise to register theoretic success in which case it must provide or strive to provide logical explanations for its medical interventions.

It is true that while most medical traditions pass the first condition of the efficacy criterion, many medical traditions, especially NMTs, do not fare well when it comes to the second condition. In other words, while most medical traditions do boast of the practical success of most medical interventions, many NMTs do not measure up regarding theoretic effectiveness by providing critical explanations for their interventions. I, however, insist that a medical tradition should not be dismissed simply because it does not provide satisfactory explanations for its effective medical interventions. NMTs nonetheless, must set aside ample time and conscious effort to always engage such traditions to seek sustainable explanations. Hence, in my opinion, although both are important, the condition of practical effectiveness is more crucial and takes precedence over the criterion of theoretic effectiveness especially when the ultimate end of medicine is viewed as ‘cure’.

Generally, the criteria of medical equality and efficacy ensure that all medical traditions constantly work towards attaining the goal of medicine, that is, to inquire into the nature and causes of health and disease for the purpose of cure, understanding or explanation, and prevention. They ensure that they are all considered based on the effectiveness (practical and theoretic) of their response to given health issues; to the extent that they respond to the goal of medicine. Hence, it is with the consciousness of medical equality and efficacy that we turn to African Traditional Medicine (ATM).

African Traditional Medicine (ATM) and the Crises of Medical Practice

African Traditional Medicine (ATM) refers to a medical tradition indigenous to Africa. Just like other medical traditions, Africans have medical systems comprising of knowledge and practices used in the diagnosis, prevention, and elimination of physical, mental, or social imbalance and the restoration of

health and weakness. These systems were grounded in the knowledge, practical experience, observations, beliefs, and philosophies handed down from generation to generation of Africans. The African culture greatly influences the perception of issues of health, wholeness, illness, and death in ATM; what is believed to be the cause of disease and disharmony, how they are approached; what therapeutic solution is sought, and the places they are sought (ONAH and USANG 2018, 1-2).

It is, however, important to note that ATM does not suggest the existence of a seamless uniformity in medical knowledge and practices across Africa such that what is said of one ethnic group in Africa is true of all others. There are slight (and even in some cases, great) differences in the approaches of different groups to medical issues. That is why we speak of "medical systems," not "medical system." Hence, it is only reasonable to say that ATM is representative of what medical practice is in most of Africa. Consequently, we use the term ATM to designate medical explanations and methods that pervade most of Africa. Hence, sub-medical traditions such as those of the Yorubas, Hausas, Zulus, and Gĩkũyũs fall under ATM.

Just like many NMTs, the methods of acquiring knowledge and treatment practices in ATM are undergoing critical and scientific scrutiny. Most of the physical aspects of ATM have been considered amenable to science and projects of integration are on-going in many parts of Africa. However, the spiritual aspects of ATM still pose a lot of difficulties. The acquisition of medical knowledge and intervention using methods like divination, magic, sorcery, and witchcraft remains suspect (ONAH and USANG 2018, 3). Some of these methods and interventions are guarded by secrecy, shrouded in mystery, and often appear grossly illogical. Although ATM does not score well, when theoretic effectiveness or success is considered, the patronage it enjoys witnesses to its practical effectiveness. More so, the epistemological and ethical principles that underpin it provide possible solutions to the epistemological and ethical crises in medicine.

At this juncture it is to be granted that ATM has its own epistemic grouses to respond to but these shortcomings do not prohibit ATM from proffering possible solutions to the epistemological and ethical crises in medicine. The same way the epistemic crises in WM does not prevent it from laying claim to medical knowledge. Now, some of the major epistemic challenges of ATM are measurement, codification and objectivity. Serious efforts have been made nonetheless, in tackling these problems, as there are indications that the physical components of ATM have been made available for scientific study and analysis just as we shall see in the example below about the study of the herbs that eradicated the symptoms and signs of HIV. Another challenge still abounds, and that is how to make scientifically amenable, the spiritual dimension of ATM. Well, I argue that, this obviously falls outside the scope of modern science and that ATM does not need validation from science in this regard. Afterall, modern science is not the only source of human knowledge and science admittedly cannot prove everything. It can neither confirm or deny all of reality (LOWER 2020).

Therefore, the epistemological approach employed in ATM is simply multi-evidential (ME). According to this approach, which is for the most part comprehensive, multiple sources, elements, and processes feature in the accessing, assessing, and expanding of medical knowledge. These sources, elements, and processes include visible as well as invisible aspects of reality—the physical, the social as well as the spiritual or mystical aspects of reality. In ATM, the consciousness of these aspects of reality shapes medical inquiries and the nature of medical interventions such that whatever counts as medical knowledge must consider these aspects of reality. Hence, a typical medical intervention in ATM is a complex attempt to bring a patient into harmony with the physical, social, and spiritual forces in the universe. In ATM, health is not simply conceived in terms of the absence of disease, but harmony among these forces; it entails a state of balance or equilibrium that an individual has established within himself, with his society, his physical environment, and the spiritual (ONAH and USANG 2018, 1). This epistemological disposition corroborates the multifactorial etiology or causality cherished in ATM. Even in contemporary African societies, the belief in the possibility of natural as well as supernatural causes of illness is very common and in some places even prevalent. This disposition ensures that while there is little or no difficulty in accepting biomedical, mechanistic, or naturalistic explanations for illness, mystical or supernatural causes are not completely ruled out (ONAH and USANG 2018, 4; ABDULLAHI 2011, 116). In other words, in the event of illnesses or diseases, multiple causes, explanations, and therapies are entertained. This is why for instance, ATM through the use of herbs and other natural remedies can boast of fair success like its Western counterpart in the attempt to cure HIV/AIDS. A recent study under normal scientific conditions verified the effectiveness (clinical and laboratory responses) of a local herb, Nigella sativa, and honey in the eradication of the signs and symptoms HIV (ONIFADE and OGUNRIN 2013).

This approach supported by ATM is very important for the resolution of the epistemological crisis in medicine. However, it is very important to note here that ATM's potentials, through the ME approach, to resolve the epistemological crisis in medicine does not simply lie in its appeal to multiple evidence, explanations, and methods. The random or arbitrary validation of empirically verifiable, unverifiable, and yet-to-be-verified interventions, explanations, and methods is problematic. If the multi-evidential nature of ATMs triggers medical equality without consciously placing a premium on medical efficacy, the results will be devastating. Hence, ATM's potentials to resolve the epistemological crisis in medicine through the ME approach lies primarily in the attitude of epistemic flexibility that undergirds the ME approach. This attitude ensures that, in medical practice, various forms of evidence, explanations, and methods are welcomed and never dismissed without serious consideration of their usefulness, whether or not they have conclusive scientific or empirical grounds. With this attitude, ATM overcomes most of the limitations and excesses surrounding classical responses to the epistemological crisis in medicine. The criterion of medical efficacy always comes to temper whatever excesses there is.

This is further demonstrated and instantiated in the contrasting epistemic stances of the allopathic approach that characterizes WM and ATM's homeopathic character. For one, ATM's homeopathic nature is multidirectional, employing various genuinely applicable healing regimens and most importantly it observes 'the whole' of the individual. Whereas, the allopathic approach of WM is more streamlined as it seems only to be interested in the disease or the ailing part of the person. Accordingly, ATM's homeopathic treatment is built on the case taking in which disease diagnosis is relatively less essential to the individuality of the person. WM's allopathy on the hand, is narrowed in such a manner as to only attempt to relieve the symptoms of diseases and most times overlooking all other aspect of the patient.

Consequently, unlike EBM, the ME approach has a broad view of what counts as evidence. It dares to tolerate even non-empirical evidence and explanations for medical interventions. It opens up new possibilities of explanations and methods in medicine. The ME approach challenges the consensus that medical knowledge and explanations must be evidence-based, evidence especially as construed in EBM. Although it acknowledges the value of theoretic effectiveness, it sees the primacy of practical success over theoretic success. It dares to intervene in cases where ordinary empirical methods of treatment and explanations fail.

Among other things, the ME approach explores the possibility of basing medical knowledge also on the beliefs and experiences of the people. It sees the relevance of local beliefs about causality in understanding population health and in drawing behavioural interventions (AMZAT and RAZUM 2014, 33). Since it pays attention to local knowledge, beliefs, and less formal methods in medical interventions, it is not limited only to interventions ready to go into clinical trials and this boosts its potentials for massive innovations. Most importantly, epistemic flexibility in the ME approach ultimately deals with the medical hegemony created by MCC and EBM. This is why, beyond other political considerations, WBT easily fits into ATM. In this case, ATM has greater potentials to attain the goals of "integrative medicine" since it is open to consider and combine a variety of medical approaches in medical interventions (BERNDTSON 1998, 22-25).

Concerning the ethical crisis, the understanding of the human person in traditional African philosophy presents a competitive solution to the quality-of-care crisis. In traditional African philosophy, a patient is a person, a 'being-in-community', not an individual material or mere physical entity; he is not an isolated, atomic individual, but a being in a community with beliefs, values, and preferences; he is inherently (intrinsically) a communal being, embedded in a context of social relationships and interdependence.

This communitarian understanding of the human person is strongly rooted in the Ubuntu philosophy, which is an African ethical or humanist philosophy focusing on people's allegiances and relations with one another. According to Ubuntu, 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 person unless it is in his best interest and the interest of the community because if

he suffers, he does not suffer alone but with his corporate group: when he rejoices, he is not alone but with his kinsmen, neighbours, and relatives (INNOCENT 2016, 2). In this case, the community has an ontological primacy and independence and this is well ingrained in the minds of the people (GYEKYE 2010; MENKITI 1984). Therefore, the sense of community characterizes and guides all traditional institutions including ATM.

With Ubuntu in ATM, a twist to the traditional patient-physician dyad is possible. Ubuntu's model is more of a "patient-community-physician triad." With this triad, the community comes in whenever the health of an individual is at stake. In simpler terms, members of the community, family, and kin, complementing the efforts of the physician, become "bed-side healers" through care and acts of solidarity. In other words, the community does not leave the care of the sick to physicians alone. They contribute heavily to the care of the sick. Hence, health and healing become a collective effort. More so, the ethos of the community—its tradition, norms, and taboos—guide medical interventions and relations with patients. The physician, therefore, does not act from his volition. S/he, as well as other members of the community has the task of not only healing the sick but preserving the community and all its components.

In this triad, the community as expressed through family and kin, is directly involved in the decision-making process regarding the kind of care an ailing patient receives. WM is often silent on this note or it simply sacrifices the input of the community on the altar of patient autonomy or expert opinion. From a pragmatic standpoint, there is the need for a seamless relationship between the physician, the community and the patient, because, above and beyond all, it is the family and kin of the patient in almost all instances who stay to care for the patient after the physicians must have administered their treatment. In most cases, they provide moral support, find ways to sooth pains and even bear the financial burden of the treatments. This is what the Ubuntu model capitalizes and it is unlike anything in WM, that there is a shared harmony of identity and solidarity between the community, the patient and the healer under the bond of moral obligation.

The patient-community-physician (PCP) model that underlies ATM resolves a majority of the problems in the ethical crisis of medicine and those raised by traditional attempts at resolving these problems. For instance, its conception of a person as a being with a communal significance addresses the issue of the objectification of a patient in medicine. Also, it surpasses the paternalistic approach in channelling the power of making medical decisions from the physician to the community. In doing this, the authority and role of the physician are not undermined insofar as he acts following the reasonable and established ethos guiding the community. In the same vein, it resolves the issues with patients' autonomy created by the informative approach. The community ensures that the sick does not take harmful medical decisions. Since the physician as well as the community know and might even share the patient's moral traditions and ethical values, language or dialect, idioms, and other communication signals, both verbal and nonverbal, the difficulties posed by the interpretive approach is adequately addressed (AGBOR and NAIDOO 2013, 33). This also resolves the difficulties with time posed by the deliberative approach.

This might seem impossible to universalize but it is a hurdle that can easily be crossed when we factor in how physicians are trained and prepared for patient care. For example, as against how physicians ought to know the moral traditions of their patients, I argue that values and moral convictions of patients can be factored in when looking at patient demographics. In fact, because of the role of cultural beliefs in shaping peoples' concept of health and illness, some have already argued that health care workers in this era must undertake some training process that will aid them to identify with the various cultural beliefs of the people they deal with (COLLINS and BURNS 2007, 38). Moreover, community shall always be the community no matter the geographical location. The family (spouse, parent, sibling etc.) of the patient is almost and always a constant. Hence, there shall be little to no drawback in any attempt to universalize the PCP triad.

Inaugurating an African Philosophy of Medicine and Bioethics (APMB)

It is understandable, for at least two reasons, that the mainstream and dominant tradition of the philosophy of medicine and bioethics (PMB), does not pay much attention to NMTs. The first reason is that PMB, even when it offers claims regarding medicine in its generality, it focuses on WBT, which is the most widespread medical tradition. The second, and more important reason, is that PMB, in reality, cannot sufficiently explore the depths of every medical tradition. However, as it has been made evident, great potentials lie within NMTs to provide solutions to the rising puzzles in medicine, and only a critical engagement and investigation into NMTs can facilitate the unleashing of these potentials. Hence, I consider the establishment of contextualized philosophies of medicine and bioethics that will ensure the consistent contribution of NMTs to the medical discourse a crucial matter. Here, I only attempt to set out the landscape for an African philosophy of medicine and bioethics (APMB).

APMB seeks to explore the conceptual, metaphysical, epistemological, ethical, and socio-political foundations of ATM. On the conceptual level, it seeks to understand and define the conceptual substrata of ATM; to understand and interrogate the concepts of health, medicine, disease, suffering, and death in ATM. On the metaphysical level, it interrogates the metaphysical worldview of holism that underpins ATM and its doctrine of natural and supernatural causation. On the epistemological level, it seeks to critically examine traditional methods of acquiring and expanding medical knowledge in ATM. It addresses the methodological issues involved in medical interventions given by traditional healers. It interrogates medical explanations offered by traditional African societies to questions of significance arising in medical practices that people everywhere long to understand. Further on, on the ethical level, it addresses moral questions that arise in ATM. It concerns itself with how we can ground medicine and bioethics in the values of the African people. It seeks to contribute to the solution of moral dilemmas in health care from a perspective that takes African

values seriously. On the socio-political level, it examines health-care policies and seeks to influence the framing of future policies, especially in favour of the preservation of effective practices in ATM. This can be achieved by the conference of African philosophers, traditional healers, Africans trained in the Western medical tradition and academics in the sciences and humanities who are interested in ATM. Similarly, a systematization of the discipline can be deliberated upon in conferences and meetings held by International Society for African Philosophy and Studies (ISAPS) or similar national bodies (OKWENNA 2021).

The goal of APMB is not merely to chronicle and romanticize indigenous medical methods and explanations. APMB, being a second order activity, critically interrogates and evaluates these methods and explanations. African Philosophers of medicine and bioethicists, shall through both their combined deliberative and investigative efforts, seek to ascertain their correctness, validity, and suitability; and to ground them on more plausible, truer, and formidable foundations consistent with the realities of modern living. Hence, with the reality of globalization, APMB exposes ATM to criticisms and entertains the possibility of revising some of its practices and explanations in the light of more plausible practices and explanations in other medical traditions. Here, Kwasi Wiredu's proposal of "ground rules" for dialogue and intercultural interaction in an era of globalization is highly recommended (WIREDU 2010, 64). Hence, while preserving certain aspects of ATM, ATM must be open to truths, methods, and technologies from other medical traditions. It would be unwise to ignore truths in other medical traditions in the name of preserving tradition or culture.

Furthermore, it is important to add that in APMB, there shall be no separate inquiry into the medical issues different from the bioethical issues in ATM such that "African Philosophy of Medicine" is distinct from "African Bioethics." In this paper, the distinction between the "philosophy of medicine" and "bioethics" only succeeds conceptually (ENGELHARDT 2002, 2; MARCUM 2012, 4). Philosophy of medicine and bioethics (PMB) essentially functions as one general field of investigation with areas of special focus (THOMPSON AND UPSHUR 2018, 5). While the philosophy of medicine is said to focus largely on epistemological and metaphysical issues in medicine, bioethics focuses on the ethical. However, there is a deep overlap between these aspects of medicine (ENGELHARDT 2002, 99). Hence, the paper considers APMB as a single discipline that critically engages ATM all-round.

Conclusion

I have desired, from the start, to provide a catalyst that provokes deliberate inquiries into different medical traditions and thought systems to seek solutions to philosophical issues in medicine. Hence, I launched such an inquiry by investigating ATM and traditional African philosophy. My inquiry shows that while the attitude of epistemic flexibility which underlies the multi-evidential (ME) approach supported by ATM responds to the longing for an adequate epistemic attitude that guarantees improvement in medical knowledge and

practice, the patient-community-physician triad (PCP) and its emphasis on the role of the community in medicine responds to the quality-of-care crisis. Also, the ME approach in ATM addresses the medical hegemony that surfaces in many reflections on medical issues today. I do not by this inquiry suggest that ATM is in perfect shape. Certain aspects of ATM still require critical engagement and updating. First on the list are those aspects that associate medical interventions with the metaphysical, spiritual, mystical, or invisible. This is why I express great faith in APMB. APMB, among other things, promises not to simply scratch the surface of philosophical issues that arise in the theory and practice of ATM but to critically explore their depth, and make ATM contribute to global questions and challenges in contemporary health care practice and research. African philosophers, medical practitioners, and those interested in ATM are invited to direct their critical powers to the establishment and development of this field of inquiry.

Relevant Literature

1. ABDUALLAHI, Ali Arazeem. "Trends and Challenges of Traditional Medicine in Africa." [African Journal of Traditional, Complementary, and Alternative Medicines], pp. 115-123, November, 2011. No.8. Paperback.

2. ADU-GYAMFI, Samuel & ANDERSON, Eugenia. "Indigenous Medicine and Traditional Healing in Africa: A Systematic Synthesis of the Literature," [Philosophy, Social and Human Disciplines], pp. 69-100. 2019. Vol 1. Paperback.

3. AGBOR, Ashu Michael & NAIDOO, Sudeshni. "A Review of the Role of African Traditional Medicine in the Management of Oral Disease." [African Journal of Traditional, Complementary, and Alternative Medicines], pp. 133-142, July 13(2) (2016. Vol 13. No1. Paperback.

4. AMZAT, Jimoh and RAZUM, Oliver. [Medical Sociology in Africa], 2014. Springer: Dordrecht. Paperback.

5. BEHRENS, Keith. G. "Towards an Indigenous African Bioethics." [SAJBL], pp. 32-35. June, 2013. Vol 6. No1. Paperback.

6. BERNDTSON, Keith. "Complementary and Alternative Medicine—Integrative Medicine: Business Risks and Opportunities." [Physician Exec.], pp. 22-25. Nov-Dec, 1998. Vol 24. No 6. Paperback.

7. COLLINS, Robert and BURNS, James. [A History of Sub-Saharan Africa], 2007. Cambridge University Press: Cambridge. Paperback.

8. ENGELHARDT, Tristram. "The Philosophy of Medicine and Bioethics: An Introduction to the Framing of a Field." [The Philosophy of Medicine], Tristram ENGELHARDT Ed., pp. 1-14, 2002. Kluwer Academic Publishers: New York. Paperback.

9.____."Bioethics and the Philosophy of Medicine Reconsidered." [Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal], 2002. Vol. 50. Ronald CARSON & Chester BURNS Eds. Kluwer Academic Publishers: New York. Paperback

10. GIFFORD, Fred. "Philosophy of Medicine: Introduction," [Handbook of Philosophy of Science: Philosophy of Medicine], Vol 16. Fred GIFFORD Ed., Elsevier: Amsterdam. Paperback

11. GYEKYE, Kwame. "Person and Community in African Thought," [Person and Community, Ghanaian Philosophical Studies], Kwasi WIREDU Ed., pp. 101-122. The Council for Research in Values and Philosophy: Washington, DC. Paperback

12. HAVE, Henk Ten. "From Synthesis and System to Morals and Procedure: The Development of Philosophy of Medicine," [Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal], pp. 105-123, 2002. Vol 50. Ronald CARSON & Chester BURNS Eds., Kluwer Academic Publishers: New York. Paperback

13. Imbo, Samuel. [An Introduction to African Philosophy]. 1998. Rowman & Littlefield Publishers: Lanham. Paperback.

14. INNOCENT, Ester. "Trends and Challenges toward Integration of Traditional Medicine in Formal Health-Care System: Historical Perspective and Appraisal of Education Curricula in Sub-Sahara Africa," [Journal of Intercultural Ethnopharmacology], pp. 1-5, 2016. Vol 5. No 2. Paperback.

15. JO NAPOLI, Donna. [Treasury of Greek Mythology: Classic Stories of Gods, Goddesses, Heroes, and Monsters], 2011. National Geographic Society: Washington DC. Paperback.

16. LOWER, Stephen. "The Limitations of the Scientific Method," [Chemistry Libertext], N.P, August 2020. Retrieved September 2021.

17. Marcum, James. [Philosophy and Medicine: The Virtuous Physician], 2012. Vol. 114. Springer: London. Paperback.

18. MENKITI, Ifeanyi. "Person and Community in African Traditional Thought," [African Philosophy: An Introduction], Richard WRIGHT Ed. 1984. University Press of America: Lanham. Paperback.

19. OKWENNA, Chrysogonus M. "Mapping Out the Grounds for African Philosophy of Medicine and Bioethics." [Paper forthcoming in Sophia: African Journal of Philosophy]

20. ONAH, Gregory and EYONG, Usang. "The Concept of Health and Wholeness in Traditional African Religion and Social Medicine," [Arts and Social Sciences Journal], pp. 1-5, 2018. Vol 9. No 4. Paperback.

21. ONIFADE, A. A and OGUNRIN, O. O. "Effectiveness of a Herbal Remedy in Six HIV Patients In Nigeria," [Journal of Herbal Medicine], pp. 99-103, 2013. Vol 3. No 3. Paperback.

22. RICHTER, Marlise. "Traditional Medicines and Traditional Healers in South Africa." Conference Paper at the Treatment Action Campaign and AIDS Law Project (2003).

23. SOLOMON, Miriam. [Making Medical Knowledge]. 2015. Oxford University Press: Oxford. Paperback.

24. STEGENGA, Jacob. [Care and Cure: An Introduction to Philosophy of Medicine]. 2018. The University of Chicago Press: E-book.

25. THOMPSON, Paul & UPSHUR, Ross. [Philosophy of Medicine: An Introduction].2018. Routledge: London. Paperback.

26. WEBER, Daniel. "Medical Hegemony," [International Journal of Complementary and Alternative Medicine], pp.1-2, 2006. Vol 3. No 2. Paperback.

27. WHO. [African Traditional Medicine: Report of the Regional Expert Committee: AFRO Technical Report Series]. 1976. WHO: Brazzaville. Paperback.

28. _____. [General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine]. 2000. World Health Organization: Geneva. Paperback.