African Bioethics: An Explanatory Discourse

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Abstract

It is argued that current discourse on bioethics in most institutions of higher learning has remained trapped in western categories of thought and, as a result, this discourse has remained without anything significant to say about African bioethics. The bias of this discourse can be discerned from the fact that, for the most part, it takes a western scientific and philosophical outlook as its starting point for bioethical reflection in the African context. The bastardisation that has for so long been inflicted on African traditional healthcare practices by missionaries and western-trained anthropologists has made an enormous contribution to the silencing of a meaningful discourse on African bioethics. The contemporary scholarly realisation that all bioethics are culturally conditioned is an invitation for African bioethics to be brought into the frontiers of scholarly debates on bioethics in the African context. This paper will argue that since the majority of the African population relies on the African traditional doctor for most of their health needs, an authentic discourse on bioethics in Africa must seriously consider the hold which African traditional healthcare practice has on African people.

The Resilience of African Bioethics

A friend of mine who is both a devout Christian and highly educated was involved in a car accident from which he sustained minor injuries. He was taken to the hospital and examined by the doctor who prescribed him painkillers and subsequently discharged him. Although he had managed to recover from shock the following day, he proceeded with his family to consult a traditional doctor. Three weeks after a visit from the traditional doctor, the whole community was invited to his house for an ancestral ceremony, at which we all ate, sung, danced

and drank to our fill. It became obvious that there was another diagnosis that had been left out by the western-trained doctor in the hospital and could not diagnose the relationship between the car accident in which my friend had been involved and the ancestral realm. It is common knowledge in most of our African communities that sometimes priests, western-trained African doctors, professors, political leaders, kings and chiefs consult the traditional doctor at critical times of their lives. While most Africans might make use of the western medical healthcare services, in many cases, they still proceed to see the traditional doctor. They do not throw away the medication they are given in hospitals but rather one finds them taking their hospital medication simultaneously with that prescribed by the African traditional doctor. Sometimes African traditional doctors themselves go to hospitals for diagnosis and treatment. This observation has led me to the idea that while there has been a tendency among academics and most of our health institutions in Africa to talk of bioethics solely in terms of western categories of thought, African bioethics has not yet been given serious scholarly reflection. The problem with this academic habit is that it has turned a blind eye to the real nature of African bioethics.

The urgency of a discourse on African bioethics emanates from the observation that the inherited, western healthcare system does not provide us with an adequate understanding of life, death, health and disease within the African context. The majority of the African population lives in a context in which the traditional doctor is more available than the western doctor. What bioethics means to the majority of these people is peripheral to most of our scholarly discourses on bioethics. Recent efforts by the South African government to integrate African traditional doctors with existing western-oriented medical institutions through legislation, has been met with mixed feelings. While some African traditionalists have applauded such moves as bold and noble, there are those who belong to the western-oriented medical profession that have reacted with disgust.

The western-oriented healthcare system is based on the belief that a good healthcare system in Africa will prevail once the traditional African healthcare has been converted to a western healthcare system. This self-proclaimed supremacy of the western healthcare system has been a stumbling block to postcolonial discourse on African bioethics. An important observation that has been made by scholars is that while the majority of the African people rely on the services of the traditional doctor, they would prefer to be quiet about it. The silence of the majority of Africans on African bioethics can be attributed to the condemnation of African traditional healing by advocates of western medical practices.

The Bastardisation of African Bioethics

The recent Traditional Health Practitioner's Bill introduced by the South African government, in consultation with representatives from organisations of Afri-

can traditional doctors, has triggered mixed reactions from various sectors of South African society. For the most part, it has been African traditional doctors who have welcomed the possibility of equal treatment of western-trained doctors and African traditional doctors under the new health laws. However, African traditional doctors have also been aware of the negative response that the Bill was going to receive from their western trained colleagues. As chairperson of the Mpumalanga task team on traditional healers, Gogo Keizer Gumede-Maebele puts it: "They are going to complain and say we are illiterate and don't know anything, this is what they have been saying all along. But they will have to accept our letters" (see *Mail and Guardian*, 30 August 2004, www.mg.co.za). Obviously, the sentiments by Gumede-Maebele are an expression of a conflict that has always existed between western-oriented health institutions and African traditional doctors. Her sentiments are justifiable when seen in light of the response that the Traditional Health Practitioner's Bill received from a Non-Governmental Organisation called "Doctors for Life" (see *Mail and Guardian*, 11 August 2004, www.mg.co.za). Doctors for Life (DFL) objected to the passing of such a bill on the grounds that the practice of traditional medicine was "potentially harmful to patients". The objection to the Traditional Health Practitioner's Bill is discriminatory against African Traditional Religion because DFL has called into question the relationship between healing and African religious beliefs and practices. The organisation has argued that the bill should not be passed because "most traditional healers made use of intangible forces or spirits in their healing practices, and local practitioners were priests of the religious system of African traditional religion" (see *Mail and Guardian*, 11 August 2004, www.mg.co.za). It was also argued by DFL that it was irrational to allow for the regulation of practices and medicines that had not been scientifically validated. In other words, as African traditional medicine falls outside the domain of scientific validation, it cannot be regulated. DFL went on to allege that African traditional doctors would be a danger to public health because the African health care system is, essentially, primitive (see *Mail and Guardian*, 11 August 2004, www.mg.co.za).

The arguments made by DFL hinge on two premises. The first premise is that the scientific nature of western healthcare practices makes them more reliable in comparison with African traditional healthcare practices. The second premise is that because African traditional healthcare practices are connected to African Traditional Religion, any legislation of its healthcare practice is tantamount to a civil legislation of a particular religion. While this type of reasoning and attitude towards African traditional healthcare practices has haunted African medical ethics for decades, it is argued in this paper that the position of DFL ignored the empirical fact that the majority of the African population believes, and relies, on traditional healthcare practices. Failure to take this empirical fact into consideration has been a stumbling block to dialogue between these two

healthcare practices in post-colonial Africa. A genuine dialogue based on unprejudiced listening between the two healthcare practices that could have given rise to the emergence of an authentic African bioethics in post-colonial Africa. Karl Maier has observed that:

> In other parts of the developing world, such as Brazil and India, traditional medicine has been taken more seriously by governments than in Africa. In India, traditional medicine is offered in the hospitals and university curricula. Research into traditional African medicines has been minimal, suffering equally from prejudice and widespread reluctance of the healers themselves to reveal their medical secrets. (Maier 1998: 78)

The implication of Maier's observation is that whilst other developing countries have taken practical steps to incorporate traditional healthcare practices into their inherited, western healthcare practices, it seems that post-colonial Africa has not yet come to appreciate the richness embedded in its own indigenous healthcare system. As we have seen in the position taken by DFL on traditional healthcare practices, the elevation of scientific empiricism has been used as a tool for denying the validity of African healthcare practices as well as its traditional doctors who treat the majority of the African population. This appeal to science has been rejected by scholars such as Ali Mazrui *et al* (1999: 636) who have argued that:

> [Western] science could not begin to appreciate method or value in traditional science in Africa until the stage of relativity when Western science began to shift emphasis from discrete entities to the complexities in nature and the universe...

and that pre-colonial Africa had:

> ...elaborate classifications of plants into families and subgroups according to cultural and ritual properties which ...were so detailed and complex that modern botanists have a lot to learn from the basis of comparison and classification. (1999: 636)

In the same vein, one of South Africa's most well-known traditional doctors, Vusamazulu Mutwa (1996: 200-201) rejected the idea of the incompatibility of African traditional medical practices and science when he said that "our people

also knew things which today have been confirmed by the greatest scientists and for which our people suffered ridicule and contempt at the hands of people from Europe and other continents of the world in the past". Mutwa illustrated his observation with the example of his grandfather who used to perform a ceremony that involved singing and dancing in the corn- field in order to encourage crops to produce greater harvest. At the time, missionaries condemned this practice as "superstitious rubbish" and, according to Mutwa (1996) it has taken the west a long time to understand that this was not superstition but a very sophisticated scientific truth:

> But now scientists believe that if you pray or play sweet music around plants they grow better. And it is cruel to deprive a people of something they have been doing for a long time and does no harm, only good. The missionaries did not know that there are many kinds of prayers. (200-201)

In the light of Ali Mazrui and Credo Mutwa's insights it appears that the main stumbling block to the emergence of African bioethics is also related to the legacy of colonialism and Christianity. Historically, western assumptions about African medical knowledge systems and practices are partly based on the belief that as Africa developed scientifically, traditional African medical practices based on "magic" and "witchcraft" would give way to scientific explanations. This colonial belief in a pan-scientific medical practice was also spiced with an element of medico-epistemological arrogance. This can be discerned in the work of ethnologist Philip Junod (1938) who claimed that:

> African doctors' ideas about disease are often absurd. When one hears a Native doctor talk about the 'snakes'[1] going around in human body...one sees at once the futility of his theories. (114-115)

Ignorance masquerading as scientific medical knowledge became integral to the condemnation of African medical knowledge systems and practices. Moreover, this condemnation of African medical knowledge systems and practices extended to the African traditional doctor who is also described as a phenomenon of ignorance:

> A Bantu doctor has no stethoscope and no idea about proper auscultation. He uses his eyes a little, but his chief means of diagnosis is divination with his bones. From his early youth the Umuntu believes in his 'bones', and it is difficult to persuade him that the principle underlying the system is

> entirely wrong and unscientific, being purely magic. I personally think that the reason why so many educated Bantu are rather reticent about expressing their opinion on 'bone throwing' is the fact that they know very well that the system is fundamentally unscientific and entirely illogical. (Junod 1938: 115)

One of the fallacies that permeated anthropological studies during the colonial period was that one culture's medical experience and practices could be used as the standard measure for judging medical practices of other cultures that were encountered. Within these evaluations of other cultural medical practices, one cannot fail to notice the superiority that is accorded to western, scientific medicine. This belief in the superiority and infallibility of scientific medicine was also based on Charles Darwin's theory of evolution. The main presumption was that medical knowledge systems and practices that were different to the western, scientific paradigm reflected earlier, primitive stages of human evolution. This understanding of evolution presupposed the inevitable extinction of medical practices that were not pursued within western, scientific parameters. This dogmatic faith in science as the driving force behind evolution and the only plausible path to civilisation, led Junod to pronounce the ultimate extinction of African traditional healthcare practices:

> Magic is bound to disappear amongst the Bantu as it did amongst Europeans. Education and scientific training will deliver the Bantu mind from magic, having already done so to a large extent. There is little which will be of a positive value from a new Bantu society in the old ideas of magic. ...The Bantu have developed curious divination systems and strange taboos, which, being based on error and misconceptions, have no element of a constructive nature. The quicker the Bantu are entirely free from these taboos and these misconceptions, the better. (Junod 1938: 116)

Utterances such as these were not only venomous, but also constituted an utter negation of African medical knowledge systems and practices.

It was not only ignorance that led to the condemnation of African indigenous medical practices as the western healthcare system was inevitably bound up with western ideology. Being ideological in theory and praxis, the argument that has been advanced by the historian Terrence Ranger, is that the main ideological concern of this healthcare system was to serve and protect the health of the colonisers with whom Africans might come into contact with (Ranger 1992: 257). In other words, the healthcare system in African colonies served the health

and economic interests of the colonial masters and therefore western medical practices were completely functionalist. For example, a text that was supposed to teach children about hygiene in Benin read as follows:

> The white people need palm-oil, but the palm tree does not grow in their cold home country. They need cotton, maize and other things. If you die, who will then climb up the palm tree, who will produce the oil, who will carry it to the company? The administration needs taxes. If your children do not stay alive, who will pay them? That is the reason why it [the colonial administration] spends money for medicine to finance heifers which should provide vaccines. (cited in Bujo 1998: 189)

The western healthcare system in Africa can be described as functionalist in that the motive behind the provision of healthcare for Africans emanated from the economic advantage of having healthy workers. As Benezet Bujo has observed:

> The aim of this care was to maintain the workforce so that the colonies would not collapse. It is clear that the health of the black population was degraded to the point of merely being a means of production...Medicine, just like work became some kind of coercion. (Bujo 1998: 189-190)

Within such a healthcare system, African traditional medicine was condemned even though the majority of the African people depended on traditional healthcare practices. This condemnation did not deter Africans from using their traditional healthcare practices. Under colonial domination, in order to survive, Africans, "learned to give the appearance of accepting the objectives of their colonial masters by making some concessions which at least met the conditions of peaceful coexistence" (Rensburg *et al* 1992: 320). In other words, while many Africans accepted the Western healthcare system, they knew that it could never completely fulfil their health needs. There are scholars who argue that missionaries used western medicine as a technique for conversion of Africans to Christianity in which medical practices became integral to bearing witness to the superiority of the western worldview, including religion:

> The asserted superior power of European medicine over African treatment of disease was held to demonstrate the validity of Western rational explanation over African superstition...mission nurses thought more in terms of combat. (Ranger 1992: 257-259).

Consequently, in this "combat", the battle line was drawn between western medicine and African traditional medical practices. However, the dissemination of western medicine through health care neglected the spiritual dimension of disease and failed to address the need for spiritual healing amongst Africans who encountered a western, Christian worldview that "compartmentalised" healing by relegating it to the realm of hospitals and doctors and therefore could not displace the African traditional worldview of the connection between illness and misfortune (Ranger 1992). Not only did the colonial healthcare system, underpinned by Christianity, create a situation of perpetual inadequacy in African bioethics, its evangelical crusade was also aimed at demonising African bioethics. This demonisation of African bioethics became indispensable to the 'civilising mission' of Christianity. For this reason, one finds a Jesuit priest by the name of Burberidge reprimanding fellow westerners who were sympathetic to African indigenous healthcare practices as follows:

> To test the argument, assume it is true. What follows? All the wickets of the whites having gone down, let the blacks have their innings. What a score they would put up? Suppose some wizard with medicated ox-tail to banish from this sunny land the very shadow of civilised rule. Let the native be left entirely to his own devices, untrammelled by administrator or missionary; let him be stripped of every vestige of European influence. Out science! Ring in wizardware! Back to the good old native customs! Now at length shall the land be cleansed of all that bodes woe. (Burberidge 1925: 22)

Within the psyche of the Christian missionary, African bioethics represented all the dark forces that went hand in glove with the 'uncivilised' or 'primitive'. In this demonising crusade against African bioethics, missionaries embarked on an obliterating attack against the African traditional doctor:

> He is not a witch, he is the fountain-head of witchcraft. He is *par excellence* the man of the 'bones' and the ceremoniously sealed packet and horn. He can tap at its salient points the occult energy stored up in Nature's reservoir and harness it to his drugs. Thus equipped he is able to detach the vulnerable part of your composite soul, and, looking at it, though you be a thousand miles away, by the mere pronouncement of your name smite you dead. (Burberidge 1925: 23)

What is implied in the above quotation is that the African traditional doctor was a source of evil. The African traditional doctor was also the object of fear

because of the power that he/she wielded within the community:

> He has been described by one who knows him well as 'the man from below'. The keys of the under-world are indeed in his hands, and he is ever more at home than when he is eliciting information from the dead. (Burberidge 1925: 24)

A similar argument has been made by Michael Gelfand who questioned,

> ...what is the future of the witch doctor[2] in Africa? There can be only one answer – there is no place for him. Because in spite of his many qualities the *nganga* is today the greatest single obstacle to a more enlightened way of life and to the African's progress in civilisation. (Gelfand 1967: 120)

According to this way of reasoning, the road to civilisation, which was already being paved by western medical practices, spelt the ultimate end to African bioethics and traditional medical practices. The 'natural' extinction of African traditional medical practices was supposedly assumed to be to the benefit of the Africans themselves:

> The *nganga* is the hub round which the spiritual world revolves, and so long as he functions as a dispenser of antidotes to witchcraft, so long will the African's bondage of fear continue. (Gelfand 1967: 120)

Since the African traditional doctor has not disappeared, it seems history has vindicated the incredulity of the African traditional healthcare practices in a way that missionaries and anthropological scholarship under colonialism have both failed to comprehend. Amidst all this ferocious attack, African bioethics has continued to survive and to exert an enormous influence among the majority of the African people who rely on this medical practice. The challenge for African bioethics, in this regard, arises from the need to embrace these two healthcare practices in a dialogical manner, such that they can affect a single healthcare system in post-colonial Africa. An important step towards a dialogue between these two healthcare practices has to be grounded upon an understanding that all bioethics are culturally embedded.

The Cultural Embeddedness of Bioethics

While there is a common argument that espouses the view that one cannot speak about African culture as a homogenous phenomenon, this paper seeks to affirm

this diversity but also the notion of a common "Africanness" amongst African people in terms of culture and world-view (Kasenene 2000: 348). There are many ethical commonalties and beliefs that are shared by indigenous African societies such as a belief in ancestors, an understanding of an individual as communally constituted as well as a relational world-view. It is these commonalities that should be the foundational basis for a discourse in African bioethics. From the perspective of the cultural embeddedness of bioethics, African postcolonial theorists argue that we need to take into consideration the fact that one cannot make absolute claims about bioethics, nor should African bioethics be considered as inferior to that of the west. For example, Akin Makinde has argued that theories and practices of medicine have a cultural basis and it is because of this notion of social embeddedness, that African medical practices are inextricable from African culture and belief systems:

> From this point of view the concept of illness, diagnosis, treatment, life and death must also have a cultural dimension. (Makinde 1998: 91)

Makinde's argument has been echoed by Isaac Sindiga who has pointed out that:

> .....each cultural group handles its medical problems in a particular way, and has it own world-view, traditions, values and institutions which have developed over time to handle disease and illness. Also, each culture has its own disease aetiologies, medical terminologies and classification, medical practitioners, and a whole range of pharmacopoeia. (1995: 20)

The implication of Sindiga's observation is that one cannot postulate, with logical impunity, a particular healthcare practice as engendering eternal truths that are applicable everywhere regardless of cultural context. While western medical practices tend to see disease in terms of the functioning of the body, in the African context, disease is understood in terms of a causal relationship between the "visible" and "invisible world" (see Sindiga, 1995). In the same vein, Gloria Waite has suggested that an African understanding of disease should be seen as a medico-religious in contrast to a biotechnical medical system (Waite 1992: 214). Within this paradigm of medico-religious disease and causation, physical causation presupposes spiritual causation. This implies that an authentic diagnosis of disease in a traditional African context has to take into account the reality of the inseparability of the physical and the spiritual. Philosopher, Augustine Shutte (2001) repudiated the western, biotechnical medical tendency of restricting diagnosis to physical causation on the grounds that:

> One cannot regard the human body as a merely physical system, a complex machine that is simply the instrument of a person who uses it. It is the physical aspect *of a person*. One's attitude to it is part of one's attitude to the person. (131-132)

A healthcare practice that is purely scientific in its conceptualisation and treatment of disease would inevitably fail to embrace the spiritual dimension of human sickness. Within the African traditional context such a healthcare practice is construed as an exercise in dehumanisation. With its strong emphasis on the idea of the dignity of the human body, African bioethics view western medical practices as problematic because of the way in which the body is treated in such a way that renders the person insentient. In an African cultural context where a human being is viewed holistically, a healthcare practice that places emphasis on merely repairing human organs is inadequate because it cannot give a comprehensive view of disease and causation. John Janzen expresses his discontent with the western, scientific healthcare practice on the grounds that it has severed itself from a holistic world-view:

> Western medicine and medical practitioners have shifted the focus of medicine away from the cosmos to the human body. As a result of this fixation, physiology, pathology, and physical diagnosis became standard and specialised traditions of inquiry in which subsequent tendencies of narrowing the scope of medical taxonomies would develop. (Janzen 1982: 4)

It could be argued that it is because of the African holistic view of healing that is part of the reason why many Africans have resorted to complement western medicine with that which is provided by the African traditional doctor. Another argument that is levelled against the current discourse on bioethics comes with the claim that such discourses have relied heavily on western, analytical philosophy. Light and McGee (1998), for example, have argued that western bioethics, draws heavily on analytical philosophy, and as a result, has been:

> forced to practice a form of methodological imperialism, choosing problems that suit their methodological devices, for it is methodology that drives most disciplines and defines the professional identity of practitioners. (4-6)

Light and McGee's argument is that western bioethics, with its distinct flavour of analytic philosophy, cannot avoid the temptation of divorcing bioethics from the social context in which it is embedded. Within such discourses, Fox and Swazey (1998) have observed that:

> Thought experiments are one of any array of cognitive techniques used in bioethics to distance and abstract itself from the human settings in which ethical questions are embedded and experienced...(6)

However, this philosophical habit has a tendency to decontextualize bioethical issues and, as a result, the danger is that ethicists emphasise certain elements of bioethics that are culturally irrelevant, or even unethical, when seen from a particular cultural context. In light of the argument of the social embeddedness of bioethics, a tragic situation that has beset African bioethics is that western-oriented cultural healthcare practice has divorced itself from the cultural and social context that has been dominated by African traditional healthcare practices. This is evident in the values that underpin western bioethics, such as that of atomic individualism in which the individual is severed from all his/her relational spheres of existence and asserts the primacy of doctor-patient confidentiality as well as individual choice and autonomy. It is therefore argued that if bioethics is contextually and socially embedded, it is imperative that a genuine conceptualisation of African bioethics must arise from an appreciation of African traditional medical practices. The starting point for a discourse on African bioethics is the African traditional doctor.

African Bioethics and the Legacy of the African Traditional Doctor

The African traditional doctor has a crucial, if not indispensable, role to play in African bioethics because s/he provides a dimension of health that is virtually absent in most western-oriented health institutions. While western-oriented health institutions work within a mechanistic paradigm in their diagnosis and treatment of disease, the traditional doctor has a holistic approach whereby disease and suffering are understood as caused by a situation of disharmony in human, environmental and spiritual relationships. Through a diagnostic procedure with bones, snuff or tail, the traditional doctor learns not only about the cause of illness, but also what must be done in order to restore harmonious relationships. However, the diagnosis of the traditional doctor is not restricted to the individual only but rather we find that the diagnosis that has been done on the individual is also implied for the whole family (cf. Gelfand 1985: 6). The manner in which traditional doctors diagnose, as well as treat, shows that African bioethics is based on a holistic world-view and a relational individual ontology. In other words, the individual's ailment is understood in terms of relatedness and interrelatedness between the individual and all those realities that constitute existence. Magobe Ramose made a crucial observation when he said that in the African context:

> The individual is recognised from the perspective of the wholeness in the form of the family or the wider community. It is within the network of family or communal relations that the individual experiences himself or herself and is experienced by the community. This is the cultural foundation for the recognition not only of the principle of interdependence between the individual and the community, but also of the principles of sharing, mutual care and compassion. (Ramose 1999: 96)

Thus in African bioethics the predominance of relationality can be discerned from the fact that the African traditional doctor performs his/her professional duties with greater sensitivity to the fact that the individual is entangled in a web of relationships. Within this relational paradigm, the individual experiences himself (and is experienced by others) as socially and cosmologically constituted. John Mbiti made a crucial observation when he noted that the African understanding of disease goes beyond the mere physical causation of disease:

> Even if it is explained to [an African] patient that he has malaria because of mosquito carrying malaria parasites has stung him he will still want to know why that mosquito stung him and not another person. (Mbiti 1969: 222)

In other words, physical symptoms do not remain solely in the realm of mechanical explanations rather they also have to find their complementary explanations in the spiritual realm. The question: 'Why has this happened to me?' shows that disease and suffering find their ultimate explanation and meaning in the realm of the symbiosis between the visible and the invisible realms of existence. It is the reality of relationality that cements the gap between the physical and the spiritual. The ability to go beyond the physical implies that the African traditional doctor is endowed with a characteristic that makes them possess a peculiar charisma that is not readily available in western-oriented healthcare institutions. In an interview with a traditional doctor concerning evil and human suffering, Kirwen was told by his informant that:

> [Evil] is caused by the immorality of the living, and that immorality must be neutralised if the moral order is to be restored. It is my work to divine the cause of evil, to figure out the source of immorality that is provoking the problem. (Kirwen 1987: 29)

From the perspective of an African traditional doctor, human suffering is intrinsically conjoined to moral behaviour – hence the African traditional doctor is

not only a specialised expert in his or her field of medicine, s/he is also the guardian of moral values. Vusamazulu Credo Mutwa recalled been taught by his mentor when he was training to become a traditional doctor as follows:

> My grandfather taught me that a healer without compassion for all life in his heart is like a drum without its skin. He is like a river without water, he is like a human being without reproductive organs. (Mutwa, 1996: 16)

Traditional doctors are not trained solely to become experts at healing. The moral values of the community are an integral part of their training. It is a profession that demands the upholding of moral values by reminding individuals and the community that such values have been the source of social cohesion and tranquillity from time immemorial (Gelfand 1981: 72; cf. Sundermeier 1998: 198). On the profession of African traditional doctors and their obligation to observe values of the community, Mbiti (1969) characterises African traditional doctors as "friends, pastors, psychiatrists and doctors of traditional African villages and communities" and for this reason:

> medicine men [sic] are expected to be trustworthy, upright morally, friendly, willing and ready to serve, able to discern people's needs and not be exorbitant in their charges. (218-223)

In the same vein, Suzan Campbell (1998) has argued that African traditional doctors, especially in impoverished rural areas, fulfil an important role in providing basic health care to individuals and entire communities. Since the individual's health, or sickness, is indispensable to the wellbeing of the community, a sickness that afflicts the individual becomes a communal sickness and therefore the diagnosis that is given by the African traditional doctor is relevant to the entire community. It is a common practice in African bioethics that one does not consult the traditional doctor alone and usually the entire family are present at the consultation as patients themselves. This practice even happens in cases where African people visit hospitals, as observed by Oscar Mbambo:

> Instead of one person coming in for treatment, the patient would be accompanied by a sort of entourage. It is the right of the company to sit in during consultation because your health is the concern of everybody. That's why nobody goes to the doctor unaccompanied. ...The whole family travels with the patient. The communal travel is part of healing process. (Mbambo 1996: 110; cf. Makhaye 1973: 158)

Communal participation in the individual's illness, and treatment, is an authentication of the philosophy behind African bioethics that asserts that the experiences of suffering which the individual might go through are also communal experiences. The community is integral to the patient's decision making and healing processes. Within the context of African bioethics, the healing process that is affected by the traditional doctor calls for the full participation of the community and family through the observance of *amasiko*. It is this quest for wholeness that makes communal participation indispensable to the healing process. In a way, this becomes an affirmation of the African ethical maxim that says *muthu u bebelwa numwe* ("A person is born for the other") (Kasenene 2000: 349). Commenting on this African ethical maxim, Peter Kasenene reminds us of the deeply communal nature of the traditional African context:

> ...one cannot regard even one's own life as purely personal property or concern. It is the group which is the owner of life, a person being just a link in the chain uniting the present and future generations. For that reason one's health is a concern for the community, and a person is expected to preserve this life for the good of the group. (Kasene 2000: 349)

African bioethics brings into focus the whole question of doctor-patient confidentiality, which for so long has been part and parcel of the discourse of western ethics. In western bioethics, one finds that the idea of confidentiality is primarily based on atomic individualism and the notion that the individual is endowed with intrinsic properties that cannot be subsumed from the generality of human existence. In this regard, confidentiality implies that the individual patient has an inviolable right to deal with her sickness and all matters of her health in a manner she chooses. If the patient is the whole community, or family, as it is the case in African bioethics, it is at such a level that confidentiality is upheld. The primary aim of the traditional doctor is not only to enable healing of the individual patient, but also to ensure that harmonious relationships are established at all levels of existence. Since the individual exists in a state of communion and communicability, the sickness and its cause(s) is also revealed to the traditional doctor with, and without, the patient's consent.

The very idea that the individual is relationally constituted implies that for there to be good health, the individual and the community must always be conscious of the symbiotic relationship that exists between the living and the ancestors. Ancestors are indispensable to the understanding of the sickness of the individual as well as to the flourishing of the community, bearing in mind that the division of existence between the living and the dead is implausible from the point of view that African people see life as continuous (Murove 1999: 15). The community of existence comprises of God, ancestors, human beings and the

natural environment. Hence, it becomes wholly unintelligible to have a discourse about life with reference to one of these realms to the exclusion of others. When the individual's life is inflicted by disease, the explanation filters through all these realms implicitly and explicitly. In the final analysis, the absence or presence of sickness is embedded within a relational explanation and it is mainly for this reason that the idea of ancestors is pivotal to African bioethics.

African Bioethics and the Ancestors

Ancestors are custodians of the moral fabric of African traditional societies. In remembrance of their existence, the living share and celebrate life with the ancestors so that these relationships can be strengthened. While ancestors protect their descendants against the tragedies of life, their protection is primarily premised on the person's ability to remember the past. Ancestors are an embodiment of the past, present and future. In the realm of ancestor-hood, all these dimensions of existence are reduced to one totality in the sense that the past consists of those values, or *amasikho*[3], that are to be remembered in the present in order to safeguard the future. Memories of the past influence the present because the individual or the community's ethical decisions cannot be divorced from what has transpired in the past:

> ....an ethical active subject always understands his actions as making present the ethical experience of his [sic] ancestors and attempts to shape these actions accordingly. (Bujo 2001: 34)

Furthermore, it is the ethical responsibility of the traditional doctor to foster anamnestic solidarity by serving as a link of communion, and communication, between the community and the ancestors. Bujo has also argued that for healing to take place we have to bear in mind that, according to the African worldview, there are multiple realities that are interrelated with each other to the extent that what happens in one of these realities also occurs in the other. He writes:

> Since the community is always both visible and invisible, this dimension is not limited to the dead, but embraces the entire supernatural world, including not only the spirits but God himself. Mostly, however, illness concerns the earthly community and it's dead. In concrete terms, the cause of an illness lies primarily in interpersonal relationships. It is always a sign that something is wrong in the community, in its two dimensions of the living and the dead, and this means that the re-establishing of the broken interpersonal relationship cannot be a matter for

> doctor and patient alone: it demands the participation of the entire community. (Bujo 2001: 34)

In the light of the above quotation, we can deduce that the illness of the individual finds its full explanation in the two realms of existence. Firstly, it is understood as a manifestation of fractured relationships within the community of the living. Secondly, it signifies an existential situation of disharmony between the community of the living and the community of ancestors. Sickness occurs because of the tendency of the living to forget their ancestors. The establishment of communication through remembrance affects both healing and wholeness. The living community is accountable to the ancestors for their actions in the same manner that the ancestors are summoned by the living to account for their actions. This mutual accountability between the past and the present culminates into the fact that ancestor-hood implies moral exemplarity in the context of communion and communication with one's progenitors (cf. Mutwa 1996: 20; Nyamiti 1984: 19-25).

Through the mediatory role of the traditional doctor, ancestors are able to impart knowledge as well provide diagnosis and healing. The medical knowledge of the traditional doctor is not entirely personal knowledge but rather it is given as a gift for the common good. To give an example, when receiving a consultation fee, the traditional doctor does not take it into his own hands straight away. Instead, the payee is instructed to put the money on the floor. This gesture symbolises that the work to be done will be done on behalf of *abaphanzi* or the ancestors. This also implies that medical knowledge and healing capabilities are not for the individual's personal self-aggrandisement but for the common good. In other words, medical knowledge, and its dissemination, is not an individual's personal privilege because it is transmitted to the individual by the ancestors for the well-being of the entire community (cf. Mutwa 1996: 31-32). Whilst I will not pursue this thought further in light of the space limitations for this paper, I would like to conclude this article by making suggestions on what I think should be the plausible route for future discourses on African bioethics.

African Bioethics and the Future

Vera Buhrmann observed that within the African context, there is a need to come up with an approach to health care theory and practice that recognises the richness that can arise from cultural exchange:

> My hope is that through this knowledge we will complement and enrich one another and be stimulated to growth and development of greater awareness and increased consciousness. This should in turn enable us to live in two worlds with greater degree of comfort. (Buhrmann 1984: 100)

Evidently, this insightful remark shows that the time is already overdue for all serious minded scholars in post-colonial Africa to stimulate a discourse on African bioethics that genuinely reflects the real nature that should characterise a discourse in African bioethics. There is no medical practice that has the monopoly on truth. All medical practices can learn immensely from each other. What is taught at our institutions of higher learning must reflect bioethical questions that are embedded in the African context. This also follows that medical knowledge must be contextualized and that indigenous knowledge systems must be used in a way that enriches and widens its horizons. On the other hand, if we are to take the attitude of colonial anthropological scholarship and the view of early missionaries on African medical practices, as adopted by Doctors for Life (DFL) towards African traditional medical practices, it becomes difficult to develop a culture and attitude of learning from each other.

We are in a position to come up with an effective health care system in post-colonial Africa by integrating the two health care systems through genuine dialogue between African traditional healthcare practices and western medicine. All health care systems should share the same space without either of them claiming superiority over the other. In an attempt to bring these health care systems together, Ali Mazrui reminds us that,

> What can be taken for granted is that ideas can express further ideas if they are systematically referred to one situation after another. To change the metaphor, if an idea is fertile, it may well conceive a different child if it is mated to a different kind of situation. There is always the possibility that it may produce nothing new, but the cross-breeding is worth attempting all the same. (Mazrui 1967: 4)

In the light of the above quotation, the future of a vibrant African health care practice should come as a result of cross-breeding between the mechanistic world-view, as is entrenched in western health care practice, and a holistic world-view which we have in African traditional medicine. African bioethics begins with the appreciation of the role of the African traditional doctor in the dissemination of health care in Africa. This appreciation can only be possible when we realise that all the judgements and evaluations that have been made thus far by the critics of African traditional medical practices, should not dissuade us from making a serious reflection on the would-be nature, and form, of African bioethics. At a time when health care practice has become too materialistic, it is a matter of great urgency that a more holistic approach to health care provides the path into the future.

Notes

1 In some African languages, 'snake' or *nyoka* is a word that is used to describe illnesses such as diarrhea in a metaphorical manner. It does not mean that Africans believe that a person has a snake in his or her stomach. Illnesses common to children such as infantile diarrhea have their own indigenous names that are sometimes difficult to conceptualize when translated into western categories of thought. For example, in the Zulu language a child is referred to as having a bird (*inyoni*). This does not literally mean that the child has a bird that flies inside his/her body (Masaire 1996: 48).

2 The missionary and early anthropological characterization of the African traditional doctor as 'a witch' or 'witchdoctor' is a misnomer because one cannot be a witch and a doctor at the same time. Knowing how to cure witchcraft cannot turn one into a witch. Similarly, a western-trained medical doctor who knows how to treat disease cannot be named a 'disease doctor' or a 'virus doctor'. The idea of naming the African traditional doctor as a 'witch doctor' was obviously intended to give an explicit impression that African traditional doctors were solely specialized in treating witchcraft. Mutwa, a traditional doctor himself, maintained that an African traditional doctor: "will never cast a spell upon anybody. He can neutralize a spell, he can stop it; but the moment a [traditional doctor] harms a person, he is no longer [a traditional doctor]. He become a sorcerer, one we call *umtagatin* ...doer of evil deeds" (Mutwa 1996: 28-29).

3 *Amasiko* refers to those traditional values, or practices that must be observed as a way of affirming one's identity and stages of growth in the community. To give an example, when a child is born, a goat is slaughtered as a gesture of incorporating the child into the life of the family and the community of ancestors. These rituals serve as a reminder that the individual belongs to a community.

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