

DISCUSSION

ETHICAL CONSIDERATIONS IN AFRICAN TRADITIONAL MEDICINE: A RESPONSE TO NYIKA

DONNA KNAPP VAN BOGAERT

Keywords

ethics,
traditional medicine,
cultural relativism,
informed consent,
confidentiality,
paternalism

ABSTRACT

Like other so-called 'parallel' practices in medicine, traditional medicine (TM) does not avoid criticism or even rejection. Nyika's article 'Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS' looks at some of the issues from a traditional Western ethical perspective and suggests that it should be rejected. I respond to this article agreeing with Nyika's three major criticisms: lack of informed consent, confidentiality and paternalism. However, as traditional healers are consulted by over 70% of South Africans before any other type of healthcare professional, a blanket negation of TM is not possible, nor is it politically feasible. A pragmatic approach would be to work within the current structures for positive change. I point out that, as all cultural practices do, TM will change over time. Yet, until some regulations and change occur, the problem of harm to patients remains a major concern.

INTRODUCTION

From the onset, it should be made clear that the terms 'traditional medicine' (TM) and orthodox/Western medicine (O/WM) are politically loaded and neither should be viewed as all-damning or all-righteous as they are embedded in a wide variety of practices. Like other so-called 'parallel' practices in medicine, TM does not escape criticism or even rejection. In Nyika's 'Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/

AIDS',¹ TM is viewed from an African perspective: notwithstanding that traditional medicine is not specific to Africa alone.

In South Africa, TM is comprised of two major branches: herbalism (healers) and traditional healing (diviner-diagnosticians). The herbalist (e.g. izinyanga) treats a symptom with herbs and remedies (muti) without making a diagnosis; he chooses and

¹ A. Nyika. Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS. *Developing World Bioeth* 2007; 1: 25–34.

employs germane remedies. The traditional healer (e.g. sangoma), in contrast, relies on his or her spiritual advice as well as tools (e.g. throwing bones) to diagnose the disease and its cause in a holistic manner (i.e. involving the patient, the closer community and the larger community, which involves the ancestors); like the herbalist, he or she administers medicines.

The gist of Nyika's article is that TM should be rejected unless it is subjected to regulations similar to those of O/WM. The major ethical argument against TM focused upon by Nyika is that it is problematic, or even impossible, to consent to the unknown (i.e. the lack of scientific evaluation of the medicines used in TM). Nyika highlights three major criticisms against TM: lack of informed consent, paternalism and, to a lesser extent, lack of confidentiality. From a Western perspective of medical ethics (at least as represented by 'principlism') these appear as good reasons to reject the practice. In this commentary, I will mainly focus on these three issues. I will suggest that applying the rules of Western medical ethics to TM would be tantamount to depriving it of its core values, and that to understand its practices and ethical implications we are obliged to look to the context and conditions that give it meaning. Finally, I will conclude that the practice of TM will change over time but that the question of harm to others remains a great concern.

1. THE IMPOSSIBILITY OF CONSENTING TO THE UNKNOWN

In TM, the lack (or impossibility) of informed consent is certainly a rightful concern. The argument presented is that without scientific knowledge of the composition, ingredients and strength of a traditional potion it is impossible to foresee the results and possible complications of its use. It follows, so runs the argument, that one cannot give consent to the unknown. It equally follows that these medications should be submitted to scientific scrutiny (e.g. animal experimentation, toxicity tests, clinical trials, etc. before licensing the manufacturing and marketing of the drug). At first glance, this seems reasonable: out of the three

arguments against TM, the question of whether one can consent to the unknown is the weightiest. However, it is not specific to TM alone. For, if we are to be fair, and avoid double standards, the same rules should apply to 'parallel' medicines (e.g. homeopathy) now widely practiced in the Western world. Notably, in the last few years, guidelines and regulations appear to be more and more in place.²

The 'unknown' is the major focus in many TM practices, not in a medicinal but a spiritual sense. The 'spirits', using the vehicle of traditional healers, prescribe the particular potion (muti) to be used. TM sees the whole of the patient, and his or her place in the family and the community of the living and the dead (what Nyika calls 'necromancy'). It looks at the spiritual cause of the patient's illness (e.g. displeased ancestors and witchcraft). As the metaphysical is not separated from the physical, both diagnosis and treatment then have a sort of 'mystical' overtone. It is this inherent mystical or spiritual aspect found in many types of TM that leads us to a further muddle.

In agreement with Nyika, we can admit that the notion of informed consent is negated in TM consultations because one (or one's family members representing the index individual) cannot be informed of medicinal effects when their efficacy has not been proved/disproved. It is possible that a traditional healer's (TH) patient could be informed that the muti was not scientifically proven and that its results (positive, negative, side effects, etc.) could not be guaranteed. Then the patient would be informed and could consent or not to take the muti. However, that does not get us very far, for the issue is more complex. For example, we are obliged to accept that many of those who consult (at least many types of) THs do so because of their particular belief system: THs are often the spiritual leaders of communities. According to one report, they 'are priests of the religious system of African Traditional

² For examples, see Homeopathic College of Canada. 2006. *Regulation of Homeopathic Medicine*. Toronto, ON: Homeopathic College of Canada. Available at: <http://www.homeopathy.edu/regulation.htm> [Accessed 19 Oct 2006]; and Indian Council of Medical Research. 2000. *Ethical Guidelines for Biomedical Research on Human Subjects*. New Delhi: Indian Council of Medical Research. Available at: <http://www.icmr.nic.in/ethical.pdf> [Accessed 19 Oct 2006].

Religion and function as such.³ From that perspective, it becomes a matter of faith in the ancestors or spirits to advise the TH of the proper type of muti to dispense. Then it rolls back upon the integrity of the TH to be worthy of the patients' trust. So, are we looking at informed consent within a belief system, in a health profession, or in a combination of both? I suggest that we should accept that many of those who consult this type of TH do so because of their beliefs. This should be familiar, for it runs parallel to the history of 'Western medicine': first magical in nature, then religious, then gradually, over time, becoming 'scientific'.

Perhaps we should ask if the notion of informed consent is the correct way to look at the issue as 1) it is framed in individualistic terms, and 2) the concept of being an individual is an enigma in most of these settings. Yet, even though we are faced with applying an O/WM ethical approach in either medicinal or spiritual forms, Nyika rightfully identifies that the patients who are involved may be at risk.

2. HARM TO OTHERS

Harm and the degree of harm produced by cultural practices are, of course, linked to the complex and debated issue of cultural/moral relativism: a topic beyond the focus of this commentary. Yet, in keeping, it is suffice to say that the real question to consider is, as James Rachels asks, 'Is the practice harmful?'⁴ Indeed, it should be acknowledged that in South African O/WM hospitals it is not uncommon to admit patients with herbal (or even water) intoxication. Yet, to be fair, no practice of medicine is totally devoid of some harm. Equally, O/WM medicine has its side effects, complications and failures. The major difference seems to be that O/WM has particular legal and ethical mechanisms (guidelines, codes and regulations) in place, which, over

time, have served to regulate, or at least try to diminish, the amount of harm, whereas TM lags far behind. Perhaps it is the more gripping media reports of bad TM practices, for example, 'cures' for HIV/AIDS, sex with virgins to rid oneself of 'bad blood', the use of human body parts, vaginal secretions, and scrapings from armpits for making traditional remedies, etc. to which Nyika refers.

Certainly, such practices are deplorable; they lie on the arch of greatest harm and should be abolished. However, it is important to note that within the TM community there is recognition of the problem, as Serbulea writes:

Anecdotic evidence shows that 70% of healers in suburban areas in Africa are charlatans. At the same time, special efforts need to be made to differentiate authentic healers from charlatans. Some of the criteria for distinguishing a real healer are the family connection for generations to a respected healer, his/her acceptance to collaborate with modern medicine and refraining from claims of curing all diseases.⁵

A major problem in this admixture of belief system and medical practice seems to be just how one might separate the impostors from the genuine. It would seem like some type of regulation might help us out in this.

The South African Traditional Health Practitioners' Bill (1993) does provide for a Council empowered to make this distinction.⁶ However, there are some worrisome aspects of the Bill. For example, all members of the Council are ministerial appointees, which provides for no independent input. While the category of a legal representative is included in Council representation, there is no provision for an ethicist. In fact, the only mention of ethics is found in Objectives of the Council (point 5.O):

³ M. Serbulea. 2000. *Traditional Medicine: Accessible Public Health Care for Indigenous Peoples*. Geneva: United Nations University. Available at: <http://www.ias.unu.edu/research/details.cfm/ArticleID/579> [Accessed 19 Oct 2006].

⁴ J. Rachels. 2001. The Challenge of Cultural Relativism. In *Moral Relativism: A Reader*. P.K. Moser & T.L. Carson, eds. New York, NY & Oxford: Oxford University Press: 53–58.

⁵ Minister of Health. 2003. Traditional Health Practitioners Bill. (As introduced in the National Assembly as a section 76 Bill; explanatory summary published in Government Gazette No 24751 of 14 April 2003.) Pretoria: Ministry of Health. Available at: <http://www.info.gov.za/gazette/bills/2003/b66-03.pdf> [Accessed 19 Oct 2006].

[The objects and functions of the Council shall be to] determine policy, and make decisions in terms thereof, with regard to traditional health practitioners and traditional health practice in matters of education, fees, finance, registration, professional conduct, ethics, disciplinary procedure, scope of traditional health practice, interprofessional matters and maintenance of professional competence.⁷

Moreover, such ethically packed terms as, for example, professionalism, professional conduct and professional competence are not defined, thus left open for wide interpretation. The Bill, however, does state that diagnosing, treating or offering to treat (as well as purporting to have a remedy to cure) cancer, HIV/AIDS or other terminal diseases is recognised as an offence. While this may be viewed as a step in regulating TM practice, one may rightfully ask if it is sufficient to protect the public from harm: its morally relevant terms are wobbly and vague and, thus, subject to a myriad of interpretations.

3. PATERNALISM

Nyika states that, if one takes it at face value, there would seem to be little doubt that TM is paternalistic: the healer knows best.

One could argue that, in traditional societies (with their emphasis on communalism) where patriarchalism and male domination are the rule, and where less emphasis is put on the individual and his or her autonomy than in contemporary Western society, this argument is probably less weighty to the insiders than to supporters of the ethical rules of O/WM. This, however, does not mean that paternalism is permissible just because it has always been part of a way of life: paternalism is a complex issue, as illness often compels patients to look to doctors to take all the power, to make all the choices and to be free to act for them.⁸ The asymmetrical power relationships between healers and patients are placed under pressure when accepting the right of the person to make his or her own informed choices con-

cerning health care. Yet, under the guise of 'the patient's best interests', O/W medical practitioners often impose their own interests and values on the patient as opposed to adhering to those of the patient. Even in contemporary Western-type medical practice, paternalism has not been eradicated.

We can admit that paternalism exists in both arenas, and even agree that strong paternalism, at least as perceived from the West, is the current mode in TM; and, we can admit that harm occurs in both types of practices. However, it seems that Nyika places TM on the pendulum's arch of greatest harm and strongest paternalism and therefore concludes that it should be rejected. Concerning these issues, there are two major points that I suggest should be considered:

- (1) TM belief systems of sickness and wellness vary according to region, tribe and family. Thus, there is a danger in lumping all of TM and all its practitioners into the same categories of harm and paternalism.
- (2) In O/WM we tend to view paternalism from an individualist perspective, in that such behaviour generally includes no particular effort on the part of a doctor (an outsider) to learn about, for example, his or her patient's, or family's, values, views, perspectives and interests. From the perspective of an insider, and as a long-term member of the community, is it not likely that a traditional healer would have knowledge of the patient's or family's beliefs, values and interests? So is strong paternalism even the term we should be using?

4. CONFIDENTIALITY

Amongst the three arguments, the third argument (i.e. the lack of confidentiality) might well be the weakest. In South Africa, the National Department of Health and the Health Professions Council are in the process of registration and regulation of THs, which includes four types of practitioners: diviners (sangomas), herbalists (izinyanga), traditional birth attendants, and traditional surgeons (iingcibi).⁹

⁷ Ibid.

⁸ H. Brody. The Chief of Medicine. *Hastings Cent Rep* 1991; 21(4): 17-22: 19.

⁹ Treatment Action Campaign. 2005. *Equal Treatment*. Muizenberg: Treatment Action Campaign: May. Available at: <http://www.tac.org.za/ET/EqualTreatmentMay2005Issue15.pdf> [Accessed 19 Oct 2006].

In order to be granted registration, THs first have to be registered with the Association of Traditional Healers. Concerning confidentiality, the principle advocated is, 'as prescribed by the patient.' This means that, on the patient's request, confidentiality will be respected. This shows that TM should not be seen as carved in stone; there is a gradual acceptance of some ethical concepts: the patient is given the choice to have her confidentiality respected.

RISING ISSUES

The main question regarding the argument against TM is: If TM has to comply with the tenets of O/WM (mainly autonomy and confidentiality) can it remain true TM (in the sense of what it has always been and largely still remains)? One has to keep in mind that we are talking about two radically different views on healing. Western medicine deals primarily with an autonomous individual expecting to know the diagnosis, the prognosis and the implications of the proposed action plan, the right to a second opinion and the right to withhold consent and so forth. With some fortunate exceptions to the rule (*viz* the holistic approach recommended in family medicine), O/WM tends to 'isolate' the sick organ from the rest of the person looking for a material cause of the illness. TM and O/WM represent different ways of 'knowing'.

The West, through a variety of well-known ways, influenced and changed indigenous cultures, including health care systems. In contemporary times, the West has failed to recognise and assist in the provision of acceptable medical care to the world's deprived. Such considerations served, and serve, to enhance the role of TM in the many communities in which it operates. The current trend towards recognition of other cultures and traditions as valid in their own right, for example, the international fad emphasising the use of 'natural' products (e.g. herbal supplements) as opposed to those that have been scientifically proven, are also factors which feed into the recognition of TM as an entity in its own right. Such considerations move us towards a collaborative venture with TM that is currently politically correct.

The supplement to an issue of the *South African Medical Journal*, entitled *Bridging the Gap*, indicates that in South Africa, 80% of patients first consult a traditional healer, then, if needed, a 'Western' medical practitioner.¹⁰ In South Africa, there is an estimated 200,000 traditional healers (and about 20,000 O/WM practitioners).¹¹ In the face of this reality, the collaboration between Western and traditional medicine and the potential role of THs is supported by the South African Medical Association (SAMA).¹² Instead of rejecting TM, SAMA supports the view that one should embark on culturally sensitive participatory planning, and a partnership between TM and O/WM practices. Moreover, it emphasises the real harm resulting from ethno-pharmacology. SAMA does not condone practices like female genital mutilation simply 'because it is part of someone's culture.' This appears to indicate that it recognises that there is a role for TM in society: that it is better to acknowledge and collaborate with TM rather than negate its existence. This is recognition of the reality factor that, if banned, embedded cultural traditions simply go underground.

Another interesting perspective on TM is its financial aspects. The Bill may also be viewed as a logical consequence of the large growth within the TM industry; it is estimated in South Africa to have an annual turnover of about Rand 250 m.¹³ This may reflect some features of globalisation/medicalisation of the 'natural' as 'good'. Interestingly, while the South African Bill does allow registered THs to charge medical schemes for their services, Mr Sazi Mhlongo, president of Traditional Healers of South Africa, is recorded in an interview stating:

Such payment would be convenient for patients but inconvenient for us traditional healers . . . We want to be paid in cash when we burn our imphepho (muti for invoking the ancestors). Now, without cash, how will we be able to communicate

¹⁰ D.A. Hellenberg et al. (South African Medical Association task team). 2006. *Bridging the Gap: Potential for a Health Care Partnership between African Traditional Healers and Biomedical Personnel in South Africa*. Pretoria: South African Medical Association.

¹¹ Ibid.

¹² Ibid.

¹³ Staff writer. 2006. Traditional Healers Recognised by South African Lawmakers. *afrol News* 9 Sept. Available at: <http://www.afrol.com/articles/13912> [Accessed 19 Oct 2006].

with our ancestors? . . . Besides, since some medical aid schemes are fake we would be giving our services for mahala.¹⁴

CONCLUSION

Agreeing with Nyika, one cannot consent to the unknown. Medicines must meet the same rigid standards, testing and clinical trials before they are administered to people. TM is strongly paternalistic; it is a currently embedded social product. Confidentiality, though some admission is provided, remains problematic or at least presented in a different frame. So we should reject TM based on non-adherence to internationally accepted ethical principles. Yet, we cannot do this because to millions of people it provides value and meaning. What we can do is to advocate for ethical concepts to be included in all transactional aspects of TM and O/WM in practice

¹⁴ Sowetan. 2001. Traditional Healers Scorn Medical Aid for Cash. *The Sowetan* 21 February; and see CNN.com. 2004. *Inside Africa Traditional Healers in Africa Demand More Recognition. (Transcript)* 30 October. Atlanta, GA: CNN.com. Available at: http://transcripts.cnn.com/TRANSCRIPTS/0410/30/i_if.01.html [Accessed 23 Jan 2007].

and legislation. Another reason why we cannot simply reject TM is because to view it (as well as O/WM) as unchanging (in, e.g. ethics or drug therapies) is a mistake. To view any society as traditional, or traditions in a society as stagnant, denies their fundamental nature: they change. 'Absolute changelessness', as Gyekye writes, 'is impossible and cannot be considered a necessary condition of any human society.'¹⁵ For example, from the earliest days of medicine well into the 20th century, the paternalistic model of Western-type medical practice was the norm: it changed, and is changing. There are no good reasons to think that TM practice will not undergo changes as well. In the practice of TM, at least some separation of the metaphysical from the physical will most likely happen over time. However, during this period, and Nyika is correct, people will be harmed: that is the reality.

The importance of the article is its relevance to our times, places and practices and Nyika is to be complimented for bringing these rising issues to our attention.

¹⁵ K. Gyekye. 1997. *Tradition and Modernity: Philosophical Reflections on the African Experience*. Oxford: Oxford University Press: 218.