A comparison between medicine from an African (Ubuntu) and Western philosophy

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Abstract

I consider the *Ubuntu* way of caring for the sick in terms of the *Ubuntu* world-view by systematizing the scattered views. I argue that this world-view is underpinned by the regulative concept of sharing and that caring in *Ubuntu*-thinking can only be understood correctly in terms of sharing. I substantiate my exposition in terms of what Africans themselves claim *Ubuntu* is and relate its meaning to African thinking in general. I consider the uniqueness of this world-view by showing how an African thinker compares it to Western world-views on causality and critically consider these comparisons. I apply this world-view to African medicine and evaluate the *Ubuntu* idea of causes in medicine in comparison with causality in Western thinking by considering the two frameworks of medical care in terms of their viability respectively. I conclude that causal patterns in medicine are controversial in both thinkings but argue that it sets the framework for intercultural communication that can lead both to a better understanding of each other and to some positive developments in medicine. These ways of dealing with the topic represents the significance of this article as an addition to existing knowledge.

Abstrak

Ek oorweeg *Ubuntu*-benadering om siekes te versorg in terme van die *Ubuntu*-wêreldbeskouing deur verspreide beskouings te sistematiseer. Ek voer aan dat hierdie wêreldbeskouing onderlê word deur die regulatiewe begrip van deelname en dat versorging in *Ubuntu*-denke slegs reg verstaan kan word in terme van deelname. Ek rugsteun my uiteensetting in terme van wat Afrikane self beweer wat *Ubuntu* is en lê 'n verband van die betekenis van hierdie begrip met Afrika-denke in die algemeen. Ek oorweeg die uniekheid van hierdie wêreldbeskouing deur aan te toon hoe 'n Afrika-denker dit vergelyk met Westerse wêreldbeskouings oor kousaliteit en oorweeg hierdie vergelyking krities. Ek pas hierdie beskouing toe op Afrika-denke oor geneeskunde en evalueer die *Ubuntu*-beskouing oor kousaliteit in geneeskunde in vergelyking met Westerse geneeskunde deur die twee raamwerke krities vir lewensvatbaarheid te oorweeg. Ek kom tot die gevolgtrekking dat kousale patrone in die geneeskunde in beide gevalle kontroversieel is, maar voer aan dat 'n raamwerk daargestel word vir interkulturele kommunikasie wat in beide gevalle tot 'n beter verstandhouding tussen die twee kulture kan lei en kan bydra tot positiewe ontwikkelings in die geneeskunde. Hierdie wyse waarop die onderwerp benader word verteenwoordig die betekenis van hierdie artikel as 'n toevoeging tot bestaande kennis.

Introduction

Medicine is often thought to be an objective science with no links to world views. In this paper I critically consider African traditional treatment of diseases in terms of their views of especially causality in comparison with Western views in order to show how medicine is imbedded in world views as types of conjectures. I analyse African views of medicine with special reference to Ubuntu thinking in terms of the concepts of sharing and caring as the key concepts in terms of which this world view can be systematized. I show the importance of the comparison for intercultural communicantion, especially in South Africa.

In African medicine the sick is treated or cared for in a particular way in terms of African traditional thinking which is claimed as being different from Western thinking (e.g. the germ theory). A very important reason for this is that it is claimed that the African view of what a human being is differs from other views, more especially, from the so-called Western view. A view of what a human being is has wide implications for how human beings are treated in different life situations such as pupils or students, employers, subordinates, brothers and sisters, parents, children, and sick people. To treat people in a certain way in any specific situation, implies a universal way of thinking of what a human being is. This universal way of thinking is called by different names, such as a world-view, a way of life, frame of reference, conceptual scheme, web of beliefs or a view of life.

Ubuntu as a world-view (higher level concepts)

Ruel Khoza regards Ubuntu as the collective consciousness of intra-human relations of the Africans which incorporates for him the memories and experiences common to all mankind. He points out that Edward Blyden regards this world-view as part of the African personality in the sense that Africans have their "own sense of God or Supreme Being, their own moral codes and therefore their own spiritual life" (Khoza, R. 1994, p 1). Khoza argues that the distinctive collective consciousness of Africans is manifested in behaviour, expression and spiritual

self-fulfillment, encompassing values such as universal broth-erhood for Africans, sharing, and treating and respecting other people as human beings. Added to this is Chinkada's views that *Ubuntu* involves the sensitivity for the needs and wants of others, alms-giving, being sympathetic, caring, considerate, patient and kind and Makhudu's view that *Ubuntu* means quali-ties such as warmth, empathy, understanding, communication, interaction, participation, reciprocating, harmony, a shared world-view and co-operation.

These concepts are mentioned at random without linking them systematically or contextualising them. There is therefore a need to do both by conjecturing. In order to do so it is neces-sary to analyse their meanings with reference to ordinary use.

"Sharing" bears on the share as a part or portion someone owns or which is allotted to him or her or to a group; it can also mean that which a person or group contributes to a package; the capital stock of a group or a company can also be divided into equal parts or shares which can be possessed by indi-viduals or by sub-groups, for that matter, and which carries the right to the owners to receive a proportion of the company's profit; it can also mean to share one's possessions with others, such as a communal use of a motor car, a house or income; part of the latter meaning can be to divide or apportion the proper-ties of owners as individuals equally among all the members of a family, a group or a community; it can further mean to contrib-ute to a portion of specific expenses such as sharing the cost of holiday accommodation or the renting of accommodation; one can also join with another by e.g. sharing an umbrella.

The sensitivity for the needs and wants of others, qualify a particular emphasis on that kind of sharing where ownership of particular commodities is apportioned to provide for these needs. "Sensitivity" can mean to respond to something in an appropriate way (as in the more literal sense of responding to stimuli). In order to be sensitive it means to be aware (in par-ticular in this context) of these needs implying taking stock of these needs from time to time or to be perceptive to these needs. This interpretation is borne out by the use of "consid-erate" and "sympathetic": in being considerate, one must be thoughtful towards other people; "considerate" seems also to be qualified by "patient" and "kind": it means that one should not just reject or being critical towards the needs of others, but positively consider them (kindly and patiently); "sympathetic" pertains to a feeling of love ("warmth" - affection or cordiality) and understanding another person's moods or personality from which it follows that to understand another person, one should be congenial. This idea is strengthened by "empathy": this means that to imaginatively entering into another subject's feelings and to identify with it. This does not necessarily imply that one should be congenial (in the sense of being of having the same frame of mind). To be congenial, implies to have simi-lar frames of mind, or perhaps, similar world-views or ways of life. This may be in contradiction to "patient" or "kind" where the idea is to understand someone else's needs without being congenial. "Needs" bear on certain essential wants (to be re-quired of necessity) and not luxuries without which people can do. To attend to a person's needs requires a "caring" attitude (showing compassion by being troubled or concerned about someone else's condition). However, it seems that "needs" in this context are qualified by the other person's personality or frame of mind in terms of which "essential wants" are qualified,

unless "patient" or "kind" can prove the opposite. This does not seem to be the case if we consider the uses of the concepts "interaction", "harmony" and "co-operation": "Interaction" is concerned with a mutual or reciprocal action or influence; to interact, means to act on or be in close relation with each other. "Harmony" requires agreement in action, opinion, feeling, frame of mind, or viewpoint which implies a shared world-view. "Co-operation" bears on a joint operation or action requiring as-sistance or the willingness to assist. This idea is strengthened by "communication": it relates to the imparting or exchange of information, ideas or feelings. This implies that people must understand or come to an understanding of each other.

I suggest that the attempt to interrelate this cluster of concepts shows what is intended by Edward Blyden's view that Afri-cans have their "own sense of God...their own moral codes ... and their own spiritual life" (as quoted above) and what Khoza means by "collective consciousness". It also explains more about rationality, morality and human dignity: reasons are given why these cluster of concepts are acceptable for reflecting the true human nature; understanding another person in terms of his/her frame of mind determines the type of morality in terms of communal ethics; the dignity of another person is expressed in terms of empathy: respect for another person's view of life. An indication is also given of the meaning of "I am, because you are" in terms of congeniality.

No further indications are given of how these concepts are applied to specific situations, but it seems that Auniversal broth-erhood@[1] is very important and that this may be a cue or a guideline to understand the other concepts: brothers are part of a family and the family unit is regarded by most African thinkers as the basic paradigm for community life. From the way the network of concepts are analysed, it seems that "shar-ing" in terms of universal brotherhood, is the dominating con-cept in *Ubuntu*-thinking. It is dominating in the sense that it underpins the meaning of all other concepts. World-views show in most cases that they are underpinned by key-propositions: for example, in the case of materialism it is believed that all things consist of matter; in animism, it is believed that all things are spiritual. In *Ubuntu*-thinking it seems that it is believed that all ways of life can be reduced to sharing. Key-propositions can enable us to understand how world-views differ from each other since these key propositions are regulating principles for the particular way of thinking. To identify a key proposition has two advantages: it can be regarded as an important step towards understanding a basic position of applying relatively abstract concepts to concrete situations; it can also be used to compare different world-views in an attempt to establish the unique position of each of them.

World-views and human action

Different positions adopted led to different practices on the grassroots level so penetrating the different categories men-tioned. A legal system, for instance, will differ when driven by self-interest and competition than when driven by subordina-tion; the distribution of goods in an economic system will dif-fer when underpinned by intellectualism than when under-pinned by subordination; and so with the other categories. What is to be noted is that each fundamental position pro-vides a deductive system for human action. This deductive system can be called a conceptual scheme or a frame of refer-

ence in terms of which a person understands the world-view he subscribes to, so enabling him/her to make certain choices for action and giving meaning to his/her own life. In all these cases people relate to each other in certain ways. In a capitalist society or a dominant one, people will relate mainly via competition ending in a rat race; in a socialist society people will relate mainly via sharing which may affect productivity in a negative way. The way we treat people, will depend on such basic points of departure.

From these examples we note that certain fundamental positions constitute ways of life. These ways of life represent world-views in terms of which people *give meaning to their own life* in terms of a *web of beliefs*.

World-views encompass all human actions as they are manifested in the categories of institutional life in terms of regulative concepts[2]. These categories are issues such as family life, education, legal system, economic policies, political structure, welfare policy, and such other institutional or social structures that may be identified in a society or community, or that may be essential for any society to function well according to the demands of the eco-system.

The theoretical framework of *Ubuntu*-thinking presented above, should be applicable to any of the mentioned institutions mentioned above. The application should also show the viability of this thinking, and be at the same time, in conjunction with its viability, a litmus test for its practical usefulness.

In the next part it will be applied to medicine. In this case caring for the sick is the way sharing is thought to be applied.

Application to medicine

In this part of the paper I deal with the way people relate or should relate to patients as physicians, nurses or family and friends in terms of *Ubuntu* as a form of African Humanism. What is necessary is to get a clear understanding of what the focus of sharing is in the case of patients. For the African, sharing in this case means medical care which should not just focus on the body of the person, but on the whole person. What is meant by the whole person, is to be understood in terms of the dictum "I am, because you are", where "I am" is regarded as the "product" of his fellow men, ancestor spirits and supernatural forces, represented by "you are". Empathy as directed to the understanding of the frame of reference of another person as a sick person includes therefore more than just a person's body for the African or *Ubuntu*-thinker. Sickness is regarded as the result of disturbed relationships with his or her fellow men. This implies that *Ubuntu*-thinkers have a particular idea of causes for diseases which is regarded by them as different from Western ways of thinking. Their views of *causality* constitutes the frame of reference of the disease of which a person suffers and *caring* can only make sense for them and their healers in terms of this frame of reference. *Caring* is how *sharing* is manifested: the healer is not supposed to deal with a physical object in terms of mere mechanical causation, but with a person as a whole in terms of interpersonal relationships ("I am be*cause* you are").

This interpretation is borne out by the views presented by Ademuwagen.

The African view of a disease

The nature of a disease

Z.A. Ademuwagun illustrates what is involved in *healing* (which has implications for the *nature* of a disease):

"... for any healing to be regarded as complete, a patient must be integrated into his total setting. For example, a patient just discharged from hospital is not considered as completely cured until some observable measures have been taken to integrate him socially, emotionally, psychologically, spiritually and ritually or religiously through a complex process which synthesizes the peoples's sociocultural beliefs, values and practices in matters of birth, life, health, disease, death and health practice. This explains, for instance, the inclusion of sacrifices with drug prescription and administration in traditional methods of healing: sacrifice plays a positive psychological role in the patient's total integration into society; it also serves as reconciliation of the patient with the natural and supernatural powers, thereby guaranteeing the recovering patient a balanced emotional and social wellness" (Ademuwagun, Z A 1978, p. 93-94).

We note that the following factors are regarded as relevant to understand the *nature* of a disease in terms of purported *causal patterns*: sociocultural beliefs, values and practices relating to birth, life, disease, death and health practice; another factor mentioned is the person's emotional state, but not much is said about it, except for referring to "balanced emotional ... wellness" (in Western context this may mean feelings such as joy, sorrow or fear); the psychological state is also not clarified but has something to do with a person's integration in society (in Western context, again, it means the mental make-up or structure of an individual that causes him to think and act the way he does); the spiritual aspect is perhaps the same as religious beliefs which are concerned with the person's relationship with natural and supernatural powers. Although it is difficult to reconstruct the *causal chain* from the "given" *causal patterns,* I suggest that the causal chain can be represented in the following way: a person angers the supernatural powers by misconduct towards his fellow men (which can be rephrased in *Ubuntu*-jargon by "I am not because you are not", or "I am what I am, but not because you are"; this means that a person no longer keeps to the demands imposed on him by his community and so finds himself in a position of social disintegration); the natural powers may set in to cause physical illness, emotional instability, psychological tension and/or stress.

This interpretation is borne out to an extent by the way *healing* is described by Ademuwagun: he argues that sacrifices with drug prescription and administration in traditional methods of healing plays an important part in the person's total integration in society and serves as reconciliation of the patient with the natural and supernatural powers. From this we note how the *causal chain* of diseases is addressed or "switched" in the healing process.

Diagnosis of diseases

However, this *causal chain* is not directly given, but should be *diagnosed.* Ademuwagun points out that this holistic-ecological approach[3] is also applied in the *diagnosis* of an illness:

"Traditional healers operate a composite set of procedures to find out whether or not a person is really sick, and if sick the causal factors are diagnosed. Complete diagnosis takes into consideration the ecologic complex of the total environmental setting of men. Biological, social, cultural, psychological, spiritual and supernatural causal evidences are usually involved. For example, through an intricate process of interviews, the causes of insomnia may be traced to the contravention of certain cultural ritualistic taboos or superstition; offences against certain divinities, ancestors and supernatural powers..." (Ademuwagun, Z A, 1978, p. 91).

Insomnia is mentioned as an example by Ademuwagun to show that insomnia is related to the environmental setting by the Yoruba. However, it should be noted that the example of insomnia can in most cases, if not all, be associated with psychological conditions which makes it easier to explain a disease in terms of holistic causal chains (especially including social disintegration). Insomnia may be regarded as a purely psychological condition which can be distinguished from physical conditions. This leads to the problem of distinguishing between *physical* and *psychological* conditions and how this distinction will affect the *holistic* framework of understanding a person in terms of *sharing* as *caring*.

Physical and psychological conditions

In Western medicine certain states such as insomnia are regarded as psychological in nature whereas appendicitis, malaria and cancer are classified as physical diseases. According to Ademuwagun the Yoruba also distinguishes between physical and socio-psychological sickness. Headaches, malaria, fever, and dysentery are classified as physical sickness, and illnesses caused by unemployment, lack of money, strained human relations and inability to get along with others, are regarded as socio-psychological illnesses. Physical illness is diagnosed if a person becomes immobile: the patient cannot get out of bed and move about to perform his/her routine work, with the result that the person is unhappy and unproductive; other symptoms mentioned are high or low temperature of the body, observable skin diseases, diarrhoea and vomiting.

From this discussion the question arises as to how to distinguish between physical and psychological conditions.

We find a mixed description of physical and psychological conditions and the difference between the two, although admitted, is not clear. This position makes it difficult to tell how medical caring should be applied in terms of the African holistic approach (and perhaps also in Western contexts). The implication is that in one case caring should focus on the physical condition and then on psychological and sociological factors as described in the previous quotation. The exact distinction is also problematic in Western medicine in terms of the idea of psychosomatic conditions. This term is used, on the one hand, to blur the distinction between the body and the mind but, on the other hand, the distinction is somehow maintained by using two terms in this combination. In African thinking, as represented by Ademuwagun, no distinction is drawn between the body and the mind, although a distinction can be drawn between physical and mental diseases: in both cases persons are involved and not two different entities to be cared

for differently.

If the belief of the African that illness is both a bodily and a spiritual condition as the object of caring is acceptable, then the duty of the physician or nurse includes much more than just caring for patients' bodies. However, the idea of a *causal chain* that includes the factors mentioned above may not be as clear as it seems to be. For this reason it is necessary to take a specific look on how the Africans think of causality. What concerns us here, is not so much an analysis of the theoretical framework of the African view of causes, but whether theory can be joined to practice.

The African view of causes: theory and practice

In Western tradition the tendency is to operate with the mechanistic notion of causality. In African thought causality includes the mechanistic as well as the non-mechanistic ideas of causality. Sogolo (Sogolo, G. 1995. P H Coetzee, and M E S van den Berg, (eds): p. 205) argues that the African approach to the explanation of diseases shows a combination of both the mechanistic and the non-mechanistic explanatory models which provides a fuller, more comprehensive understanding than the exclusive use of either[4].

Sogolo quotes the example given by Troxell and Snyder (Sogolo, G. 1995 P H Coetzee, and M E S van den Berg, (eds): p. 6-7) about the different explanations that can be given of the causes of the outbreak of a fire. The fire fighters reported that children playing around with matches caused the fire and the physicist explained it as the ignited match. The point, for Sogolo, is that the two types of explanation are not in conflict with one another. These two explanations are regarded as complimenting each other in providing more details in the explanation of the fire outbreak. In addition to this, it is shown that a psychologist may explain that the children's behaviour was caused by their parents entertaining them with match tricks and a sociologist may explain their behaviour by the fact that their parents ignored them due to domestic problems. Both the psychologist and the sociologist would claim that the parents are the cause of the fire. Examples of this kind may further be extended by claiming that smoking may be the cause of the fire in the sense that smokers were always in the habit of leaving matches for the children to play with or that the birth of the children caused the fire, since if they were not born in the first place the first incident would not have occurred.

These examples are supposed to demonstrate that infinite kinds of causal explanations can possibly be given for a single event which does not imply that one explanation is superior over another one; secondly, it is supposed to demonstrate that different explanations are complementary and non-mutually exclusive which means that together they constitute adequate or complete explanation of the fire incident. This example, it can be argued, surely has a practical impact: without the children no fire; without the matches no fire, without the smokers no fire; and so on. The causal chain cannot be denied.[5]

Against this background, the causes connected to diseases are then dealt with. Sogolo (Sogolo, G. 1995. P H Coetzee, and M E S van den Berg (eds): p. 9) claims that people's general conception of health and disease is linked to their cultures as represented by their overall world-view. This constitutes for

the African a holistic conception of disease or illness.

A man is said to be ill in Yoruba thought when he is unable to perform his/her routine work or social duties. Sogolo points out (quoting Vusi Sithole) that the Yoruba word *alafia* (translating "health") "embraces the totality of an individual's physical, social, psychological and spiritual well-being in his total environmental setting" (Sogolo, G. 1995. P H Coetzee and M E S van den Berg 1995 (eds): p. 10).

Sogolo has similar ideas to that of Ademuwagun about the nature of diseases but expand on the practical impact of these ideas. The whole human being is considered either well or in a state of disease and not merely some part of it. According to this view it is not diseases that should be treated but human beings. A traditional healer does not associate diseases with specific parts of the body by starting to diagnose an illness by a physical examination of the patient's body as it happens in Western society. Instead the traditional healer is primarily concerned with the patient's background in socio-cultural and in divine/supernatural relations.

The practical impact of this approach is believed to be substantiated by the fact that an illness or disease can be explained by reference to several causes just as in the case of the fire outbreak. Sogolo argues that "an African healer may attribute a disease to a scientific/natural cause, not too dissimilar to the germ theory of modern medicine. Yet he may also believe that the same disease is 'caused' by supernatural forces. He would then proceed to cure the disease in these two seemingly incompatible directions" (Sogolo, G. 1995 P H Coetzee and M E S van den Berg (eds): p. 11).

Sogolo points out that this is a form of animism which is common in the history of every society. He uses stress as an example to illustrate that people in a state of stress are more susceptible to their affliction then those not socially disturbed, since stress reduces the natural resistance of the body against certain diseases. In a Western context stress, for example, can be related to a situation where the business of a person is at the verge of a collapse. In an African context stress is mainly due to strained relationship either with one's spiritual agents or with other persons within one's community. This is for Sogolo similar to the practice in modern orthodox medicine whereby medical scientists explain certain diseases by a conjunction of the germ theory and the patient's reduced resistance to stress. To restore the body to a state of increased capacity to heal itself means that the pharmacological efficacy of the drugs is maximised: and this is the purported way of joining theory with practice. Sogolo points out that confidence and positive belief in modern medical practice produce favourable results and that this is parallel to the approach of the African healer. The patient's belief that his physician is competent and that the drug works, helps to restore his body to a state of harmony between it and the applied drug. Anxiety is in Africa believed to be an outcome of bewitchment, leading to phobias. Bewitchment should therefore firstly be addressed as the cause of the anxiety. And, according to Sogolo, it works.

This means that the belief is not just being *stated,* but that it is also *acceptable.* This links up with Sogolo's distinction (Sogolo, G. 1995. P H Coetzee and M E S van den Berg (eds): p. 218) between the beliefs being *held* and being *true, meaningful* or

rational. Being held, these beliefs play an important role in the diagnosis of diseases and they affect the pharmacological activities of drugs. Sogolo argues (quoting Rowe D) (Sogolo, G. 1995. P H Coetzee and M E S van den Berg (eds): pp.16-17) that psychotropic drugs are like aspirin which takes away the pain of toothache without healing the tooth. If a person believes that he/she has a good reason to be anxious or depressed, the drug does not change his/her belief and the effect of the belief overrides the effect of the drug.

Another problem arises as to how non-physical entities can possibly interact with a physical entity. Sogolo is aware of this conceptual problem and points out that where the non-natural forces are social or psychological factors, the problems may be adequately handled by a psychoanalyst. However, no dichotomy of this kind is constituted for him by the natural and the supernatural in African thought. He argues that the apparent conflict between people's explanation of illness may still be resolved by invoking the difference principle between primary and secondary causes or "how" and "why" questions. Primary questions are related to questions on the meaning of life which cannot, according to Sogolo, be resolved by applying canons of scientific reasoning. He questions the applicability of scientific reasoning to primary causes and argues that there is neither an absurdity involved in an integrated diagnostic process which blends the natural with the supernatural and nor in a curative process involving the pharmacological activities of herbs and the appeasement of supernatural entities.

Sogolo regards this argument as parallel to the example of the fire outbreak. His main argument is that what stands as an acceptable explanation depends on our interests in the matter. He argues that

"Just as the conjunction of the explanations by the fire fighters, the physicist, the psychologist, etc., provides a fuller explanation of the cause of the fire outbreak, so would the various ailments mentioned in Maclean's examples provide a fuller comprehension of the pharmacological powers of the drug." (Sogolo, G. 1995. P H Coetzee and M E S van den Berg (eds): p. 17).

However, it should be noted that stress is here used as a particular kind of example in an attempt to show that the theory has a practical impact. As has been pointed out above, this kind of example is classified in Western medicine as *psychological* and not *physical.* The question arises as to whether the same results can be achieved with examples such as cancer or malaria. This is important, because the point of departure of *caring* as *sharing,* is *empathy:* if the theoretical framework is misconstrued, understanding the mental framework of another person towards which *empathy* is supposed to be directed, is also misconstrued. It is arguable whether the construction of "how"and "why" questions or primary and secondary explanations always function in conjunction in all kinds of diseases. What may be helpful is to compare this thinking with Western thinking in order to clarify the issue of a framework.

Western and African medicine

In Western medicine the main focus by physicians are on diseases as physical matters. A physical matter is regarded as a bodily state. In the case of a disease, certain bodily organs, for

example, are not functioning in a proper way. This improper functioning can be restored by the administration of drugs, by an operation or by chemotherapy. To care for a patient suffering from a physical disease, involves being able to diagnose the disease, to apply the types of treatment described, and to monitor the recovery. The causes of the disease are linked to the function of the body. Part of this procedure is also to explain to the patient in ordinary terms what the disease involves and what the prognosis is. This may be regarded as the psychological side which is not necessarily to be regarded as part of the treatment (a possible misconstruction of the framework). It is not part of the treatment if it can be shown that discussing the disease with the patient can make no difference (causal connection) to the prognosis which does nct mean that the discussion should not be performed in terms of the obligation of the physician to the patient's dignity as a human being. But this is regarded in Western medicine as a separate issue requiring different forms of expertise and is not be confused with the physical treatment as such. The main focus of caring in such cases is on the body of the patient. Where so-called holistic causes can be shown to make no difference to the physical treatment, they are not considered as relevant causes by the Western physician.

This discussion enables the patient to adopt a certain attitude towards his disease. This attitude may be described as realistic or unrealistic; as relevant or irrelevant; as practical or unpractical; as wrong or right; as appropriate or inappropriate; as involving false or true beliefs; and, as pessimistic or optimistic. To address the attitudes of patients towards their illnesses requires skills which do not strictly fall within the scope of a physician and therefore is not part of his obligation since an obligation is related to competences.

The argument that the patient has certain beliefs about his illness and that this should be taken into consideration by acknowledging them and dealing with them as if they are part of the causal structure of the disease, should not easily be generalised. A person suffering from terminal disease such as cancer may believe that he/she has sinned against the ancestral spirits. This belief may lead him/her to avoid physical treatment and to perform sacrificial rituals in order to appease the anger of the ancestral spirits. This may both lead to the worsening of his physical condition by exhaustion and causing him/her to vomit, and to the development of the cancer which could have been stopped by physical treatment. If this is true or acceptable, it constitutes a clear example of the misconstruction of the framework for at least some diseases.

This example purports to demonstrate that beliefs of patients should not just be accepted as Sogolo argues, because some beliefs may not be in the interest of patients. Caring is directed towards the welfare of the patient and if this is undermined (framework misconstrued), a different approach should be adopted.

The example of the fire outbreak does not illustrate how the causes identified by the psychologist or the sociologist can be used in fighting the fire by the fire fighters using chemicals or water. The psychological or sociological causes are at most relevant to prevent not to stop the fire. However, the preventive measures as described in terms of human action, may also fail despite attempts to educate children in certain ways. Hu-

man beings are free to act in certain ways which undermines the idea of cause as a strict sequence of events. Preventative measures in terms of physical conditions like fencing off hay crops or keeping fuel safely locked, are more directly relevant to preventing fire outbreaks.

The same distinction can be drawn in the case of diseases where we talk of cure and prevention. This distinction is blurred in Sogolo's discussion of the fire outbreak as an analogy for people's beliefs about their illnesses.

However, this does not mean that the treatment of certain illnesses such as ulcers do not involve using psychological methods. Certain kinds of ulcers are believed to be caused by tension which can be related to work situations, family problems or political struggle. What can be said of certain ulcers, cannot necessarily be said of any type of illness, or perhaps of any type of ulcer.

In caring for patients the scope of the caring should be determined in terms of relevance. The beliefs of the patient should be taken into consideration in terms of the meaning life has for the patient without taking all the beliefs for granted, either as true beliefs or as parts of causal chains. Patients should be referred for further help or caring by the physician if he himself is not qualified to deal with the wider scope of the illness. However, it is advisable that syllabi for physicians or nurses should include psychological training in order to deal with wider issues which are not too complicated.

Conclusion

What firstly emanates from this discussion is the problem of the uniqueness of Ubuntu-thinking.

The theoretical framework of the Ubuntu world-view can be said to contain concepts which do not guarantee a unique position[6], since these concepts (such as sharing, empathy, and caring) can and are used in many other world-views, ideologies or conceptual schemes. Take Capitalism as an example: in Capitalism "sharing" may practically have another meaning in its application, but, it can be argued, the basic or formal meaning may remain the same. Sharing in terms of salaries, bonuses, subsidies for housing schemes, the institutionalisation of welfare, and insurance schemes may be different from sharing in terms of dividing the commodities and the profits, personally caring for the aged, shared accommodation, and communal responsibility for risks, but the question is whether it is only a difference in terms of how social life is organised with the same objects or whether two different structures are involved. It can be argued that there will be no difference in the result whether you stir a cup of tee clockwise or anticlockwise, in both cases the sugar will dissolve. Similarly, whether you care for the aged by accommodating them in institutionalised old age homes or take your elders with you in your own home, does not make any difference to the fact that they are cared for in terms of shelter and food. In both cases, so the argument can go, they have shelter, food and medical care. A counterargument to this is that in the first case mainly an impersonal (anonymous) relationship is established whereas in the second case the relationship is personal. The impersonal relationship bears on another kind of empathy directed to understanding the need of a person mainly in terms of his/her physical make-up which is by impli-

cation regarded as incomplete in Ubuntu-thinking. The personal relationship includes the whole person and especially the friendship and love of friends and family. This includes structures of communication (mother, brother, sister, friend) which do not exist in the case of impersonal relationship (doctor, patient, nurse). However, it should be pointed out that in Western medicine the personal relationship is not necessarily excluded: the division between medical expertise and family involvement is still in place, although not morally expected or enforced, if you wish. The impression is created that care in Ubuntu-thinking is directed towards (the framework) of the whole person implying that medical expertise must include the personal as well. To put it differently: universal brotherhood involves family ties with all persons in the community as one big family, and for this reason medical expertise is viewed as only part of these family ties. The unique position of Ubuntu-thinking as caring for the sick, is therefore not in terms of being unparalleled, but in terms of a difference in explicitly demanding or prescribing a moral duty which cannot be said to be that explicit in Western medicine. The crux of the difference is that "caring" for the sick in Ubuntu-thinking has a wider application (another frame of reference) then what is commonly accepted as medical care in Western medicine.

A second point concerns the views on causality: on the one hand, no clear distinction is drawn between reasons and causes by Ubuntu-thinkers, and, on the other hand, the idea of causality, except from being controversial in general, is questionable in terms of a chain of causes that can be generalised in terms of Ubuntu-thinking. We noted that the most examples used by Ubuntu-thinkers to prove their view of causal connections, are relatively taken from the psychological field: stress is caused by bad relationships with fellow men or by physiological diseases. In Western thinking bad relationships are regarded as a reason for stress, and so with physiological diseases (as a reason for stress), but stress or a bad relationship is not regarded as a cause for physical diseases such as rubeola or malaria. It is not clear whether this distinction is drawn in African medicine, If not, the framework of a disease in terms of the holistic approach can be misconstrued.

A third important point is that intercultural communication is possible on the basis of the fact that African medicine and Western medicine do not operate with completely different approaches to diseases in such a way that no theoretical or practical access is at all possible between the two approaches. On the contrary, each can learn from the other and fruitful mutual verification is possible which can lead to better treatment of diseases. This in itself is more than enough reason for further research in this area towards which this article has been intended to make a stimulating and provocative contribution.

Notes

1.   "Universal brotherhood" is also regarded by Okolo (C B Okolo, *African Philosophy: A short Introduction* (Cecta Ltd, Nigeria, 1993) p. 30) as an important characteristic to explain his idea of "being-with-others". We find similar ideas in the cases of Okolo (1993a: 8 - 21) and Makinde (M A Makinde,

African Philosophy, Culture, and Traditional Medicine Centre for International Studies, Ohio State University, 1988) pp. 23 - 58).

2.   The search for a regulative concept, guiding principle, key proposition or criterion for the application of a concept(s), can be regarded as one good philosophical strategy to gain greater understanding of a vague issue or to come to grips with the hierarchy of a system. Sometimes systems of thought or conceptual schemes can use the same components but they can differ with respect to their ordering. This is what is shown in this part with respect to African Humanism, Western Humanism, Individualism or Collectivism: certain basic positions (regulative concepts) pervade the system with the result that we have completely different meanings, although the coordinate system can be the same.

3.   Other accounts of this holistic approach to diseases can be found in Lewis (A Lewis, Health as a Social Concept, *The British Journal of Sociology*, (Vol 4,1953): pp. 113 - 115), Carothers (J C Carothers, *The African Mind in Health and Disease*, World Health Organisation, Geneva, 1953)pp.: 71 - 166) and Maclean (U Maclean, *Magical Medicine*, (Allan Lane, London, 1971) pp. 30 - 43, 101 - 112).

4.   This position is also defended by Sodipo (J O Sodipo, 'Notes on the Concepts of Cause and Chance in Yoruba Traditional Thought', *Second Order: an American Journal of Philosophy*, Vol 11, No 2. 1973 pp. 12 -20, and Carothers (J C Carothers, *The African Mind in Health and Disease*, pp 13 - 17).

5.   A distinction should be drawn between the causal chain of one episode of causes of events and the *generalisation* of these causes. This was a problem with which Hume struggled.

6.   "Uniqueness" is a controversial concept and is often used ambiguously. Basically it means without equal or like or unparalleled (Latin: *ānicus*, from *ānus*, one) ; in this sense it means being the only one of a particular type, single or sole. It is controversial in the sense that some of the types or things referred to, have no links in meaning among themselves as types or things so that it does not make sense to talk of "similar to", "dissimilar to" or "compared to", since no general categories of comparison can logically exist in terms of the very meaning of "unparalleled". This has epistemological implications for explaining the world in terms of some types in terms of the components of which it is constituted if all or some components are unique or even if one component is unique. Often, however, "unique" is used in the sense of "being different": a cat may differ from a dog but is not unique or unparalleled in the sense of "animal". "Unique" may also be used in the sense of "this cat is unique", either to refer to the ability of the cat to talk as different from all other cats or all other animals. In this case it is only the one property of the cat that is regarded as "unparalleled" and not the other properties or the particular cat as "cat" This shows some of the ambiguous uses of "uniqueness".

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