



The Concept of Health Care Ethics among the Larteh of Ghana: Implications for Medical Practice in Ghana

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ABSTRACT

This research analysed traditional healthcare ethics as perceived by the people of Larteh in Ghana. It is an ethnographic research that studied narratives of health care ethics and analysed their contents. The research attempted to extrapolate unique elements of what might be called the Larteh traditional system of health care ethics, showing their significance for health care in public and private health care centres and hospitals in Ghana. Thus using an ethno-medical approach, generally within the scope of Gyekye's theory of communalism and Bertalanffy's general systems theory, the paper argued that though some of the ethical ideas contained in the narratives constitute fragments of ethical behaviour among healers, they largely reflected ethics of health care practice known to Western or Orthodox medical practice such as confidentiality, professionalism, limited non-maleficence and paternalism. Nonetheless, other elements could provide important lessons for improving the care of patients in Ghana. The paper concluded that Larteh's traditional ideas of health care provide ethical principles that not only preserve the dignity of the patient but also teach principles that can contribute to the development of health care generally. The significance of this paper is in its ability to provide a framework for interpreting traditional healthcare ethics.

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INTRODUCTION

Ethical considerations in caring for the sick date back to the ancient Greek period.¹ An important achievement that occurred in health care during this epoch was the introduction of the Hippocratic Oath which sought to provide a pathway for health care practice generally. The oath had meaning for the author, the Greek community, and ancient medicine.² With the advent of Christianity during the medieval period, 'health care ethics' received attention from Christian theological discourse. For example, surgery was considered a 'bad' medical practice because it was believed that a soul inhabited the body. An attempt to cut into the body was therefore considered an interference in God's work of creation. However, by the time of the Renaissance (the 1300s – 1600s), much of these ideas had given

¹ Plinio Prioreschi, "A History of Medicine, Volume II, Greek Medicine, Omaha" (Horatius Press, 1996); Evert Timmer, "Medical Ethics and Evolution," *Journal of the Royal Society of Medicine* (SAGE Publications Sage UK: London, England, 1994); Werner Jaeger, "Aristotle's Use of Medicine as Model of Method in His Ethics," *The Journal of Hellenic Studies* 77, no. 1 (1957): 54–61.

² Fabrice Jotterand, "The Hippocratic Oath and Contemporary Medicine: Dialectic between Past Ideals and Present Reality?," *The Journal of Medicine and Philosophy* 30, no. 1 (2005): 107–28.

way as a result of philosophical enquiries and scientific discoveries. Throughout these epochs, little was known about a unified system of 'health care ethics' that guided medical practice at the time. Until the 1960s, it was only the Roman Catholic Church which was engaged in what became known as 'medical ethics'.³

Today, Western medicine can boast of a system of healthcare ethics that hinges on ethical theories such as justice, beneficence, non-maleficence and autonomy.⁴ Much recent discourse on health care often focuses on 'bioethics' as a result of success in medical technology. This historical development of an 'ethic' of health care points to a society's traditional ideas about health care that developed over time. In essence, a society's indigenous knowledge systems offer a unique way of building upon aspects of life particularly health. This is because healthcare issues receive much attention in nearly all communities. In Ghana, for example, several studies have shown how traditional medicine has and continues to contribute to health care delivery generally.⁵ Most of these works discuss in detail, the nature, efficiency and resilience of traditional medicine over the years. There are equally studies that show the possible link between traditional medicine and orthodox medicine. Nonetheless, in spite of the attempts, these studies are limited in providing a unified system of traditional 'health care ethics.' And yet traditional medical practice would seem to have a body of knowledge regarding the ethics that guide the practice. Hence as part of the global interest in indigenous knowledge systems (IKS) for contemporary challenges, this paper studies Larteh narratives of healthcare ethics and analyzes their contents as an attempt for constructing what might be called the 'Larteh traditional system of healthcare ethics.' Thus, given that there is growing public concern regarding the ethical conduct of healthcare providers today,⁶ one wonders whether a people's indigenous knowledge may offer some useful guidance to healthcare providers.

LITERATURE REVIEW

Traditional Medicine in Perspective

It is difficult to construct the history of traditional medical practice in Africa. What is certain, however, is that the practice is ancient. The difficulty in obtaining a history of African Traditional Medicine (ATM) stems from the fact that traditional medical practice cannot be traced to a specific individual as Western (Orthodox) medicine will trace its history to either Hippocrates or Imhotep. Nonetheless, in spite of this historical challenge, the African religious worldview has always provided information on the 'therapy-seeking and therapy-selecting behaviour' of Africans.⁷ Nonetheless, quite a number of the early scholars of indigenous African medicine (often non-Africans) would seem to have misconstrued the African approach to medicine. Studies concerning traditional medicine in Africa were previously associated with religious beliefs and rituals.⁸ The immediate point of reference according to Sindiga is the work of Evans-Pritchard.⁹ Sindiga argues that such studies observed that diseases from an African perspective had both moral and social dimensions. This way of thinking flowed from the British School of Anthropology. This school of thought projected the notion that as

³ Luigi Santacroce, Lucrezia Bottalico, and Ioannis Alexandros Charitos, "Greek Medicine Practice at Ancient Rome: The Physician Molecularist Asclepiades," *Medicines* 4, no. 4 (2017): 92.

⁴ W H Donovan, "Ethics, Health Care and Spinal Cord Injury: Research, Practice and Finance," *Spinal Cord* 49, no. 2 (2011): 162–74.

⁵ Peter White, "The Concept of Diseases and Health Care in African Traditional Religion in Ghana," *HTS: Theological Studies* 71, no. 3 (2015): 1–7; Vincent Assanful, "The Persistence of Indigenous Medical Practice in Ghana," *Communication, Culture and Health*, 2015, 151–65; Bright Adjei, "Utilization of Traditional Herbal Medicine and Its Role in Health Care Delivery in Ghana: The Case of Wassa Amenfi West District" (2013); Patrick A Twumasi, "Medical Systems in Ghana: A Study in Medical Sociology," (*No Title*), 1975.

⁶ Seetharaman Hariharan et al., "Knowledge, Attitudes and Practice of Healthcare Ethics and Law among Doctors and Nurses in Barbados," *BMC Medical Ethics* 7 (2006): 1–9.

⁷ Isaac Sindiga, "African Ethnomedicine and Other Medical Systems," *Traditional Medicine in Africa*, 1995, 16–29.

⁸ P Stanley Yoder, "Issues in the Study of Ethnomedical Systems in Africa," in *African Health and Healing Systems: Proceedings of a Symposium*, 1982, 1–20.

⁹ Edward Evan Evans Pritchard and C G Seligman, *Witchcraft, Oracles and Magic among the Azande* (At The Clarendon Press, 1937).

far as Africans were concerned, disease causation was mostly a supernatural element, particularly witchcraft.¹⁰ This notion led some scholars to describe indigenous African healers as ‘witch doctors’. In his own words, Mutungi writes:

Witch doctors (*awe* in Kamba) devote their activities to the care and healing of the sick by use of native herbs and paraphernalia that go with such practices in the given society.¹¹

The above argument presents two ends of a pole. On one end of the pole is the confirmation that the notion of disease causation among Africans is usually within a religious purview; a phenomenon, which is still prevalent. The persistence of the religious dimension to disease in Africa is proof of the assertion that the African is ‘incurably religious.’¹² On the other end of the pole is what may be described in this paper as an ‘academic trap’ into which many African scholars of indigenous medicine fall. Although some scholars believe the situation is as a result of colonial influence, it appears some African scholars who felt the need to correct this erroneous impression about the African therapy-seeking behaviour either ‘romanticised’ the issues or fell into the same trap as their European counterparts.¹³

Inferring from Mbiti, witchcraft always has an undesirable end. It is that which seeks destruction rather than restoration.¹⁴ Obviously, traditional African healers seek to restore rather than destroy life. However, in the process of healing, a traditional healer may employ mystical powers to neutralize the powers of a witch if it is established that the cause of a disease/sickness is as a result of some witchcraft power.¹⁵ This does not suggest that traditional medical practitioners double as witches. The researchers maintain that there are traditional healers schooled in ethnopharmacology. Then there are shriners/diviners who cast and/or block out spells by sacrificing animals to ward off evil spells. In another sense, Twumasi describes the traditional medical practice as that which employs magico-religious techniques in treating sickness.¹⁶ This way of arguing implies traditional African healers double as magicians. In no deliberate attempt to define the two terms, magic could be described as manipulative, involving techniques that often seek to fulfil the desires of the ‘user’ whereas religion is supplicative, always making an appeal for the will of the divine to be done. This explains why traditional medical practice, in its proper place, often involves divinatory practices as a first step to diagnosing the cause of the sickness before treatment. In most cases, the remedy to the sickness is revealed through divination.

According to Twumasi, traditional medical practice is supernatural. He explains the supernatural to mean that which is beyond human comprehension. He further distinguishes between scientific medicine and indigenous African medicine on the basis of empirical evidence. According to him, whereas the former seeks an explanation for the cause of diseases based on the Germ Theory, the latter does not. Nonetheless, if supernatural is that which is inexplicable, then it is safe to submit that African traditional medicine has no supernatural elements as put forward by Twumasi.¹⁷ This is because traditional medical practitioners are able to give an explanation for the cause of a disease even when it is believed to be spiritual. Thus, the cause of a disease may be inexplicable (supernatural) to the patient but certainly not to the traditional medical practitioner who has the spiritual advantage to discern. This situation persists because a number of the clients who consult traditional healers believe they have been bewitched.¹⁸ Perhaps this observation is what compelled early writers to perceive traditional healers as witch doctors. However, this line of thought is rather too narrow and does not

¹⁰ Onesmus Kimweli Mutungi, *The Legal Aspects of Witchcraft in East Africa: With Particular Reference to Kenya* (East African Literature Bureau, Kenya, 1977).

¹¹ Mutungi, *The Legal Aspects of Witchcraft in East Africa: With Particular Reference to Kenya*, xvi.

¹² Edward Geoffrey Parrinder, “Religion in Africa,” 1969.

¹³ Simon Kofi Appiah, “Africanness-Inculturation-Ethics: In Search of the Subject of an Inculturated Christian Ethic,” in *Forum Interdisziplinäre Ethik*, vol. 26 (Lang, 2000).

¹⁴ John S Mbiti, *African Religions & Philosophy* (Heinemann, 1990).

¹⁵ Sindiga, “African Ethnomedicine and Other Medical Systems.”

¹⁶ Twumasi, “Medical Systems in Ghana: A Study in Medical Sociology.”

¹⁷ Twumasi, “Medical Systems in Ghana: A Study in Medical Sociology.”

¹⁸ Twumasi, “Medical Systems in Ghana: A Study in Medical Sociology.”

allow for other possibilities. The indigenous worldview on disease causation is usually the handwork of an enemy.¹⁹ This enemy may be a witch, a malevolent spirit, or even a friend(s) who for the purposes of competition may employ the services of a spiritualist to inflict sickness on their victim.

There are also occasions where the sickness is seen as punishment from an aggrieved ancestor or a god. According to Sindiga, another confusion pertaining to ATM is the absence of 'theoretical formulations of medical systems.'²⁰ Drawing from Irwin Press's definition, a medical system may refer to 'a patterned interrelated body of values and deliberate practices, governed by a single paradigm of meaning, identification, prevention and treatment of sickness.'²¹ A medical system must have a 'concept of disease causation, nosology, prophylaxis, therapy-seeking and therapy-selecting behaviour; therapy management and choice, range of practitioners, etc.'²² Thus, there may not be a physical laboratory for carrying out tests and diagnoses for the treatment of diseases. Indigenous Africans however, have a concept of disease causation, therapy-seeking and therapy-selecting behaviour, therapy management and choice, and a range of practitioners. That is a medical system. That system may also take into account the belief (or faith) of the patient and relatives.

Types of Traditional Healers

The existing classification of indigenous healers is in four categories. These include traditional birth attendants, faith healers, spiritualists and herbalists.²³ Böhmig isolates bonesetters from this list and introduces a new class of herbalists called 'neo-herbalists.'²⁴ While traditional birth attendants assist in managing complications that may occur during pregnancy, faith healers, largely from "African-based syncretic churches", resort to prayers in handling diseases.²⁵ The diviners employ divinatory practices in diagnosing and healing sicknesses while the herbalists rely heavily on plant medicine in the treatment of diseases.²⁶ While acknowledging that these categories of healthcare providers exist in the indigenous society, it is also important to note that some are not indigenous to Africa. Faith healing for instance, which is often African-Christian based, should not be considered indigenous to Africa. Moreover, the aforementioned classification presents a duplication of roles as some healers may combine spiritual and physical healing. Thus, generally, traditional medical healers may be grouped into two. Those who rely on techniques as well as physical medicinal components such as herbs, and barks of trees among others for the provision of health care and those who combine spiritual and physical components for healing. The former may include traditional birth attendants as well as herbalists while the latter may include diviners. The traditional profession of medicine is like any other trade with its own distinct organizational structure. One could become a traditional healer mainly through training or a long period of observation.²⁷ Many of those who have gone through training are people who felt called into the profession and therefore submitted themselves to coaching under the guidance of an established traditional healer. This 'call' to the profession of healing is often occasioned by spirit possession.²⁸ The profession is open to both men and women. The estimated number of traditional healers in Ghana today is about 80,000.²⁹ In Larteh, one may find all categories of healers as mentioned above. There are those who rely on techniques and herbs, barks of trees among others

¹⁹ J Kwabena Asamoah-Gyadu, "Signs, Wonders, and Ministry: The Gospel in the Power of the Spirit," *Evangelical Review of Theology* 33, no. 1 (2009): 32–46.

²⁰ Sindiga, "African Ethnomedicine and Other Medical Systems," 17.

²¹ Sindiga, "African Ethnomedicine and Other Medical Systems."

²² Yoder, "Issues in the Study of Ethnomedical Systems in Africa."

²³ Assanful, "The Persistence of Indigenous Medical Practice in Ghana"; Twumasi, "Medical Systems in Ghana: A Study in Medical Sociology."

²⁴ Christine Böhmig, "Ghanaian Nurses at a Crossroads: Managing Expectations on a Medical Ward," 2010.

²⁵ Assanful, "The Persistence of Indigenous Medical Practice in Ghana," 155.

²⁶ Twumasi, "Medical Systems in Ghana: A Study in Medical Sociology."

²⁷ Böhmig, "Ghanaian Nurses at a Crossroads: Managing Expectations on a Medical Ward," 53

²⁸ Twumasi, "Medical Systems in Ghana: A Study in Medical Sociology."

²⁹ Böhmig, "Ghanaian Nurses at a Crossroads: Managing Expectations on a Medical Ward," 54.

for the provision of health care and those who combine spiritual and physical components for healing. An overview of Larteh which is the focus of the study is provided next.

Profile of Larteh

Larteh³⁰ is a small town in the Akuapem state in Southern Ghana. It is situated on the top of the *Akonobepow*, the range of hills which cross Akuapem from South-East to North-West. It is home to the famous Akonedi shrine which occupies an important space in Larteh's religious traditions. Like several other African countries, Larteh is largely a farming community with an agricultural system based on both cash and food crops such as maize, cassava, cocoyams, yams and plantains. Although, close to Accra the capital of Ghana, the physical isolation of the community has helped to retain much of its culture.³¹ It must be noted that the distinct character of Larteh as an indigenous community in Ghana, with little or no modification to its culture, stems from the role of the Akonedi Shrine. As indicated earlier, the Shrine, in addition to its role of preserving Larteh culture, occupies an important space in the indigenous religion of the people.³² For many of the people who live in Larteh, the shrine provides space for receiving traditional health care. Such a centre is also likely to preserve much of the ethical ideas regarding health care in the community making it appropriate for a study such as this.

There are three languages in use in Larteh. These are Guan, commonly referred to as Lete, Twi and English with Guan being the predominant language spoken in Larteh.³³ But most indigenes prefer to use Twi as a medium for communication. Larteh is one but politically divided into two - Larteh Kubease and Larteh Ahenease. Traditional Medical Practitioners in Larteh are in two main categories: There are priest-healers and non-priest healers. The priest-healers are those who merge traditional medicine with spiritual components. The non-priest healers consist of those who depend heavily on herbs and other plant extracts. These are ethno-pharmacologists (or herbalists) informally schooled in botanicals. In Larteh, diseases are thought of as having spiritual and relational causes. The geographical location of Larteh is found on the map below.

³⁰ In constructing the profile of Larteh, there was, in addition to the sources hereby acknowledged, reliance on work done by the lead author herein as part of his M.Phil thesis. (See Hackman-Aidoo, A. To Eat or Not To Eat: A Study of the Role of African Traditional Religious Food Ethics in the Traditional Food Practices Of Larteh, Ghana [Unpublished M.Phil thesis submitted to the Department of Religion and Human Values, University of Cape Coast, 2014].

³¹ David W Brokensha, "Social Change at Larteh, Ghana," (*No Title*), 1966.

³² K. Ampene, *History of the Guan-Speaking Peoples of Ghana: The Undisputed Aborigines of Ghana* (Philadelphia: Starspirit Press, 2011); Brokensha, "Social Change at Larteh, Ghana."

³³ Mercy Akrofi Ansah, "Focused Constituent Interrogatives in Lete (Larteh)," *Nordic Journal of African Studies* 19, no. 2 (2010): 10.

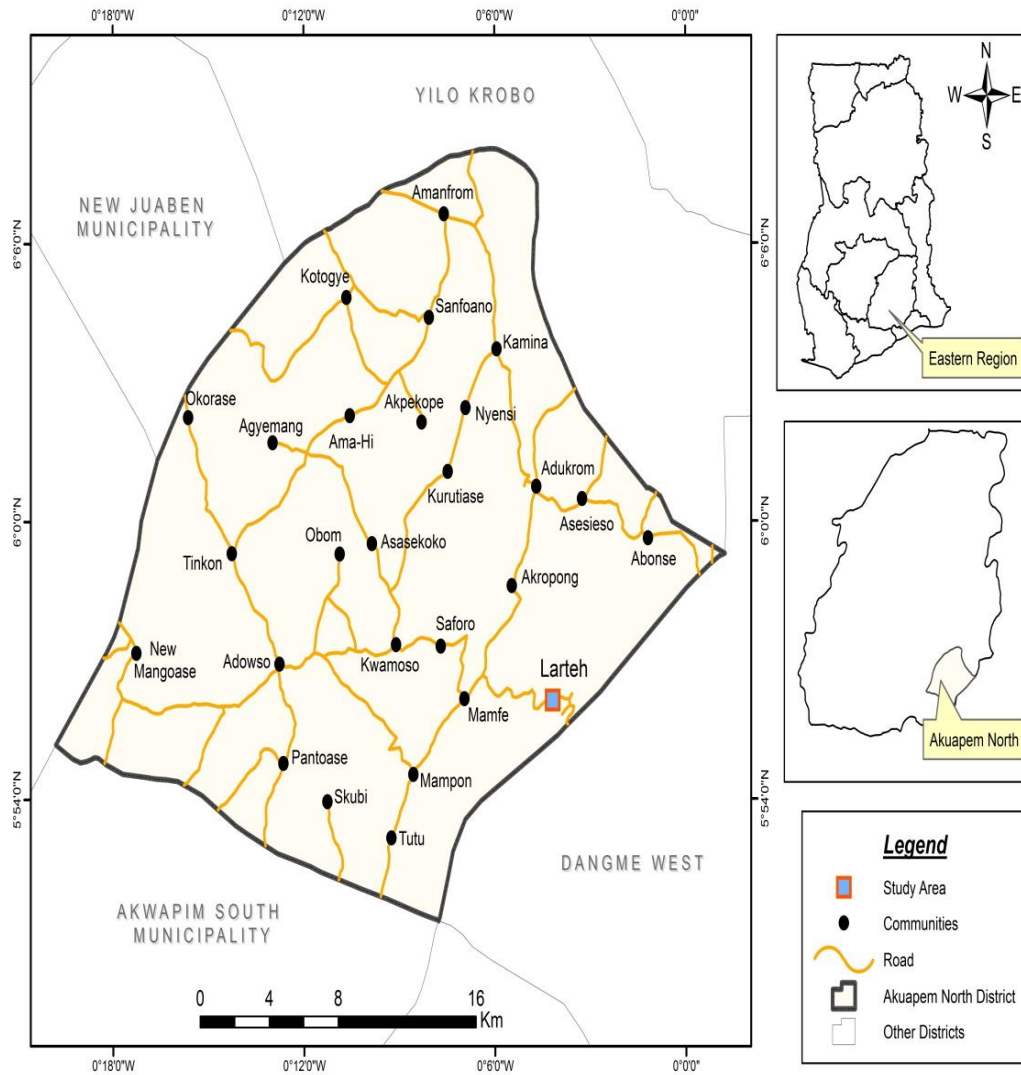


Fig. 1 - Map of Akuapem North District

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The above diagram shows the map of Akuapem North District in the Eastern Region of Ghana. It is in this district that the study area is located. Larteh is identified on the map by a deep orange spot with a light blue background.

CONCEPTUAL FRAMEWORK

The concept of healthcare ethics has received varied interpretations. Nonetheless, it is commonly used to refer to the guiding principles regarding care for the sick. It deals with the conduct of the healthcare provider in terms of what is perceived by the relevant public [health professionals] as the standard of behaviour. In this paper, the concept of healthcare ethics is derived from the perspective of the theory of the Indigenous Knowledge System. Indigenous knowledge refers to a society’s body of knowledge accrued over a period.³⁴ Thus, ‘traditional health care ethics’ is conceptualized in this paper to refer to a society’s body of knowledge arising out of the experiences of health care practices over a period.

³⁴ Paul Sillitoe, “Indigenous Knowledge in Development,” *Anthropology in Action* 13, no. 3 (2006): 1–12.

THEORETICAL FRAMEWORK

This paper is built on two theories: The theory of communalism³⁵ for studying African ethics and the general systems theory.³⁶ Communalism is based on the notion that a person does not live in isolation but, among other individuals. The general systems theory emerged as a response to the scientific principle that a system could be properly understood if it is broken down into its smaller units or components. Bertalanffy argues that scholars should do the opposite by studying the dynamics of the interconnectedness that exists between the various components rather than focusing on each. This theory ties in well with the African sense of communalism in that although sickness is an individual experience, it always takes a social dimension. No one is healthy unless the entire community is. Thus, Larteh's healthcare practices are explored within the framework of the theory.

METHODOLOGY

The ethnographic approach or better still an ethno-medical approach which provides insight into the way people 'perceive and handle sickness including diagnosis and treatment' is often the most convenient way in healthcare studies.³⁷ This approach argues that each cultural group has its own traditions and values about diseases, which are developed over time.³⁸ Such a group will have its own 'terminologies, practitioners and medicines with their distinct purposes' as well as the expected behaviours of the medical practitioners.³⁹ Since ethnosience allows for an 'accurate recording of indigenous knowledge and decision-making systems,' it is appropriate for a study such as this.⁴⁰ Actual data production relied on instruments such as unstructured interviews and observation with the aid of audio recorders and writing materials. The technique for sampling was purposive since it deals with specific subjects (traditional healers).

The ethnographic approach or the ethno-medical approach which provides insight into the way people 'perceive and handle sickness including diagnosis and treatment' was adopted for this study.⁴¹ This approach was appropriate for this study as it captures a group's traditions and values about diseases, which have been developed over time.⁴² Similarly, since ethnosience allows for an 'accurate recording of indigenous knowledge and decision-making systems,' the researchers deemed it appropriate for the study.⁴³ In order to observe and critically describe the healthcare practices of the people, one of the researchers lived in Larteh for a considerable number of weeks to observe and interact with many traditional healers. There were also occasional visits to Larteh which were intended to clarify inconsistencies that occurred after transcribing the field notes. Actual data production relied on instruments such as unstructured interviews and observation with the aid of audio recorders and writing materials. The technique for sampling was purposive since it dealt with specific subjects

³⁵ Kwame Gyekye, *Tradition and Modernity: Philosophical Reflections on the African Experience* (Oxford University Press, 1997).

³⁶ Ludwig von Bertalanffy, *General System Theory: Foundations, Development, Applications* (G. Braziller, 1968).

³⁷ Horacio Fabrega Jr, "The Need for an Ethnomedical Science: The Study of Medical Systems Comparatively Has Important Implications for the Social and Biological Sciences.," *Science* 189, no. 4207 (1975): 969.

³⁸ Barbara L K Pillsbury, "Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems," *Social Science & Medicine* 16, no. 21 (1982): 1825–34; Fabrega Jr, "The Need for an Ethnomedical Science: The Study of Medical Systems Comparatively Has Important Implications for the Social and Biological Sciences."

³⁹ Sindiga, "African Ethnomedicine and Other Medical Systems."

⁴⁰ Dennis M Warren and Edward C Green, "Linking Biomedical and Indigenous African Health Delivery Systems: An Assessment of Collaborative Efforts during the 1980s," in *Conference on Ethnomedical System in Sub-Saharan Africa: A Cultural Perspective on Traditional Medicine and the Concept of Disease*, African Studies Centre/University of Leiden, Leiden, June, vol. 1, 1988, 6.

⁴¹ Fabrega Jr, "The Need for an Ethnomedical Science: The Study of Medical Systems Comparatively Has Important Implications for the Social and Biological Sciences," 969.

⁴² Fabrega Jr, "The Need for an Ethnomedical Science: The Study of Medical Systems Comparatively Has Important Implications for the Social and Biological Sciences.," Pillsbury, "Policy and Evaluation Perspectives on Traditional Health Practitioners in National Health Care Systems."

⁴³ Warren and Green, "Linking Biomedical and Indigenous African Health Delivery Systems: An Assessment of Collaborative Efforts during the 1980s," 6.

(traditional healers). In all, 7 healers were interviewed. These included six (6) males and one (1) female. It is remarkable that the practice of traditional medicine in Larteh, particularly in the area of ethnopharmacology, is dominated by men. With the exception of some healers who consented to have their names mentioned in the work, the researchers chose to use pseudonyms for all other respondents for the purposes of confidentiality and anonymity. The discussion employs descriptive and analytical tools based mainly on inference from the data gathered. This way, key issues, patterns of ideas, and concepts are synthesized.

FINDINGS

In all, the researchers observed fragments of some ethical behaviours among the participants. Nearly all healers claimed to have acquired such ethical codes from their trainers albeit uncodified. Nonetheless, in spite of the fragmented nature of such ethical behaviours, they largely reflect patterns of Western healthcare ethics such as confidentiality, professionalism, limited non-maleficence and paternalism. Thus for convenience and to place the discussion within the proper context, the results are analysed within these broader spectra of healthcare ethics. The point ought to be made though that given the similarity in responses, there is a deliberate attempt to present excerpts of some responses received. In this regard, the excerpts presented herewith may not reflect the number of healers interviewed.

The four themes that came to bear during the field research; confidentiality, professionalism, limited non-maleficence and paternalism are subsequently discussed in the context of Larteh's healthcare practices.

a. Confidentiality

It is trite that healthcare providers owe a duty to take care of patients entrusted to their care. This duty may be twofold: a duty not to harm and a duty of confidence. Confidentiality requires that healthcare providers must keep as secret, information which patients may freely give about their conditions or what the healthcare provider may discover through examination. This doctrine owes its root to the Hippocratic Oath which required ancient Greek physicians to commit themselves in the following words: "What I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men [sic], which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."⁴⁴

A breach of confidentiality may have awful consequences on health care delivery. On the other hand, where confidentiality is guaranteed, the benefits abound. In the main, confidentiality ensures a secure environment in which patients may give full and frank information about their sickness.⁴⁵ The net effect is that public confidence in the healthcare system is protected. Nonetheless, there are occasions where a breach of confidentiality may be justified. Such a breach may be necessary to protect the life of a patient's partner or close associate. For example, where easily transmissible or highly contagious venereal diseases are involved, a breach of the duty of confidentiality may be justified on grounds of protecting other lives. It is also not a breach if a patient's information is shared among a team of health professionals handling a patient. However, where appropriate, the rules require that the transfer of information from one physician to the other must be with the knowledge and consent of the patient. Thus the rules allow for a breach of confidentiality where consent for disclosure is practically impossible. In such a situation the healthcare providers must satisfy themselves that they are acting in the best interest of the patient.⁴⁶

It has been suggested that the principle of confidentiality is completely a Western concept and has no place in traditional healthcare practice. Manda contends that there is no such thing as confidentiality in traditional healthcare practice and that even if there was, it is completely

⁴⁴ Domoka Lucinda Manda, "Confidentiality in African Healthcare Ethics: A Problematic Concept?," *Journal of Gleanings from Academic Outliers* 1, no. 1 (2012), 135.

⁴⁵ Annette J Braunack-Mayer and Ea C Mulligan, "Sharing Patient Information between Professionals: Confidentiality and Ethics," *Medical Journal of Australia* 178, no. 6 (2003): 277–79.

⁴⁶ Braunack-Mayer and Mulligan, "Sharing Patient Information between Professionals: Confidentiality and Ethics."

impractical.⁴⁷ Manda's contention is hinged on the view that given the communitarian nature of African society, an individual's sickness is equally communal sickness and that from the period of diagnosis to the stage of treatment, family members are involved and therefore there cannot be absolute confidentiality in traditional health care practice. Manda states thus;

“... the concept of confidentiality in traditional African healthcare ethics as it plays out in the Western setting may not exist, because the principle of confidentiality in African bioethics is applied and upheld at the request of the patient. In traditional African healthcare ethics, when a patient requires medical attention from traditional healers, his or her family and/or community members often accompany the patient. The information given during the consultation process is available for family and sometimes community consumption.”⁴⁸

It is indeed telling that the African society is communal in nature. There is family and communal support for individuals who may fall sick. Therefore to the extent that family members may be involved in every stage of the healing process, there is a strong presumption that there cannot be absolute confidentiality in African traditional healthcare practice. Nonetheless, the researchers observed a certain level of confidentiality among traditional healthcare practitioners in Larteh. Disclosure of patient information is often made to families of patients who are bedridden and are unable to make any decision by themselves. This practice is not exclusive to traditional medical practice. Confidentiality as applied in Western medical practice requires close relations of the patient to know everything about the patient's condition. However, it was discovered that among the people of Larteh, although sick persons are often accompanied by relatives to see the healer, there are occasions when a patient, without the assistance of family, may seek treatment for a disease that is less ravaging. Under such circumstances, there is absolute confidentiality. Traditional healthcare ethics prohibit a healer from discussing a patient's condition with another healer. Thus among the Larteh, there is a strict prohibition for a healer to third-party disclosure as well as patient to third-party disclosure. This is premised on the fact that a patient may unknowingly disclose information about himself to a person who may be the cause of his sickness. For example, the following excerpt reveals how a traditional healer ensures confidentiality:

Per the nature of the work, sometimes I encounter people with a 'horrible' past. Some have been cursed because of some sin they committed. Such people will confide in me and open up their secrets to me. But when they do, I must protect them by covering up their shame and not pointing fingers at them when I see them on the street. I only perform the necessary rituals needed for treatment. There was a case involving a young man who slept with someone's wife and was cursed. When I found out, I called some key personalities within the husband's family I could trust and resolved the matter quietly. The husband was compensated and the necessary rituals were performed. After this, the patient got healed.⁴⁹

Thus from the excerpt, one may safely conclude that it is completely untenable to assert that there is an absence of confidentiality in traditional African healthcare practice.

b. Professionalism

The concept of professionalism denotes competence and ensuring that healthcare providers behave in ways that comply with the standards set.⁵⁰ Interest in “professionalism” has had a steady growth in medicine.⁵¹ Nearly all medical schools around the globe have medical professionalism as part of the curriculum. Nonetheless, it is not sufficient to know in theory, the professional standards of a health

⁴⁷ Manda, “Confidentiality in African Healthcare Ethics: A Problematic Concept?”

⁴⁸ Manda, “Confidentiality in African Healthcare Ethics: A Problematic Concept?” 11.

⁴⁹ O. Dankwa, personal communication, 2/03/2020.

⁵⁰ Michael Dunn, “On the Relationship between Medical Ethics and Medical Professionalism” (Institute of Medical Ethics, 2016).

⁵¹ Mark G Kuczewski, “Responding to the Call of Professionalism,” *Cambridge Quarterly of Healthcare Ethics* 12, no. 2 (2003): 144–45.

care provider. There must be concrete evidence of professionalism in health care delivery. Medical professionalism concerns those virtues or attributes that foster health practitioners' abilities to recognize, interrogate, and to enact the ethical duties they possess.⁵² These virtues may include fidelity to trust, benevolence, compassion, intellectual honesty, courage, and truthfulness.⁵³

The researchers discovered a certain level of professionalism among Larteh traditional healers. Top on the list was avoidance of dual relationship [a sexually induced relationship] and admission of competence. Larteh traditional healers acknowledge that an acceptable relationship which must exist between the healer and the patient is one of the healer-patient relationship. Where the relationship travels beyond this boundary, the healer has missed the mark. Additionally, a healer must be honest to admit the limits of his competence. This is what Buyx et al call 'intellectual honesty'.⁵⁴ Thus where a healer is deficient, he must be honest about it. Similarly, where a healer makes a mistake with diagnosis or treatment, he must have the courage to disclose his mistakes to the patients. One healer described his professional approach in the following excerpt:

A mentally challenged woman was sent to a healer to heal. The healer admitted the patient to his house and successfully cured the lady of her mental sickness. However, after the treatment, the healer asked for the lady's hand in marriage which the family willingly accepted. This is because a lot of people would have seen the lady when she was mentally unstable. Maybe she even exposed herself in public while she was ill. When this happens, people may not want to have anything to do with you because mental illness is a disgraceful sickness. The lady herself accepted the offer because she felt her image was at stake. But the healer cannot have sexual relations with the patient while she is undergoing treatment. If you do that the medicine will not work because you have touched the profession with filth.⁵⁵

This excerpt is to the effect that the "professional standards" of traditional health care are akin to maintaining objectivity and ensuring that the healer is uninfluenced by his pent-up affection for the patient. These standards may not be codified in a single document but are evident in traditional medical practice.

c. Limited Non-Maleficence

Traditional medical ethics is hinged on the principle of "*primum non nocere*" which literally means, first (or above all) do no harm.⁵⁶ This principle has also been described as "the cardinal ethical principle sacred to medicine."⁵⁷ It is unclear which part of the Hippocratic Oath is translated as "*primum non nocere*". Nonetheless, it is trite that the Hippocratic Oath requires doctors to always do what is in the best interest of their patients and to avoid harmful practices. In effect, the doctor must help and not harm.⁵⁸ It has been suggested that the principle of non-maleficence derives from the principle of beneficence.⁵⁹ Nonetheless, it would appear that it is impractical to achieve beneficence without some harm. Thus the principle of non-maleficence must be understood within the context that sometimes, to achieve the benefit, some risk of harm must be entertained. For example, a patient with melanoma on her foot may have to lose a leg to save her/his life. In this regard, McGarry, and Chodoff,

⁵² Dunn, "On the Relationship between Medical Ethics and Medical Professionalism."

⁵³ Alena M Buyx, Bruce Maxwell, and Bettina Schöne-Seifert, "Challenges of Educating for Medical Professionalism: Who Should Step up to the Line?," *Medical Education* 42, no. 8 (2008): 758–64.

⁵⁴ Buyx, Maxwell, and Schöne-Seifert, "Challenges of Educating for Medical Professionalism: Who Should Step up to the Line?"

⁵⁵ O. Dankwa, personal communication, 2/03/2020.

⁵⁶ Raanan Gillon, "' Primum Non Nocere' and the Principle of Non-Maleficence.," *British Medical Journal (Clinical Research Ed.)* 291, no. 6488 (1985): 130.

⁵⁷ Louis McGarry and Paul Chodoff, "The Ethics of Involuntary Hospitalization," *Psychiatric Ethics*, 1981, 203–19.

⁵⁸ Gillon, "' Primum Non Nocere' and the Principle of Non-Maleficence."

⁵⁹ McGarry and Chodoff, "The Ethics of Involuntary Hospitalization."

therefore suggest that beneficence and non-maleficence in medical practice must always be considered together.⁶⁰

Albert Jonsen has provided constitutive elements of the principle of ‘non nocere’. According to him, the principle reminds doctors that medicine is a moral enterprise in which the infliction of harm, can be justified only in the interests of “human benefit”. The benefit may be to the patient, the patient’s family, or others. Other strands remind doctors that in assuming care they also assume an obligation to exercise “due care” and they must balance intended benefits against risks and harm, be they physical, psychological, or social, as evaluated not only by the doctors but also by the patients and by society.⁶¹ Jonsen argues that the Catholic doctrine of double effect must be understood within the context that one needs a way of assessing how to act when a proposed good action also has a risk or certainty of unintended but clearly foreseen bad effects.⁶²

The data produced from Larteh revealed that traditional healers have an appreciable level of knowledge of the principle of non-maleficence. They are convinced that a healer’s primary objective is to do good and avoid harm. One traditional healer described the principle in the following excerpt:

The art of healing is a gift from *Onyame* (God) for the treatment of sicknesses. And therefore if someone comes to you to be healed, understand that you are acting in the place of God as a healer. God does not kill and so a healer must always avoid harmful practices. Even if you have something against the patient, you are not permitted to harm the patient for as long as he remains under your care. A human being has dignity even to the point of death.⁶³

The implication is that Larteh traditional healers consider, as a professional duty to save lives regardless of whether a patient is a friend or a foe. Personal sentiments do not influence a healer’s professional duty.

d. Paternalism

Gerald Dworkin has defined paternalism as “the interference of a state or an individual with another person, against their will, and justified by a claim that the person interfered with be better off or protected from harm.”⁶⁴ Thus it is “an action performed with the intent of promoting another’s good but occurring against the other’s will or without the other’s consent.”⁶⁵ In medical paternalism, the concept refers to acts of authority exercised by the physician in directing care and distribution of resources to patients.⁶⁶ Implicit in these definitions is the principle of beneficence as an important foundation of paternalism.⁶⁷ It is settled that both medical paternalism and governmental paternalism thrive on the moral foundation of the principle of beneficence. Nonetheless, what appears to generate some debate is the interpretation which must be attached to the term interference. According to James Childress, a more plausible interpretation of interference is non-acquiescence in the preferences, choices, and actions of others. In his view, paternalistic actions aim at protecting or promoting the welfare of individuals themselves, and they do so by not acquiescing to the preferences, choices, or actions of those individuals.⁶⁸

Paternalism, particularly medical paternalism has always been seen as an affront to individual autonomy. At the very least, Ronald Dworkin maintains that paternalism is disrespectful, demeaning, and insulting to the intended autonomous beneficiary.⁶⁹ However, proponents of paternalism argue that the intended benefits of a paternalistic action are what must be considered. Childress maintains

⁶⁰ McGarry and Chodoff, “The Ethics of Involuntary Hospitalization.”

⁶¹ McGarry and Chodoff, “The Ethics of Involuntary Hospitalization.”

⁶² McGarry and Chodoff, “The Ethics of Involuntary Hospitalization.”

⁶³ L. Ababio, personal communication, 2/11/2020.

⁶⁴ G Dworkin, “Paternalism,” in *Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, 2010, <http://plato.stanford.edu/archives/sum2010/entries/paternalism/>.

⁶⁵ Brian C Drolet and Candace L White, “Selective Paternalism,” *AMA Journal of Ethics* 14, no. 7 (2012): 582–88.

⁶⁶ Drolet and White, “Selective Paternalism.”

⁶⁷ James F Childress, *Public Bioethics: Principles and Problems* (Oxford University Press, USA, 2020).

⁶⁸ Childress, *Public Bioethics: Principles and Problems*.

⁶⁹ Dworkin, “Paternalism”; Childress, *Public Bioethics: Principles and Problems*.

that even though, theoretically, both beneficence and respect for autonomy are prima facie binding, their respective weights can only be determined in specific situations. Drawing from Beauchamp and Childress, he enumerates a number of conditions that must be met in order to justify strong paternalistic actions that infringe on the principle of respect for autonomy.⁷⁰ These conditions are reproduced as follows:

1. A patient is at risk of significant, preventable harm.
2. The paternalistic action will probably prevent the harm.
3. The paternalistic action is necessary to prevent the harm.
4. The projected benefits of the harm prevention to the beneficiary outweigh its risks to the beneficiary.
5. The paternalistic action involves the alternative that least restricts the beneficiary's autonomy while still securing the benefits for him or her.

The above conditions are focused on the benefits that an individual may derive from a paternalistic action. It is remarkable to note that paternalism may be categorized into three main forms: pure, mixed⁷¹ and selective paternalism.⁷² In pure paternalistic actions, the intended beneficiary must be an individual whose own good is sought.⁷³ Mixed paternalism is directed both at the individuals affected and at the impact their actions have on other individuals or on the society. In effect, it “seeks to benefit particular individuals, to protect public health, to avoid burdens to third parties.”⁷⁴ For example, a law requiring the mandatory wearing of a nose mask in the wake of covid-19 is certainly paternalistic. However, such a law is intended to protect the individual who wears the mask and others. Thereby preventing the possible spread of the virus. Selective paternalism refers to the use of paternalism when shared decision making breaks down.⁷⁵ However one may look at it, paternalism is an important consideration in ethical decision making in that it provides a balance between “an ethical obligation to neither withhold guidance nor abdicate professional responsibility to patients.”⁷⁶ The researchers discovered pure paternalism among traditional healers in Larteh. They hold the view that it is the healer who has the expertise and whose guidance must be followed. This paternalistic view is succinctly captured in the following excerpt:

No, the patient does not know anything about his sickness. If he knew, he would not have come to me. In fact even the healer does not ‘heal himself’. I acquired my knowledge of herbal medicine from my father but I remember that whenever he fell sick, he asked me to prepare some herbs for him...I admit patients depending on the situation. For example, if I see that the sickness is caused by someone who lives in the same house as the patient, I will decide to admit him/her, because that fellow will have access to him/her.⁷⁷

DISCUSSION

The above themes which emerged out of the study, to a large extent reflect the four principles of biomedical ethics as fashioned out by Beauchamp and Childress; respect for autonomy, non-maleficence, beneficence, and justice.⁷⁸ These principles were themselves developed in response to deficiencies with some ethical theories such as the Kantian theory which requires all persons to be treated with dignity as well as the application of rules which have wide acceptance. Similarly, whereas consequentialists focus on acts which produce the best effects, virtue ethics and care ethics focus on

⁷⁰ Tom L Beauchamp and James F Childress, “Principles of Biomedical Ethics. Eighth” (Oxford University Press, 2019).

⁷¹ Childress, *Public Bioethics: Principles and Problems*.

⁷² Drolet and White, “Selective Paternalism.”

⁷³ Childress, *Public Bioethics: Principles and Problems*.

⁷⁴ Childress, *Public Bioethics: Principles and Problems*.

⁷⁵ Drolet and White, “Selective Paternalism.”

⁷⁶ Drolet and White, “Selective Paternalism.”

⁷⁷ L. Ababio, personal communication, 2/11/2020.

⁷⁸ Beauchamp and Childress, “Principles of Biomedical Ethics. Eighth.”

good character formation and people's feelings and the relevance of relationships respectively.⁷⁹ It is remarkable that the flexibility with which these principles are adaptable to different ethical situations and cultures has been acknowledged. These principles are discussed seriatim. Respect for autonomy deals with respecting persons' capacities to make decisions for themselves. In medical settings, physicians are usually confronted with the challenge of evaluating the decision-making capacities of patients. Specifically, physicians are to evaluate the extent to which patients 'understand the diagnosis and available treatment options, appreciate the risks and benefits of treatments, and offer reasons for their decisions'.⁸⁰ It is settled that competent adults are better able to make decisions regarding their health if they have a good appreciation of the diagnosis and treatment options. But the same cannot be said of children and mentally incompetent patients. Trujillo maintains that respect for autonomy is in different degrees and that the principle of respect for a patient's autonomy is satisfied if it can be ascertained that a physician consulted with close relatives on a patient's prior conversation or referred to some living will or some advance directives in specific situations. Thus respecting a patient's autonomy includes deference to prior conversations, advance directives, or living wills. Findings revealed that in Larteh's traditional healthcare practice where family members took decisions on behalf of 'incompetent patients', it was largely based on prior conversations with the patients even to the point of death. What is considered counter-productive and less positive is the strong presence of the doctrine of paternalism in Larteh's traditional healthcare practice.

Non-maleficence as already discussed above implies avoidance of harm, while beneficence means doing good. According to Trujillo the two principles 'represent two sides of the same coin, as medicine often sets health as its destination but painful, risky treatments as its path'.⁸¹ In essence, physicians must always balance the harms and benefits of available options.⁸² This perhaps explains why traditional healers often trigger a father-child relationship (paternalism) between themselves and patients on the basis that the healers know all about the patient's condition. This conflicts with the principle of autonomy. In as much as this may be less positive, Dworkin, Drolet and White and Childress have argued that the intended benefits of paternalistic action are what must be considered.⁸³ It is telling to note that the healer is, in most cases, better placed to understand a patient's condition and the treatment options or risks of treatment. Thus to the extent that a patient lacks a full appreciation of his condition and the risk of treatment, any paternalistic act intended for the welfare of the patient may have far reaching benefits.

The principle of justice which does not have direct relevance to traditional medical practice, concerns the distribution of benefits and burdens in society. It implies asking who an institution serves, and at what cost to whom. Thus providing medicine for citizens is fair. The data revealed that traditional medicine is accessible to all.

SUMMARY

This paper has demonstrated that traditional medical practice is not without defined ethical principles albeit informal. Like orthodox medical practice, the findings lean towards an appreciable level of professionalism among traditional health care practitioners in Larteh. It is remarkable that the Western medical profession is anchored on some regulatory body mandated both to investigate and sanction wayward practitioners who violate the Code of Ethics. This is largely due to its formal nature. Nonetheless in Larteh, there is no such body. What is evident from the study is that traditional healers in Larteh believe that the art of healing is a gift from God that is intended to be used for the benefit of humans. To that end, healers who violate ethical codes or engage in acts that are detrimental to the

⁷⁹ G.M.Trujillo Jr. "Principlism in Biomedical Ethics: Respect for Autonomy, Non-Maleficence, Beneficence, and Justice." *1000-Word Philosophy: An Introductory Anthology*, (2021), 1. <https://1000wordphilosophy.com/2021/02/16/principlism-in-biomedical-ethics/>

⁸⁰ Trujillo Jr. "Principlism in Biomedical Ethics: Respect for Autonomy, Non-Maleficence, Beneficence, and Justice," 1.

⁸¹ Trujillo Jr. "Principlism in Biomedical Ethics: Respect for Autonomy, Non-Maleficence, Beneficence, and Justice," 1

⁸² Trujillo Jr. "Principlism in Biomedical Ethics: Respect for Autonomy, Non-Maleficence, Beneficence, and Justice," 1

⁸³ Dworkin, "Paternalism"; Drolet and White, "Selective Paternalism"; Childress, *Public Bioethics: Principles and Problems*.

health of their fellow humans will be punished by God or even their ancestors. Such punishment may be in the form of sickness or losing the efficacy of one's medicine.

There is also sufficient evidence that although sickness is an individual experience, for Africans and the Larteh in particular, it usually takes a social dimension. Thus, a community bears a stake in helping to restore an individual's health. This ties in well with Gyekye's theory of communalism and Bertalanffy's general systems theory. However, this may be an affront to the principle of confidentiality in traditional healthcare practice.

In all, four ethical themes were derived from the study namely; confidentiality, professionalism, limited non-maleficence and paternalism. The professional competence of Larteh traditional healers is demonstrated by the avoidance of dual relationships between the healer and the patient. There is also clear admission of competence and where none exists, Larteh traditional healers are honest to admit incompetence. The researchers discovered also, an appreciable level of confidentiality in the healer-patient relationship. Nonetheless, Larteh traditional healers adopt a pure paternalistic approach to healing. This in their view is counter-productive as it may have undesirable effects on patient autonomy. But largely, Larteh traditional healers consider it a duty to save lives irrespective of the status of the relationship with patients.

CONCLUSION

This study has examined traditional healthcare ethics as perceived by the people of Larteh in Ghana. The research demonstrated that traditional medical practice in Larteh is not without defined ethical principles albeit informal. Four Western ethical themes were discussed in the context of Larteh; confidentiality, professionalism, limited non-maleficence and paternalism. The interactions with the Traditional healers revealed that their practices possessed some elements of the four themes. It can thus be concluded that Larteh's traditional ideas of health care provide ethical principles that not only preserve the dignity of the patient but also teach principles that can contribute generally to the development of health care in private and public practice in Ghana.

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