INFORMED CONSENT IN WESTERN (USA) MEDICINE AND IN AFRICAN (IGBO) TRADITIONAL MEDICINE: A COMPARISON

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Introduction

At the very moment in human history when globalization has gained ascendace, we are easily tempted to ignore the profound cultural difference in bioethics that continues to exist among nations and continents. One such substantial cultural difference is the process of medical informed consent. African Traditional Medicine (ATM) is still popular in Africa despite the powerful impact of Western medicine. It is estimated that more than 80% of people in Africa use ATM.² Part of the reason behind this is that ATM is relatively affordable and available to the poor people who cannot afford Western medicine. ATM tends also to be holistic in its approach to health, attending to the physical, psychological, and spiritual wellbeing of the patient. However, ATM is often seen as unscientific. It is alleged that it lacks proper information regarding the composition, ingredients and strength of the drugs; it is therefore difficult to predict the results and possible complications of the use of its drugs. Consequently it is said that it is impossible

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to consent to ATM since it is impossible to consent to something unknown.

This article explores the concept of informed consent in ATM, paying particular attention to the concept of autonomy in African bioethics and how it affects the understanding of informed consent in ATM. The article compares the concept of informed consent in ATM with that of the USA, as a representative of the Western bioethics. It argues that because of the African communal culture, that places emphasis on relationship, ATM adopts a relational autonomy that is fostered and exercised in relationships with other people—relatives, friends and community. This relational autonomy contrasts with the individual rights oriented autonomy in the USA, which emphasizes individual patient rights. This accounts for the difference in the concept of informed consent in both ATM and USA-Western medicine. The article also contends that, with the improvement in the ATM pharmacological practices, and with better regulatory and monitoring policies, which guarantee better knowledge of the therapeutic potency, the side effects and the level of toxicity of the herbal medicines, proper informed consent is ensured.

Informed Consent in the United States of America

Informed consent is a relatively new concept in medical ethics even in the United States. Nonetheless, informed consent existed long before it was legally adopted in the physician-patient relationship and its formulation and details have changed considerably. Informed consent as a term didn’t become prominent until the

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1950s after the Nuremberg trials.\(^5\) Before the widespread adoption of informed consent, the principle of paternalism was dominant. The principle of paternalism presupposed that due to experience and expertise, the physician knows best what the patient needs. However, it was not until the early 1970s that informed consent received scholarly scrutiny which continues until today. In recent years, the focus of informed consent has shifted from the obligation of the physician or researcher to disclose information, to the quality of a patient’s or a research subject’s understanding and acceptance, or even refusal.\(^6\) In moving away from paternalism, informed consent has been shaped in Western thought by an understanding of autonomy that greatly emphasizes individual freedom and individual rights.\(^7\) To properly understand informed consent, its connection with the principle of autonomy needs to be explored.

**Autonomy**

Etymologically, the word “autonomy” has its origin from two Greek words *autos* meaning “self” and *nomos* meaning, “rule,” “governance” or “law.” Autonomy stands, therefore, for “self-rule or self-governance of independent city-states.”\(^8\) The autonomous person acts freely according to a self-chosen plan. Such an individual is not supposed to be controlled by others. That is why liberty (independence from controlling influences) and agency (capacity for intentional action) are identified as the two essential conditions for autonomy in the Western culture. For example, Beauchamp and Childress recognize that some other condition could be added to enhance the meaning of autonomy.\(^9\) One of the

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6 Beauchamp and Childress, *Principles*, 77.
9 Ibid., 61.
conditions that needs to be added is the community which is especially pertinent to cultures like those of Africa. In such cultures, the individual is not isolated from the community and, likewise, the individual’s autonomy and decisions are understood within a context of community. Individual liberty and the independence component of autonomy tend to have been overemphasized in the USA ethos. This sort of understanding of autonomy, supported by the first and fourth Amendments of the US Constitution, has been adopted as a significant ethical justification for informed medical consent in the USA. This approach to autonomy emphasizes individual freedom, individual rights, the right of self-determination and free choice, thereby necessitating a legal need to obtain consent for any act to be performed on the person’s body. For example, as far back as 1914, in an American case, Schloendoff vs. Society of New York Hospitals, Justice Cardozo ruled that “Every human being of adult years and sound mind has right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”

Cardozo did not really rule about a consent that was informed, it was in another case in 1957, that it was ruled that physicians “have the duty to disclose any facts which are necessary to form the basis of an intelligent consent by the patient to proposed treatment.”

**Elements of Informed Consent**

From the foregoing discussion, it can be seen that informed consent is not just permission to treat. Rather, it can be described as the pact in which a capable patient voluntarily entrusts or refuses to

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entrust his case to a clinical professional\textsuperscript{12} after considering information from the professional regarding the treatment. The following elements have been identified in informed consent:\textsuperscript{13} (i) Competence, (ii) Disclosure, (iii) Understanding, (iv) Voluntariness, and (v) Acceptance. In other words, one has to be competent; one has to receive a detailed disclosure; one has to understand the disclosed information; and one has to voluntarily accept or refuse the intervention in question.\textsuperscript{14}

This ethical approach to informed consent is different from the legal doctrine of informed consent as well as from the courts’ understanding of informed consent, which tends to focus largely on the obligation of disclosure.\textsuperscript{15} The courts require disclosure based on a physician’s general obligation to exercise reasonable care by offering information. Lawsuits have occurred over informed consent as a result of injury to the patient brought about intentionally or negligently by the physician’s failure to disclose.\textsuperscript{16} In contrast, ethically informed consent has less to do with the liability of specialists as agents of disclosure and has more to do with the autonomous choices of patients and subjects. Thus, the disclosure of information is “less vital in clinical medicine than a health professional’s recommendation of one or more actions.”\textsuperscript{17} Medical convention and malpractice law influenced the courts’ understanding of informed consent. However, this ethical emphasis on autonomous choice does not diminish the importance of disclosure in informed consent.

\textbf{Disclosure:} Physicians are duty-bound to disclose the following: (a) those facts or descriptions that patients usually

\textsuperscript{13} Beauchamp and Childress, \textit{Principles}, 79.
\textsuperscript{14} Beauchamp and Childress, 79.
\textsuperscript{16} Beauchamp and Childress, \textit{Principle}, 81.
\textsuperscript{17} Ibid., 79.
consider material in deciding whether to refuse or consent to the proposed intervention. For example, the nature and purposes of the intervention, risks and benefits involved, diagnoses, prognoses, and alternatives. Also required are information the physician believes to be material, the physician’s recommendation, the purpose of seeking consent, as well as the nature and limits of consent as an act of authorization.\(^\text{18}\)

It is worth noting here that, even though these components of disclosure are required in the informed consent in the USA, study shows that many physician-patient encounters in outpatient practice were far from fulfilling these requirements. For instance, one study on ‘informed decision-making’ revealed that in over 3500 clinical decisions, only nine percent met the investigators’ definition of completeness for informed decision-making. The authors concluded that “by the most minimal definition consistent with an ethical framework, decision-making in clinical practice may fall short of a basic level of patient involvement in routine decisions.”\(^\text{19}\)

**Understanding:** Informed consent requires that the patient understands the information disclosed, at least the essential information. Such understanding does not have to be complete since a grasp of the central facts is generally sufficient. A patient or the surrogate usually ought to understand at least what a healthcare professional considers as relevant to authorize an intervention.\(^\text{20}\) These include the nature and purposes of the intervention, risks and benefits involved, diagnoses, prognoses, and available alternatives.

**Competence:** Competence involves being legally of age to exercise a legal right including rights to make healthcare decision

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and decisional capacity. The person needs to have the ability to communicate choice, understand relevant information, appreciate the situation and possible consequences, and manipulate information. Thus, when individuals “lack the ability to make decision that promotes their well-being in keeping with their own previously expressed values and preferences,”\(^\text{21}\) we say they are incompetent. Being competent to make a decision is different from willingness to make a decision. Being competent or having the capacity enables, but does not obligate, a patient to act autonomously or independently. Furthermore, a person can be competent in one thing and not in another. For example, a patient may be competent in deciding what to eat but not in making medical decision. Therefore, lacking the ability to make medical decision does not mean that one is incompetent in other things.

**Voluntariness:** Voluntariness requires that after the patient has received the information and understood the core message, one “acts voluntarily to the degree that one wills the action without being under the control of another’s influence.”\(^\text{22}\) Sickness, psychiatric disorders, drug addiction or substance abuse can diminish voluntariness. However, this analysis is restricted to control by other human beings. For example, if a physician orders a reluctant patient to undergo dialysis and coerces the patient to comply by threatening to abandon that patient, then the physician’s influences appear like control. Whereas, should a physician persuade the patient to undergo the procedure when the patient is at first reluctant to do so, then the physician influences, but does not control, the patient.\(^\text{23}\)

**Acceptance:** Having received and understood the disclosed detailed information, the competent patient voluntarily\(^\text{24}\) does one of the following: either decides in favour of the planned

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\(^{22}\) Beauchamp and Childress, *Principles*, 93.

\(^{23}\) Cf. Ibid., 94.

\(^{24}\) Ibid., 93.
intervention and authorizes it or refuses to go on with it and therefore declines to authorize the intervention in question.

Exceptions to Informed Consent Requirement in the USA:

In the USA, the requirement for the informed consent as a prerequisite for treatment may be suspended in the following circumstances.

**Emergency Care:** A patient can be treated without informed consent if there is clear, immediate, and serious threat to life and the time it would take to offer an informed consent would significantly increase the risk of the patient’s mortality or morbidity. In this case, the courts have ruled that physicians treat patients under the doctrine of implied consent, with the assumption that reasonable patients would consent to such treatment if they were able. Implied consent is said to occur when a patient agrees to be treated at an institution: by asking to be treated, the patient agrees to routine hospital procedures like physical examination. The treatment that is provided without informed consent should be in accord with standard medical practice. In other words, it should be the treatment that most physicians would tend to recommend for the condition in question.

**Therapeutic privilege:** Therapeutic privilege occurs when the physician judges that informed consent might itself seriously harm the patient. The reason for this must be documented, and when possible, consent must be obtained.

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Waiver: Finally, in a waiver, a patient can give up his right to informed consent and delegate someone else, but s/he must be aware and be counseled as to her/his legal and ethical right to informed consent. The physician should not be the initiator of the waiver. The reason for the waiver is to be documented in case of later questioning as to inappropriateness and litigation.\(^\text{29}\)

Having outlined the concept and practice of informed consent in the USA, the next section explores the concept and the practice of informed consent in ATM and compares it with that of the USA.

African Traditional Medicine

The term "African Traditional Medicine" means the medical practices and knowledge of the Africans. It existed before the arrival of modern Western medicine to Africa and continues till date. The method incorporates plants, animal and mineral-based medicines, spiritual therapies, manual techniques as well as exercises, diagnosis, treatment and prevention of illness and maintenance of health and well-being.\(^\text{30}\) This has evolved over thousands of years interchanging with other regions like the Mediterranean. It is recorded that the "medicine of ancient Egypt, reflecting African impulses, shaped ideas of neighbouring civilizations, including the medicine of classical Greek and Roman antiquity."\(^\text{31}\)

Traditional medicine is not particular to Africa; rather, people all over the world "developed unique indigenous healing traditions" and practices, which are defined by their culture, beliefs, and environment. More or less, these healing traditions and practices


attended to the health needs of these communities over the centuries.

In Africa, as is the case in other continents, such as Asia and Latin America, traditional medicine helps to meet some of the primary health care needs of the people. It is reckoned that up to 80% of the population of Africa use traditional medicine for primary health care. In Nigeria, as well as Ghana, Mali, and Zambia the use of herbal medicines at home is the first line of treatment for 60% of children with fever resulting from malaria. ATM has a rich bio-resource base since 90% of ATM is based on plants. This is good because it is reckoned that Africa is endowed with a rich biodiversity of about 40,000 plant species. More than 4,000 of about 6,377 species are used as medicinal plants. So, the raw materials are available.

**Nature of health and disease**

Unlike its Western or American counterpart, the African Traditional Medicine approach to healing is holistic because its concept of health is likewise holistic. Good health includes mental, physical, spiritual, and emotional well-being for patients, their immediate and extended family members as well as for the

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32 WHO, *Traditional Medicine.*


community. Good health is also "conscious harmony with God and the creation, an alliance of love with all beings, a sympathy with all that is pure and happy, a participation in the spirit and life of 'The intelligent Universe,' and entire concord of purpose with the infinite original." Ill health is the reverse of all these.

While the western approach to treatment is analytic, ATM focuses on the whole human being. During the medical intervention, the mind, soul as well as the body of the patient is considered together. In traditional African belief, it is recognized that the gods, the spirits and the ancestors do influence human affairs including health and illness. Thus, the cause of disease or ill health in ATM is sometimes attributed to mystical forces or spirits. That is why the traditional medicine doctor employs divination in the diagnostic process to discover the mystic forces involved.

Likewise, medical intervention is inextricably linked with African Traditional Religion (ATR). In Africa, religion pervades all aspects of life. There is no real formal distinction between the sacred and the secular, between the religious and the non-religious or mundane, between the spiritual and the material aspects of life. Major A. G. Leonard summarized it thus:

The religion of these people is their existence and their existence is their religion. It supplies the principle on which their law is dispensed and morality adjudicated. The entire organization of their common life is so interwoven with it that they cannot get away from it.

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38 Ibid., 62.
As in Judaism, Africans believe that medicine comes directly from God and that God is the healer. An Akan proverb asserts thus: "If God gave you sickness, He also gave you medicine." The practice of medicine is, therefore, linked to God and the divinities till today.

**ATM Practitioners or Doctors**

Traditional medical practitioners or traditional doctors are those who provide healthcare by using plant leaves, barks, roots, fruits, animals, dead insects, and mineral substances. They are recognized by the community in which they live as competent to provide such healthcare. Most of them acquired their skills through inheritance and apprenticeship. They undergo a lengthy initiation and training and these programs vouch for their competence. In traditional African society, the traditional doctor can be a herbalist, healer-diviner, or a traditional priest. Among the Igbo of Nigeria for example, the traditional doctors (dibia) are delineated into three groups as follows: (a) *dibia-ogwu*, the general physicians, (b) *dibia-afa*, the diviners or fortune tellers, and (c) *dibia-aja*, the ones who offer people's sacrifices to the gods. In some cases, the general physician, the diviner, and the priest can be the same individual. In that case, that individual divines the cause of illness, the treatment and plays the part of the general physician as well as the priest if need be. They diagnose out of experience acquired from training and years of practice.

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African Traditional healers can be very caring and have the interest of their patients at heart. They are expected to be "trustworthy, morally upright, friendly, willing and ready to serve, able to discern people's needs; and they do not charge too much."44 They also provide the needed answers to the adversaries imposed upon the community by outside forces that the people do not comprehend. They prepare charms and prescribe the rituals to neutralize the effects of the enemy's charm. They ward off evil spirits and intervene between the community and the divinities as well as the spirits. Furthermore, they advise the "community head when to embark on community purification rituals in order to remove the burden imposed on the community by contravening the society's norms and taboos."45 Like other professionals, some of them are skilled in their work, healing psychotherapy, counselling etc. Some of them, however, are not good in their work and some perform shady activities like preparing charms for good luck or fortune to pass exams, to succeed in business or make money. A good example is the case at hand in Tanzania. Some ATM doctors, or rather charlatans, came up with the ridiculous idea that a wealth potion prepared with a body part of an albino is sure to deliver the desired wealth. This sparked the hunting down of albinos in Tanzania for body parts.46 As a result of this, the government has

44 Ibid., 46.
45 Dime, African Traditional Medicine, 47.
banned all the ATM doctors in the country from plying their trade for now.\textsuperscript{47}

**Some Recent Developments in ATM**

In 1978, WHO, in conjunction with UNICEF, called on their member states to recognize, and promote cooperation between ATM and Western medicine as a vehicle of realizing the goals of the primary healthcare initiative. WHO made this call because it realized that traditional medicine forms the main and often the only source of health care in many areas of the developing world.\textsuperscript{48} This call renewed and heightened interest in ATM in various places and at various levels, leading to developments and improvements in ATM. Some of these developments and improvements include: the formation of organizations and associations of ATM practitioners; the establishment of research and educational or training centres, and the garnering of political commitment to ATM. One of the bodies that is still absent is Ethics committee for ATM. There exist some non-ATM research ethics committees which take care of research studies involving human subjects. But there is need for ethics committees in clinical institutions for both traditional and Western medicine. Let us now examine some of these developments and improvements, one by one.

**Organizations and Associations**

In the wake of the call and campaign made by WHO, the status of ATM practitioners was boosted. They began to reach out more to


one another and to form more support groups and associations. Organizations and associations of ATM practitioners now abound. Examples of organizations include Association for Scientific Identification, Conservation and Utilization of Medicinal Plants of Nigeria (ASICUMPON); Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM); Traditional Medicine Healers Associations Bulamogi county, Uganda, to mention but a few. These groups and associations share information regarding their experiences in the practice of ATM and the *materia medica*. They share information about new herbs and medicine, their usages, therapeutic potency, side effect, the etiology of diseases and their treatment. The groups also facilitate the regulation, monitoring and evaluation of ATM practices and the practitioners. They serve as peer review.

**Research Institutes**

Besides the formation of associations of ATM practitioners, there are establishments of ATM training and research Institutes such as Pax Herbal clinic and laboratories Ltd., St. Benedict's Monastery, Ewu-Ishan, Nigeria; Centre for Scientific Research into Plant Medicine, Ghana; *Centre Experimental de Médicine Traditionnelle* (CEMETRA, dominantly Senegalese); and *Promotion de Médicines Traditionnelles* (PROMETRA, international) which abound in many WHO member countries of Africa. The research institutes promote and protect traditional medicine and indigenous science through scientific research, education, training, advocacy, and through local and international exchange of research results, cultural and spiritual ideas.49

Political Commitments

Following the call of WHO to member countries, the fiftieth session of the WHO Regional Committee for Africa adopted the Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems, in 2000 at Ouagadougou, Burkina Faso. The African Union Heads of State and Government that met at Abuja, Nigeria, in April 2000 and at Lusaka in July, designated the period 2001-2010 as the decade for ATM to show their commitment. This strengthened the collaboration between WHO and the African Union, offering WHO the authority to form and assist African committees in developing and publishing regulatory and ethical codes and policies for ATM and its practitioners.

Now federal and local governments in some countries of Africa have in place some regulatory and monitoring systems for ATM and its practices. For example, the Ghanaian Ministry of Health, in October 2004, issued the Code of Ethics and Standards of Practice for Traditional Medicine Practitioners; and South Africa has the Traditional Health Practitioner’s Act No.22 of 2007, and the Traditional Healers Practitioners Code of Ethics, of 2010.

ATM Versus Western Medical System

There are varying degrees of development in the relationship between ATM and the Western medicine in Africa. Some countries have not begun the integration of the ATM into the National Health Care System. Some have only established a system of registration and regulation of ATM practitioners; and others, like Ghana and

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South Africa, have truly incorporated ATM into their primary health care system.\textsuperscript{51}

Finally, what do these developments mean for informed consent? The developments confirm that ATM is not a quack or illicit practice, but an effective health care service recognized locally, nationally and internationally. Thus, there is the call for its integration into the National Health Care System. The developments also confirm that ATM has a scientific base upon which it can be evaluated like the Western medicine using empirical science. Thus, the pharmaceutical products of ATM are tested, regulated, and monitored. Now we turn to the analysis of informed consent and its practice in ATM.

**Informed Consent in the African Worldview**

Just as the concept of informed consent in the USA is shaped by the understanding of autonomy, so also, the concept of autonomy informs the understanding of informed consent in ATM. Therefore, in order to really grasp the concept of informed consent in ATM, it is necessary to take a look at the understanding of autonomy in the African worldview. Before continuing with the discussion, it will be appropriate to note here that since there are various local cultures in the continent of Africa, there will be some nuances in the understanding of autonomy and informed consent across the continent and even within any one of the countries of Africa. It will be difficult, though not impossible, to articulate all the different nuances in the understanding of autonomy and informed consent in all the African countries and cultures in a short article such as this

one. However, there is a basic underlying understanding that is common to the people of Africa. This article will, therefore, attempt to articulate some general common understanding of autonomy and informed consent in African thought while at the same time highlighting a few examples from some local cultures as representative of Africa.

**Autonomy in African Worldview**

As in the American bioethics, autonomy, in the African bioethics, more than the other elements of informed consent, helps to define informed consent. Therefore, it requires a special attention and exposé. A good understanding of the concept of autonomy in African thought requires an understanding of the individual in relation to the community. A brief look at the person vis-à-vis his or her community is, therefore, in order here.

**Individual and the Community:** In Africa, persons are defined both individually and communally. Individuals are defined in relation to their community.\(^{52}\) John Mbiti, a renowned writer on African culture and religion, expresses the relationship of an individual to the community in Africa in his book\(^{53}\) as follows,

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In traditional life, the individual does not and cannot exist alone except corporately. He owes his existence to other people, including those of past generations and his contemporaries. He is simply part of the whole. The community must therefore make, create, or produce the individual; for the individual depends on the corporate group... Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: “I am, because we are; and since we are therefore I am.” This is a cardinal point in the understanding of the African view of man.54

The African ethos presupposes an existing community into which individuals are born. Thus, there is in this community an organic relationship between the individual members. African bioethics asserts that persons are relational and interdependent beings because Africans believe that persons are, by nature, social beings and are embedded in the community by social ties. They are to a large extent constituted and defined by their social or communal ties. This idea differs markedly from the notion of the nature of human being as asserted by such social contract philosophers as John Locke, John Rawls and Thomas Hobbes. These social contract philosophers claimed that, in their original nature, human beings were first isolated individuals but later decided to live together by contract. Thus, in the dominant western view, the tendency is to move from individuals to society, whereas, in Africa, there is a move from society or community to individuals. In other words, there is an acknowledgment or confirmation of an existing community (“we are”), which is a basis for defining the “identity of the existent and thinking self (‘I am’).”55

54 Ibid.
55 Menkiti, “Person and Community,” 167; and Ikuenobe, Philosophical Perspectives on Communalism, 53ff.
**Concept of Autonomy:** However, it is not the community alone that defines the individual or personhood, rather, the individual helps to define himself or herself and the community as well. Individuals evaluate and reappraise the inherited values, beliefs and practices, and sometimes, even, challenge the community. Sometimes, it would seem as if the individuals have no will and autonomy of their own, that the individuals are lost in the community. That is not the case. Persons are partly the product of the community and partly help to define themselves, that is, they are partly their own individual products. The work of Kwame Gyekye, an African Professor of Philosophy at the University of Ghana, and a visiting Professor of Philosophy and African-American studies at Temple University, supports this view. Gyekye argues that the fact that it is possible for individuals to re-evaluate existing or received values of a community and to inaugurate new ones implies that the self can set some of its goals and, in this way participate in the determination or definition of its own identity. The upshot is that personhood can only be partly, never fully, defined by one’s membership in the cultural community.  

Therefore, Gyekye sees the concept of autonomy in African bioethics as moderate as opposed to radical autonomy.  

Furthermore, because individuals are never isolated beings but always members of a community, who are in interdependent relationships with other people, it is better to speak of relational autonomy. Here autonomy is exercised in relationship with other people, relatives, friends and members of the community. Choices and decisions are made with the relatives, friends and members of the community bearing in mind the good and interest of the family, relatives, friends, community, and that of the individual concerned.

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57 Ibid., 36-41.
When individuals make personal choices and decisions, they consult relatives, elders, or community representatives, as may be appropriate. Besides consulting these others, the individuals also consider seriously their good and interests. This process applies also to medical and moral decisions. However, sometimes, conflict of interest may arise, between an individual's interest and that of the community. The resolution of such conflict is built into the principles. The way communal principles are framed and the way people are socialized, minimize the conflict.

Here are some proverbs drawn from various ethnic groups of Africa which help to illustrate some of the points I am making about the relationship between the individual and the community, relational autonomy et cetera. Kudha radingu dhedho dzdjo, or even a hawk returns to the earth, in order to die there. This Behema proverb is a criticism of individuals in a community who avoid contact with the community or individuals who think that they can develop independently of the community. The proverb cautions such persons to be aware that they are not fully human without the community and that their venture will fail. It also shows that individuals can and do develop partly apart from community or contest community's norms, values and practices. Individuality is not obliterated by the communal structure. Along this line also the Igbo of Nigeria say, Otu nne na-amu ma otu chi adighi eke, or although siblings may be of the same mother, each possess her or his own fate or destiny bearer spirit (chi). First, it recognizes the common origin or community. Then there is an acknowledgment of individuality; that a person does have an individual existence, personality and a certain degree of autonomy.

58 Ikuenobe, Philosophical Perspectives, 77.
Another proverb that speaks of the relationship between an individual and the community is *Otu aka ruta mmanu ya ezuo ibe ya onu*, or, if one finger is smeared by oil it soils other fingers. This adage from the Igbo of Nigeria underscores the point that what affects the individual affects the community. The individual exists in relationship with others in the community.

It means then, that in ATM, when it comes to authorizing or refusing medical treatment, individuals do not just decide on their own. While the Western bioethics of the USA places emphasis on the individual autonomy, authorizing one to consent or refuse medical treatment without consulting other people or so much consider their interest, ATM emphasizes relationships and therefore relational autonomy. In ATM one consents or refuses medical treatment in relation with relatives, friends or community members. Some of these people accompany the patient to see the ATM doctor. Some sit in the physician-patient meeting. The process of informed consent takes place within this context, and the treatment is authorized or refused. In other words, the patient gives the final consent following the consensus reached by the group and not just by the individual patient. This sort of relational autonomy with emphasis on corporate existence does not stop at decision taking only but includes other forms of support and solidarity. When a member of the community is ill, it is as if the community is ill too.61 As the family and community are part and parcel of the decision-making so also they show their solidarity in other forms as needed, such as lending financial support. For example, they may assist in paying the hospital bill, or assist the patient, and sometimes the patient’s family, with food and drink. Through the time of illness and treatment, the relatives, friends and members of the community, are available for evaluation, consultation and further decision regarding the patient. This sort of relational

autonomy with emphasis on corporate existence makes it necessary to include or incorporate the community and the family in seeking informed consent even in clinical setting.

**Paternalism**

Likewise, it is difficult to speak of paternalism in this relational autonomy. Autonomy is exercised in relationship with other people rather than by other people. The emphasis is on relationships because human beings exist in relationships with others and are partly socially constituted. Moreover, in many cases, especially in the rural communities, given that the traditional doctors are often members of that community, they know not only the customs but the families and their history. They have multiple roles, as elders, as members of the community and as physicians. They are, therefore, in a position to speak for the family. It is difficult, then, to speak of paternalism, at least, in the sense of the Western individual right oriented autonomy.

In this form of relational autonomy and emphasis on relationships, the rest of the elements of informed consent may bear the same title or name as in the American bioethics; they acquire nuanced meaning and practice pertinent to relational autonomy and communal culture. Unlike in the USA, the emphasis in the African context is not so much or only on the patient being given the information, understanding the information, or being competent. Rather, the physician-patient relationship is open to the pertinent relatives and/or community elders of the patient. They can sit with the physician to make the necessary decisions regarding the medical intervention. The meaning of this will become clearer as we analyze each of the remaining elements of informed consent.

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Competence

Besides autonomy, other elements of informed consent include competence, disclosure, understanding of information, voluntariness, and acceptance or refusal. Regarding competence in the African context of relational autonomy and communal relationships, other than the concern for the patient’s capacity to make medical decision as is required in the Western/American bioethics, one would be thinking also of the capacity of the patient’s relatives and community members to make medical decision. The patient’s contribution will depend both on the patient’s age and state. Generally, only adults or emancipated minors can actively join in such decision making. Every culture has its own way of distinguishing adults from children.\(^\text{63}\) One of these ways is by some form of initiation, by which individuals pass to adulthood.\(^\text{64}\) The civil government may have a different legal age stipulated by civil law as the age of exercising legal right and decisional capacity.

Disclosure

Furthermore, as applies in the American bioethics, disclosure of relevant information is required in ATM. The practitioners are

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required to furnish the patient and the group with the facts that are usually considered material in deciding whether or not to refuse or consent to the proposed medical intervention. This requirement is now enshrined in the codes of the ATM practitioners of some African countries such as Ghana as follows,\textsuperscript{65}

Traditional Medicine Practitioners shall inform/educate all clients fully of their conditions, management, as well as procedures involved in the treatment, which they intend to administer, and the possible risks involved, except in emergency situations when the client is unable to make a decision and the need for treatment is urgent.\textsuperscript{66}

\textbf{Understanding}

If patients and their relatives were to make meaningful decision regarding an intervention, they have to comprehend the information given them. It could be difficult when the medical treatment in question is a complicated one. Or in divining the cause of the sickness, the result of the divination may not be easily understood by a young and uninitiated patient. Hopefully, someone, an elder, among those accompanying the patient, would understand the information and help to explain it to the patient and others. This is the added advantage the African practice of informed consent would have over the Western or USA process of informed consent.

In some instances, where the particular ATM doctors have earned the peoples’ confidence; the patient and his or her entourage


leave the decision and or the choice of treatment in the hands of those ATM doctors. They do not worry about understanding the information being given by the doctors.

**Voluntariness**

Following our discussion so far, we can say that when a patient abides by decisions reached in relational autonomy and collective decision making, the patient is not necessarily being coerced. Rather, autonomy is exercised in relationship with others—relatives, elders, and the community, through consensus. And the best interest of all is considered. However, sometimes the patient may see things differently and reach a contrary decision. The family or the community will respect the patient’s wish after unsuccessful efforts to get him or her to see the group’s point of view. They may see the person as being disloyal. Nevertheless, in some serious cases, especially when the patient is judged incompetent, for example in cases of mental illness, they may prevail on the sick person to following their decision. On the other hand, the ATM doctors are required to respect the patients’ decisions and not coerce them.

**Acceptance or Refusal**

Finally, when competent patients, along with their relatives have received and understood the information given, they can freely accept the proposed intervention and, therefore, authorize it. Or they can refuse the intervention by not authorizing it. As noted above, they can also abdicate their rights and leave the doctor to make the call. This is the same as in the USA system. The difference is that, as aforementioned, in a situation where the patient toes the line explicitly contrary to the interest of the family and community, the people will respect the choice but may not be
happy. They may look at it as betrayal and pay no further attention to the patient as happens among the Mbuti people of the Congo.67

Exceptions to Informed Consent Requirement

Emergency Care: As in the USA, in case of emergency, the ATM practitioners are permitted to treat without consent.68 For instance, the Ghanaian code of ethics requires ATM doctors to attend to patients below the age of 18 only when such minors are accompanied by responsible person/s; except if it is an emergency. In case of an emergency, an ATM doctor is permitted to treat even a minor without consent. Likewise, adult patients can be attended to in an emergency without consent.

Therapeutic Privilege: Similar to the USA procedure for informed consent, the ATM physicians may judge that discussing the intervention with the patient might further endanger the patient’s health. In such a case, the physicians would talk it over with the family members or relatives of the patient. If they agree, then the patient is excluded from the consent process. However, in the African context, the relatives or the elders may initiate the exclusion, if they judge that involving the patient might seriously harm the patient. They will try to convince the ATM physician not to give the patient any information regarding the patient’s sickness. The two parties will try to arrive at a consensus.69 In some cultures, such as among the Igbo of Nigeria, it is permissible to keep the medical bad news from the patient. It is generally considered to be for the best interest of the patient, the therapeutic good of the patient. The information is given to the relatives, who sweet coat it for the patient.

68 Ministry of Health, Code of Ethics, Sect. 2, Article 36.
Waiver: Patients, in the African culture, can waive their right to be part of the informed consent process. This is understandable and there is no fear of litigation. Patients, especially older patients, are likely to yield their right to make medical decision to their children, relatives and elders. For example, among the patriarchal societies like the Igbo, Yoruba and Ibibio of Nigeria; and the Guji and Borana of Ethiopia, the first born (especially the male) child is usually expected to take up the right to lead the decision making for the parents in such cases. Among the matrilineal of Ghana, the nephews would do that. This prerogative is also seen in the inheritance right in Ghana. Nephews would work the farms of their maternal uncles, and afterwards they would inherit the property. Even though times have changed, this custom persists. On the other hand, for a young married woman, the husband would be expected to take up the responsibility of leading the decision making for her. In the event that he is unable, then, the elder child and the woman's sister or parents will step in.

Before rounding up our discussion on informed consent in ATM let us consider one major factor that is posited as mitigating informed consent in ATM. This is the issue of some "unknown information."

The Issue of the Unknown

Some scholars have raised a question about informed consent in ATM; whether there can be really informed consent because there seems to be many unknowns in the ATM. Aceme Nyika, for example, fears that sometimes the potency, the side effects, and the level of toxicity of the medicine are not known. Consequently,

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71 Galanti, Caring for Patients, 80.
72 Ibid.
this leads to serious unforeseen results and complications. Thus, Nyika wonders how one can truly consent to the unknown in such a circumstance. She concluded that it is difficult to inform the patients or their surrogates of the effects or side effects of the treatment if these have not been proved.

Nyika’s concern has now become an issue of research. If truly the therapeutic potency, the side effects, and the level of toxicity of a medicine are not known, such a medicine should be under trial and not be used. The Policy guiding ATM prohibits the use of such medicine. For example, the Ghana National Drug Policy under section 5.0, which deals with the Local Manufacture of Pharmaceutical and Traditional Medicinal Products, expresses the objective of the Ghanaian government as the promotion of self-sufficiency in the production, packaging and marketing of essential drugs, as well as herbal preparations. The aim of this, according to the document, is to decrease the dependency on imported drugs. In spite of these necessities, the document strongly warns the local manufacturers to ensure the quality, efficacy, safety and affordability of these products.74

In pursuance of this need to ensure the quality, efficacy, safety and affordability of medicine in general and traditional medicines in particular, the policy stipulates that:

Only drugs conforming to nationally accepted and/or internationally recognised quality standards shall be permitted to be manufactured and distributed in the country.
The regular and thorough inspection procedures for manufacturing and quality control facilities shall be instituted by the FDB.75

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75 Ibid. nos. 5.3.2 and 5.3.3
Also, being under trial, a medicine should follow the regulations and guidelines for medical research or clinical trials involving human subjects. There is, for instance, the Research Guidelines for Evaluating the Safety and Efficacy of Herbal Medicines. This document was adapted by WHO for Africa from the Western Pacific Research Guidelines for Evaluation of the Safety and Efficacy of Herbal Medicines, which was put together by the Manila office of the World Health Organization Regional Office for the Western Pacific in 1993. The guidelines for ATM stipulates how to test and evaluate both short and long term toxicity of medicines, the required doses, as well as the number and sex of animals for the research.

Furthermore, the Model Code of Ethics for Traditional Health Practitioners in WHO African Region, also, deals with the conduct of research on the evaluation of the safety, efficacy and/or quality of traditional medicines on humans especially in collaboration with scientists or institutions, traditional health practitioners or their associations. Section 5, Article 4, of this code, which is entitled *Experiments Involving Human Subjects and the Use of Traditional Medicines*, requires that members of such a research team shall:

a) Participate in such joint experiments involving human subjects only when all the ethical standards are fulfilled. Each experiment should receive prior ethical clearance and approval by the appropriate authority, as well as the written consent of the subject.

b) Immediately report, to the principal investigator of the research team, any adverse findings, especially when the health and/or wellbeing of the subject are in danger.

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Otherwise, in the general administration or in the use of the ATMs, the ATM doctors ought to tell the patients the truth regarding the side effects and the level of therapeutic potency of the medicines concerned. Then, they leave it up to the patients and their relatives or their surrogates either to consent to or to refuse the treatment. This would be in line with the physician-patient relationship espoused in medical ethics and in the code of ethics for the ATM practitioners, to furnish the patients with true and adequate information.77 Tools for Institutionalizing Traditional Medicine in Health Systems in WHO African Region, for example, requires ATM practitioners to

show a high sense of integrity at all times in their interaction with their patients. Inform their patients about the procedures involved in the treatment, which they intend to administer. Respect the right of a patient who either accepts or refuses treatment by traditional medicine, except if the law requires such treatment of the disease. 78

The Ghanaian Code of Ethics and Standards of Practice for Traditional Medicine Practitioners corroborates these ethical standards thus:

Traditional Medicine Practitioners shall inform/educate all clients fully of their conditions, management, as well as procedures involved in the treatment, which they intend to administer, and the possible risk involved, except in

77 WHO African Region, Tools for Institutionalizing, 51. See also Code of Ethics and Standards of Practice for Traditional Medicine Practitioners in Ghana, article 35. It is interesting that these codes are using the language of Western codes in addressing the patient rather than the patient and the relatives or community members.

78 WHO African Region, Tools for Institutionalizing, Section II, articles 1, 2 & 3.
emergency situations when the client is unable to make a decision and the need for treatment is urgent.79

Nyika’s fears have been overtaken by the developments and improvements in the ATM and its practices. The therapeutic potency, the side effects, and the level of toxicity of most common herbs and traditional medicines are now known.80 ATM and its practices are being standardized and regulated, as we showed above, thanks to the research and experiences of individuals, associations, research institutes and the networking among various ATM practitioners both within a nation and internationally. For example, the following countries—Burkina Faso, the Democratic Republic of the Congo, Ghana, Mali, Nigeria, Kenya, Uganda, and Zimbabwe—are collaborating in the research and evaluation of herbal treatments for HIV/AIDS, malaria, sickle cell anemia and Diabetes Mellitus.81 It is possible in ATM, therefore, to have informed consent.

Finally, following from the reasons adduced above, the idea of ATM and its practices being mixed with magic or being magical, shoddy and secret, is practically gone, or at least, fast disappearing. The secrecy is giving way to a new openness, aided by training, the involvement of governmental and non-governmental organizations as noted above. However, in spite of the openness and government involvement, ATM still maintains its community and holistic approaches to health and disease, integrating social ethics, African traditional religion (ATR) and moral values. The belief still persists that the well-being of an individual entails harmony between the body, mind, and spirit; that wholeness requires maintenance of a

79 Code of Ethics and Standards of Practice for Traditional Medicine Practitioners, article 35.
good relationship with the community, including the ancestral world and the external environment.\textsuperscript{82}

Conclusion

By paying attention to the understanding and practices of elements of informed consent especially autonomy, this article makes a comparison of informed consent in the USA and in ATM. The Western bioethics as represented by the USA understands and emphasizes individual autonomy and individual patient rights to make final healthcare decision, hence, the individual rights oriented informed consent. On the other hand, ATM which arises from a communal culture that emphasizes relationships, communal values, and consensus decision making adopts the relational autonomy mode of informed consent, wherein final medical decision is made following consensus opinion by friends, relatives, or community members.

The article also established that because autonomy is exercised in relationships with relatives, friends or community, it is difficult to speak of paternalism in ATM. Likewise, with the improvement in the ATM pharmacological practices, and with better regulatory and monitoring policies, a better knowledge of the therapeutic potency, the side effects, and the level of toxicity of the herbal medicines, is guaranteed; therefore, a proper informed consent is ensured in ATM.

Finally, the article recognizes that the individual right oriented informed consent works for and suits USA society, relational autonomy model does the same for ATM in societies of Africa. It is not a matter of which is right or wrong, but a question of what suits and works for each society. Therefore, in this age of global bioethics, both ways of defining and practicing informed consent need to be respected as legitimate processes that they are.

\textsuperscript{82} Code of Ethics and Standards of Practice for \textit{Traditional Medicine} Practitioners, vi.