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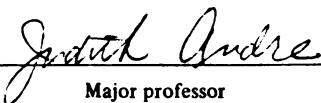
Family Confidentiality:
A Sound Moral Principle in the African Context

presented by

Chad Gandiya

has been accepted towards fulfillment
of the requirements for

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FAMILY CONFIDENTIALITY: A SOUND MORAL MEDICAL
PRINCIPLE IN THE AFRICAN CONTEXT

By

Chad Nicholas Gandiya

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ABSTRACT

FAMILY CONFIDENTIALITY: A SOUND MORAL MEDICAL PRINCIPLE IN THE AFRICAN CONTEXT

By

Chad Nicholas Gandiya

Confidentiality is a useful moral principle in medicine. Nevertheless, questions are raised regarding the type of confidentiality that would best respect and do good in cross cultural settings. Drawing upon the African concepts of personhood, disease and treatment which are essentially social, I present the case that, in African cultures like the Shona which has socio-centric conceptions of personhood, disease and treatment, family confidentiality should be observed. It is the best way to respect and to do good for them. However, for cultures like the American which has a more individualistic conception of personhood, disease and treatment, individual confidentiality should be observed because it is the best way to respect and to do good for them.

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For my wife Faith, a true companion and a tower of strength and
our three children Tapiwanashe (TP), Tariro and Tonderaishe.

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This thesis would have been impossible to complete without the help I received from my academic advisers, family and friends. Although words would not adequately express my gratitude for the contributions of these people, the Shona have a maxim that they use when words fail to express their gratitude: kutenda kwakitsi kurimumwoyo (the thankfulness of a cat is in the heart, i.e., it is not vocalized).

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The African saying that a child can never thank its mother enough for the milk it sucked expresses my feelings about both my

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Introduction

Western medicine on the African continent derives from either the English or the French models of medicine because of the colonial ties which these two European nations have with Africa. Lately, the influence of American medicine has been increasing on the African continent. Now, with an ever increasing influence from western medicine and western medical values since the beginning of the colonial period, traditional African values such as community and personhood become jeopardized endangering essential African identity and culture.

English and French medical values and practices were not introduced in Africa in a vacuum because African traditional medical values and practices were already in existence. These traditional medical practices were deeply rooted in their traditional customs and beliefs. The principle of individual confidentiality is one of those western medical practices introduced on the African continent. According to the western concept of the principle of confidentiality, doctors may not reveal what they learn

about their patients without the patients' permission, except (1) to other health care professionals (HCPs), when necessary to help the patient and (2) as required by law. The African people practice "family confidentiality" which adds a third exception: (3) to the appropriate members of the patients' families. The two practices at times conflicted and caused tensions in relationships among the African people.

In Zimbabwe, the AIDS epidemic brought this conflict to the forefront. The National AIDS Control Program (NACP) (Zimbabwe) which is a government body responsible for anything to do with HIV/AIDS stressed strict individual confidentiality and they expected the AIDS service organizations to follow suit. This raised problems for the AIDS patients. Individual confidentiality which was emphasized by AIDS counselors tended to isolate AIDS patients from their families. The African people look at illness not as an individual affair, but as a family or community affair. An individual's distress is not viewed as that person's problem alone but as that of the family or community requiring a family or community solution.

It was this conflict between individual and family confidentiality in the context of the AIDS epidemic in Zimbabwe that challenged me to examine the moral principle of confidentiality in medicine within the African context. The challenges I got through both my pastoral ministry and my involvement in AIDS work in Zimbabwe especially in the area of counseling HIV+ and AIDS patients highlighted for me some of the issues surrounding confidentiality. One of the things that surfaced in the course of counseling African clients with HIV/AIDS was that, one was not just simply dealing with the individual client, but with both immediate and extended family members and their beliefs.

Purpose and Methodology:

I, therefore, wish to examine the kind of ethical principle of medical confidentiality that would serve the best interests and needs of the African people in biomedicine within the African context. The methodology that I employ is interdisciplinary in nature. I will largely draw upon the insights of Medical Anthropology and Philosophy. However, references to other disciplines such as Religious Studies and Sociology will be made where appropriate. An

anthropological analysis will help in the understanding and evaluation of the stories that I use to illustrate African/Shona concepts, beliefs and practices relevant to this thesis. These stories are not based on field research but on personal knowledge and experiences of my Shona cultural beliefs and practices as well as personal experience in pastoral ministry and working with HIV+/AIDS patients. I will also use some materials from relevant literature on African/Shona and Anglo-American cultures. Examining the moral medical principle of confidentiality requires a philosophical analysis in order to determine the kind of confidentiality that will best respect and do good for the African people in their context.

The thesis will therefore proceed as follows:

(1) *Chapters 1 & 2* will examine the background against which the African concept of family confidentiality can be discussed. This involves looking at the African concepts of personhood, disease and treatment. The Anglo-American concepts will be described so as to provide a background against which to describe African mores. This examination will reveal that the Shona people, as with most other groups

of African people, have a strong socio-centric conception of personhood, disease and treatment.

(2) *Chapter 3* will discuss the resulting moral difference in what kind of confidentiality should be practiced. Both individual confidentiality practiced in North American biomedicine as well as in the western world in general and family confidentiality in African traditional medical practices will be discussed. Then I will draw the implications that family confidentiality will have on biomedical practice in the African context.

(3) *Conclusion* - the conclusion drawn from these discussions is that, in African cultures like the Shona, where people are connected to their families in the ways discussed in this thesis, family confidentiality should be observed. It is the best way to respect those people and to do good for them. However, in cultures where persons are thought of as separate from their families, individual confidentiality should be observed because it is the best way to respect them and to do good for them. Therefore, I recommend that the ethics community should give consideration to the African concept of family confidentiality as a sound ethical principle in medicine within the African context.

Chapter 1

Beliefs About the Nature of a Person

"Over himself, his own body and mind, the individual is sovereign."¹ J.S. Mill

"I am because we are, and since we are, therefore I am."² J. Mbiti

The concept of personhood varies cross-culturally. The North American variety of personhood is based on the western cosmology where the individual is the central figure (Gordon 1988). This individual is a distinct independent or sovereign unit living in society (Shweder & Bourne 1982, Gordon 1988). Central to this conception of personhood are two fundamental ideals. The first ideal is that of equality. It is based on the Kantian philosophical belief that each person is an end in themselves and never a means (Steven Lukes, 1990). As such, this belief requires equal respect of persons as ends in themselves because of their inherent dignity as individuals. The second ideal is that of liberty. This ideal presupposes other related ideas like freedom, privacy and self-development. For example, a person is considered free when they are self-determining; when they can claim a sphere of thought and action in which they can

exercise the right not to be interfered with (Andre); and also when they are able to shape their life's course thereby, enabling them to realize their potentialities. Without each one of these three ideas, liberty is incomplete.

The observations of anthropologists like Shweder and Bourne (1982), Gordon (1988) of western society point us to a society that is based on "atomism". Although a person has blood connections through birth, they do not determine or control the behavior of that person. It is the individual who chooses who they want to be, how they want to order their life, where they want to live and with whom they want to live etc. The individual is the supreme governor of their behavior and actions. J.S. Mill succinctly expresses it when he says; "Over himself, his own body and mind, the individual is sovereign."³ The individual belongs to society only as a distinct independent person. Thus, the individual in the North American context is "ego-centric" (Shweder & Bourne 1982; Gordon 1988). According to this characterization of the individual, Shweder and Bourne (1982) tell us, "society is imagined to have been created to serve the interests of some idealized autonomous, abstract

individual existing free of society yet living in society."⁴ The North American perception of personhood awards primacy to the individual. Deborah Gordon tells us that it is supported by a moral code of "rights" rather than "duties" (Gordon 1988). Recently, gun control in the United States of America was strongly resisted by those who did not want gun control because they saw it as an infringement on their constitutional right (individual) to own any type of gun they wanted. The rights of an individual are protected by the American Constitution. Lukes sees individualism as being enshrined in such important American national documents like the American Declaration of Independence and the Declaration of the Rights of Man⁵.

The African concept of personhood, however, is different from the North American variety. It is socio-centric and not ego centric (Shweder and Bourne, 1982). It is deeply rooted in community. Individual interests are balanced with, and at times subordinated to those of the community. An individual in the African community is regulated by strict rules of interdependence that are context-specific and particularistic. There are rules governing behavior towards kinsfolk and ancestors, rules

governing marriage, participation, identity etc. A proper understanding of the African concept of personhood would need to take community seriously in the definition of personhood in the African context. In addition, other factors related to what it means to be a part of the African community like identity (through totems), participation, connection with ancestors and achievements would also need to be considered. The reason for considering these factors is that African cultures like the Shona people of Zimbabwe think of persons as connected to their families and clans in those ways. I am now going to walk you through some examples from the Shona culture in Zimbabwe that illustrate the role played by community and each of these other factors in defining a person.

1:1 Community

Originally, Shona communities were composed of members of the same totem but this has changed over the years as people of other totems have been accepted into other communities. The key stone of the Shona traditionally way of life is the extended family - a network of uncles, aunts, cousins, grandparents, grandchildren and in-laws who work

together for the common good and for mutual self-help. The relationships are much closer than in the western world. Mother's sisters are also "mothers" and their children "brothers or sisters." If help is needed, one turns first to the rest of the family. If there is a funeral, the work is done by the family. If counseling is needed, one turns to the family counselors; if a wedding feast is to be celebrated, the family joins together to provide and prepare what is necessary. Weaknesses in one member of the family are balanced by the strengths in others. For example, if a woman is a bad mother, there are other mothers to keep children from being traumatized. If a biological father leaves home or is deceased, there are other fathers to keep the children from growing up fatherless. Children born out of wedlock are easily absorbed into the family. All individual members of the family, community even clan are known by relational terms like uncle, aunt, brother, sister, grandfather/mother etc. It is this network of relationships including the ancestors that make up the Shona family, community or clan. In describing what a clan is, Fr. Tempels says:

It is the whole constituted by the individuals who compose it. It is the ensemble of interior names, started by the founders of the clan. Every newly born is therefore named with an interior name chosen from these names, that is to say from the individuals, who constitute the clan. The Bantu will say to the newly-delivered mother: "You have born our grandfather, our aunt, our uncle, etc."⁶

There is some similarity in what Fr. Tempels observed in East Africa and the type of comments Shona people make about their pregnant relatives concerning their pregnancy. For example, relatives make comments like: "You are carrying our uncle, aunt, son, daughter or grandfather/mother" etc. depending on the nature of the relationship. When the baby is born, again relatives come to congratulate the mother with gifts like live chicken, grain, baby clothes, money etc. They congratulate her saying: "congratulations aunt, you have born us our niece/nephew, grandfather/mother". At times the baby is greeted using the same relational terms.

Those not related make remarks about the child being their potential daughter or son-in-law when they meet or greet a pregnant woman. If they become aware that the woman had a baby recently, they congratulate the mother saying: "congratulations, thank you, you bore us our daughter or son-in-law."

The above example shows that the individual is always seen in relation to, and in communion with other people. Every Shona person is born into this revered web of strong relationships. No one is considered as an isolated individual. Birth, in African thought, is seen as a means of inserting the person into a life current or original structure with its many strong webs of close relationships. An individual is born into an existing society and therefore, into a human structure, the latter being the product of the former. Being born into an existing community suggests a conception of personhood as being communitarian by nature. Given this insertion into the human structure through birth, we must then, take cognizant of the group as a founding factor which emerges as a family, community or clan. This human structure, according to Ruwa'ichi, "plays the role of a magnetic field of experience. In this field muntu (person) thinks, feels, believes, hopes, loves, aspires and grows; in short, there he lives and is formed."⁷ It is not surprising that in such a context, it is the community that defines who the person is and who the person may become. This is partly the reason why Professor Mbiti, a prominent African theologian, says that the individual in

the African community is conscious of himself in terms of, "I am because we are, and since we are, therefore I am."⁸

Both Mbiti's and Ruwa'ichi's observations show the pivotal role played by the community in defining and understanding personhood.

At every level, Shona traditional culture is profoundly communal. The individual's personal sense of security and self-worth comes from the person's place in the group, rather than from personal successes or failures. Stewart Lane's observation in Malawi are also true of the Shona. He observed that,

"cooperation is more highly regarded than competition, submission to authorities more valued than independence, and responsibilities more important than rights."⁹

Traditionally, in Shona villages, almost all work and play is done in groups, and decisions made, whenever possible, by consensus. Special care is taken to avoid or minimize division. Overt decision-making is handled by a select group of elders who take the feelings of the community as a whole into consideration. Everyone in the decision-making group is given an opportunity to voice an opinion. Each speaker begins by emphasizing points of agreement before touching on

points of disagreement. The group then tries to reach consensus, but if that is impossible, a recognized leader makes the decision for the group. Usually this person's decision is accepted gracefully by everyone. Professor Wiredu made similar observations in other sub-Saharan African cultures.¹⁰

The first generation of African political leaders after gaining their national political independence from European colonial governments, used this communal characteristic of African life to rally people together for the purposes of building their new nations. For example, former president of Senegal, Leopold Senghor said, "Negro-African society puts more stress on the group than on individuals, more on solidarity than on the activity and needs of the individual, more on the communion of persons than on their autonomy. Ours is a community society."¹¹ The late president of Kenya, Jomo Kenyatta, commenting on traditional life in Kenya said, "According to Gikuyu ways of thinking, nobody is an isolated individual. Or, rather, his uniqueness is a secondary fact about him; first and foremost he is several people's relative and several people's contemporary."¹² It can be observed from these statements that African social structure

with its underlying socio-ethical philosophy, was and very much is, communitarian.

It is easy to conclude from such examples and statements that: (a) all that matters in African society is the collectivity and nothing else and (b) that the individual loses their identity to the community. Nothing could be farther from the truth than this. The African concept of personhood strikes a balance between a person's collective and personal identity. While the collective identity marks the person as a member of society or a given community, the personal identity marks a person as a unique individual. This individual has a name which differentiates them from others as well as talents which delineate personal identity. These talents can complement or be complemented by those of others in the community. Thus, the emphasis on the person's individuality and freedom is always balanced against the total social historical circumstances.

The African concept of personhood demands an ontological equilibrium where both personhood and community are ranked high (Gyekye, 1992). Personhood in African thought should neither be sought in an isolated individual, since to do so is regarded by the African people as

unhealthy, unrealistic and even abominable, nor in the collectivity because it denies the person's individual qualities, but in the community of persons where each preserves their originality, without denying or contradicting that of others. The Bali saying that, "We dislike the arrogance of eggs, they seem to be all alike", becomes very relevant if the balance is heavily tilted towards the collectivity. If it is tilted towards the individual, the Shona people will quickly remind ziva kwavakabva (know where you came from) or ziva kuti uri ani (know who you are). The word "know" used in this sense carries the connotations of remembering or not forgetting. Thus, the sayings remind the person of their connectedness and collective identity because they help define who they are. Therefore, individuality and communality in African society are completely integrated within the person.

1.1.1 Identity

African Philosophy defines a person in terms of the social groups to which people belong (Gyekye, 1992). In Zimbabwe, these social groups are identified in terms of the totem of the group. The totem binds together people who

share a common ancestry and history. These people may be scattered all over the country and may even not know each other. But, once a common totem is identified, then, immediately they regard themselves as related. A totem identifies a person. It shows which group of people one belongs to in a tribe (a tribe is composed of people of different totems). It also helps define who your relatives are.

Traditional Shona greeting, for example, requires that you greet people by their totem name. If you do not know it, it is expected that you ask. A common form of Shona greeting goes as follows: you shake hands as you say, hello. If you are not sure you recognize them you ask the person either who they are (understood as asking for their totem or family name) or whose son/daughter they are. Once the identification is made and the totem is known, then the clapping of hands follows. As they clap their hands, they will at the same time say, makadini shumba (how are you lion), if the other person's totem is lion. They will also ask about the health of the people where they have come from. When they part, they will ask each other to greet the relatives where they are going.

Totems are also used to delineate who a person can or cannot marry. In Shona society, totems identify a person. It is important that couples are properly identified before and during the marriage process so as to avoid relatives marrying each other. Marriage in African society is not an individual affair. The following example shows what happens from the time two people fall in love to the time that they get married. The girl introduces her boyfriend to her aunt. The aunt ensures that they are not related by asking about the boy's totem and family. The boy, likewise, introduces his girlfriend to his uncle who will also ask about the girl's totem and family. When they decide to get married, they will inform the same aunt and uncle who will in turn inform the respective parents of the couple.

The girl's family and relatives will hold a meeting to decide in advance what the lobola should be and which girl's uncle will act as her father during the procedures even though her real father may still be alive. The boy's family and relatives will also hold their separate meeting to decide on who the mediators should be, how much lobola they should take with them in anticipation of what the

prospective in-laws might ask and when they should visit the girls parents for the negotiations.

During the negotiations the real parents of the girl are not directly involved. They are only consulted when there are glitches. The boy's mediators negotiate with the girl's uncles, brothers and cousins and their wives. Uncles and aunts are considered to be one's parents in Shona culture. The first important question that is asked of the mediators after they have declared their intentions is what their totem is. Totems reveal the relatedness of people who may not otherwise know each other even though they share the same totem. For example, if a person's totem is bird, that person is assumed to be related to all those whose totem is bird. Marriage of people of the same totem is forbidden. If it has to be, the relatedness has to be severed before the marriage can go on. Families rarely do this. When they do, it is normally in cases where the family ties in the past cannot be traced. There are cases however, where people of the same totem have been allowed to marry each other because family ties in the past could not be traced. In such cases the ancestors are informed and the totem-relatedness is

severed by giving an ox to the girl's parents and performing a simple ceremony nullifying the relatedness.

Totem names identify the individual with the group or clan. They emphasize the belongingness of the individual to the clan. A person feels known and greatly honored when its used. When Shona people want to thank somebody and show them their appreciation of what they have done, they use totem names and never first names. For example, in years past when hunting was an important preoccupation of the men, when they brought home game, women and and those men who stayed behind thanked them using totem and praise names as well as family and clan names. Again, first names were never used.

What we observe in these three examples is that the individual is identified in terms of their relation to the family or clan and never as an unconnected person. Although first names are used, they are considered less important than totem names. First names emphasize individuality but totem names emphasize group identity.

1.1.2 Participation

Participation is crucial in the African community. Living is not just existence in the community, it is participation in the common life of the family, clan and community. The Shona people have many aphorisms that advocate involving others in one's affairs and at the same time strongly discourage chindingoveni (individualism). For example, Zano vaviri (two heads are better than one), in the Shona context it means that one should always seek other people's advice when doing something or when anything happens like misfortunes, illnesses etc. Another aphorism, Varume varume, kutsva kwendebyu kudzimirana (Men are men, when their beards burn, they help each other to put out the fire) means that a problem becomes lighter when people face it together. Hence, the participation and advice of all members of the family or community in such activities like birth, marriage, sickness, death, village courts, festivals etc. is vital. However, in order to participate, one needs to be informed or notified first. This protocol of notifying is very critical in the Shona community because it enables participation. The Shona people consider hearing about important things like marriage, illness or death etc. in the

life of the family, relatives and community without the proper protocol of notifying as hearsay. This is not acceptable to them. Let us take illness and death as examples. If one's wife has a life threatening disease, it is incumbent upon the husband to notify her parents or closest relatives of this fact. They in turn will notify some of their relatives and may even make some suggestions regarding alternative medical care such as the one given by traditional healers. They will also offer you whatever support they can give.

Failure to inform them can be interpreted in many different ways. It can be taken to imply that you are accusing them of having caused her illness or that you are trying to hide something evil that you might have done to her that resulted in her illness. Some may interpret your failure to notify them as implying that they are not important, which is an equally serious charge just like the first two. The situation is made worse if she dies. Traditionally, you cannot bury her body in the absence of her family or closest official relatives. If her parents were not informed of her illness it becomes very difficult for you to inform them of her death. The parents may even

respond by saying, "it is impossible, our daughter is alive and well. There is no need for us to come at all." They can still respond in the same manner even if someone had unofficially told them of their daughter's death. You can not go ahead with the burial without an official representative from your deceased wife's family because there are certain traditional rites that are performed by them alone and no one else. There are known cases where bodies start to decompose before they are buried because some protocol was omitted. Such situations are normally resolved when the family of the son-in-law admit their oversight and pay a fine to the wife's parents or family. The following story illustrates both the importance of notifying and participation in Shona society.

Mary was still living with her parents when she became pregnant. Following Shona tradition in such circumstances, she left home without her parents' knowledge and went to live with her boyfriend John. John did not inform Mary's parents' that he had their daughter as traditionally expected. Serious problems arose between Mary and John over John's extra-marital affairs. Mary disliked John's loose living. She voiced her disapproval and suggested that the

money he was wasting with other women should be saved for lobola (bridal price). John did not like being told what to do. He beat her very hard. Although Mary could tell John's parents her problems, she did not because she thought she would not get a fair hearing. She could not go back to her parents because relations had not been restored since she eloped. In rage, Mary poured kerosene over her body and lit herself in order to commit suicide. She was badly burnt. Although she was taken to the hospital, there was nothing much that could be done for her. The doctors told John and his parents that Mary did not have much longer to live. In the meantime, Mary's parents heard about the incident by hearsay. As is the custom, they waited for John's relations to come and formally inform them. But, for John's relations to do this, they needed to at least go through part of the marriage procedure. Time was not on their side. Mary died before they could go through these procedures. Mary's parents heard about their daughter's death through the grape vine. Again, they could not do anything until they had been formally informed by John's relations. John's family could not go ahead and bury Mary's remains. Tradition forbids it if her relations are not present, and worse still if they

have not been informed. To cut a long story short, John and his relatives eventually went to see Mary's parents. They went through the marriage procedure first. This was followed by informing Mary's parents of her death. They paid heavy fines at each stage for failing to observe tradition thereby causing pain to Mary's family and relatives. After all this had been done, they finally started making burial arrangements together now that relationships had been normalized.

We see in this story that flouting tradition by failing to inform Mary's parents that he had their daughter, John's family prevented them from vital participation in the relationship of John and Mary. It cut Mary off from her family. However, when faced with serious illness and death, John and his relatives could not escape from dealing with Mary's family and relations. They desperately needed their participation. All this emphasizes that a person in Shona culture is not alone. They are an active participant and not a passive element in the rhythm of nature. In this context, to be is to participate. The above example in particular, serves to accentuate at least two of the many important things about a person in African culture.

First, issues relating to life threatening illnesses are considered to be family or extended family affairs rather than just personal. The family or extended family should therefore be informed about the existence and nature of the illness. Together, the family members decide where to go for treatment. If a decision is made to consult traditional healers, family representatives and the patient go together. Issues of confidentiality are discussed by the members of the family. In some cases it is they who decide who should or should not be told and not the patient.

Second, the protocol of notifying enables those concerned to participate meaningfully either in the life or activities of other members of the family/community. The importance of this can be seen in that, as Mulago who has done extensive research among the Bantu people of Zaire tells us:

The life of the individual is grasped as it is shared. The member of the tribe, the clan, the family, knows that he does not live to himself, but within the community. He knows that apart from the community he would no longer have the means of existence. In particular, he knows that his life is a participation in his forefather's life, and that its preservation and strengthening depend continually on them.¹³

1.1.3 Connection Through Time

Ancestors are considered part and parcel of the African community. As such, they are included in family and community affairs. Although they are believed to know everything that happens to the living family, none-the-less, it is believed that they expect to be notified of every major event happening in the family. For example, if a person is going on a long journey such as going out of the country, e.g., for, education, the family will go into the traditional hut where they will 'speak' to the invisible ancestors about the family member's impending journey. They will ask the ancestors to look after that person, prosper their journey and bring them back home safely.

An African community or family therefore, is one that consists of the physically living, the "living dead" or ancestors and those yet to be born. Father Tempels observed that:

For the Bantu, man never appears in fact as an isolated individual, as an independent entity. Every man, every individual, forms a link in a chain of vital forces, a living link, active and passive, joined from above to the ascending line of his ancestry and sustaining below the line of his descendants.¹⁴

Death in African culture does not mean annihilation and it does not make the ancestors redundant. They are believed to preside at all important ceremonies like birth, marriage, investiture, death and burial. As a result, their participation is considered indispensable in the lives of their descendants. Below is Paul Chidyausiku's description of one of several traditional events that take place before burial. In this incident the person called Hombarume had died. Chidyausiku tells us that after the body had been bathed as prescribed by tradition and all mourners had been fed well, the close friend of the family (Sahwira) advised the elders that all was ready. The Sahwira then asked "the father of the person" (in this case it was his eldest uncle) to commend Hombarume to his ancestors and ask them to welcome him home. The uncle started by clapping his hands rhythmically. The rest of the men assembled there joined him. He clapped for a while and then started to address the family ancestors:

There is your child
you who have gone ahead of us
we say welcome him home
the home of his great grandparents
the home of his fathers and mothers
the home of all our people who lie
peacefully near so many ant-hills

welcome him into the company
of his uncles, brothers and sisters....
We place Hombarume into your hands
you Chongoma who left us last year but one
We ask you to lead him by the hand
to your uncle Chinhoyi who died before you did
Together lead him along
to the company of our brave hunters and warriors
who look after us and protect us against our enemies
and against human-eating lions....
We also appeal not only to you people from his fathers
side,
but we appeal especially to the people of his mother's
side
and we say there is the child of your womb, there is
Hombarume, welcome him home.
We appeal to you in the confidence
that no cow ever turned away from its lowing calf!
When he decided to get married
we first commended the herd of cattle to you
before they were delivered to the in-laws
Now that you have allowed it that he be dead,
we are placing him in your hands.
We are now moving him from here
and we are taking him to a new home.
You will not accuse us
of not commending the child in your care,
all here assembled are my witnesses....
But before we take Hombarume to his his new home
we would like to remind you
even though you need no reminding at all,
that Hombarume was not "a male walking stick"
No, he is a man with a family.
There is his widow
and there is his only son.
They need looking after and to be protected.
Now that their protector is out there in the winds
and may be helpless himself
before the home-bringing ceremony next year,
We plead with you
to look after his family for him.
We shall do our best on this side of the grave,
that we can assure you,

but there are other things only you can....
 (Paul Chidyausiku, 1984:95-96)

The procedure described above shows not only a strong belief in the connection between the living and the dead, but the role that the dead are believed to play in the lives of the living. Their participation is valued and considered sacred. It is this vital participation in the lives of the living families and community that ensures their continued connectedness with them. Without it they can easily be forgotten. Mulago aptly describes the importance of this participation when he says:

Participation is the element of connection, the element which unites different beings as beings It is the pivot of relationships between members of the same community, the link which binds together individuals and groups, the ultimate meaning, not only of that unity which is personal to each man, but of that unity in multiplicity, that totality, that concentric and harmonic unity of the visible and invisible worlds.¹⁵

1.1.4 Achieved Personhood

There is a sense in Shona language and culture in which personhood is a status conditional on certain social achievements. It is not automatic, but something that is achieved and conferred on the individual by the community. Professor Wiredu quotes an incident that

happened in Zambia in 1979 during the last series of talks that eventually led to the independence of Zimbabwe. He says:

In 1979, President Kaunda of Zambia gave high praise to then Prime Minister of Britain, Mrs. Margaret Thatcher, for her unexpected constructiveness during the last series of negotiations that led to the termination of white minority rule in Zimbabwe. He said that she was 'truly a person,' and he immediately provided a key to this choice of words. In Zambian language and culture, personhood is not an automatic quality of the human individual; it is something to be achieved, and the higher the achievement, the higher the credit. On this showing the 'Iron Lady' received very high marks indeed.¹⁶

Although Mrs. Thatcher was a person before president Kaunda made his remarks, she, however, earned a higher status of personhood as it were, in the eyes of most African leaders by her valuable contributions during those talks. This is why president Kaunda, representing other leaders could say that now she was truly a person.

Among the Shona people, when a person succeeds or does things beyond people's expectations like helping in the development of the community, looking after one's family, parents and relatives well, (especially when things are hard), people make comments like, "this is truly a person", or "this is a man or woman." In other words, the community

confer personhood on that person just as president Kaunda did on Mrs. Thatcher. It is also possible for someone to fail to achieve personhood. The following example will illustrate both how personhood can be achieved and how one might fail to achieve it.

A lot of African countries gained their national independence in the 1960s. When Zambia became independent in 1964 many men in our village went to Zambia as political refugees and others went in search of better paying jobs. Still, others went to South Africa even though the conditions were no better than in our own country. The only difference was that there were more jobs available there than at home. The families of these people and members of our community expected them to be economically better off when they came back than when they left. One man whom I remember very well came back and built modern brick houses for his family and his parents. In addition to this, he built a store in our community. He also bought a grain milling machine which serviced the community. Some people in our community remarked that he was truly a person. Others said that he was a real man.

In contrast, there were others, who, after many years in either Zambia or South Africa, came back with very little if at all. Community members could be heard commenting that, "they were not persons." Other ways of failing to achieve personhood include laziness or spending one's income on beer and loose living and failing to provide your family with the basic necessities of food, shelter and clothing.

Summary

This chapter has shown us that personhood in the African context is defined in terms of a number of things that reflect the communal aspect of African life. Shona people of Zimbabwe identify themselves in terms of their totems and not first names. These totems link the dead, the living and those not yet born. These three groups make up a family or community in African culture. The individual in this society is always seen in relation and communion with other people. The individual thinks of themselves in socio-centri terms. One of the essential elements of living in community is participation by all members of that community both living and dead. Thus, the involvement of the ancestors is considered important in the life and activities of the

living. Finally, we have also seen that there is a sense in African culture in which personhood is achieved and conferred by the community on an individual. All these ideas taken together, define personhood in African society.

Given such a socio-centric definition of personhood in Africa, the next chapter will deal with how illness and treatment is viewed in the same society. The first two chapters will provide us with the necessary background and context in which to discuss the concept of shared confidentiality.

Chapter 2

Illness and Treatment in the African Context

"African medicine does not primarily treat diseases, but sick people. One cannot therefore understand African medicine by regarding its pathogenetical concepts and its nosology, but rather from its cosmology ..."¹⁷ W. Bichmann

Just as the previous chapter showed that the Shona understand persons to be more essentially social than westerners do, this chapter will show that they also understand disease and its treatment to be more essentially social. But first, in the anthropological tradition of contrasting two systems, I want to review the cultural context out of which biomedicine emerged.

Western biomedical system has to be understood within its cultural context because, as Brown, like other critical medical anthropologists (Baer et al. 1986, Lock 1986, and Hepburn 1986) reminds us: "biomedicine is a cultural product and is itself a cultural construction of reality."¹⁸ Other writers like Hepburn (1986), Sullivan (1986) and Osherson and AmaraSingham (1981) tell us that from the 17th century a dualistic image of humans predominated in western culture. Seventeenth philosophers like Descartes "treated the known body as entirely external to the consciousness which knows

it" (sullivan 1986: 339). Osherson and AmaraSingham (1981) say that Descartes described the human body as a machine that performed all the physiological functions of man. They quote Descartes' Treatise on Man which states that:

... all these functions in this machine follow naturally from the disposition of its organs alone, just as the movement of a clock or another automat follow from the disposition of its counterweights and wheels; so that to explain its functions it is not necessary to imagine a vegetative or sensitive soul in the machine, or any other principle of movement and life other than its blood and spirits agitated by the fire which burns continually in its heart and which differs in nothing from all the fires in inanimate bodies.¹⁹

Thus Descartes ideas contributed a lot towards making mechanism an important model in medicine. However, Osherson and AmaraSingham also tell us that:

although Descartes' model of absolute mechanism was never fully accepted in biology ... Yet the mechanistic model of man and the universe had tremendous influence on 17th century and 18th century thought and has continued, ... to influence the practice of medicine in significant ways.²⁰

One of the results of such a mechanistic view of the human is that the body came to be regarded as a host to disease and the disease was seen as a biological phenomenon in human bodies. Disease took on a separate existence from the patient. It became the "thing" that is treated and not

the patient. Thus the patient and their body were, as it were, two different entities. One came to be regarded as more crucial to "treating disease" than the other which was more or less set aside as inessential. Brown observed that "for the practitioner of biomedicine, disease is the expression of pathology alone. It can be identified by its signs and symptoms or diagnostic tests and it can be categorized according to its biological characteristics."²¹ In other words, according to biomedicine, disease is knowable and treatable as an entity independent of the patient and the patient's social circumstances. Hence the focus of western biomedicine tends to be more on the disease and the goal becomes one of knowing and healing the disease. What is lacking in this approach is a fuller experience of illness - one that would include the patient's social context. Patienthood, as Sullivan (1986 p. 346) tells us, is "a social state rather than simply a biological one." Medical anthropologists like Scheper-Hughes and Lock (1987) Osherson and Amarasingham (1981) according to Hepburn (1988), tell us that this "dualistic, mechanistic and desocialized image of the human body has predominated western culture since the 17th century."²² It is now part

and parcel of the biomedical practitioner's culture. If this is true, then Brown's observations are enlightening when he says that, "the taxonomy and the diagnostic systems of biomedicine are based on the practitioner's cultural assumptions about causality and the nature of reality."²³

Western medicine tends to view disease as something belonging to an individual rather than a group. The disease is seen as a biological occurrence that takes place in individual bodies. Hence, when a sick person visits a physician, the physician looks for the cause of the sickness in the individual and treats "the disease", the infection or bacteria etc. Disease or illness becomes a matter that is dealt with exclusively by the patient and the physician. The illness of a person becomes such a personal thing that the sick person considers it more or less shameful if others know about the illness. Social relationships do not usually feature in the physician's diagnostic procedures.

Likewise, just as western medicine sees disease as something belonging to an individual, western treatment of disease focuses on treating the isolated individual. Biomedical institutions like hospitals, doctors' surgeries etc. isolate patients from their natural surroundings,

families and neighbours. In this setting, as Sharon Hepburn tells us, "treatment is generally viewed as technical intervention in an essentially mechanical problem."²⁴

Quoting McKeown (1971) she goes on to say:

"this technical orientation is learned in medical education, which begins with the study of the structure and function of the body and then proceeds to the examination of selected malfunctioning bodies."²⁵

This western biomedical emphasis on the individual is consistent with their individualistic conception of personhood which is based on their cosmology where the individual is the central figure.

The above observations raise important questions about biomedical practice in cross-cultural settings. Some cultures like the Shona see things differently. For instance, there are differences about cosmology, conceptions of personhood as well as cultural assumptions about causality and the nature of reality. Other cultures do not regard health as just the absence of disease but as a social phenomenon involving a person's social relations with family and community members or as harmony with both the natural and supernatural worlds. Just as medical systems vary a lot

cross-culturally, so do the assumptions about causes of disease and treatment.

Written discourse made it possible to review one of the social origins of biomedicine. African tradition has no such written discourse partly because they relied on oral tradition. I will use concrete examples from Shona culture to illustrate the points I discuss in this chapter. With that in mind, I now want to show some assumptions about the causes of disease and patient treatment in the traditional Shona culture of Zimbabwe.

2. Shona Beliefs about Causes of Disease and Treatment

"Witchcraft is a theory of causation, but it is a theory which explains causal links which modern scientist do not attempt, cannot attempt to explain The belief in witchcraft provides explanation for the particularity of misfortune. It does not for the African, provide the whole interpretation of misfortune."²⁶ M. Gluckman

Traditionally, among the Shona people, as is the case with other sub-saharan peoples of Africa, illnesses are widely believed to have natural and supernatural causes (Chavhunduka, 1978; Fink, 1989). Traditional medicine takes these causes seriously in its interactions with patients. For some Shona people, the perceived cause of an illness

determines the choice of the type of therapy that is sought. The choice is between biomedicine, traditional medicine and spiritual healing performed by the "prophets" of the African independent churches. While many people take their illnesses to biomedical practitioners in such places as hospitals, clinics and private surgeries, others take theirs to traditional healers such as herbalists, diviners and diviner-healers. There are also those who, for religious reasons, will not consult traditional healers or biomedical doctors. Instead they take their illnesses to the "prophets" in African Independent Churches who are believed to have healing powers. In most cases, the same illness can be referred at different stages to a biomedical-practitioner, a traditional healer or a "prophet". At other times, the different types of medical practitioners and spiritual healers are consulted simultaneously. This behavior is not unique to Zimbabwe. According to Chavhunduka (1978), Gould (1960) observed the same behavior among the peasant villagers in North India. Gonzales (1966) too observed the same behavior among the peasants in Guatemala.

2.1 Natural Causes

The Shona seek to explain not only the "how" but also the "why" of health and illness. The "how" level of accounting for health and illness includes illnesses they believe to be caused by foreign organisms like worms, viruses, injuries sustained from accidents, weather changes especially in the cases of colds and coughs etc. This can be described as an empirical or natural understanding of illness. There are some resemblances between such Shona beliefs about causes of illnesses and western beliefs. Take weather changes for example, every fall in America, healthcare officials remind people to have flu shots in preparation for the winter when some people are most vulnerable to the flu virus.

Other illnesses are regarded as a sign of old age. For example, an old person (70 years and above) suffering from back-ache may refuse to go to hospital because, as far as they are concerned, back-aches are to be expected in old age. Professor Chavhunduka cites an old man (80 years old) who thought that he did not need medical aid for his backache because of his age. He said:

I am very old you know. I have had my time on earth and I will soon be with my ancestors. I can't be bothered going to the hospital; I am too old. Every old man suffers from these pains.²⁷

However, it is considered unusual for a teenager with no known back injuries to complain of back pains. The elders will suspect that the pain is caused by indulging in sex. Nothing else is believed to stress teenagers' backs other than premature sex.

Another example of an illness that is attributed to old age is poor eye-sight. An old man in one of the rural missions of the Anglican Church in the the Buhera district was almost blind in both eyes. He could not go anywhere or do things on his own because of very poor eyesight. His children failed to persuade him to see an eye doctor. As far as he was concerned, his poor eyesight was due to his old age. My father saw him several times before he could agree to to see an eye doctor. He told him about some of the achievements of biomedical technology citing my grandmother who had a similar problem as an example. She was older than he. She had eye surgery which improved her eyesight. The old man agreed to see an eye doctor who suggested surgery on both eyes. He agreed to having surgery performed on one eye

and if it worked, then he would have the other eye done also. To his surprise, his eyesight in the one eye that had surgery had improved a lot. He needed no further persuasion to have the other eye done.

Some discomfort is considered as a normal part of life. For example, People with mild headaches, coughs, stomach-aches or the common colds reflect this attitude when asked about their health. Some of the responses are as follows: Handisiri kurwara asi musoro wangu or mudumbu mangu ndimo murikurwadza chete (I am not sick, but I have a headache or stomach-ache only). Such responses are not different from the way some Americans with the same kind of discomfort would respond. However, when such discomforts or illnesses fail to respond to medication or persist over a long time, they cease to be normal because normal illnesses are expected to respond to treatment. The persistence of an illness is considered to be abnormal, and must therefore have other explanations. Once an illness is considered to be abnormal, the choice of treatment changes, usually from biomedicine to traditional medicine. The traditional medical practitioners are believed to be better at dealing with abnormal illnesses than biomedical doctors.

Let us for a moment look at Tapfuma who was a parishoner in one of the Anglican parishes I served in Harare. He was barely 40 years old when he was promoted to a managerial position in one of the large departmental stores in Harare. He fell ill and was admitted at Harare Central Hospital suffering from kidney pains. His illness was at first regarded as normal by his family and friends. He stayed in Hospital for about two weeks before he was discharged because he was feeling better. A week after being discharged from hospital, Tapfuma went back to work. However, a few days later, he started to complain of the same pains he had had before. In addition, he complained of both stomach and back pains. This time his family suggested that they visit a traditional healer first before going to the hospital. The traditional healer they visited lived outside of Harare. They were told that Tapfuma had been bewitched by one of the workers who was vying for the position he got. The traditional practitioner told them that Tapfuma had stepped on some medicine placed by the worker in question at the gate leading into Tapfuma's place of work. Tapfuma was given two types of medicine, one for rubbing on his body daily and the other for putting in his tea at

breakfast. He was well enough to return to work after two weeks. He did not have to go to the hospital.

What can be observed in this story is that when Tapfuma's kidney pains recurred and persisted, the family's belief in the natural causation of Tapfuma's illness changed and so did their choice of the medical practitioner. They believed that Tapfuma's illness was no longer natural or normal because of its recurrence especially only a few days after going back to work. The timing of the recurrence of the illness for them was not coincidental. Their suspicion was confirmed by the traditional healer they visited.

2.1.1 Treatment

Most of these illnesses cited in this section are considered natural because they are not believed to be caused by spirits or human agents with supernatural powers to cause harm. Illnesses that are considered natural are in many cases responded to in a matter-of-fact way. Herbal or other concoctions are administered as appropriate e.g., orally, as ointment or through incisions on the skin. In some cases over the counter drugs are used or help is sought at the nearest health care clinic for basic medical treatment.

Serious illnesses that are also considered normal are referred to biomedical doctors.

The patient is always accompanied by a relative when they go to see a doctor. The person who accompanies the patient is expected to know the doctor's diagnosis and instructions to the patient. However, many doctors trained in the western model do not permit relatives into the consulting room because they want to maintain confidentiality. The relative expects the doctor to inform them about their diagnosis and whatever instructions they may have given to the patient. If the doctor does not provide this information, the relative will then ask the patient to explain what the doctor did and said. Upon their return home, it is the person who accompanied the sick person who is asked what the doctor's diagnosis was and whether there were any instructions given. The relative will explain everything from the time they left home until they returned. After that the person will then ask the patient to fill in any gaps and correct any misinformation. This is just one example of the intrinsically social nature of treatment in Shona society; the last section of this chapter looks at that in more detail.

2:2 Supernatural Causes

The "why" level of accounting for health and illness looks at the circumstances within which an illness occurs as Tapfuma's story cited earlier shows. Many of those circumstances make it possible to go beyond the "how" level. At the "why" level attempts are usually made to impute responsibility for the illness to either an interpersonal or spiritual factor both of which are supernatural causes. Illnesses that are believed to be supernaturally caused are those that are perceived as being caused by avenging spirits (ngozi), ancestors or through witchcraft.

Most of the supernaturally caused illnesses are essentially social disruptions of relationships in a family, community or society. Harmonious relationships play an important role in the health of the African people. Just as illnesses that are believed to be supernaturally caused are essentially social disruptions, therapy of such illnesses is also essentially social. The traditional healers deal with such diseases primarily by righting the patients' situations, their relationships with people whom they are most intimately concerned.

2.2.1 Witchcraft (huroyi)

The Shona people believe that witchcraft is a supernatural ability to cause harm to others that is possessed by some people. The activities of the witches (varoyi) are believed to be beyond human powers. It is believed that they are capable of manipulating the forces of nature in order to mysteriously cause illness. Some of the illnesses perceived as being caused by witches often start as normal illnesses. In such cases, biomedical help is sought first. When the illness persists and fails to respond to treatment, it is then considered abnormal and witchcraft is suspected. Some friends and relatives will even advise the sick person that their illness is an "African illness" (hosha yechivanhu). As such, biomedicine is believed to be ineffective. Only the traditional healers are believed to have the capability of dealing with an "African illness" caused by witches. They believe that it is only after the traditional healers have neutralized the harmful medicines of the witches that biomedicine can be effective. The following cases serve to illustrate this belief. In one of his research cases Dr. Chavhunduka tells us that:

Cecilia was married to a businessman who owned buses which ran between Salisbury [Harare] and the Tribal Trust Lands [Communal Lands]. In addition he owned a shop in Highfield [a high density residential area in Harare].

Cecilia complained of chibereko (lower abdominal discomfort as a result of pain in the uterus) She said, 'This disease is very common among women. It is caused by dirt from men.' She visited a private doctor in Salisbury [Harare]. She was given some medicine to take for one week and she appeared to be better after the treatment.

After about three weeks she was attacked by the same illness and this time she visited a traditional practitioner with a member of her family. She told me that, 'Chibereko is an African disease and that is why the private doctor failed to cure it.' She was given some medicine which she continued to take. Her condition improved²⁸.

Here is another case coming out of my work as rector of an Anglican Church parish in Harare. Chipso was a single parent who was employed as a domestic worker by a well to do family. Although her income was very small, she somehow managed to look after her three children relatively well. All the children were in school. She always paid her children's school fees on time. She woke up one morning complaining of severe abdominal pains, headache and general body weakness. She called her brother and uncle who lived in Harare to notify them of her illness and that she was going to hospital. The brother and uncle made arrangements for

other family members to meet her at the hospital. Her employers dropped her at the outpatient clinic at Parirenyatwa Hospital in Harare on their way to work. Chipso was hospitalized. During her first three days in hospital, she was under close observation while various kinds of tests were being conducted. Word spread around Chipso's relatives and friends that she was in hospital. Her parents came from their rural home to see her. Many came with gifts to give her.

At the end of her third day in hospital, the doctors informed Chipso that they needed her permission to do surgery in order to correct what was causing her pain. Chipso refused to sign the authorization papers because she had not discussed the prospects of surgery with her family. She told the doctors that she could go into surgery only with the express permission of her members of the family.

She told her family during the visiting hours of the following day. They advised her not to go ahead with the surgery until they had consulted a "prophet" about the causes of her illness and whether the surgery will be successful. Representatives of her family consulted a "prophet" that evening. They were told that foul play was

involved. She had been bewitched by a jealous relative because she had a secure job and looked after her children well. The "prophet" also told them that she would have died had she gone ahead with the surgery. They were given "holy water" to take to Chipu. She was to drink some of it and pour some into her bath and bathe. Then, she could go ahead with surgery. The "prophet's" instructions were followed. Chipu's surgery was successful. She was back at work within four weeks.

In both cases we see not only more than one form of medical practice being used both simultaneously and at different stages of the illness, but, the involvement of the family in the treatment of the patient also.

2.2.2 Ancestors (Midzimu)

We saw in the previous chapter that ancestors are considered to be part and parcel members of the African community. One of their roles in the community is that of guardianship. They are believed to be the protectors of their progeny. In order for them to fulfill this role, the Shona people believe that a special ceremony known as kurova guva (to carry out final funeral ritual) has to be

performed (usually a year after burial). Through this ceremony then, the spirit of the dead person is invited back home and enabled to join the community of ancestors and assume the protective role of the offspring. If the kurova guva ceremony is not done, it is believed that ancestors can cause illness among the offspring as a way of drawing their attention to the omission. Pastorally, this has remained a hot issue among both christians and non-christians. It seems to touch at the heart of the Shona culture. The importance of this ceremony was emphasized by many of Chavhunduka's informants, one of whom stated:

I believe in ritual ceremonies such as kurova guva in a very big way because if such things are not done there will be trouble at home because children can be sick and if you go to ask the traditional practitioner about the misfortune you will be told that you must perform the kurova guva ceremony for your dead father or uncle.²⁹

I remember a parishoner in Harare by the name of Charles. He was the eldest child in his family. Charles was a leading member of my church. When his father was seriously ill, he refused to join his uncles and aunts in consulting the traditional healers about his father's illness. He asked them not to inform him whatever the traditional healers told

them about his father's illness. The reason he gave for not consulting traditional healers was that he was a christian (christian teaching forbids the consultation of traditional healers who are diviners). Charles' father eventually died. A year after his burial, his uncles reminded Charles to perform the kurova guva ceremony for his father. He vehemently refused. There was nothing they could do because the ceremony requires the authorization and the participation of the eldest child. Three years after his fathers death, Charles' son fell ill. He tried many biomedical physicians but for some reason his illness persisted. His uncles and aunts advised Charles that he should consult the traditional healers if he loved his son. Although he resisted for a while, he eventually succumbed and went secretly (so that church members would not see) with his uncles to consult a traditional healer. They were told that the reason the hospitals failed to cure his son was that his son's illness was caused by his dead father who wanted Charles to perform the kurova guva ceremony. The traditional healer reminded Charles' uncles and aunts what they already knew about preparing for the ceremony and how to conduct the ritual. With the help of his uncles and other

relatives in the village, the ceremony was performed. Charles told me that he was very skeptical about the efficacy of this ceremony. He went through it in order to please his uncles and also that in the event of his son's death, his relatives might not accuse him of neglecting his son by not consulting the traditional healers. He then said, "You know what, Father Gandiya (addressing me)? From that time on my son started to respond to medication and he is fully recovered now. I know that what I did was wrong. However, I don't know what to make of my son's recovery."

What can be observed from this story is that the illness of Charles' son and the kurova guva ceremony were not matters between Charles, his son and his dead father alone. The extended family was involved in every way, for example, in giving advice to Charles, the search for a cure for his son and in the preparation and performance of the kurova guva ceremony. Just as the Shona marriage procedures requires the full participation of the whole family, so do the kurova guva ceremony. The participation of the extended family is vital. They help with the preparations for the ceremony and they have special functions that only they and

no one else can play in the ritual. The very nature of the ritual makes it impossible for one person to do it alone.

Ancestors are also believed to cause illness if taboos are violated and if the family fails to honor them. They do this by removing their protection from the family or an individual. This, then means that the family/individual is open to the attack by enemies (witches) and evil spirits.

2.2.3 Aggrieved spirits (Ngozi)

Aggrieved spirits are the spirits of the dead to whom an injustice such as being murdered, abuse such as a grown up hitting their parent etc. was done when they were still alive. The Shona people believe that the spirit of the aggrieved person will come back demanding justice. This is usually in the form of a number of unexplained illnesses and deaths in the extended family and not just the immediate family of the person who committed the injustice. The illnesses and deaths, it is believed, will stop when the extended family admit their guilt and make the appropriate restitution to the designated surviving offspring or relative of the murdered victim. Human life is considered to be very sacred by the Shona people. No individual person has

any right to take it away from anyone. An avenging spirit of a murdered person is greatly feared by the Shona people because they believe that it can attack any member of the murderer's extended family.

Thus, the protection and preservation of the extended family becomes the pressing concern for the whole extended family and not just the immediate family of perpetrator. They also believe that it can take a long time to recognize the cause of the illnesses and deaths. At times this is due to the fact that the culprit(s) themselves may be dead. Only traditional healers and "prophets" are believed to have the ability to divine and recognize such spirits as the cause of illnesses and deaths. They tell the relatives and the patient what must be done to propitiate the offended spirit, or to make right broken relationship or to overcome the evil powers of the witch and sorcerer.

2.3 Treatment

According to Shona beliefs, illnesses are multicausal. As such, they require a multidimensional approach for treatment - one that touches not just the individual patient but spills over to the whole family, community and even the

departed. One of the reasons why Shona traditional healers are consulted a lot in Zimbabwe is because of their multidimensional approach to healing the patient. This characteristic is reflected in the traditional healers themselves. The traditional healer combines the functions of a priest, psychiatrist, herbalist, diviner, counsellor etc. As priests, together with the spirit mediums, they interpret the metaphysical wonders that God provides; they analyze the relationship between the deity and the people; they advise people how to pray to the creator in times of misery such as droughts or plagues or happiness like harvest festivals. Their work as psychiatrists involves seeking the root cause of a problem or illness before dispensing herbal medicine or referring the patient to a hospital.

Take for instance, the following case:

Chido and Jane were best friends. They lived in same communal area but not in the same village. Their villages were separated by a river. They went to the same school and their villages shopped at the one shopping center that served five villages. Chipo and John were dating. They were beginning to make plans for marriage. Jane was well aware of their plans. However, Jane was seduced by John and had sexual intercourse with him and became pregnant. She felt very guilty about what she had done. Although she wanted to open up to her friend, she found it very difficult to do it. She stopped seeing her friend. When Chipo made the efforts to find out what was wrong with her she

always found an excuse. Although she managed to hide her pregnancy from the public by tying her stomach and wearing oversized dresses, she became very depressed and started to have other somatic symptoms. Her relatives took her to a hospital where dementia was diagnosed and was treated for it. But her health did not improve. The relatives took her to a traditional healer who through divination told them of the broken relationship between the two friends and how this came about. The girl concurred that it happened. The traditional healer prescribed some herbs for the somatic symptoms and then advised them on how to go about righting the broken relationship. The relatives made sure that the procedures were followed and in no time she was healed. Although their relationship was restored, it was never the same again.

In the case cited above, the traditional healer is seen combining the roles of herbalist, doctor, counsellor and psychiatrist.

The Shona people recognize the importance of harmonious relationships for their health, hence most of their explanations about causes of disease are based on human relations. Peaceful living with neighbors, abstention from breaking taboo as well as obeying the laws of gods and men, are essential for the protection of oneself and one's family from disease. While modern medicine has triumphed in the great advances it has made for example, for treating human diseases, traditional medicine in Zimbabwe seems to have transcended the limits of modern medicine approach by taking

into account the powerful influences and interplay of individuals with their families, their culture and their environment. All these affect the bodily states of individuals causing the total dis-ease of patients, their families and their society. Traditional medicine recognizes the importance of not viewing the individual's distress as theirs alone; because every illness touches in important ways the lives of everyone around the sick people.

Turner who carried out research in Zambia noted that:

"The sickness of the patient is mainly a sign that "something is rotten" in the corporate body. The patient will not get better until all tension and aggression in the group's inter-relationships have been brought to light and exposed to ritual treatment... The raw energies of conflict are thus domesticated in the service of the traditional social order."³⁰

In such cases, the approach of the healer is to provide "social therapy". The healer deals with disease essentially by dispensing herbal medicine to the patient and sometimes to other family members, righting the patients' situations and their relationships with other people.

It is important for us to note the role of the family and community in the treatment of their sick. In Zimbabwe, a traditional healer is often consulted by the family or relatives of the sick person with or without the patient.

The healers are not given the history of the illness or symptoms because they are expected with their "second sight" to see beyond what ordinary people perceive, and know who is ill, what has caused the illness and how it should be treated. However, some are known to elicit the information from their clients and their relatives. The relatives are involved throughout the healing process. They make important decisions about the treatment of patients and what medical system to use at a particular stage of the illness. The healer at times may suggest that the patients consult a diviner or a biomedical doctor before he/she can treat the patients or after they have treated the patients. In other cases the healer may recommend that the patients be removed from their existing social environment or conditions while under the healer's treatment. By recommending the removal of the patient from their home surroundings to that of a relative of the patients' or families' choice or even to the healer's home, the healer may well be relieving the patient of the effects of a tension laden atmosphere.

Since beliefs about witchcraft among the Shona people reflect broken relationships in the community or family, righting those relationships become crucial to the healing

process. Comaroff noted that among Southern African societies, illness was "perceived as an expression of social conflict or cosmic disorder, revealed in disruptions in the normal relations of men, spirit and nature."³¹ It becomes imperative that the family, clan and community participates in order for the patient to gain total health. Traditional healing has room for the kin group, family, clan or community to participate in diagnosis and treatment. The healer, patient and the patient's family make unanimous decisions for the healing of the patient. They are all involved at every stage of the healing process. The family and community become a healing family or community through their participation in the healing of the patient. This can be in the form of preparation for both family and community healing rituals that can include brewing traditional beer, providing food that is eaten on the occasion, dancing, etc.

In comparison, biomedicine tends to isolate patients from their natural surroundings, companions, family and neighbors in the alien world of the hospital. In Shona society entering hospital means separation from a comparatively large group of kinsfolk and friends and may thus be a traumatic experience for the patient. Family

members feel frustrated when they are kept out of the consultation room so that the patient can be seen in private. They are even more frustrated when a diagnosis is not revealed to them. Traditional healers are very much aware of this and they take the community context of their patients. Sister Patricia Swift, a senior lecturer at the School of Social Work in Harare, Zimbabwe, notes that biomedicine in Zimbabwe "treats an illness as a matter to be dealt with exclusively by the patient and their doctor, but it is very much the concern and even the responsibility of the whole family."³² Although it may be necessary to isolate patients in order to provide efficient management of patient care, it none-the-less fails to acknowledge the important role of the kin group. The participation of the family and society is generally limited to paying the enormous bills incurred during treatment. The care of the family and community is ignored and yet they too are threatened by the illness of one their members. This approach to patient care overlooks a fundamental Shona belief regarding the way they deal with stress and socio-physical ailments. For the Shona people, problems are considered to be the affair of the whole family (including the departed members in the spirit

world) and not just the affair of an individual. Thus, as Sister Patricia Swift says:

"no person need feel alone and there is recognition that a problem experienced by one member of the family system may be an expression of a wider problem within the whole system and the whole family will take responsibility for dealing with it. In many western families it is hard for them to recognize that problems of one individual can be symptomatic of a general malaise within the family system."³³

2.5 Summary

We have noted several things in this chapter. First, we saw that Shona traditional cultural assumptions about causes of illnesses and their treatment have a strong social emphasis than those of biomedicine. Shona people include witches and spirits among the social agencies of disease. According to Chavhunduka (1978), these witches and spirits have something to do with the patient's internal psychic or moral state and the patient's external relations with other people. Causation and treatment of illnesses are therefore, regarded holistically. The Shona people believe that illnesses are multicausal and therefore a multidimensional approach to healing is required in order to restore the patient to good health. This is one reason why different medical systems are used in the healing process.

Second, we also noted that Shona concepts of health, illness and treatment have a community focus. The patient is never left alone to cope with an illness. This is why even adults are usually accompanied by family members or friends when they seek therapy. Illness among the Shona people then, is family or communal rather than an individual affair. The family play a major active role in the health seeking process.

Third, we saw that harmonious relationships are more or less a pre-requisite to good health among the Shona. The healing process in traditional medicine involves the mending of the broken relationships in addition to giving herbal medication and or referring patients for biomedical help. Given all the things we have noted in this chapter, the next chapter will discuss the kind of confidentiality that should be practised in such a context.

Chapter 3

Confidentiality

The first two chapters showed that the Shona people have a socio-centric understanding of personhood, disease and treatment that focuses on the family or community. This is different from the North American understanding which is "ego-centric" (Shweder and Bourne, 1982). Such an understanding tends to fragment a person and focuses primarily on the individual. Given these different understandings between the American and Shona people, this chapter examines whether the type of ethical principle of confidentiality used in the American context is applicable in the African context. In Zimbabwe, biomedical doctors in general practice individual confidentiality but traditional healers and the Shona people practice family confidentiality. In traditional Shona culture family members are very much dependent on each other both in health and in sickness. Their lives are closely intertwined as is amply demonstrated in the stories I walked you through in the first two chapters regarding their conception of personhood, disease and treatment. We saw in the previous chapters that issues relating to marriage, health, community affairs etc.

involve the participation of the whole family. Chindingoveni (individualism) is highly deplored. Hence, the Shona have many maxims that strongly discourage individualism. For example, they say; Zano ndega akazooneka nembonje pahuma (A person who does things alone without consulting others gets hurt) or Rume rimwe harikombi churu (literally translates - one man does not circle a hill). This maxim means that a person will always need the help of others. Individual confidentiality is an affront to Shona culture because it places too much emphasis on the individual and not the community. It tends to separate the individual from the community. For that reason it is given lip service only by many Shona patients. The conclusion that I reach in this chapter is that individual confidentiality which in most cases is only given lip service should give way to family confidentiality which the Shona people have always lived by.

3.1 Individual Confidentiality

When I analyze the way confidentiality has been defined by western writers I find that more emphasis is put on the secrecy of knowledge or information about a patient or client that a physician acquires during the normal process

of interacting with patients. For example, Edwards defines confidentiality as:

A socially publicizable and enforceable pledge to keep a secret or hold in confidence information about the client which is gained by the professional during the normal course of client-professional interaction.³⁴

Garret too, in describing confidentiality says:

Confidentiality is concerned with keeping secrets. A secret is knowledge which a person has a right and/or obligation to conceal.³⁵

What I interpret from these two quotations is that confidentiality in medicine has to do with keeping or respecting secrets. These secrets have something to do with the knowledge or information that a physician obtains in a therapeutic context. It is only the premise that this information will be used for therapeutic purposes that legitimizes the healer's access to the "secret". This type of confidentiality stressed in western medicine is one that I describe in this thesis as "individual confidentiality". It means that doctors may not reveal what they learn about their patients without their permission, except (1) to other Health Care Professionals (HCPs), when necessary to help the patient and (2) as required by the law. However, when analyzing such definitions of confidentiality, the same type

of questions raised by Patricia Mullan when addressing Ethical issues in rehailitation come to the surface.

Questions like, "who decides what is to be kept secret? Who owns the secret? Who keeps the secret? From whom is the secret to be kept? Who is the person who is known?"³⁶ The answer to each question affects the answer to the others.

3.1.1 Principles Grounding Confidentiality in Medicine

The moral principles grounding confidentiality in medicine can be divided into three broad categories. There are those that are utilitarian in nature concerned about "the welfare of the society as a whole as opposed to the welfare of the individual" (Fleck Module 8A). Fleck goes on to say that "the welfare of society as a whole would severely be compromised if there were not a strong commitment to respect or patient confidentiality among health care professionals."³⁷ Without a commitment to confidentiality, it could be argued, some diseases like sexually transmitted diseases would probably go untreated and would likely spread to others there by endangering the whole society. Therefore, confidentiality protects society.

The flip side of the concern for the welfare of society is the concern for the welfare of the individual. Physicians expect confidentiality in medical practice. One of the arguments they use to support confidentiality in medicine is based on beneficence. They say that the moral principles of grounding confidentiality in medicine produce greater good for the patients. The general expectation of confidentiality in medicine is believed to encourage the patients to be open with their physicians thereby enabling the physicians to effectively help them (Beauchamp and Childress, 1994; Edwards, 1988; Fleck, Module 8A; Kottow, 1986; Siegler, 1994 etc.). Confidentiality, it can be argued, removes the fear patients might have about disclosing possible embarrassing conditions they may have. For example, a patient with a sexually transmitted disease (STD) who would be afraid of that condition becoming public knowledge might more freely seek help if the patient knew that information about this condition will be kept confidential. In such a case, it is the patient who benefits from confidentiality in medicine. Society benefits too, when the patients' being healthy benefits others, for example, controlling the spread of STDs, persuading pregnant women not to use drugs, alcohol

etc. or at least not to be afraid to seek medical help and be candid with the doctor.

Following on from the beneficence argument, physicians see the moral obligation to preserve confidentiality as a duty of fidelity. Both health care professionals and lay people see the observance of confidentiality as part and parcel of what it means to be a good doctor. Good doctors are committed to the welfare of their patients. They are faithful and loyal to their patients. Hence, according to Fleck, "respect for confidentiality is a part of the larger physician's obligation of loyalty to the patient" (Fleck, Confidentiality Module 8A p. 7.). Physicians are believed to owe this loyalty to their patients. Patients are usually in a vulnerable position and they can easily be taken advantage of. Upholding the principle of confidentiality involves a commitment on the part of the health care professional to protecting patient rights so that the patient is respected and not abused or exploited.

Confidentiality can be described as being based on the principle that every individual has a right to be self-determining. This is not a right for individuals to do whatever they want. Rather, it is a right that distinguishes

persons as special beings who have the ability to choose principles they live by as well as choosing their relationships with others. When this right is respected, the patients are enabled to make their own personal decisions that affect their own lives. Confidentiality in this case gives patients a sense of control "over private or personal information about themselves" (Edwards, 1988) or of their life. It also gives them control over who knows their information because what is known about them can harm them, give them stress or can change the nature of an act or relationship (Andre, 1986). Patients want control about the way people perceive them and about the degree of intimacy and vulnerability. Some HIV+ (Human Immuno-deficiency Virus positive) people or AIDS patients find that their right to self-determination and independence becomes threatened once their HIV status becomes public knowledge. Since most cases of AIDS in the western world are the result of self-exposure by sexual practices and the use of IV (Intravenous) drugs, HIV+/AIDS patients find themselves ostracized, discriminated against, blamed for both their condition and for posing a serious threat to others in society. As a result, some lose their jobs and others lose their insurance

coverage etc. It can, therefore, be argued that confidentiality protects the individual's right to independence and self-determination. It gives the patients a sphere of privacy which as Judith Andre states is a "form of ease like peace and quiet" (Andre, 1986 p. 311). For patients who have their health to worry about, it means that there is one less thing to be concerned about. Patients like any other person may find that privacy, at times, provides them with a sphere "to think and act independently" (Andre, 1986) without pressure, coercion or fear. This sphere of privacy then, can strengthen and protect those rights that are violated when confidentiality is breached.

The confidentiality bolstered by these principles is an ideal that has been upheld by the Hippocratic Oath and the various Medical Ethics Codes like the American Medical Association (AMA) and the Canadian Medical Association (CMA). This ideal is adhered to even more strongly by those medical associations that regard confidentiality as an absolute principle like the World Medical Association (WMA) and the International Code of Medical Ethics (ICME) (Beauchamp & Childress 1994). Confidentiality is also an

ideal that has been passed on from one generation of medical students to another through their training programs.

However, many ethicists and health care professionals see it as a *prima facie* duty only. When confidentiality is taken as a *prima facie* duty it means that although it is binding, it can, nevertheless, in special circumstances, be overridden by competing and stronger duties or obligations (Fleck, Module 8A, Edwards, 1988, etc.) as we will see in the next paragraphs.

3.1.2 Moral Considerations for Breaching Confidentiality

Although confidentiality has been regarded as an indispensable moral principle in western medicine by both physicians and lay people, there have been occasions when it has been considered morally right to breach it. For example, on utilitarian grounds, confidentiality can be treated as a *prima facie* duty because there are times when preventing harm by breaching confidentiality produces the greatest happiness. On the grounds of autonomy, it could be argued that it is not a right to do whatever you want. Other peoples' rights to autonomy are affected by our actions and there are occasions when confidentiality has to be breached

in order to respect other persons as persons. This is usually done when other contending duties are considered to outweigh the moral duty of confidentiality (Beauchamp & Childress, 1994; Edwards, 1988; Fleck, Module 8A; Gillet, 1987 etc.). These considerations for breaching confidentiality are generally agreed on by ethicists and many health care professionals are threefold.

First, when health care professionals have the express permission of their patients they can morally reveal material otherwise held secret. However, for the patients to be able to give their consent they need to be well informed about the implications of disclosure. For example, when AIDS was first discovered some patients could easily give their consent without realizing the full implication of their consent simply because they did not quite understand the disease. Questions are often raised therefore, even when patients give their express permission, as to how informed their "informed consent" is.

Second, when the rights of a third party are threatened or are at stake, then confidentiality can be breached in order to protect that person. A good example of this is the Tarasoff vs. Regents of the University of California case³⁸.

In this example, a woman was murdered by her boyfriend who was an outpatient at the University of California at Berkley, hospital. The boyfriend told his psychiatrist about his intentions to kill the woman. Although the doctor informed the police, he failed to warn either the woman or her family. Justice Tobriner argued that the doctor-patient relationship in this case imposed a duty to warn the woman. Thus, according to Justice Tobriner, the duty to protect was a stronger and a higher competing duty that should have overridden that of confidentiality.

A third consideration has to do with a physician's legal obligations. The law may require the physicians to report epileptic seizures to the division of motor vehicles so as to protect both the patient and society. Other breaches of confidentiality required by the law include child abuse and STDs etc. When the rights and interests of identifiable individuals and society are at stake, then, the duty of confidentiality is outweighed by that of protection and non-maleficence. However, as with the obligation of confidentiality, which for many physicians is *prima facie*, the legal requirements are regarded by some physicians in the same manner. In cases where the physicians think that

obedience to law jeopardizes the interests of their patients resulting in medical neglect, discrimination, loss of jobs or insurance etc. for morally unjustifiable reasons, they may feel justified in breaking the law.

On the whole, both the principles for maintaining medical confidentiality and for breaching it are largely concerned about the interests and rights of the individual person and collections of individuals. The interests of the family as a unit do not feature at all in the principles even in third party considerations for breaching confidentiality. Take for instance, tuberculosis patients who are put into quarantine not because we do not want them to hurt their family members as such, but simply to protect all other individuals. What is missed here is the recognition that any harm done to any member of the family unit is harm to the others.

I think that one reason for this lack of family focus is that adult children in America and in most western societies in general are ordinarily pretty separate from their families. Both a cause and an effect of living separately is that there is no focus on the family. Since do not live together, they do not depend on one another for the

necessities of daily life and they do not need one another's permission to do anything. The individual stands alone. This is a complete opposite of what you would find in Shona culture. We have already seen in the illustrations given in the first chapter that the family (both immediate and extended) is involved and in many cases their permission is sought as in the choice of a marriage partner. The western and in particular the American emphasis on the individual in both the principles grounding confidentiality in medicine and the moral considerations for breaching them shows that "individual" confidentiality is the best way to respect people and do good for them in societies that are individualistic in outlook like the American society.

3.1.3 Individual Confidentiality and the Physician's

Knowledge:

In the doctor-patient relationship someone has the obligation to keep confidentiality. According to the definitions stated above, that obligation rests with the physician. Physicians know things about patients that others do not. This knowledge comes from several sources. First, physicians' special training enables them to know things

about patients that others are not privileged to know. For example, physicians might be able to see at a glance that someone has a certain skin disease or illness. They may also touch and make a diagnosis based on what they feel and see e.g., tonsillitis, appendicitis, jaundice, nephritic syndrome (renal failure) etc. In other cases, special technologies are used by specialists like radiographers who can scan the head or x-ray the body. The physician can look at the x-ray pictures and interpret what is going on in a person's head or body e.g., cancer, slip disc, tuberculosis etc. It requires special training to be able to interpret what the pictures show and physicians as well as other health care professionals have that special training.

Second, in western culture patients themselves tell physicians things they at times do not ordinarily tell other people. Sometimes they do this because the information is necessary in order for the physicians to help them. One good example can be that of the sexual history of a patient in the diagnosis and treatment of STDs. Having that kind of background knowledge can help physicians make diagnoses and makes it possible for them to give patients useful advice. In Africa, in the case of malaria fever which often starts

like other fevers, physicians would be able to make quick diagnosis if they knew something about where the patient lives and what places they have visited and whether they have had malaria before. This information will enable them to determine whether they live or have been to mosquito infested areas or not. This knowledge can enable them to conduct appropriate tests and start malaria treatment before it is too late.

Third, there are times when physicians "stumble" across the knowledge. This occurs at times when information simply slips out in the course of a conversation or examination e.g., the presence of a tatoo or scarification marks on a patient's body or one's religious beliefs etc. For example, in Zimbabwe, if a patient has scarification marks on certain parts of their body like ankles, waist, chest etc., a doctor can assume that the patient has either been to a traditional healer or to someone who has knowledge about traditional medicine. Some patients might mention difficulties at work in the course of explaining the stress they are under. Although strictly speaking, the doctor only needs to know you are under stress, not how obnoxious you find your boss or workmate, that information can help a doctor judge how

the patient is taking stress or how much pressure the person is under.

All this knowledge gives power to the health care professional. It gives them control over the patient in a therapeutic relationship as critical medical anthropology tells us (Lock 1988, Comaroff 1993, Watzikin 1991 etc.). Ideally, it should be used for the patient's good but unfortunately, it is also abused on numerous occasions. Some health care professionals use the knowledge they gain in a therapeutic relationship to gossip with other health care professionals about the patients, their relatives and friends who visit them.

By virtue of their training, physicians become experts on patients' illnesses. They possess special medical knowledge which is largely technical. They are the ones who know what to ask, what to cut out from a patient's story, what form treatment should take and even what is best for the patient. The physician is, then, the knower and the patient is the known. This enables the physician to have access to patient information that no one else has. It is this patient information that is kept secret by the

physician. The ability , therefore, to act on that information becomes the physician's privilege.

3.1.4 Individual Confidentiality and Personhood

In the North American context, the people who are not told this "secret" are family members, relatives and anyone else who cannot use that information for therapeutic purposes of that particular patient. Even some people who could use the information therapeutically have no right to it. A doctor cannot arbitrarily pass on a patient's records to their new doctor without the patient's permission. However, most doctors do it regularly in certain circumstances within a health care institution anyway. The casualness in medicine violates some of the principles they claim to live by. My doctor at Olin Health Center passed on my medical health file to a medical student working with him to gain experience without my permission. I happened to know the student from one of the local churches I have served. I would have been really embarrassed and worried if that file contained information that I did not want anyone else not related to me other than my doctor to know about.

Some patients with terminal illnesses are not told about the terminal nature of their illness. For example, Kathryn Taylor tells us that some cancer physicians do not tell their patients about cancer diagnosis because they deem it not to be in the patient's best interest (Taylor 1988).

But the number of people in the therapeutic circle who can claim to have legitimate access to that medical information can be staggering. Take for example, Seigler, who, when his patient requested a guarantee that the confidentiality of his hospital record be respected decided to make a survey to see if he could give such a guarantee. He told the patient that he could not because he estimated that there were at least seventy-five health professionals and hospital personnel who had access to his patient's medical record (Seigler, 1982).

The list of people who are not told the secret supports the premise in western medicine that defines persons as individuals practically separate from families. For example, adult siblings in America are generally pretty separate from and independent of their immediate families and even more extended families. Unlike many African societies where people still live together or maintain property in their

villages, relations still look up to you for help with some of the necessities of life and still need one another's permission, blessing and help to do some thing, the American society does not. They do not live together, neither do they depend on one another for the necessities of daily life nor need one another's permission to do anything. Dr. Brody's story about "Confidentiality and Family Members"³⁹ highlights this point. In this article Dr. Brody draws our attention to the mistake that he made when dealing with one of his patients. He tells us in the story that his patient was "a 67-year old retired single school teacher hospitalized for radiotherapy to palliate metastatic breast disease."⁴⁰ Dr. Brody felt that he could share this information with the patient's only living relative who was her sister. The patient was very upset when she discovered through her sister that the doctor had told her about her condition. She considered herself separate from her sister. She thought that she was the one to decide who should and should not be told about her health condition. Dr. Brody then concluded that, as far as this patient was concerned, he had breached confidentiality by disclosing information about her to her sister without her consent. His analysis

makes clear to the reader that he interprets his well-intentioned action of disclosure to the patient's sister as a mistake. He should not have done it. The patient in this story considered herself to be independent of her only known surviving family member. The connectedness that Dr. Brody might have assumed to exist between his patient and her sister was not there. It was not her sister's business to know about her health condition. Confidentiality in this context serves the individual. Had Dr. Brody done this in the Shona setting, it would have been acceptable. The question I am raising is, what happens to our understanding of confidentiality in a context like that of the Shona people where persons are viewed as connected to their families? Who is confidentiality supposed to serve in such a context? The assumptions that apply in the western context may not be appropriate in the African context.

Individual confidentiality in biomedicine, therefore, has to do with: (a) the health care professional's knowledge gained in a therapeutic context, (b) secrets known to the health care professional and patient alone or the HCP alone about a patient. Underlying all this is a particular perception of personhood - one that Deborah Gordon defines

as "ego centric", an independent and self-determining individual (Gordon 1988).

3.2 Family Confidentiality

Health care professionals in Africa also care about the health care of persons just as their counter parts in North America do. They care about respect for persons but their situation is different. The understanding of persons in their situation does not simply mean being concerned about the individual, their ability to choose or to be self-determining, but also what happens to the family. They too are faithful and loyal but their patients are vulnerable in a different way. For example, in Zimbabwe, an isolated Shona is in a lot more trouble than an isolated North American.

We have seen that Africans and North Americans differ significantly in their conceptions of personhood, disease and treatment. The Africans emphasize the social nature of personhood, disease and treatment more than their western counterparts. As Cheryl Sanders (1994) noted, their beliefs are holistic and not dualistic, they are inclusive and not exclusive, they are community oriented and not individualistic - valuing the family and community over the individual, and they are spiritual and not secular -

acknowledging the pervasive power of the spiritual world over the physical world. Such an ethos is very different from the Anglo-American ethos. Again, as Cheryl Sanders (1994) tells us, most literature in the field of biomedical ethics has been written by Anglo-American writers who write from their own perspectives as Anglo-Americans e.g., Tom Beauchamp and James Childress etc. The question that I am raising in this thesis is: given the differences in cultural conceptions of personhood, disease and treatment between the Shona people and the North Americans, how does the moral principle of confidentiality that Anglo-American Bioethicists write about operate in the African context?

I am suggesting in this thesis that given the Shona people's socio-centric understanding of personhood, disease and its treatment, a principle of "family" confidentiality should be considered within the African context. The principle of individual confidentiality focuses on the rights of the individual by expecting doctors not to reveal what they learn about their patients without their permission, except to other health care professionals (HCPs), when necessary to help the patient and (2) as required by the law. The principle of family confidentiality

adds a third exception: (3) to appropriate members of patients' families. The appropriate members of the family can be the patient's parents, older uncle or aunt, brother or sister. In Shona culture, one's uncles and aunts are also one's fathers and mothers. The Shona relational term used when addressing them is either father or mother. They are considered to be one's parents even when one's real parents are still alive. In the absence of a blood brother or sister, one's older cousins stand in for them.

Family confidentiality does not mean loss of confidentiality at all. We can still ask the same questions we asked earlier concerning: who should be told and who should not be told? Who decides what is to be kept secret? etc.

3.2.1 Family confidentiality and Personhood

As with individual confidentiality, family confidentiality also has to do with a particular understanding of personhood. The Shona understanding of personhood is socio-centric as was amply illustrated in the first chapter. Shona people identify themselves in terms of their relation or connectedness to the family or clan and

never as unconnected individuals. We saw in the first chapter the centrality of the Shona community in defining a person. The individual is always seen in relation to, and in communion with other people. Thus the Shona think of persons as connected to their families and clans in the following ways:

(a) *Totems*, the totems which they use show a person's connectedness to the family/clan. They are considered to be more important than first names.

(b) *participation* in family/community affairs, individuals do not live simply for themselves but within communities. As such, participation in the common life of the family/clan or community is essential.

(c) *connection through time*, an African community includes the living, the dead and those yet to be born. Thus ancestors are considered to be integral members of the African community.

(d) *conferment of personhood*, this shows the role of the community in the shaping of a person according to their understanding of personhood.

All these connections in Shona culture emphasize the strong social nature of their understanding of personhood.

It is within such a strong socio-centric understanding of the concept of personhood that I am inviting the ethics community to revisit and re-examine the moral principle of confidentiality. To what extent would the moral principle of individual confidentiality which is emphasized in most western cultures be applicable in the Shona culture? Probably not to a large extent partly because their understanding of personhood is very different. Thus, I am proposing to the ethics community that in such contexts as that of the Shona people a moral principle of family confidentiality should be practiced for the following reasons:

In the first place, given the way Shona people are connected to their families (as already shown), family confidentiality would be the best way to respect the Shona people. This moral principle is social in nature and it would bring families into the circle of those who are given information about a patient's medical condition. It would also be consistent with the Shona people's socio-centric understanding of personhood.

Second, on the grounds of beneficence, family confidentiality in the Zimbabwean setting would benefit the patient through better treatment, patient care and family support. Let me illustrate using the AIDS situation in Zimbabwe as an example of how family confidentiality can both respect and do good for AIDS patients. Zimbabwe has a population of about ten million people. The Zimbabwe government minister of Health, Dr. Timothy Stamps, estimated in mid-1993 that there were about one million Zimbabweans infected with the AIDS virus. The increase in the number of people sick with AIDS has put tremendous strain on the already strained health care system. Health care institutions cannot cope with the demand for hospital beds by those suffering from AIDS. Most hospitals have resorted to discharging AIDS patients from hospitals so as to make more room for patients with diseases other than AIDS. AIDS patients are given any available medicines to alleviate their pain and treat all treatable opportunistic diseases but they are accepted and treated as outpatients. The ethicality of this practice would be a topic for another paper. What I want to draw your attention to is that caring for AIDS patients is very much left to their families.

Individual confidentiality breaks down in such cases and the traditional practice of family confidentiality takes over. AIDS service organizations in Zimbabwe like the AIDS Counselling Trust and Family AIDS Counselling Trust (F.A.C.T.) emphasize family confidentiality in their counselling programs and in the training of home based care givers.

I want to share with you the story of my cousin Nyika who was diagnosed with cancer in 1989. He called together representatives from both sides of his family so that he could tell them his bad news. I represented my father at this family gathering. When we were all gathered, his father started to address us saying;

"Excuse me (pamusoroyi) the Ngweme and the Shumba (these are totem names of the families represented). We are gathered here because Nyika our son has called us. He has something he wants to tell us about his illness and so without further ado, I ask him to speak." Nyika started by thanking us all for having come. Then he gave a brief history of his illness, how it started and what treatment he had received so far. He went on to say, "My fathers and mothers, the disease I have is called cancer and there is no cure for it. I wanted you all to know that no one bewitched me and that we did not do anything to displease our ancestors. There are many people with the same disease as I have and I thought you should all know."

When he had finished speaking, his oldest uncle said, "we heard everything you told us and we thank you for sharing with us the sad news. Zvino toita maonera

pamwe (Now we can attend to this illness together). We are going to discuss the matter and we will inform you of our plan of action. However, we would like to assure you that we, your fathers and mothers will not leave any stone unturned in our search for a cure. Who knows, there might be a healer who can help us."

When I visited Nyika two months later, he told me that the family was doing all they could to find help for him. They had performed the traditional ceremony of offerings (kupira midzimu) in order to appease the ancestors and they had been to a renowned traditional healer who gave them some herbs to use. I asked him why he was allowing them to waste time and money in doing all these things when he knew that all their efforts were "futile". His response was: "I know that there is no cure for my illness. But their efforts are not futile. They make me feel that I belong to them. There is never a moment that I am left alone. My illness has not cut me off from my family and community. This is their way of showing me their love, care and support as well as the lengths to which they are willing to go in order to help me. I don't want to disappoint them, after all, their efforts help me feel good."

Nyika's experiences of family support, love and care were also experienced by many of my AIDS clients and other patients I ministered to in my work as a priest. I invite you the reader to imagine what this kind of support and love would mean to a patient suffering from a disease that has a lot of stigma attached to it like AIDS. The families' involvement in patients' illnessess demonstrates clearly that their illnesses do not cut them off from their families and communities. Patients do not have to bear the burden of

their illnessess alone. Family confidentiality allows the families to love, care and support their patients. In the case of AIDS, it can help families know and understand the disease as well as learn appropriate care of AIDS patients. Surrounded with such kind of love, care and support, patients will not feel any less human because of the nature of their illness.

Third, family confidentiality in the Shona context would enable the patients and their families decide on where to die. African patients who are terminally ill usually ask for this information so that they can leave hospital in order to die at home. Appropriate family members in many cases ask and expect the doctors to tell them the prognosis of their patient so that they can decide with their help when to take the patient from hospital to die in their own home. Most Shona people (especially the elderly) want to die in their own homes surrounded by their loved ones and be buried at the same burial ground as their ancestors. Thus, it could be argued that family confidentiality in such contexts makes both patient and family autonomy possible.

A fourth consideration has to do with finance. Most Shona people want to be buried at the same place as their

ancestors. If one dies away from home it becomes very expensive to transport the remains to one's village. In Zimbabwe the cost of transporting a corpse is a lot higher than the cost of transporting a seriously ill person. Some patients do not want their survivors to incur the heavy financial burdens of transporting their remains home for burial. Others fear that transportation costs may prevent them from being buried at the communal burial ground where their ancestors were buried. The financial consideration is one reason why some terminally ill patients would be eager to leave hospital and die at home. Again, in such cases family confidentiality would be the best way to respect a person and do good for them. For the same reasons, it could be argued on utilitarian grounds that family confidentiality produces the greatest good for both the patients and their families. Since the Shona concept of personhood is strongly focussed on the community, family confidentiality because of its social nature can be the best moral principle grounding confidentiality in medicine in the Shona context that can do the most good for the Shona people.

3.2.2 Family confidentiality and Perceptions of Disease and Treatment

Family confidentiality also has to do with a certain perception of illness. The Shona people view illness and treatment in the same way as they do personhood. Illness for them is a lived experience of the total person, that is, the bio-psycho-social person. It is seen as a social affair because it affects the patient's extended family. A relative's illness is regarded as family's also. This is reflected in the way they talk about that person's illness. They identify themselves with the sick person's illness to the extend of speaking about it in the first person plural e.g., isu tarwara (we are really ill) or tarwara zvekuti tawekutotenda kana taswera (we are so ill that we are thankful when we live through another day). When the patient recovers from an illness or is in the process of recovery a relative or family member when asked about that person's health can respond by saying tawekunzwa zvirinani hedu mazuva ano (we are feeling better these days). This kind of language expresses the social nature of illness among the Shona people.

As we also saw in the previous chapter, treatment involves members of the family. All are affected by the burdens of illness and have a stake in its outcome. Therefore, disease and treatment are not considered as isolated phenomena. Rather, they are considered within the larger framework of human relations. In the physician-patient relationship, the physician is not only dealing with the individual patient, but with the immediate and extended family or community in as far as they are part and parcel of who the patient is. This is one reason why those who accompany sick people to the doctor's surgery feel frustrated when the doctor both keeps them out of the consulting room and does not tell them the diagnosis. As far as they are concerned, the information that a physician might have about a patient should not be a secret between the physician and the patient, but should include them and other members of the patient's family. Family members feel that they should take the responsibility of understanding the illness, diagnosis and not the patient who should not be bothered but concentrate on getting well. Some physicians who know Shona culture reveal patient's medical information to the appropriate family members of the patient who can be

an uncle, elder son or aunt. Although according to the guidelines of their profession such physicians will be regarded as having done something unethical, as far as the patients' families are concerned, the physicians will only have done what they expect a good physician will do in those circumstances. The physicians action enables them to make appropriate plans for the patient's future welfare (as in the case of someone whose legs are going to be amputated) as well as making them better care givers (in cases of AIDS, tuberculosis or for a patient who requires a special diet). At times that information helps the family to make decisions regarding the choice of alternative healers. However, it is not every family member who is told. Among those who are not told are young children, distant relatives and even some close relatives whom the patient and elderly members of the family for whatever reason choose not to tell. In addition, those suspected of causing the illness are also not told. Knowing who caused the illness is important because it is believed that this neutralizes the illness and helps both the patient and family to deal with the illness.

There are also cases whereby some terminally ill patients may not want their families to know that they are

dying. The reason that is usually given is that they want the family members to carry out their daily work without worrying too much about them. In Shona culture, a good doctor in such a situation is one who recognizes what is happening and overrides the patient's wish by revealing the patient's condition to the appropriate members of the family. This enables them to brace themselves for the inevitable and to quietly start making appropriate arrangements without telling the rest of the family what they know about the patient's condition. Those patients who do not want the appropriate family members to know about their condition are generally considered to be selfish and attempting to cut themselves from the family. The doctor's action in such a situation as described above would produce the greatest good by serving not just the best interests of the family members but, in the long run, of the patient also. Thus, on utilitarian grounds, the doctor's action would be exonerated.

3.3 Implications for Practice

Family confidentiality would greatly transform biomedical practice in the African context. Normal practice would certainly differ from that in the west in that according to tradition the patient would usually prefer family confidentiality. The patient expects and wants the family to be involved in their health care. The biomedical practice of excluding family members from the consulting rooms would give way to the practice of inviting family members into the consulting rooms for:

- (a) history taking and some physical examination. Family members can help by providing relevant historical information.
- (b) discussion of what the doctor found and recommends - bearing in mind that in most African cultures an individual person's trouble or illness is not that person's alone, discussion of the doctor's findings and recommendations would help both the patient and the family members.

Family confidentiality would also mean that doctors could speak with the patient's family in the absence of the patient without fearing that they were doing something unethical. One scenario when this could happen is when an

appropriate member visits the patient and finds the patient asleep. Rather than wake the patient, the family member can speak with the doctor about the patient and be given relevant information concerning the patient. Another scenario could be when a patient is refusing medication or food. The doctor can talk to family members without the patient's permission and ask for their help in persuading the patient to take medication and eat.

Second, there are times when family confidentiality would involve going against the patient's wishes. For example, (1) when a dying patient does not want family members to know that they are dying or, (2) when a seriously ill patient does not want family members to know the extent of their illness so as to protect them from worrying too much. The response of the family members to both examples is one of suspicion. They suspect that there must be broken relationships somewhere within the family that have led the sick person to be secretive about the state of their illness. Shona culture believes that dying with unsettled grudges has serious repercussions for the surviving family. They will, therefore, go to great lengths to try to have everything settled before the person dies. This is why

family members expect doctors to tell them the health status of their dying relative. According to them, if a dying family member has grudges against anyone in the family, then, they would want them to know details of their patient's health.

In both situations cited above where the patient might not want members of the family to know, family confidentiality in the African context would require doctors to disclose patient information to the appropriate family members for the same reasons we cited in the previous section such as, (a) what is good for both the patient and family, (b) funeral costs, (c) tradition about burial places, (d) the patient's connectedness to the family and (e) family support and understanding.

Conclusion

The discussion in the first two chapters showed that the Shona have a strong socio-centric understanding of personhood, disease and treatment that is focussed on the community. The third chapter showed that the moral principle of family confidentiality if practised in the Shona context would be consistent with such an understanding and would be beneficial to both the patients and their families. Family confidentiality is not being proposed as a moral principle for all situations in all cultures. For those western cultures such as the American where people consider themselves as separate from their families and not as connected as the Shona people, individual confidentiality should be observed because it is the best way to respect people and do good for them. But for cultures where people are connected in ways discussed in this thesis, family confidentiality should be observed because it would be the best way to respect such people and do good for them. Therefore, the ethics community in the Shona context should give equal if not more consideration to the moral principle of family confidentiality than individual confidentiality

because it is part and parcel of the Shona culture and it respects them as people.

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