African Ethno-ethics and Bioethical Principlism: Implication for the Othered Patient

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Contents

Abstract

This chapter affirms the importance of the ethno in African moral discourse with particular reference to bioethical discourse. It begins by showing that the deductions of moral theories – normative, meta, or applied – from African thought is made possible through a deliberate and careful understanding of the ethno ethics of African peoples often revolving around the concept of relationality or Ubuntu. It instantiates this by showing that the primary contribution of African bioethicists to the predominantly Western notion of Principlism and its four cardinal principles of respect for autonomy, beneficence, non-maleficence, and justice, is the principle of relationality which is extrapolated from African ethno-moral culture. If this is the case, the chapter asserts further that the understanding of who the othered patients are in an African bioethical context and how the principlist principle of relationality may be beneficial or harmful to them is only possible within the context of the ethno of personhood in African cultures. The chapter concludes by highlighting some practical ways health care providers can take the ethno and context more seriously in order to improve the quality of health care delivery to patients.

Keywords
Ethno . African . Bioethics . Relationality . Principlism . Personhood . Othered patients

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Introduction

In recent times, philosophy is practised, and the act of philosophising is engaged in, as if, and because, place matters (cf. Janz 2004). There is an ongoing and increasing interest in comparative and dialogical world philosophies as against, and as a reaction to, the hegemonic and supremacist claim of philosophy by the West. The context and place situatedness of philosophy is necessitated partly by recent recognition and realisation that philosophy in general, or specific concerns in philosophy in particular such as epistemological, moral, ontological, aesthetic, and feminist concerns, cannot be understood and fully appreciated solely from the philosophical lenses of the West but through a deliberate and concerted effort to unveil and appreciate the cultural, racial, geographical, ideological and placial determinants of these concerns. To be sure, even Western philosophy that enjoyed a strong supremacist hold on philosophy for a long time is a product of the deliberate articulation and projection of culture, place and race of the self over the other. Therefore to avoid the poverty of philosophical knowledge, the importance of place and context cannot be overemphasised. As Elvis Imafidon (2019, 25) puts it,

> Philosophieren sehr stark charakterisiert ist durch Differenzen; Differenzen, die von spezifischen Kontexten und Diskursorten herreichen. Das Rohmaterial, oder die Zutaten, mit denen Philosoph/innen ringen, und der Stil, der Ansatz und die Methode, die sie anwenden, um dies zu tun, sind oft bestimmt durch die Orte, an denen sie wohnen, Orte sowohl im geographischen als auch theoretischen Sinn. Die Arbeit eines Philosophen kann in der Regel am besten verstanden und gewürdigt werden, wenn man zu allererst den physischen Ort und die Ereignisse, die an diesem Ort zu seiner Lebenszeit dort geschehen, sowie die vorherrschenden philosophischen Traditionen seiner Zeit, mit denen er im Einklang steht oder von denen er sich abtrennt, versteht. Jeder Versuch, die Arbeit eines Philosophen außerhalb dieses geographischen und theoretischen Kontexts zu verstehen, macht es schwierig, die Arbeit angemessen zu würdigen, und ist möglicherweise auch schwierig zu bewerkstelligen.
> (… philosophising is densely characterised by difference, differences ensuing from specific contexts and spaces of discourse. The raw materials or ingredients as it were that philosophers grapple with and the style, approach and methods that they employ in doing so are often determined by the space in which they dwell, spaces that are both geographical and theoretical. A philosopher's work can often best be understood

> and appreciated by first of all, understanding the physical space and events within that space happening within his time and age as well as the dominant philosophical tradition in his time that he aligns with or breaks from. Any attempt to understand a philosopher's work outside of these geographical and theoretical contexts makes it difficult to appreciate such work and may in fact be difficult to do.).[2]

Emphasising the importance of place in philosophical discourse does not in any way undermine the very essence of philosophy or what makes any discourse from a Western, African, Eastern or other place philosophical, for although "a philosopher's philosophising is one of many forms philosophising determined by the context from which she philosophises from,... her philosophising remains philosophical because it has the very essence of philosophy which [includes]… rigorous criticism and formulation of new concepts" (Imafidon 2019, 19).

Thus, the ethno has found its way into philosophical discourse because researchers in philosophy are more than ever aware of the importance of the place of culture, context and race in understanding the various aspects of philosophical concerns. A case in mind is the ethnophilosophy trend in African philosophy. Although there is a protracted debate in African philosophy on the extent and degree to which the ethno is relevant for African philosophy, its actual relevance is hardly in question (see Imafidon et al. 2019). Therefore, I begin in the first section of this chapter by showing the importance of African ethos and ethno-ethics as wellspring for the theorising of African moral philosophy. In the second section, I show further that the primary contribution of African bioethicists to the predominantly Western notion of Principlism and its four cardinal principles of respect for autonomy, beneficence, non-maleficence, and justice, is the principle of relationality which is extrapolated from African ethno-moral culture. In the third section, I explore the concept of othered patients in an African bioethical context and show how the principlist principle of relationality may be beneficial or harmful to them through an understanding of the cultural

[2] Translation is mine.

concept of personhood in African cultures. The chapter concludes by highlighting some practical ways healthcare providers can take the ethno and context more seriously in order to improve the quality of health care delivery to patients.

The Ethno as the Wellspring of African Moral Theory

Perhaps, it may be best to begin by making clear the sense in which I use African moral philosophy. By African moral philosophy, I mean the attempt by academic (African) philosophers to construct normative moral theories and to analyse moral concepts and terms, through a deliberate reflection on, examination of, and a comprehensive understanding of African moral or ethical culture. It also includes employing and applying the constructed moral theories and the understanding of moral concepts and terms in an African context in the resolution of moral dilemmas and issues as we see, for example, in African bioethics (e.g., Tangwa 2010; Murove 2005; Metz 2010a), African environmental ethics (Behrens 2013; Chemhuru 2013), African business ethics (Taylor 2014) and African land distribution ethics (Masitera 2020). By African moral or ethical culture, I mean what is customarily permissible or impermissible, good or bad, right or wrong, and the reasons provided for such in African traditions. It consists of what has become the characteristic feature, the ethno and ethos of the good in African cultures. African moral culture can thus be described aptly as African ethno-ethics and my goal in this section is to show that it has for long been the wellspring and raw material for African moral philosophy. The distinction I draw between African moral philosophy (or African ethics) and African ethno-ethics (or African moral culture) is aptly captured by Thaddeus Metz (2007, 321) when he writes that:

> In the literature on African ethics, one finds relatively little that consists of normative theorisation with regard to right action, that is, the articulation and justification of a comprehensive, basic norm that is intended to account for what all permissible acts have in common as distinct from impermissible ones… The field lacks a well-defended general principle grounding particular duties that is informed by such values… one more often finds something that is closer to moral anthropology or

> [ethical] cultural studies, i.e., discussion recounting the ethical practices or norms of a certain African people.

Thirteen years after Metz made these claims, one can say with much certainty that there is much more now than a little in the area of African moral philosophy partly because he (Metz) urged many African philosophers through his writings in African moral philosophy (e.g., 2007; 2010b; 2013) to go beyond African ethno-ethics to African moral philosophy and see the former mainly as a resource for the latter.

Hence, in the literature now available in African moral philosophy, it is difficult to see it discussed independent of African moral culture. African ethno-ethics provides a rich resource for theorisation, articulation and conceptualisation in African moral philosophy. Consider, for example, African communitarian ethics, also called Ubuntu, which has been articulated and defended extensively by African philosophers and ethicists as the holy grail of African moral philosophy. Thus, it is perhaps most fitting to describe normative ethics or moral theory in African traditions as communitarian owing to the emphasis that African communities place on togetherness, solidarity, communalistic behaviour and cooperation. The African way of speaking about morality in African communities reflect intensely a co-dependency ethos since its primary focus is communal well-being (Imafidon 2014). John Mbiti's (1969, 108–109) is famous for aptly capturing the codependency ethos in African communities when he says that "only in terms of other people does the individual become conscious of his own being, his own duties, his privileges and responsibilities towards himself and towards other people… The individual can only say: "I am, because we are; and since we are, therefore I am."

Metz (2007, 334) succinctly captures the African moral theory discernible from its communitarian ethno-ethics in the proposition: "An action is right just insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community." Thus, "harmony, friendliness, community," Desmond Tutu says, "are great

goods," adding that "social harmony is for us the *summum bonum*–the greatest good. Anything that subverts or undermines this sought-after good is to be avoided like the plague. Anger, resentment, lust for revenge, even success through aggressive competitiveness, are corrosive of this good." (1999, 35).

In articulating and defending African moral theory as communitarian, African philosophers and ethicists have thus depended largely on African moral culture or ethno ethics, drawing resources from maxims, proverbs, adages, lived experiences, storytelling and community systemic structuring and organisation. We find these glaringly in several of the major works in African ethics such as Bujo (2003), Wiredu (1992), Gyekye (1996), and Bewaji (2004), to mention but a few. John A. I. Bewaji, for example, argues for African communitarian ethics by drawing from the Yoruba understanding of the person in relation to the family. As a social self, the individual represents not only herself but also her family and must be careful not to bring disgrace to her kin. In Bewaji's words, "one is expected, even as one pursues one's own goals, to be careful not to tarnish any tradition of excellence in conduct established by one's lineage" (2004, 396).

Benezet Bujo (2003, 115) relies on maxims, adages and stories in African communities to emphasise how individual actions affect communal wellbeing, For example, he explains that an adage in Burundi says that "if one member of the family has eaten dog meat, all the members of the clan is disgraced. To eat the flesh of a dog is utterly disgraceful for a Burundi; one who does so should not think that he alone can bear responsibility as an individual for this deed, since all the members of his family and clan are involved. The wicked or erroneous conduct of one single member infringes the personal dignity of all of them, for [and here is a second adage] 'when the eyes weep, it makes the nose weep too."

Using more adages, Bujo (2003, 115–116) further explains the effect of individual actions on the highly cherished solidarity and togetherness in African communities:

> Solidarity makes itself known in good things and in bad, but with different consequences; solidarity in good things is required if one is to become a person, whereas solidarity in bad things is harmful. But not only solidarity in bad things kills the whole community; a lack of solidarity has the same effect. As the Baganda say, 'a lazy person kills the whole community.' The underlying ethical concept concerns the existential dynamism that operates only in reciprocity… Each one who commits himself to act in solidarity for the construction of the community allows himself to be brought to completion by this same community… [as] the Bashi in Congo Kinshasa say: 'two ants are able to carry a locust,' and 'one bone cannot put up any resistance to two dogs.'

In response to the usual critical point raised against African communitarian ethics as to whether the individual blindly follows the group, having no say of her own, or not being rationally convinced that she ought to follow the group, Bujo (2003, 118) uses a story to clearly assert that the individual maintains her individuality even within the communitarian and solidaristic ethical framework:

> … one fairy tale concerns a leopard and a very cunning little animal called Mbepele who were good friends and lived together in fellowship. All that they did was done in fellowship and in harmony. One day, however, Mbepele tricked the leopard by suggesting that they should each kill their respective mothers, since these obviously were useless. The mothers were to be thrown into a river. Both set off; each had to carry his mother on his head to the river and then throw her in. but Mbepele hid his mother. He wrapped a wooden mortar in a garment that he had smeared with red pigment, and when he threw the mortar into the water, the colour resembled blood – proof that he had actually killed his mother. The leopard was convinced and killed his mother... until the day came when he realised that his friend had deceived him. Then the leopard went in secret to Mbepele's mother and killed her, and from that day on, they two friends were enemies… The message of the fairy tale undoubtedly concerns the problem of the individual and the group since it shows that the individual may not blindly follow the group.

In articulating and defending the humanistic nature of African moral philosophy as primarily concerned with human welfare, Kwasi Wiredu (1992, 194) also depends largely on the moral culture of the Akan people of Ghana as expressed in adages, maxims and lived experiences. He argues regarding Akan humanism, for example, that all values derive from human interests and that human fellowship is the most important of all human needs. He

draws inspiration from the Akan maxim: *Onipa ne asem: mefre sika a, sika nnye so; mefre ntama a, ntama nmye so; onipa ne asem*, which means a person may have all the gold and stocked wardrobe in the world, but in the hour of need, those things would not respond; only a human being will. Hence, what is good in general is what promotes human interests. He thus asserts that the term 'humanistic' is very apt in describing Akan moral thinking.

Further efforts made by African philosophers to advance African moral philosophy consist of the analysis of moral concepts in African cultures, which is, speaking more strictly, a meta-ethical exercise. Wiredu, for example, (1992, 196) clarifies who a moral agent is in an Akan culture by analysing the Akan term '*obadwenma'*, which literally means 'child, thinking child'. In analysing this term, he shows that it depicts a person of ethical maturity who possesses a sense of responsibility. Bewaji (2004) also analyses various Yoruba terms in elucidating the nature, contents and aspects of Yoruba moral philosophy. For example, he explains how the terms *eewo* and *abuku* which could translate as 'taboo' and 'blemish' respectively, are essential in articulating what sort of acts are impermissible in Yoruba moral culture.

The very few examples examined above show clearly that African (moral) philosophy has remained true to one of the very essence of philosophising: abstraction from, and formulation of concepts from, the ethno and lived experiences of peoples and cultures. It is therefore practically impossible to separate African ethno-ethics or moral culture from African ethics or moral philosophy. In what follows, I pay particular attention to how this is true for African bioethics.

African Bioethics, Principlism and Relationality

Bioethics is one of those terms that do not always submit to a simple, straightforward definition; yet, those who use them do so as if they and their audience have a pretty good idea of what they are talking about. The difficulty in defining bioethics is partly because since the

emergence of the term in the 1960s and 1970s, it has quickly become a highly multidisciplinary field, cutting across such areas of interest and subjects as philosophy, science, theology, sociology, law, history and literature, such that it becomes difficult to offer a definition that properly encompasses its diverse areas of interest and, by implication, themes and issues. But there is some consensus as to what the focal point of bioethics is, which provides some basis for definitions that are widely accepted, raising minimal dust, even while accepting that the issues and themes remain varied and continue to unfold in this very vibrant and multidisciplinary field of study. In the Introduction to the third edition of *Encyclopaedia of Bioethics* (2004, xi), the editor-in-chief, Stephen G. Post explains that the word 'bioethics' "was coined in the early 1970s by biologists in order to encourage public and professional reflection on two topics of urgency: (1) the responsibility to maintain the generative ecology of the planet, upon which life and human life depends; and (2) the future implications of rapid advances in the life sciences with regard to potential modifications of a malleable human nature."

Therefore, one can define bioethics as the systematic study of the moral dimensions of the life sciences and healthcare, employing a variety of ethical methodologies in an interdisciplinary setting (see Tubbs Jr. 2009). It consists of a multidisciplinary attempt to draw up moral principles and codes of conduct that should guide activities in the medical sciences and healthcare as well as a critical reflection on the moral implications of activities in the medical sciences and healthcare. By implication, bioethics focuses on "health care delivery, research,… public policy… knowledge and ethical reflection from multiple disciplinary vantage points, recognizing the value of ethical wisdom from varied perspectives as well as the commonality of many issues and dilemmas we face" (Tubbs Jr. 2009, vii).

Peter A. Singer and A. M. Viens (2008, 1) in their introduction to *The Cambridge Textbook of Bioethics* identify three broad spheres of bioethics that all its issues and themes can be conveniently grouped into. They are:

1. Academic bioethics, a sphere primarily focused on how theoretical and practical aspects of medicine affect considerations such as special obligations or responsibilities of clinicians, what is valuable, good, right, etc., in the biomedical context and how one might go about providing systematic accounts of such considerations;
2. Public policy and law bioethics, where concerns lie in how legal and extra-legal institutions can and should be involved in the regulation of clinical and research practices; and
3. Clinical ethics, and its focus, which is directly related to how the incorporation of bioethics into clinical practice can help to improve patient care

To be sure, these spheres are interwoven and overlapping in their focus and discourse. For example, findings in academic bioethics, public policy and law bioethics are essential for any considerations and decisions in clinical ethics, and decisions in clinical ethics and public policy are often raw materials for critical and extensive deliberations in academic bioethics.

Recent developments and advancements in bioethics show that there is no singular universal approach to bioethical issues. Although, evolving from a Western space of discourse, the Western approach to bioethics remains only one lens or vantage point from which to approach bioethical issues, and any attempt to impose such an approach on other peoples and cultures will result in an unchecked hegemony and supremacy, and the colonisation of knowledge. Hence, we now have robust researches in, and contributions from, African bioethics (e.g., Tangwa 2010), Confucian bioethics (e.g., Fan 2002), Hindu bioethics

(e.g., Crawford 2003), African-American bioethics (e.g., Prograis Jr. and Pellegrino 2007), and other contexts and places. This has led to a richer and more robust field of study.

Bioethics has no doubt become very essential for the biomedical sciences and healthcare particularly in the decision-making process related to healthcare and the wellbeing of patients. Decisions must be made by healthcare providers at short notice, particularly concerning clinical ethics as they may not have the liberty to engage in a protracted and long deliberation on what the right course of action should be, in the same way academic bioethicists might have. In the words of Khushf (2004, 11),

> Bioethics is a compromise between the demands of practice and broader ideals about the ways humans should interact with one another, especially in the context of health care. On one hand, decisions must be made. Health care workers do not have the luxury of endless reflection. They must act. If they linger too long, the uncertainty and delay itself will cause major difficulties. On the other hand, if the patterns of practice are too hastily codified, the deeper ends of a humane medicine will be compromised and more problems will be created.

The recognition of the need to be decisive and yet ethical led to the establishment and adoption, by healthcare professionals and providers, of a working understanding of fairly abstract moral principles deduced from philosophical ethics that were deemed essential in making the right decisions with regards to the healthcare and wellbeing of patients. This set of principles is what is now widely referred to as principlism, consisting of four key moral principles. In the words of Donald C. Ainslie (2004, 2100), "Tom Beauchamp and James Childress present the canonical account of this method in their *Principles of Biomedical Ethics,* where they suggest that four principles–respect for autonomy, nonmaleficence, beneficence, and justice–provide the proper justificatory framework for bioethics." The label "Georgetown approach" is invoked to characterise principlism because Beauchamp and Childress wrote their book while based at the Kennedy Institute of Ethics of Georgetown University

Principlism is thus characterised by these four principles that constitute the core of its account of bioethics. These principles are so deeply entrenched in the mind of many bioethicists and healthcare professionals that clinical, moral problems are often grouped according to which principle is deemed more relevant and necessary for resolving them (Gert, Culver and Clouser 2006, 100). Consider the principle of respect for autonomy, for example. Ainslie (2004, 2100) explains that although the principle of respect for autonomy is a controversial philosophical concept it is understood and applied by health care professionals in the principlist sense as autonomous choice or the intentional choices of agents who understand what they are undertaking and who are free from undue influences on their decisions. Critical analysis, particularly from academic bioethicists, has sought to lay down rules that help to improve the practicality of these principles and determine their limitations and the conditions of their application. However, principlism often sticks to these four principles and often does not create room for other principles that may be vital in the healthcare and well being of patients, particularly in specific contexts and places. This has been the critical point raised against principlism by African bioethicists.

African bioethics as a decolonisation imperative, has emerged and become a vibrant research area in, roughly, the last three decades as a reaction to the strong tendency in bioethics scholarship to present bioethics as a purely Western discourse. It is an attempt to Africanise bioethics (Barughare 2018), presenting it as a set of moral principles derived from African communitarian values. African bioethics is thus the exploration of African contribution to reliable healthcare delivery and the wellbeing of patients through indigenous African moral principles, medical ethics and academic discourse. In the words of Cletus T. Andoh (2011, 69): “This is what might be referred to as *ethno-ethics* and consists of a set of shared beliefs, values, categories, and assumptions that are implicit in the languages, practices and beliefs of African cultures.” Andoh specifically identifies traditional

phenomena and practices like proverbs, maxims, tales, songs, mythology, male circumcision and marriage as sources of African bioethics.

One key African contribution to bioethics is the communitarian moral theory discussed in the first section of this chapter. In communitarian ethics, relationality is salient in understanding aspects of bioethical discourse in African contexts such as healing, wellbeing, care for patients, and the resolution of bioethical issues. An African relational bioethics emphasises harmonious coexistence among individuals and between individuals and the universe as a whole, respect for human dignity and the preservation of the physical environment (Andoh 2011, 69–70). In the words of Kevin Behrens (2013, 34),

> The emphasis on community, identifying with others and solidarity and caring makes *ubuntu* a relational ethic that prizes harmonious relationships. This challenges Western bioethics, which focuses on individual autonomy and the rational application of abstract theories and moral principles to ethical issues. It also resonates with the ethics of care, highlighting the central importance of caring, emotion and relationships in moral decision making. This philosophy echoes the call from other communitarian perspectives for bioethics to take the fact that we are embedded in communities and families more seriously.

This contributes immensely to principlism by introducing a new principle of relationality to the four cardinal moral principles. By implication, when necessary clinicians and health workers will take into consideration and acknowledge the importance of relationality and harmony in ensuring the wellbeing of patients and in reaching other health-related decisions. If, for example, webs of relationships and solidarity are essential for wellbeing, it becomes imperative for decision makers and policy makers in the healthcare and medical sciences to ensure that such a web is sustained while making decisions. Autonomy, justice, nonmaleficence and beneficence would not be the only factors that count but relationality as well.

Relationality as an African contribution to principlism does not only assist bioethics to understand healing and wellbeing in (African) healthcare systems but provides a unique

vantage point for understanding the challenges faced by what I refer to as othered patients in the healthcare sector. I dwell more on this in the section that follows.

Personhood, Relationality and the Othered Patient

I should begin this section perhaps by clarifying what I mean by the othered patient. The othered patient is a patient who suffers more deprivation of quality healthcare service on the basis of a perceived difference, or alterity. A patient is othered, or take the position of the other, if medical and healthcare personnel within the particular context of the patient see her as different from the self and allow such difference to influence positively or negatively the quality of healthcare service and healthcare related decisions reached with regard to the patient. There is a sense in which my idea of the othered patient is similar to the notion of minority patients in bioethical discourses (e.g., White 1977; Degrie et al., 2017). In one of the earliest articles on the subject of minority patients titled "Giving Health Care to Minority Patients", White (1977) notes that despite the widely held view that healthcare is a basic individual right, the economic and racial situation of groups like blacks, Indians, Mexican-Americans, Puerto Ricans and Asians puts them at a disadvantage even as they are poorly represented in the healthcare delivery system. While calling for a more culturally responsive healthcare workforce, White (1977, 27) writes that: "Schools of nursing are beginning to include cultural differences in nursing curriculums, but the majority of the nurses who practice are not aware of and are not sensitive to the needs of nonwhite patients."

Minority patients therefore often include non-white, non-Western patients, generally speaking. Healthcare providers are therefore challenged to provide a more holistic healthcare service that is culture-sensitive and that deliberately strives hard to provide quality healthcare to vulnerable and minority groups (Degrie et al. 2017).

However, although othered patients and minority patients both portray how difference and otherness may influence healthcare delivery, othered patients, it seems to me, more

robustly exemplify the problem because not all othered patients belong to a minority group. Consider, for example, when a Catholic priest sees a medical doctor who diagnoses him of a chronic sexually transmitted disease; or when a married woman in an African society who has just been told by her doctor that she is pregnant immediately demands for an abortion. In these scenarios, the difference is not based on minority status but otherness; there is often the tendency that the doctor may approach the patient as an other based on her self-understanding as well as her understanding of the difference of the priest and of the married woman such as the belief that a priest should be celibate and ought not to be having chronic STDs and the African married woman being under the authority of her husband and should not be making such a decision independent of the husband. These accounts of difference may impair the medical doctor's objectiveness in delivering the best healthcare possible for the wellbeing of her patient. These effects may emerge from a negative and even violent encounter of the other, the different, the not-self.

But there is a sense in which there is a positive encounter of the other. To be sure, otherness, or difference, is an essential part of our being; it is in fact, desirable and imperative for growth. How we encounter and appropriate it is what should either be accepted or rejected (Baum 2020). A positive encounter of the otherness or difference of the priest and the married African woman rather than inhibit quality healthcare delivery, may provide the basis for better healthcare delivery. The doctor may be more confidential in treating the priest knowing fully well how others' awareness of the priest's infection with STD may be harmful to the priest's reputation and general wellbeing since it calls his celibacy into question. The doctor is not just able to do her job, but she is also able to satisfy her patient because she recognises the otherness of her patient and encounters it positively.

To understand who othered patients are in an African context is to understand the African concept of personhood, for it is those who fail to fit within the understanding of

personhood that are othered or regarded as different. A human being must fulfil certain ontological and normative criteria to be seen as a person and enjoy the benefits of personhood which include, primarily, contributing to, and receiving from, the unity, togetherness, relationality, and solidarity of the community. Essential to the ontological conditions for personhood is possessing the biological features of an African person which, beyond the expected physical structure of the human being, also include being black or brown skinned, or more generally speaking, being melanin-privileged. This explains why persons with disability such as persons with albinism and persons with angular kyphosis will have a hard time being accepted as persons in many African communities (Imafidon 2019).

On the other hand, the primary normative condition for personhood is that a human being must live a community-accepted lifestyle and contribute to community-building. An African person has the moral responsibility to protect the community and relationality among persons and beings in the community. Failure to do so may result in the denial of one's personhood, which explains various forms of ostracism in African communities. Hence a person must both be ontologically and normatively compliant. Those who pass as persons in African cultures enjoy a harmonious relationship and there is smooth relationality among such persons which is beneficial for general survival and wellbeing, including access to quality health care and a relational healing process. But those who do not fulfil the necessary criteria for personhood may face challenges accessing the same benefits and, by implication, may be unable to access quality healthcare services. They are what we can conveniently refer to as the othered patients. The list of othered patients may vary from one African place to another but it includes, generally speaking, persons with disabilities and queer persons,

There are two key reasons why healthcare providers and bioethicists must pay attention not only to the principle of relationality discussed in the previous section, but also to the notion of personhood introduced in this section. First, understanding relationality and

personhood provides a unique perspective for understanding the healthcare challenges that the othered patients may be confronted with in African healthcare systems and how such may be best tackled. It explains, for example, why persons with albinism may not receive proper medical attention or qualitative healthcare service from healthcare personnel who have imbibed the African conception of personhood. Second, and flowing from the first, it provides a basis for understanding the limitations of relationality as an essential moral principle in African bioethics since relationships is often understood in the narrow sense to flourish between community-accepted persons. Modifications can then be made to encompass a broader sense of relationality that includes the value of relationships among all persons. The respect for relationships will, then, not be restricted by ontological or narrowly conceived normative features. Thus simply attempting to provide quality healthcare for persons with disabilities, queer persons and other disadvantaged patients in African societies without factoring in the ethno-cultural understanding of personhood and relationality in African cultures may not yield solutions.

Concluding Remarks

There is no doubt that for a long time, there has been a deeply entrenched hegemony in our global knowledge systems, including those related to healthcare delivery, a hegemony that is mostly Western, or Eurocentric. What becomes obvious from the foregoing discourse is that there is poverty of knowledge and, by implication, poor, less qualitative services, if we continue to ignore the ethno in contexts, places and cultures. However, the recent clamour for person-centred approach to healthcare or patient-centred healthcare shows that healthcare providers are in the process of overcoming deeply rooted biases and are now taking more seriously patients' ethnic diversity, patients' choices, decisions, beliefs and rights, and the socio-cultural determinants of patients' attitudes, beliefs and convictions in planning and achieving qualitative care, treatment and healing for patients. Person-centred healthcare

assists healthcare workers to be more compassionate and sensitive to the social and cultural peculiarities of patients. But this would be difficult to achieve if healthcare workers have a myopic, god's eye perception of reality while expecting patients to fit into that perspective. Part of the training of healthcare workers particularly in the area of bioethics, should consist of the study in the form of programmes, recurrent workshops and other forms of training in ethno-diversity, variations in beliefs and understanding of reality, and ethno-cultural differences in conceptions of healing, wellbeing, treatment and care. Such training should be diverse enough to provide a proper appreciation of the diversity within a context. It should also be rich and critical enough to understand these cultural diversities, how they could be beneficial or harmful to the wellbeing of those who hold them, and how to navigate the prospects and limits of culture for the wellbeing of patients. This is what African bioethicists have been doing, and continue to do, with regard to personhood and relationality as essential elements of African ethno-ethics, and navigating the prospects and limits of these elements in providing quality healthcare for African patients.

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