Articulating the sources for an African normative framework of healthcare: Ghana as a case study

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Introduction

Consider the following case studies:

> Jane was a 58-year old woman living in Northern Ghana, married to John, a lawyer and a member of the royal family of one of Ghana's ethnic groups. Jane had been unwell, had driven herself to the hospital, and when arrived was assessed as requiring oxygen. The administering nurse failed to recognize that the oxygen cylinder given to Jane was virtually empty. Jane suffocated to death in the hospital. In John's words, 'The circumstances of her death simply expose a failed healthcare system. How an Intensive Care Unit can be without a doctor or even an experienced nurse compounded by a shortage of oxygen during a resuscitation is difficult to imagine. We accept the death, we know it's not God's will.' No one has been charged for her death, no disciplinary action or structural changes have been made.

> Akua was a regular visitor to the ante-natal clinic at the Health Centre in the small fishing town of Krom, in the central region of Ghana. The nurses advised her to go to the Regional Hospital to deliver her baby since they foresaw complications beyond the capacity of a small rural clinic. Akua chose to go to a prayer camp, but she later arrived at the Krom Health Centre when in labour. Upon examination, the midwife realized that something was gravely wrong, where Akua had passed out and fell down from the delivery bed. An ambulance was called and Akua was rushed to

> the Regional Hospital, where they drove directly to the maternity unit upon arrival, but were refused, a nurse stating that Akua would need to go through the emergency unit first. Upon arrival there, Akua was declared dead. As required by law, the police criminal investigation department opened a dossier on the case. Despite serious questions around mismanagement, from the local health centre to the regional hospital, no reviews of procedure followed from this case. Akua's family accepted the death: 'it's unfortunate, but it is God who gives and takes life.' The investigative dossier has now been archived.[1]

The above cases are not uncommon in Africa. Most Africans who live on the continent and depend on local health services can tell similar stories of questionable health policies and poor healthcare delivery, leading to severe consequences for patients. Health indicators of sub-Saharan African countries paint a similar worrying picture: the entire region has an average life expectancy of under 62 years and ranks highest in children under-five mortality rates and the highest adult (15-59 years) mortality rates.[2] Numerous factors contribute to this situation, including poverty, limited access to healthcare, poor resource allocation, unavailability of good medicines, lack of qualified personnel, and so on.[3]

These systemic challenges are undeniable. Yet, in sub-Saharan countries where access is comparatively widespread, such as South Africa, Ghana, and Kenya, the worrying phenomenon of poor healthcare delivery persists.[4] [5] Though very little reliable data conveys the full scope of malpractice,[6] medical errors frequently occur with few repercussions for clinical practitioners, accompanied by little recourse available to patients and their family members. In essence, the normative mechanisms designed to deter and limit medical errors often remain weak, inefficient, or sometimes, non-existent.

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[1] These case studies come from the personal experience of the lead author.
[2] UN World Mortality Data Booklet. (2017). Retrieved April 20, 2020 from: https://www.un.org/en/development/desa/population/publications/pdf/mortality/World-Mortality-2017-Data-Booklet.pdf
[3] For an editorial review, see: Kirigia, J. M., & Barry, S. P. (2008). Health challenges in Africa and the way forward. International Archives of Medicine, 1, 27.
[4] Jeroen De Man, M., MAc, N. S., HPPF, E., Leyse, M., Josefien Van Olmen, M., & Criel, B. (2016). Patient-centered care and people-centered health systems in sub-Saharan Africa: Why so little of something so badly needed? International Journal, 6(3), 162-173.
[5] Ganle, J. K., Parker, M., Fitzpatrick, R., & Otupiri, E. (2014). A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. BMC pregnancy and childbirth, 14(1), 425.
[6] Iloh, G. U. P., Chuku, A., & Amadi, A. N. (2017). Medical errors in Nigeria: A cross-sectional study of medical practitioners in Abia State. *Archives of Medicine and Health Sciences*, *5*(1), 44.

We suggest that one way to overcome this normative inefficiency is to draw upon local ethical concepts as sources of intrinsic motivation, which can advance an enriched and context-relevant framework for healthcare practitioners. Bioethicists often presume the solution to the challenges faced in sub-Saharan health contexts lies in the widespread application of Western – putatively 'universal' – bioethical standards. Indeed, this has been the chosen approach of Ghanaian health policy. However, this paper argues that the normative inefficiency in such health contexts stems precisely from the poor normative 'grip' of the conceptual schema which underlies Western bioethical standards; the development of bioethical framework which draws upon local, ethical concepts is instead more likely to resonate with practitioners and service users.[7] Often in the context of scarce health resources, ethics is perceived to be a luxury, an inessential addendum – a view that is confirmed by the fact that training in medical ethics remains largely absent in clinical education within countries such as Ghana. We argue, however, that greater – not less – attention to medical ethics is needed if Africans are to obtain better results from the scarce resources available for healthcare. The urgency of developing a positive model of African ethical frameworks is also heightened by the common critique that African bioethics dwells more on a critique of Western models, often denouncing the imposition of Western models as a form of bioethical neo-colonialism, rather than offering a positive vision of what should be in its place. The field of elaborating ethical frameworks and corresponding normative and pedagogical tools remains to be explored.

The analysis of this paper is focused on Ghana – a country that has comparatively better healthcare coverage in the West African sub-region – though our normative agenda towards developing an African ethical frameworks in healthcare training and provision has far-reaching applicability beyond this setting.[8] We tease out the notions of the good and the ethical from two different Ghanaian ethnic groups—Akan and Bulsa—and try to show how these could enrich and even modify the way clinical bioethics is perceived and applied. We limit our analysis to the mainstream Western imported biomedical health care systems in Africa, though a similar and perhaps more pressing case could be made for the development of analogous normative frameworks to be applied to traditional herbal medicine and faith-based spiritual healing. The paucity of reliable evidence around the frequency of medical errors in the mainstream medical literature is

[7] For similar views (though variations in approach), see Tangwa, G. B. (1996). Bioethics: an African perspective. Bioethics, 10(3), 183-200; Behrens, K. G. (2013). Towards an indigenous African bioethics. South African Journal of Bioethics and Law, 6(1), 32-35; Andoh, C. T. (2016). African communitarian bioethics and the question of paternalism. Journal of Education, Society and Behavioural Science, 1-16; Fayemi, A. K., & Macaulay-Adeyelure, O. C. (2016). Decolonizing bioethics in Africa. BEOnline: journal of the West African bioethics training program, 3(4), 68; Behrens, K. G. (2013). Towards an indigenous African bioethics. South African Journal of Bioethics and Law, 6(1), 32-35. Also, see essays in Frimpong-Mansoh, Y. A., & Atuire, C. A. (Eds.). (2019). Bioethics in Africa: Theories and Praxis. Vernon Press.

[8] World Health Statistics: Monitoring health for the SDGs. (2018). Retrieved April 20, 2020 from: https://www.who.int/gho/publications/world_health_statistics/2018/en/

worsened in the spheres of traditional medicine and faith-based spiritual healers, where virtually no statistical data is available.

The paper is divided into four sections. Sections I and II survey the informal ethical administrative framework for healthcare delivery in Ghana and explore factors which may contribute to their poor enforcement and uptake. Sections III and IV focus on the cultural ethical context and tease out the concepts of the good and the ethical among the Akan and Bulsa ethnic groups within Ghana. Section V presents three tenets towards building a framework that can resonate with service-users and practitioners: ontological communitarianism; empathic humanism; and virtuous character. Section VI poses the challenge of how to build an effective normative framework into health care professional training based on these core tenets.

I. The Ethical Administrative Context

The Ghana Health Service is guided by two professional charters designed to improve health care delivery to patients – one aimed at patients and the other at health professionals.[9] First, the Patients' Charter has garnered some attention due to its explicit rights-based framing of the treatment and care owed to patients. Launched in 2002 and modelled after a similar administrative instrument in the United Kingdom, the Patients' Charter requires healthcare providers to respect the rights of patients without discrimination, with particular sensitivity to differences in gender, sociocultural and religious background and those with disabilities. The first section outlines the core rights of patients, including the right to accessible, equitable, and appropriate health care treatment, the right to patient choice, privacy, and confidentiality, and right to know the identity of those treating them, with explicit procedures for complaints and payment charges. The second half of the Charter outlines patients' responsibilities over their personal and communal health, including cooperation with healthcare providers through providing accurate and relevant information for their treatment and health, as well as compliance to prescribed treatment.

The prima facie significance of the Patients' Charter lies in the attempt to articulate certain entitlements and duties owed to patients, particularly in a context where such formal administrative mechanisms have been notably absent. However, there are clear problems with the implementation and enforcement of, as well as adherence to, its various requirements. The Charter remains an administrative and internally enforced instrument, thereby lacking the regulatory and obligatory force of government legislation. As a result, adherence to and application of the Charter is largely voluntary, enforced internally

[9] Ghana Health Service. These documents are available at: http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=45 and http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46

amongst staff within the Ghana Health Service, whilst other professional bodies (e.g. Medical and Dental Council, Pharmacy Council, Nurses and Midwives Council) are subject to different standards.[10]

Educating stakeholders on the Charter and its provisions also remains voluntary rather than mandatory, resulting in both care providers and patients often left unaware of the Charter or its specific obligations. In one study, for example, four out of ten health care staff knew nothing of the Charter, whilst close to 47% of patients lacked awareness of the Charter and one-third unable to name any examples of patients' rights.[11] According to a clinical care quality assurance report in 2012, it was acknowledged that greater dissemination of the Charter alongside the GHS Code of Conduct and Disciplinary Procedures was needed to recognise what is owed to patients, thereby helping to improve shortcomings around patient safety, staff attitudes, and patient waiting times.[12] Yet, despite this commitment, studies continue to report poor patient knowledge of the Charter, with little visibility on the wards[13] as well as the continuation of questionable practices, such as the absence of consent procedures in administering drugs for the majority of patients, disparities in patient consultation based on educational status, and a significant number of patients reporting impolite treatment by hospital staff.[14] This situation is potentially worsened in rural settings, where amongst a less literate population, knowledge of the Patients' Charter will likely be lower than that of urban and literate patients.[15]

Accompanying the Patient's Charter is the less studied, and perhaps less widely known Code of Ethics, which functions as the practitioner counterpart to the Patients' Charter. The Code outlines obligations to patients based on 'moral principles and rules of behaviour for all service personnel in the Ghana Health Service'.[16] The Code requires health care practitioners to respect the rights of patients and their confidentiality, practice patient-centred care and non-discrimination, and conduct themselves in accordance with the highest professional standards around training and avoiding conflicts of interest, particularly regarding monetary remuneration. Yet, as published on the official government website, the Code of Ethics contains important errors and omissions.[17]

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[10] Abekah-Nkrumah, G., Manu, A., & Atinga, R. A. (2010). Assessing the implementation of Ghana's Patient Charter. Health Education, 110(3), 169-185.
[11] Ibid.
[12] Report on clinical care quality assurance conference. Referenced from Yarney, L., Buabeng, T., Baidoo, D., & Bawole, J. N. (2016). Operationalization of the Ghanaian patients' charter in a peri-urban public hospital: voices of healthcare workers and patients. International journal of health policy and management, 5(9), 525.
[13] Yarney, L., Buabeng, T., Baidoo, D., & Bawole, J. N. (2016). Operationalization of the Ghanaian patients' charter in a peri-urban public hospital: voices of healthcare workers and patients. International journal of health policy and management, 5(9), 525.
[14] Abekah-Nkrumah et al., op. cit. note 10.
[15] Ibid.
[16] Ghana Health Service. Retrieved April 20, 2020 from: http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=45
[17] For example, the 'Code' prescribes that "All Service personnel shall act in collusion with any other person for financial gain." This error has been visible for at least 2 years.

II. The Motivational Vacuum

The low uptake of the Patients' Charter and the Code of Ethics is often attributed to limited resources which prevent the establishment of dissemination and training programmes for both healthcare staff and patients. However, poor resourcing is not the only reason for the lack of understanding, training, and the consequent failures in meeting expected ethical standards in health care delivery. Studies paint a more complex picture which indicates that even amongst patients with knowledge of the Charter there is a reluctance to demand better treatment for fear of being labelled as 'difficult' or undermining the perceived hierarchy between laypeople and medical experts.[18] Moreover, perceptions of workplace injustice – ranging from poor workplace collaboration, arbitrary or unfair organisational procedures, to hypocrisy in professional ethics standards between healthcare workers and management – have been shown to undermine motivation to practice good care to patients within Ghana.[19] Aberese-Ako et al outline many instances of this lack of motivation and initiative, including the following compelling case:

> On one occasion women who had completed their antenatal visit could not leave the facility, because they had to take their drugs from the antenatal pharmacy. However, there was no dispensary attendant, so the women sat waiting for another hour. The junior nurse who provided them with the antenatal service got worried and asked her superior if they could do anything about the women's plight since there was no dispensary attendant at the dispensary to attend to them. The superior responded: 'I don't care what happens. If I talk then they will report me to doctor (head of Facility B). So I won't bother myself.' Subsequently, the women who overheard her comment left the facility without waiting any longer to receive their routine antenatal drugs.[20]

Even in cases where blatant malpractice has occurred, physicians and other healthcare workers in Ghana are rarely ever prosecuted or disciplined for poor healthcare delivery, except in high profile cases covered in the media. Despite the existence of a Code of Conduct and Disciplinary Procedures, district and regional hospitals often do not have working internal ethics committees to review the ethical conduct and practices of healthcare workers.[21]

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[18] Van der Geest, S., & Sarkodie, S. (1998). The fake patient: A research experiment in a Ghanaian hospital. Social Science & Medicine, 47(9), 1373-1381.
[19] Aberese-Ako, M., van Dijk, H., Gerrits, T., Arhinful, D. K., & Agyepong, I. A. (2014). 'Your health our concern, our health whose concern?': perceptions of injustice in organizational relationships and processes and frontline health worker motivation in Ghana. Health policy and planning, 29(suppl_2), ii15-ii28.
[20] Ibid.
[21] It is assumed that the Quality Assurance Unit of the Ghana Health Service takes care of this.

One might argue that the solution to these challenges lies in better education and more robust enforcement of administrative mechanisms like the Patients' Charter and Code of Ethics. This, one might say, could lead to better enforcement measures being introduced to deal with negligent care and improve ethical standards in health care delivery. Lack of awareness amongst staff and patients is indeed a potential reason why patients do not demand the type of care and treatment that they deserve. Yet, prescribing the greater dissemination and enforcement of these weak administrative mechanisms fails to give proper regard to the complex reasons as to why there might be ambivalence towards these rights-based healthcare norms in the first place, and precisely how ethical standards could be improved in normatively defensible ways.

Two key factors speak against a reinforced regulatory response. The first factor concerns the (in)feasibility of adopting a mechanistic, regulatory approach to the improvement of ethical standards. There are both contextual and substantive reasons lying behind this concern. It is well known that African healthcare systems suffer from a chronic lack of human and material resources. Ghana has 1 doctor for 8,481 people whereas the UK, for example, has 2.8 doctors for every 1000 people.[22] Many physicians complain of excessive workloads, the lack of appropriate equipment and tools for proper diagnosis and treatment.[23] The availability of drugs is uncertain, and even when available, these can be counterfeit or substandard products. Hospitals often lack sufficient beds and patients can spend entire days on chairs in the corridors. For example, one healthcare worker stated in Yarney et al,

> We're committed to observing patients' rights, but in order to ensure for instance, confidentiality and privacy, there are certain basic prerequisites such as expanded space, enough tools and equipment. As you can see, this room is ideally to take two patients but there are currently six patients occupying it. How do we ensure privacy for example in this situation? [24]

Another respondent of Yarney et al's study suggested these practical realities meant that patients do not complain: 'They know the conditions in this facility and cannot complain about something like privacy.'[25] And speaking more generally, a healthcare worker stated, 'sometimes I'm so tired that I forget to be courteous as a health worker. […] Our shifts are long and the patients are many, so, it becomes difficult for us to observe certain ethical responsibilities'.[26]

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[22] Ghana Health Service. (2017). Retrieved April 20, 2020 from: https://www.ghanahealthservice.org/downloads/FACTS+FIGURES_2017.pdf and World Bank. Retrieved April 20, 2020 from: https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

[23] See for example: Ganle, John Kuumuori, et al. op. cit. note 5, p. 425.

[24] Yarney, L., Buabeng, T., Baidoo, D., & Bawole, J. N. (2016). Operationalization of the Ghanaian patients' charter in a peri-urban public hospital: voices of healthcare workers and patients. International journal of health policy and management, 5(9), 525.

[25] Ibid.

[26] Ibid: 531.

Second, what little ethical training that is provided in medical schools often focuses on the legal consequences of malpractice, as the ethical considerations underlying the regulatory code are interpreted solely in terms of a legalistic framework that is operationalized primarily to help healthcare workers avoid litigation for violating patients' rights. For example, a survey among 307 healthcare providers in Nigeria revealed that 42% of the respondents agreed that ethics is important only for legal purposes, in contrast to a similar study in the Caribbean where 94% of respondents disagreed with this legalistic interpretation of ethics.[27] Although the rights-based Patients' Charter and Code of Ethics are designed to encourage the disclosure and accountability of practitioners, interpreting ethical requirements in legalistic terms within a regulatory framework may in fact encourage the opposite outcome to its stated intention, with a trend towards poor disclosure of errors and substandard care. Rather than treating ethical oversight as a vital counterpart to their diagnostic and therapeutic decisions, it is perceived as rendering medical practitioners vulnerable to professional and legal sanctions that are to be avoided at all costs.

III. The Ethical Cultural Context

How, then, should ethics be properly conceptualized within health care practice in this context? The Ghanaian religious, cultural, and normative orientation towards life often emphasises acceptance of fate, deference to authority, and fostering communitarian bonds, which can be at odds with an ethical framework premised on the assertion of individual entitlements and rights. Like much of West Africa, religious faith remains important within Ghana. Many subscribe in varying degrees to the frameworks offered by Christianity, Islam and the African Traditional religions, even if they do not actively practice their beliefs. A common feature amongst these faiths is the belief in a supernatural dimension to life that can influence our earthly course, meaning that the life and death of a person are in the hands of God. Hence, if a person is destined to die at a certain moment in time, not even the most qualified doctor can avert this fate. A widespread belief in life after death, be it the Christian heaven or the Muslim al-janna or the Traditional land of the ancestors, also helps assuage the grief and anger that often come with culpable losses of life. The death of Akua, narrated at beginning of this paper, shows how these factors come into play. Rather than pursue 'justice' for Akua, the family felt it was better concentrate on assisting her orphaned children. They did not see much good in generating a conflict between the community and the health care workers at the local clinic who generally deliver good vital services to the community. No amount of justice, in their opinion, would bring Akua back to life. The greater good was to wish her eternal peace in *asamando*, 'the land of the dead': 'it is God who gives and takes life.'

[27] Monsudi, K. F., Oladele, T. O., Nasir, A. A., & Ayanniyi, A. A. (2015). Medical ethics in sub-Sahara Africa: closing the gaps. African health sciences, 15(2), 673-681.

Moreover, the notion of respect for older people and persons in authority is strongly embedded in Ghanaian culture. Service users interact with medical personnel, particularly physicians, as they would with a person in authority. This attitude of spontaneous deference and trust – even though gradually diminishing in recent times – discourages asserting demands for a certain quality of treatment, including disclosure of medical conditions and treatment options, which can appear to be challenging authority. This deferential attitude can be a fertile ground for medical paternalism. Importantly, paternalism is not in and of itself viewed suspiciously, as is so often the case within the Western medical context: service-users often prefer to rely on the decisions of medical practitioners who are perceived as more knowledgeable with specialised expertise. But even beyond deference to those within medical authority, Yarney et al's study revealed that service-users rarely complained due to their fear of recriminations as a result of being labelled difficult, where patients labelled as such were subsequently neglected on the ward. One patient stated, 'The last time I complained to the nurse about my uncomfortable bed, the administrator came over to interview me, and my bed was changed. I do not want to complain again about the mosquitoes because I am sure the nurses will think I complain too much and may not be friendly to me'.[28]

Finally, the communitarian orientation of Ghanaian culture encourages individuals to try to establish collaborative rather than contractual relationships that are almost familial in character, in all spheres of life. A visit to a hospital or a school reveals a linguistic field that is hardly found in similar Western contexts. Service users and practitioners who do not know each other exchange titles that are familial: *opanyin* (elder), *ejaa* (father/older male relative), *ante* (auntie), *papa* (father), *maami* (mother), etc. Implicitly, these titles reinforce a deferential attitude towards certain relational hierarchies. But its normative emphasis also means to establish humane and friendly interpersonal bonds that transcend formal recognition.[29] Indeed, Kwame Gyekye describes this communitarian orientation as acknowledging the common humanity of the other.[30]

Together, the Ghanaian religious, cultural, and normative orientation towards life therefore encourages attitudes of tolerance or even resignation towards poor healthcare delivery. Religious fatalism leads people to accept death as explicable only through the supernatural: wrongful death due to the negligence of medical personnel or institutional failures is imbued with broader religious significance and meaning. Respect for authority, moreover, discourages accountability on the part of healthcare providers, hence many cases of medical errors go unchallenged. Finally, the confrontational actions that are sometimes necessary to enforce and assert one's rights run contrary to the importance of building communal,

[28] Yarney,et al., op. cit. note 24, p. 525.
[29] It is amusing to note that Forbes Magazine in 2011, speaking from a Tourism perspective, listed Ghana as 11th Friendliest country in the world and highest among Africa countries.
[30] Gyekye, K. (1997). Tradition and modernity: Philosophical reflections on the African experience. Oxford University Press.

cooperative relations, making people reluctant to advocate for the treatment they deserve. It is little wonder, therefore, that people are largely disinclined to enforce normative frameworks that they perceive as essentially litigious and legalistic.

IV. Ethics in the Akan and Bulsa cultures

So far, we have suggested the possibility that the lack of motivational power and impact of rights-based ethical frameworks in healthcare in Ghana may be attributable to its lack of cultural resonance. But rather than imply the unnecessary nature of ethics or the requirement for yet more institutional structures and frameworks, it in fact points to the need to explore possible internal normative resources within Ghanaian culture. We draw upon two related but also distinct strands of ethical thinking in traditional Ghanaian communities – the Akan[31] and Bulsa[32] ethnic groups – in order to generate intrinsically resonant norms and virtues with immanent motivational power. Clarifying both the grounding and content of these ethical norms and virtues will also bring into sharp relief its divergence from the legalistic and individualistic basis of current administrative instruments. Both Akan and Bulsa ethical thought have three salient features held in common: first, a deep and comprehensive ontological communitarianism, operating at both descriptive and normative levels; second, this communitarianism is expressed through empathic humanism which fosters the identification and sharing of interests with other human beings but which is also firmly grounded in a particular cosmological vision; third, the moral content of such humanistic engagement depends on the cultivation and development of character virtues which promote sociality and the flourishing of others. These ethical skills are not captured in a framework which emphasises technical, bureaucratic and legalistic procedures, nor that are equated with values drawn from Western ethical traditions, but that have their grounding in the ethics of Akan and Bulsa cultures, as we discuss below.

(i) Ontological Communitarianism

The bioethical literature commonly acknowledges the contrast between Western individualism and the communitarian orientation of African thought and practice, particularly as it impacts on standard

[31] The Akans are undeniably the largest and most influential ethnocultural group in Ghana. Akan culture has been the object of anthropological and philosophical studies since the 19th century.

[32] The Bulsa on the other hand, are perhaps one of the Ghanaian ethnic groups most removed from the Akans geographically and culturally. They are a small group in the Upper East region, more than 600 kms from Kumasi, the Akan Ashanti capital. Historically, linguistically and culturally, they are more linked to the Mamprusi of the Northern Region of Ghana and the Mossi of Burkina Faso than to the Akans.

research and health procedures (such as informed consent).[33] However, the deeper conceptual grounding of this African communitarianism demands further exploration if we are to grasp its full descriptive, normative, and motivational power.

Communitarianism itself is not an African prerogative,[34] but the manner in which it grounds the ontology of the human being is a distinctive feature of African philosophical approaches, particularly as expounded by Wiredu and Gyekye. According to Akan ontology, what it means to be a human being is fundamentally to exist within and be a manifestation or realisation of, holistic connections: this can be understood in a vertical sense (i.e. between divine and human) as well as a horizontal sense (i.e. between family ancestry, clan, ethnicity and ultimately to all and other human beings). All human beings share an *okra* (soul) that is of divine origin and makes us all 'children of God'. Links between human beings are promoted by/through the *honam* (body) and *sunsum* (spirit): the *honam* relates to the blood-line of the maternal lineage, whereas the *sunsum* represents the paternal lineage. Expressing the vertical and horizontal connectivity of the person, the Akan phrase *onipa firi soro besi a, obesi onipa kurom* means: when a person descends from above, he descends into a human society.

The relationality of what it means to be a human being is even more explicit in linguistic idioms of the Bulsa. A human being is called *nurbiik*, translated literally as 'son of a person'. Therefore, every human being is considered as one who matters to someone. Traditionally, Bulsa introduce themselves by first referring to their family names before specifying their first names. This underscores the fact that even as each has an individual identity, the person comes into being within a network of constitutive relations. Thus, both the Akan and Bulsa suggest that being in community is not an optional way of being, nor the fruit of a contract; rather, it is the ontological condition of what it means to exist as a human being.

Important implications follow from this ontologically-grounded communitarianism in Ghanaian thought: unlike a contractual framework where individually constituted beings enter into a relationship for mutual benefit, the thrust of ontological communitarianism is the givenness of a human intertwined existence. The individual and the community do not stand as two independent entities; they are mutually interdependent. This does not exclude concepts of mutual benefit or rules that can have a contractual character, but such contractual relations are always to be superseded by the priority of the social dimension of human existence, where the deeper significance of sharing with others is in how it realises and expresses what it means to live as a human being.

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[33] Tindana, P. O., Kass, N., & Akweongo, P. (2006). The informed consent process in a rural African Setting: A case study of the Kassena-Nankana District of Northern Ghana. Irb, 28(3), 1.

[34] Cf. Western authors like Taylor, McIntyre and Anscombe can be described as communitarians. However, the peculiar nature of African communitarianism with its ontological roots can be found in Wiredu, K., & Gyekye, K. (1992). Person and community. Washington, DC: Council for Research in Values and Philosophy. Or Menkiti, I. A. (1984). Person and community in African traditional thought. African philosophy: An introduction, 3, 171-182.

The most widely practiced form of communitarianism in Ghana is the Akan model. Gyekye calls this expression of communitarianism a moderate communitarianism and posits it against Menkiti's[35] version which he sees as radical. Moderate communitarianism tries to forestall oppression of individuals or totalitarianism by insisting on the unique and irreplaceable character of every member of the community. For the Akan, "the clan is like a cluster of a trees which, when seen from afar, appears huddled together, but which would be seen to stand individually when closely approached". According to Gyekye the primary role assigned to community cannot be mistaken as diminishing the individual worth of persons. The goal of the community is to provide the conditions for individuals to thrive, thus a "cramped and shackled self, responding robotically to the ways and demands of the communal structure" would be a negation of the communitarianism.[36]

This ontology also has normative significance in two senses: first, the well-being of the individual and community is both reciprocal and constitutive. Individuals are born into communities and flourish by benefitting from and contributing to the well-being of the community. Conversely, communities are constituted by individuals and exist to ensure the flourishing of each individual. This reciprocity functions as an important rejoinder to claims that African communitarianism neglects individual autonomy, though this is not denying the possibility of harmful consequences to individuals that can emerge in more radical forms of communitarianism.[37] However, Gyekye's account suggests that the mark of ethically grounded social integration is precisely when individuals cultivate virtues of moral agency and social responsibility which reflect an appreciation of and duty towards each person, grounded in the recognition of the common humanistic core which unites all individuals within the community. In cases where communal values are no longer reciprocally beneficial to the individual, the normative appeal to African humanism can aid their scrutiny, reform, or indeed, rejection.[38] Second, the respect awarded to every person is not dependent on personal achievement, but on the ontological category of being-in-relation to another being who is a person. The concept of *biik* (son or filiation) illustrates this well. The Bulsa phrase that *nworuk kan nak ku dek biik a paar kobi ya*, literally meaning that 'even lightening will never strike its own son to the bone,' or '*biak kan dom ka dek biik a paar kobi ya*' meaning 'a dog never bites its own puppy to the bone,' it will always exercise restraint or mercy. In this framework, dignity and worth is conferred onto every human being by virtue of her filiation. Recognising the filiation of individuals therefore generates duties and obligations to

[35] Menkiti, I. A. (1984). Person and community in African traditional thought. African philosophy: An introduction, 3, p. 173.
[36] Gyekye, K. (1997). Tradition and modernity: Philosophical reflections on the African experience. Oxford University Press, pp. 55-56.
[37] Kong, C. (forthcoming). 'Critical Sankofaism and Hermeneutics: The Case of Male Suicide in Ghana', in Kenneth Fulford et al., eds., *International Perspectives in Values-Based Mental Health Practice – Case Studies and Commentaries* (Springer Nature, forthcoming).
[38] Ibid.; see especially Gyekye, K. (1997). Tradition and modernity: Philosophical reflections on the African experience. Oxford University Press.

others, to respond appropriately to the needs and interests of others as fitting to their status as a being-in-relation.

For example, in the case of Jane narrated at the beginning of this paper, it would have been inappropriate for her husband, John, a lawyer, and a member of the Bulsa royal family to prosecute the nurse for negligence in a law court. For the Bulsa, John, as a royal, is a father-figure to all members of the community. As such, he would be betraying the communitarian unity, if he handed over the nurse to a 'foreign' judicial system. Traditionally, the way to handle this situation would have been to call the nurse and the elders of her family to a meeting at the chief's palace, where the issue they would *biisi biika* (talk the talk). If culpable, the nurse would be admonished and her family would be required to offer sacrifices to appease the land, the ancestors, the land (the moral order), and the departed spirit of Jane. In the current post-colonial Ghanaian context, these traditional forms of conflict resolution are not 'officially' recognized, yet they play such an important role that when ignored they impede the effective application of the 'official' rules. John's self-perception as a 'father' to the nurse and the community overrode his professional legal training.

Mainstream Western philosophers might find a normative framework grounded on ontology as unacceptable: as the naturalist truism asserts, the 'ought' of moral obligation cannot be derived from the 'is' of factual description. It is worth pointing out that this position, peculiar to the 'disenchanted'[39] modern era of Western philosophy, presupposes a cosmological vision that precludes the possibility of finding a transcendent or supernatural meaning in factual or empirical realities or event. Akan and Bulsa cosmologies, like Ancient and Medieval Western philosophical frameworks, acknowledge the possibility of metaphysical and teleological explanations to empirical phenomena.

Moreover, the normative significance of reciprocal well-being and filiation can be seen in the informal 'black tax' which exists in African societies, for example.[40] 'Black tax' is a colloquial term that represents the cultural and moral obligation of successful black individuals to bear the economic and social burden of financially assisting members of their extended families or communities, subsidising even those they have hardly met or know through economic contributions towards school fees, health bills, funerals, weddings, etc. A common assumption is that it is only natural for a financially well-off person to contribute to and assist those who are less well-off. Failure to do so is often perceived as meanness, or a failure to do good in the form of helping others, promoting the welfare of other persons in society, particularly family and those most in need.

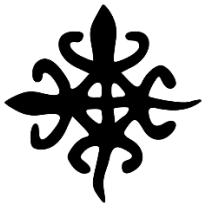
[39] Taylor, C. (2007). A secular age. Harvard university press, pp. 287-288.
[40] https://www.news24.com/SouthAfrica/News/living-with-black-tax-20180316. The 'black tax' is subject to significant public debate, but we leave these aside here.

(ii) Empathic Humanism

Both Akan and Bulsa view morality as grounded in a humanist outlook which prioritises the promotion of reciprocal human interests through empathic identification with others. According to Wiredu, for the Akans, 'What is good is what promotes human interests. Correspondingly, what is good in the more narrowly ethical sense is, by definition, what is conducive to the harmonization of those interests.'[41] The humanistic basis of Akan morality is further elucidated in customary sayings:

> [A]lmost any Akan adult or even young hopeful will proffer on the slightest provocation, that it is a human being that has value: *Onipa na ohia*. (…) The word "*(o)hia*" in this context means both that which is of value and that which is needed. Through the first meaning the message is imparted that all value derives from human interests and through the second that human fellowship is the most important of human needs.[42]

In other words, the good is that which promotes human individual and social well-being, a moral outlook expressed visually in the Adinkra symbol of the conjoined crocodiles with two heads and one stomach, called *funtunfunefu-denkyemfunefu*. The symbol underlines that humans have a common interest even though there are conflicting interests whilst pursuing the common goal. Morality, to a large extent is the attempt to harmonize the conflicting interests through adjustment and adaptation.[43]



Akan and Bulsa humanism is not an abstract ideal of a theoretical human being, but is grounded on seeing the other person as another 'me', requiring empathic identification with others. For example, many Bulsa stories articulate the importance of genuine empathy and attunement to the interests of others, particularly towards those who are marginalised or in need, often with the belief that ancestors and deities appear to their people as beggars, lepers, and strangers. In one study a Bulsa elder recounts this story:

[41] Wiredu, K., & Gyekye, K. (1992). Person and community. Washington, DC: Council for Research in Values and Philosophy, p. 194.
[42] Ibid. p. 193.
[43] Ibid. pp. 192-206.

> There once lived two brothers, Ayam and Apola, who resided in different compounds in the same village. They were both very rich. One day, a leper came to Ayam's compound to beg for food. Instead of giving him food, Ayam chased the leper away for fear that he and his family would become infected with such a contagious disease. The leper next went to Apola's house and was warmly welcomed by Apola and his family. Apola even made a feast for the leper and asked him to stay for the night. The next day, before the leper set out to go, he said his name was Awenkperik. The leper asked Apola to see him off. Halfway into the bush, the leper asked Apola to wait at a spot and he will return later. The leper came back as a healthy human being. The leper then said to Apola, 'I am god who has become a leper to test your kindness'. [44]

Two ethically relevant features are worth noting in this story. First, right action is not sufficient to express the correct moral outlook: morally upright persons are expected to be good-hearted and humane, not just principled. The moral significance of empathy marks a distinction between a minimal and a richer concept of ethics. The former is the "the observance of rules for the harmonious adjustment of the interests of the individual to those of others in the society."[45] A richer conception of ethics, however, would add a "conformity to those requirements which is inspired by an imaginative and sympathetic identification with the interests of others even at the cost of a possible abridgement of one's own interests."[46] The second view promotes human flourishing and strives for goals beyond the mere fulfilment of duty. Thus, a central detail is the way Apola treats the leper: he shows respect and kindness by warmly welcoming him into his home, sharing his food, and offering shelter for the night. Wiredu likewise recalls a popular phrase by a Ghanaian comedian who says: "Ability without sentimentality is nothing short of barbarity."[47] Such is the value of empathy that, Ganle et al. highlight the lack of empathy among health care providers as one of the reasons for low patronage of free maternal health care in Ghana.[48]

Second, Akan and Bulsa humanism is embedded within a complex cosmological vision that departs from the predominant humanist secularism predominant in Western contexts. Both the Akans and Bulsa adhere to a system of beliefs that include the existence of minor deities and a Supreme Being. The Supreme Being is conceived of as the embodiment of goodness. "God is good in the highest; but his goodness is conceptually of a type with the goodness of a just and benevolent ancestor, only in his case the qualities are

[44] Apentiik, R. (1997). Bulsa technologies and systems of thought. Calgary, p. 233
[45] Ibid p. 193
[46] Ibid p. 194
[47] Wiredu & Gyekye, op. cit. note 34, p. 198.
[48] Ganle, John Kuumuori, et al., op. cit. p. 425.

unlimited."[49] Deities and ancestors are believed to have interests in the moral rectitude and social virtues of individuals, with curses or blessings to be bestowed accordingly.

It would be misguided, however, to presume that ethics depends on a direct appeal to God or the Divine Will to uphold or proscribe moral precepts, or that their agency detracts from the humanist focus of ethics. Wiredu goes to great length to challenge the presumption that Akan morality is conceptually dependent on religion: "the will of God, not to talk of any extra-human being, is logically incapable of defining the good."[50] Deities and ancestors, however, are not above human interests; indeed, their own interests congregate around human interests. Appeals to divine sources within Akan and Bulsa humanism are in effect "practical utilitarian programmes for tapping the resources of this world."[51] Just as individuals might expect to face repercussions for their inhumane conduct, minor deities that do not deliver what is expected for human good – for example, healing from illness, abundant harvest, victory in battle, safe travels, and so on – are equally treated with contempt. The worship and veneration they receive is proportional to their capacity to assist humans in their endeavours.[52]

In sum, empathic humanism is neither the pursuit of an abstract ideal of humanity nor an over indulging emotionalism; it requires the constant effort to identify and share the interests of the other, to approach others with a respect and humanity, and a congregation around human interests – an expectation extended even to deities and ancestors.

(iii) Virtuous character

Communitarianism sets the objective standard or ideal of human flourishing and empathic humanism articulates the congregation and reciprocity of human interests; both can only be achieved through a virtuous character, another core feature of Akan and Bulsa ethical thought. In earlier studies of

[49] Apentiik, op. cit. note 44, p. 194
[50] Wiredu & Gyekye, op. cit. note 34, p. 195. 5
[51] Ibid
[52] This is not to deny the complex religious enculturation that has occurred within the African context. The superimposition and amalgamation of Christianity and Islam with their precise moral canons on African traditional cultures makes it difficult to disentangle the motivations that lie at the heart of moral discourse today. Moral objections to issues like abortion or homosexuality in Africa are often backed by arguments from Tradition—'our way of doing things'--, the Bible or the Koran—'God forbid'--, and nature—'it is against nature'. Given that the dominant positions of Africans on bioethical issues—abortion, euthanasia, homosexuality—are similar to those of conservative religious persons in the West, it is often assumed that African moral frameworks are grounded on religion and that a good dose of secularism and liberalism that come with economic prosperity will bring Africans round to holding the same values as Westerners. This assumption, unfortunately, is not backed by data. In fact, there is reason to believe that the contrary might be happening. The last three decades have seen a rise in the GDP of many African countries and the emergence of a new educated middle-class. This according to a Weberian model should have produced a diminishing attachment to religion. Yet, these decades have also seen the multiplication of churches and church-goers and the emboldenment of religious leaders to such an extent that political leaders look to them for endorsement in their electoral campaigns.

Akan culture like those of Danquah[53] and Christaller,[54] ethics has been translated as *obra*, literally meaning 'conduct' or 'behaviour'. However, Gyekye points out *obra* (life, manner of life) is a much wider concept than ethics since not all aspects of life are ethical: 'A well-articulated moral system does not necessarily produce good character; neither does knowledge of moral rules make one a good person or produce good character.' [55] A more adequate concept of ethics in Akan is *suban*, meaning character.[56] As Gyekye explains:

> The concept of character, *suban*, is so crucial and is given such a central place in Akan moral language and thought that is may be considered as summing up the whole of morality. Thus, when the Akans want to say, "He has no morals," they would say, "He has no character" (*onni suban*). *Onni suban* is much used to express moral disapprobation of all kinds. Sometimes the word pa or papa, meaning "good" (in the moral sense), is added: thus, *onni suban pa* ("He has no good character", "He has no morals," "His conduct is unethical"). An equivalent expression is *owo suban bone* ("He has bad character"). The opposite of *onni suban pa* ("He has no morals") is *owo suban pa* ("He has morals," "He is ethical, moral"), said of a person whose actions are morally praiseworthy, Being a bad person (*onipa bone*) and having a bad character (*suban bone*) are considered identical; similarly, being a good person (*onipa pa*) and having a good character (*suban pa*) are considered identical.[57]

The exercise of virtue is so important that Akan philosophers have theorized that the status of moral personhood is acquired through virtuous behaviour.[58] A person who is morally unworthy is referred to as *onye nipa* – he/she is not a person.

The rich linguistic distinctions in the Bulsa ethical framework likewise reveal a character-based account of virtue which has an aesthetic rather than deontological quality. In Buli (the language of the Bulsa), the good is often denoted in three words: *mang*, *magsi* and *nallem*. The word *mang* is an adjective that qualifies a noun to denote propriety, efficiency and authenticity and fulfilment. *Mang* is normally never

[53] Danquah, J. B. (2014). The Akan doctrine of God: A fragment of Gold Coast ethics and religion (No. 2). Routledge.
[54] Christaller, J. G. (1881). A dictionary of the Asante and Fante language called Tshi (Chwee, Twi): with a grammatical introduction and appendices on the geography of the Gold Coast and other subjects. Evangelical Missionary Society.
[55] Gyekye, K. (1995). An essay on African philosophical thought: The Akan conceptual scheme. Temple University Press. pp. 147, 149.
[56] Ibid. p.147
[57] Ibid pp.147-148.
[58] Importantly this is subject to significant philosophical debate, particularly around difficult questions as to whether this account of personhood is overly demanding. We set aside these issues for the purposes of this paper.

used as a noun. It is employed in a similar way that the English word good is used as a qualifier. The usage is not necessarily moral; it simply denotes that the noun it qualifies fulfils what is expected of it. It only becomes moral when the subject of which it qualifies is of a moral nature.

Magsi denotes what is right and that which is proper. For example, when a person who has been way from the village for a long time returns, it is right (*ku magsi*) for him to go visiting amongst her neighbours, particularly those who were bereaved during her absence. Or if a young man is interested in getting married, it is right (*ku magsi*) that the elders of his family pay a visit to the young lady's family to express their ward's intentions. From an ethical viewpoint, the notion of *magsi* refers to propriety and the observance of traditions, rules and customs.

This duty-centred notion of the good, doing the right things, however, does not capture the Bulsa moral concept of good in its entirety. A broader and more far reaching concept is *nallem*, used both as an adjective *ku nala* or as a noun *nallem*. Although there is no literal translation of this word into the English language, the nearest equivalent European concept to *nallem* is the ancient Greek *kalos*, which typically corresponds to a sense of the 'admirable', 'creditable', 'honourable'.[59] The Aristotelian usage of *kalon* further implies objects, nature, actions, or traits which strike an onlooker as 'fine' and 'fitting'.[60] Similarly, the term *nallem* means good, beautiful, elegant, nice, right. The most casual greeting among the Bulsa is *Kasia?* – how is it? — and the answer is usually *nallem*. The combination of *nallem* and *ku magsi* – that which is good and right/proper – produce a state of *masim* or *ku masa* meaning it is sweet.

An underlying sense of filiation and empathic humanism motivates behaviour that is *nallem* or morally good. The presumption is that all human beings possess the same dignity, conferred by being one-in-relation, i.e. a daughter, a son. As a result, what is worthy and good for oneself is equally good and worthy for the other person. Morality among the Bulsa is akin to the biblical recommendation of doing unto others as one would to oneself. When a Bulsa person is described as *wa nye ka nala*, her behaviour is *nallem*, it means that such a person is morally good and can be called a *nurmang* – translated literally as a real, authentic, and morally good person. Such a person will display altruistic, generous, magnanimous, considerate and collaborative traits within the community, promoting harmonious and cordial living among people and has a caring disposition.[61]

One who is *nurmang* is contrasted from other traits, such as one who is *nurkpiong*, or economically or socially successful. The meaning of this term lacks the same moral value of *nurmang*. For example,

[59] Dover, K. J., & Dover, K. J. (1994). Greek popular morality in the time of Plato and Aristotle. Hackett Publishing.
[60] Irwin, T. H. (2010). The sense and reference of kalon in Aristotle. Classical Philology, 105(4), 381-396.
[61] It is interesting to note that when the first Christian missionaries arrived in Bulsa land, they tried to translate the Roman Catholic concept of Saint into Buli. After consulting with the local catechists, they chose the nominative form of nallem. Hence Saint Peter became *Piita Nalung*. In other words, sainthood, which is equivalent to the exercise of virtue worthy of emulation is to live according to the concept of *nallem*.

when a rich person is known to flaunt her wealth through ostentatious giving (through organising feasts or gifts) the Bulsa do not normally refer to such a person as a *nurmang*, at the best, she will be called a *nurkpiong*. At the end of the ethical spectrum, a person who sows division and conflict or lacks compassion and is uncooperative in community projects is *wa nye ka tua*, meaning her actions taste bitter. A *nurbiok* (bad person) consistently places her personal interests above those of other members of the community, exhibiting a character that is greedy, egotistic, vain, and trying to obtain wealth through dishonesty or cheating others. These traits produce the state of *kaasi*, meaning broken, rotten, dysfunctional, damaged.

The moral vision expressed in *nallem* is rich, yet elusive: above all, it evokes the concept of beauty and harmony, suggesting that the Bulsa concepts of both good and wrong-doing have a distinct aesthetic quality, a sort of Greek-like *kalosgathon*. This notion of the good, from a normative viewpoint, is thus a question of harmony and integrity both on individual and collective levels. Even though it can be broadly schematised, what is *nallem* cannot be reduced to a single concept or precise duties or obligations but can only be experienced or perceived in its exemplifications.

V. Towards a Ghanaian Framework?

So far we have seen that Akan and Bulsa perspectives embed normativity within ontology, where human ethics is situated within a cosmological order that is open to the transcendent and fosters a relational communitarian morality within which virtue is construed as empathizing with the humanity of the other. From a normative viewpoint, how can these indigenous Akan and Bulsa frameworks set out a refined bioethical healthcare framework that is fit for purpose in the Ghanaian context, and what are the implications of this for training health professionals in this context?

Importantly, the idea of proposing a refined framework does not necessarily require a complete substitution or abrogation of current normative instruments. It does, however, require rethinking and broadening the theoretical framework informing the current normative tools. As we have seen, these tools, which are largely borrowed from a Euro-American context and grounded on a rights discourse, fail to capture the complexity of relational values at play in the Ghanaian context. The principal ethical challenge in this context is to ensure respect, equity and justice for every individual whilst conserving the values of a harmonious and empathic communitarian life. An approach to health care bioethics that appears to be too confrontational or insistent on individual rights, without regard to maintaining harmonious relationships fails to capture the breadth and depth of the ethical dilemmas of stakeholders.[62]

[62] Another possible way of conceptualising the dilemma is a conflict between more 'partialist' ethics in Africa and more justice-related perspectives associated with Western bioethical frameworks. For example, Christopher Simon Wareham problematises the partialist lens in African moral theories which stress the importance of familial and

Such a culturally grounded framework does not only generate new ways of thinking about ethical problems; it also brings to the fore ethical problems that would not normally be considered in mainstream bioethics. For example, the dilemma of John, the lawyer and royal family member of the Bulsa, whether or not to prosecute the hospital and nurse whose negligence led to the death of his wife. Or the choice face by Akua's family whether or not to pursue legal action against the rural clinic of Krom, which is run by an NGO, and does a lot of good to the community. One might be tempted to dismiss the inaction of the victims' families as a sign of power imbalance between an individual family and institutional structures. Whereas such an argument could be made in the case of Akua's family, it cannot be upheld in the case of John who is in a position of power with respect to the hospital where his wife Jane died. For many Ghanaians, the choice between demanding their rights and endangering cherished harmonious communitarian or ethnic or religious relationships is a real ethical dilemma.

For the existing normative tools to be effective and to resonate with the local context, two key adjustments are necessary. First, norms must be framed, not only as rights of the individual, but also in a framework and language that captures the holistic nature of the good, namely its communitarian and spiritual grounding – two domains that are typically excluded in rights-based frameworks. The Akan and Bulsa communitarian frameworks may not in themselves be anything new. However, their ontological rather than utilitarian or pragmatic grounding points to the intrinsic relatedness of every person whereby each individual contributes in their specific role towards the good of all, because each person is another 'me'. Likewise, the community is embedded within a meaningful cosmos, positing an intimate connection between a thoroughly humanistic ethic and spiritually-transcendent considerations. In classic principlist bioethical terms, the normative emphasis would shift towards a predilection for considerations of beneficence as opposed to autonomy first and foremost, though clearly respecting individual autonomy is not to be perceived as an exigency that stands in stark contrast with communitarian interests or against the spiritual imperatives of the community. In this regard, encouraging families of victims to denounce medical malpractice can be framed not so much as a quest for reparation or 'justice' but as a constructive attempt to

communal ties, suggesting that this could lead to difficult implications in terms of distributive justice of health resources (see Wareham, C. S. (2017). Partiality and distributive justice in African bioethics. Theoretical medicine and bioethics, 38(2), 127-144.). This issue lies beyond the scope of our paper, however, our immediate reply is that the claim around the partialism of African normative ethics is often overstated and rests on a misunderstanding. The communal self has an intimate connection to spiritual and ontological dimensions of personhood which rest on claims around common humanity. A stranger is therefore also a 'self-in-relation', with filial ties, and this means the medical practitioner is obliged to treat her as such (making her treatment perhaps no different to a person known to the practitioner). Moreover, though the binary between 'partial' and 'impartial' seems to be crucial to Western ethics (rooted in the importance of epistemology in moral philosophy – see Taylor, *Sources of the Self*), it is our interpretation of the African philosophical tradition that African conceptual schemas do not share the same starting premise, and as such, should not be a problematic that is necessarily imported to this context. Thanks to an anonymous reviewer for pushing us on this point.

strengthen the community against further damage: so that another 'me' or another *nurbiik* does not suffer the same plight.

Second, a less legalistic, more humanistic and virtues-based presentation of core ethical tenets will need to form the foundation of medical training, in terms of reconfiguring and emphasizing the moral character of health care practice, and in terms of formal educational programmes in ethics for healthcare practitioners. It is worth reflecting further on these two dimensions of a modified relationship between the goals of medical education and professional ethics teaching activities.

For medical education more broadly, Akan and Bulsa frameworks suggest that ethical attitudes and behaviours in professional settings must be acquired through practice and habituation. From this perspective, the training for and exercise of the healthcare professions demand a continuous defining and sharpening of the ethical habits of practitioners. This renewed emphasis involves further articulating a coherent local conceptual account of the 'good professional' such that the trainee health practitioner recognizes herself as a person embedded within a local community of likeminded people who are unified by their sharing of certain values. Professionalization is likely here to demand no overarching endorsement of a set of abstract duties or regulatory requirements, but a deep sensitization to the manifestation of health concerns in the local population, and the enactment of the same empathic humanism that underpins the community's moral code.

With regards to specific ethics training programmes within medical education, the medium of education likewise needs to be tailored so that these indigenous normative frameworks can be rendered practical and effective in supporting sound moral judgements in health practice. This requires ethics education to foster health professionals to invoke reformulated ethical values, but not to foreclose the importance of making critical and contextually-sensitive judgments concerning the application of these values. Developing the capacity to make sound ethical judgements in health practice here requires a bottom-up sensitization to the realities of ill people's lives and the interpersonal contexts in which they are situated, rather than a didactic, top-down, training in overarching moral values. Embracing the richness and messiness of practical examples that capture this insight will enable trainee health professionals to recognise a number of important ethical learning points. First, in enabling normative ethical values to be articulated in ways that capture their local provenance and practical force. Second, in revealing how an awareness of these values gives shape to a recognizable and distinctive set of ethical problems that are likely to be specific to this context. And, finally, in revealing how conflicts between values produces practical dilemmas that require professionals-in-training to adopt a critical and self-reflective attitude to determine how to resolve these dilemmas in the real world.

Reconfiguring ethics education in this way has implications for teaching strategies as well as differently specifying trainees' learning outcomes. Rather than dictating to practitioners about overarching

moral principles, strict rights, duties, or sanctions based on professional codes or medico-legal judgements, ethics training benefits from drawing on the principal modes of ethics teaching that are commonly adopted in most African settings: storytelling and proverbs. Storytelling may seem an archaic means of cultural and value transmission peculiar to peoples who rely on an oral rather than a written culture. However, Akans learn morality through the Ananse stories and Bulsas through the tradition of the *sunsuelima*, and throughout the African continent, a general outlook about the meaning and purpose of life, human destiny, the divine, conduct, and morals is conveyed through folktales and myths.[63] Such stories convey ethical principles that are familiar to every adult Akan and Bulsa.[64] This form of ethical training is not unique to Africa. Storytelling, as Martha Nussbaum states, has specific place in moral education. "Certain truths about human life can only be fittingly and accurately stated in the language and forms characteristic of the narrative artist."[65] This position is well-supported by recent work in narrative medicine that emphasises the key role that narratives can play in fostering empathic and reflective capacities[66] – not only by introducing stories into the medical classroom, but also in requiring professionals to narrate, and reflect together on, their own stories. Just as importantly, therefore, the concreteness of the moral choices of persons as presented and narrated in stories adds a lived dimension to what may otherwise seem an abstract and technical problem for the expert professional to solve. Moreover, a focus on stories and folktales allows medical problems to be presented in the broader relational contexts in which they emerge and can foster a capacity to judge soundly in ways that make equal appeal to both reason and emotion.

Proverbs are also important for ethical training, particularly in articulating the full range of values that prevail amongst the Akans and Bulsa, and that ought to be drawn upon to review and discuss the narratives presented. As Mbiti writes, 'It is in proverbs that we find the remains of the oldest forms of African religious and philosophical wisdom'.[67] Core ethical tenets can be found within proverbs, where

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[63] *Sunsuelima*, are stories that are commonly narrated to children. Usually, children from various families gather around an elder who tells these stories in a dramatized way. The names of the persons in the stories carry implicit meanings. Animals are also anthropomorphized in the stories in a way that encourages a humane perception of animals. Even though the heroes of these stories can be negative figures, the thrust of the narration usually outlines the importance of ethical values. See also Gyekye, Kwame. An essay on African philosophical thought: The Akan conceptual scheme. Temple University Press, 1995. p. 14.

[64] The story of Apola from the Bulsa tradition is an example.

[65] Nussbaum, M. C. (1990). Love's knowledge: Essays on philosophy and literature. OUP USA, p. 5. An example of how storytelling has been used for moral education can be found in what is perhaps the oldest tradition in Western culture, the Roman Catholic Church. The hagiographic texts re-interpret, tweak and present models of Christian excellence to the faithful by narrating the lives of the saints. The virtues attributed to the saints, ---Augustine, Francis of Assisi, Ignatius of Loyola, Teresa of Avila, Maximiliano Kolbe, Mother Theresa of Calcutta, etc--- to name a few, bring to life the virtues that Catholics ought to practice.

[66] See, for example, Charon, R. (2008). Narrative medicine: Honoring the stories of illness. Oxford University Press., DasGupta, S., & Charon, R. (2004). Personal illness narratives: using reflective writing to teach empathy. Academic Medicine, 79(4), 351-356., and Kumagai, A. K. (2008). A conceptual framework for the use of illness narratives in medical education. Academic medicine, 83(7), 653-658.

[67] Mbiti, J. S. (1970). African religions and philosophy. NY: Doubleday, p. 86.

sayings like *obi nne yiye nnya bone* ('The pursuit of beneficence brings no evil on him who pursues it'), or 'If you do not allow your neighbor to have (or to reach) nine, you will not have (or reach) ten' appeal to the common humanity of all which precludes egoism and fosters inclusion.[68] Closer attention to Akan and Bulsa proverbs provide the substance of social and ethical virtues, articulating the moral obligations of mutual aid and interdependence, and the view that seeking the good of the community is intrinsic to seeking one's own good. But perhaps even more importantly, the didactic quality of proverbs lies in their situational and experiential emphasis which suggests appropriate wisdom arises through the particular circumstance, described in rich, narrative form.[69]

VI. Conclusion

As attempts to provide better quality health care increases, greater attention is being paid to the ethical issues surrounding health care delivery in Africa. Drawing on the Ghanaian context, we have shown in this paper the importance of incorporating African ethical frameworks in order to reframe the ethical dilemmas facing healthcare provision as well as offer potential ethical tools that are motivationally and normatively resonant with the values of stakeholders. These tools will have to be grounded not only on universalist conceptions of rights, but will require an integration of indigenous communitarian, empathic and virtue ethics. These values, as we have shown from the Akan and Bulsa accounts, cut across ethnicities, thus enabling them to be applied above ethnic distinctions. It also calls for adequate and widespread ethical training of health care providers aimed not just at learning abstract moral principles and codes, but at sharpening sensitivity to the multiple layers of stakeholders' ethical commitments. Practical ethics can only be effective if it is grounded in values that people can identify with, and if it tackles issues that are relevant to their lives.

The project of elaborating such culturally sensitive ethical training programmes in the African context is only at its initial stages. Future efforts will have to be directed to seeing how the concepts we have identified in this paper can respond to the varied ethical challenges that arise in health care practice in Africa, and how those in frontline clinical and caregiving roles can be supported to apply these concepts in their work.

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[68] Gyekye, K. (1995). An essay on African philosophical thought: The Akan conceptual scheme. Temple University Press.p. 18; Gyekye, K. (1996). African cultural values: An introduction. Sankofa Publishing Company, p. 60 and p. 191.

[69] Gyekye, K. (1995). An essay on African philosophical thought: The Akan conceptual scheme. Temple University Press, pp. 18-20.