Medicine and culture: transcultural needs in modern Western societies

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Abstract

A distinction can be made between two types of cultural diversity in the practice of medicine: cultural diversity among the individuals involved in healthcare settings (i.e. doctors, nurses, patients, etc.), and diversity in the health paradigms now prevalent in contemporary modern societies (e.g. orthodox Western medicine, Chinese acupuncture, Indian ayurveda and Yorùbá medicine). In contrast to the received view, in which diversity is regarded as 'challenging' or 'problematic' for the provision and delivery of optimal healthcare, this paper argues that because health, wellbeing and wellness are themselves cultural goods in all paradigms of medicine, it is always possible to perform transcultural assessments of the methods, theories and practices adopted in specific paradigms of medicine.

Introduction

It is customary in contemporary Western cultures to distinguish between traditional and alternative medicine. Traditional medicine refers to orthodox medicine – medicine as practised by doctors who have undergone training in medical schools that are approved by medical associations. Alternative medicine is a generic term used to describe any other approach that employs principles and methods that are different from those of orthodox medicine. Chinese acupuncture, Indian ayurveda, Yorùbá medicine and the healing aspects of Sufism are all regarded as alternative medicines by many Western societies. Oftentimes, these medical alternatives (with their different values, methods, beliefs and conceptions – paradigms for short) clash with the Western (orthodox) paradigm of medicine. This paper is an exploration of the rationality of decision-making vis-à-vis the ethical problems that arise when a physician and a patient adhere to different paradigms of medicine in 'multicultural' Western societies.

The main problem is that multiculturalism tends to lead to relativism. Multiculturalism may be defined as 'a societal-intellectual movement that promotes the value of diversity as a core principle and insists that all cultural groups be treated with respect and as equals'.[1] If physicians are required to respect and tolerate the values, beliefs and conceptions of their patients, then we may end up with irrational and illogical decisions, and indeed, in some situations, medical practitioners may be forced to acquiesce to various types of injustices. Should we simply accept these illogical and relativistic conclusions as consequences of living in multicultural societies? This paper maintains that we need to make a crucial distinction between multiculturalism and transculturalism. Multiculturalism would maintain that no medicocultural practice or value can be evaluated independently of its associated paradigm, whereas transculturalism maintains that the values, methods and beliefs of each paradigm can themselves be subject to evaluation, while at the same time treating them with respect and regarding them as equals. My argument is that because medicine is a cultural good in all paradigms of medicine, it is always, in fact, possible to engage in transcultural evaluations when it comes to issues of health, wholeness and wellness. Simply put, because medicine is itself a cultural good, the paradigms of medicine may sometimes conflict but, ultimately, these paradigms are not incommensurable.

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Medicine as a cultural good

The word 'culture' has at least two everyday usages: on the one hand, it means 'high culture', that is, the 'best' exemplars of a society's achievements and products in the arts, literature, music, science and technology. The second sense of the word 'culture' is that in which it refers to the artificial cultivation and growth of microscopic organisms, species and plants. This second sense of the word derives its meaning from the verb 'to cultivate', 'to husband' (in the sense of agricultural techniques). These two senses of culture are linked: for not only are achievements in the arts, literature, science, etc. 'artificial' in that they are human creations, the elements of 'high' (and, of course, 'low') culture have to be cultivated, learnt, nurtured and transmitted otherwise they will wither away and die.

Medicine is, at the very least, a cultural good in these two senses: it is about the achievements of a society in its quest to understand itself as the human knower, just as much as it is about the cultivation and transference of knowledge about us as the knowing subject. There are three dimensions to these cultural aspects of medicine: the communal, the individualistic and the practical.

Culture as communal practices

Medicine is communal: it is the shared set of beliefs, practices and methods that make up a society's communal bank of knowledge on the prevention, alleviation and curing of diseases and injuries. Medicine in this communal sense is reflected in the social activities of a people as a group. One of the clearest illustrations of the communal dimensions of medicine is public health concerns in the protection, promotion and restoration of people's health. Solutions to

public health concerns require the combination of various scientific skills and social action. Public health aims to improve and maintain the health of all the people through collective or social actions. Although the communal dimensions of medicine are easily exhibited in public health, medicine as a social institution can be conceived of as a domain of inquiry that has as its goals the prevention and reduction of disease, premature death and disability; the prolongation of life and the promotion of physical and mental health; the control of community infections; the training and organization of professionals to diagnosis and treat the infirm; and the development of other social mechanisms for the achievement of these social goals.

In this sociologistic/communal sense, medicine has some key characteristics:

- It is learned;
- It is a field of human knowledge that studies and deals with the organic, environmental, psychological and biological dimensions of human existence;
- It is structured;
- It is divided into aspects;
- It is dynamic; and
- It is variable.

Culture as individual beliefs

Culture in medicine is not just about socially variable practices. It is also pyschologistic in the sense that it is a manifestation of individual beliefs about ontology, metaphysics and methods for the realization and achievement of health, wholeness and wellness. The point here really is that 'all knowledge is to some extent concerned with the knower: our attempts to know things about the natural world are also part of a much larger attempt to understand ourselves'.[2] And, in understanding ourselves as the knowing subject, we uphold various medicocultural beliefs. At one level, these beliefs might just be about faith. But at another (practical) level, they may form the content of heuristic action-guiding principles that moderate and affect human action.

So, a fourth basic way in which medicine is a cultural good is that in which it is a repository of the concepts, ideas, words, methods and other symbolic structures that individuals rely on in their day to day living. In this sense of the word, medicine as a cultural good is not just about beliefs and values that we uphold; it is also about how we internalise and operationalize these beliefs and values in regulating and controlling the organic, environmental, psychological and biological dimensions of human existence.

Culture can therefore be found not merely in communal medical practices. Nor is it confined to explicitly proclaimed beliefs. Cultural assumption can also be found in unstated psychological assumptions about how we understand, develop, treat and encounter ourselves. In this psychologistic sense of medical culture, medical values are not just about explicitly proclaimed beliefs, they are about those unstated convictions that implicitly guide and govern practical conduct in issues of health, wholeness and wellness. We may refer to these dimensions of culture as practical beliefs. This would be a fifth sense in which medicine encompasses culture.

Here is a quick recapitulation of these goods.

1. Medicine is a repository of a society's achievements in the human sciences.
2. These achievements rely on cultivated techniques that have to be learnt, nurtured and transmitted.
3. In the process of accepting and transmitting them, they become part of a community or society's general belief structures.
4. At the same time, they will become part of the specific beliefs accepted by specific individuals.
5. Finally, the acceptance and reliance of items 1–4 makes medical beliefs practical beliefs; that is, they become heuristic action-guiding principles on the basis of which we moderate, regulate and control action and inaction in issues of health, wholeness and wellness.

In the next section, I will illustrate how these five senses of medicine as a cultural good impact on the human condition in medical decision-making.

Medicine and practical beliefs

The United States Patient Self-Determination Act (PSDA) [1990] came into force on 1 December 1991. The PSDA requires healthcare providers (including: hospitals, nursing homes, hospice programs, home health agencies and health management organizations) to inform adults (at the time of inpatient admission or enrolment) about certain rights. These include: (1) the right to participate in and to direct their own healthcare decisions during an informed consent discussion; (2) the right to accept or refuse medical or surgical treatment; (3) the right to prepare an advance directive; and (4) information on the provider's policies about the utilization of these rights.

In March 1992, the Indian Health Service (the Federal Health Program for American Indians and Alaska Natives) adopted the provisions of the PSDA, but with the following condition: 'Tribal customs and traditional beliefs that relate to death and dying will be respected to the extent possible when providing information to patients on these issues'.[3] This proviso was included because of the Navajo belief that language and thought have the power to alter, control and shape the course of future events. Because of this communal belief, Navajo custom and practices require people to think and speak in positive terms. For the Navajo, it is also improper to convey or receive negative information (such as the disclosure of the risks relating to a medical treatment or future illness) because that disclosure in itself is perceived as having the power to produce and amplify the negative conditions. In medico-ethical decision making, the Navajo adhere to these beliefs, and they form the basis of Navajo actions and inactions in various contexts (including medical contexts).

The problem of course is that, in adhering to the requirements of informed consent, Western doctors typically convey information about the risks relating to a treatment in a negative manner! This creates a problem: should Western doctors on Navajo reservations adhere to the standards of informed consent contained in the PSDA and thereby risk harming their patients by the disclosure of negative information, or should they convey only positive information (which would be in line with the Navajo

medicocultural beliefs) and thereby violate the ethical requirement of informed consent?

The crux of the matter has to do with the nature of medico-ethical ontology. In contemporary Western conceptions of ethics, ethical and moral issues arise within the context of interactions and contact among natural beings. That is, issues of ethics come into discussion when we consider the implications of human and/or animal actions vis-à-vis other humans and animals. Let us describe this Westernized conception of ethics as the 'this-worldly' approach to ethics. In the next section, I will give a detailed account of an alternative medico-ethical ontology, and then evaluate the implications of this alternative ontology on the practice of medicine in contemporary, multicultural, Western societies.

Culture and the practice of medicine: the Yorùbá conception of Àrùn (illness)

Yorùbá culture and Yorùbá medicine are currently practiced in all major Western societies (including the UK, USA, Germany, Canada, France, Italy, Japan and Australia) It is estimated that there are about 120 million worldwide practitioners of Yorùbá culture. This culture, therefore serves as a good benchmark for the discussion of rationality and relativism in medico-ethical decision-making.

In Yorùbá culture and Yorùbá medicine, actions, activities and inactions involve three-way relationships among: (1) natural beings (plants, animals and humans) and other natural beings; (2) natural beings and spiritual beings; and (3) spiritual beings and other spiritual beings. The Yorùbá view the cosmos as a plain of existence in which there are various subplains, the two most important subplains being the right side (populated by good beings) and the left side (populated by evil beings) (Figure 1).

The powers on the right-hand side are the Òrìsà (the Gods). They are benevolent, but they sometimes punish humans who corrupt society. The Yorùbá pray and offer sacrifices to the Òrìsà in order to achieve their desires. Humans, nature, plants and animals are also classified as being on the right side of the cosmos.

Inhabitants of the left-hand side are the Ajogun (the anti-Gods) and they are irredeemably malevolent. The word Ajogun literally means 'warrior'; hence the Ajogun wage war against both humans and the Òrìsà. The eight warlords of the Ajogun are: Ikú (Death), Àrùn (Disease), Òfò (Loss), Ègbà (Paralysis), Òràn (Big Trouble), Èpè (Curse), Èwòn (Imprisonment) and Èse (Affliction).

There are, however, two supernatural forces that straddle both sides of the left/right divide. These are the Àjé (who are usually improperly translated as 'witches') and Èsù (the universal policeman). Èsù is a neutral element in the sense that he is neither good nor bad. He is simply the mediator between all the entities and forces on both sides of the right/left divide.

Although the Àjé ('witches') also straddle the two sides of the divide, they, unlike Èsù, are not neutral. They are allies of the Ajogun. They suck human blood, eat human flesh and they can afflict humans with various types of diseases. The Àjé are, however, sometimes benevolent. They can bless particular individuals by making them rich and successful. But often, their blessings come at a high price. For instance, it is believed that one of their favourite prices is to ask for the child of whoever is seeking their favour.

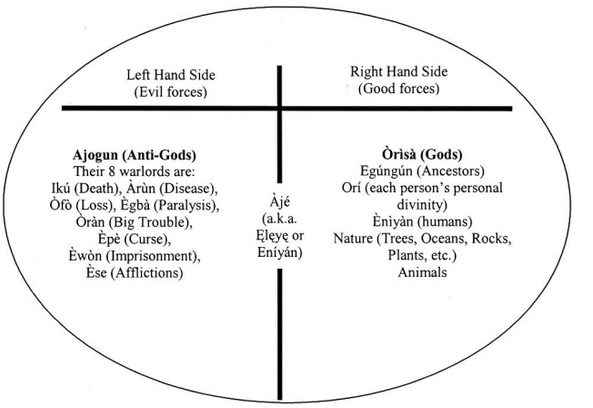

Figure 1. Functional (health, wholeness and wellness) hierarchy in the Yorùbá cosmos

This figure represents one functional hierarchical order in the Yorùbá conception of the cosmos. As the High Deity in issues of political administration of the cosmos, Olódùmarè would have been at the apex of the Yorùbá pantheon had our interests been in the political administration of the cosmos. But in the hierarchical order depicted above, Òsanyìn is at the apex because I am interested in health, wholeness and wellness in the Yorùbá cosmos. Note also that the Ajogun and the other evil supernatural forces are on the left-hand side of the cosmos, and the good supernatural forces are on the right. The entities on the right are good by nature, while those on the left are evil by nature. Olódùmarè (who is regarded as the Chief Political Executive) and Èsù (who is regarded as the universal policeman) straddle the left-side divide because their adjudications and proclamations are required to balance the incessant conflict between the entities on the left and those on the right. The Àjé also known as Eleye (Bird people) and Eníyán (negative people) also straddle the left-right divide, but they are regarded as evil. They are able to transverse the left-right divide because they function through the agency of those Èniyàn (humans) who have given up their good human nature to become Eníyán (Àjé or negative humans).

Because of Èsù's neutrality and the fact that he is neither benevolent nor malevolent, he is regarded as an Òrìsà. He has his own iconography, his own liturgy and priesthood. Human beings are also on the right-hand side of the universe. Although humans are not regarded as supernatural powers, the belief is that every individual has the potential to become a divinity.

What are the implications of these spiritualist beliefs on the practice of medicine in Western societies? The best way of introducing these differences is to start with a characterization of the differences between orthodox and alternative medicine in Western thought. Orthodox medicine is, by and large, allopathic in the sense that its methodology for the treatment of diseases is based on what may be called the contrary principle: it attempts to treat diseases with chemical agents that produce effects that are contrary, or in opposition to, those of the disease being treated. Moreover, allopathic medicine is also concerned primarily with the elimination of symptoms.

Alternative medicine (in the Western sense of 'alternative') is homeopathic. Homeopathic medicine treats like

with like: it employs herbal remedies, which, if given in minute doses, would produce in a healthy person symptoms similar to those of the sick person. Moreover, while allopathic medicine is preoccupied with getting rid of symptoms, homeopathic medicine is more concerned with identifying the causes of illness and disease in an effort to restore holistic balance in the biological system. Yorùbá medicine is homeopathic vis-à-vis the two main points above: it is not just interested in getting rid of symptoms; it is interested in identifying and removing the causes of illness, just as much as it is interested in maintaining holistic balance. So, in their efforts to restore holistic balance in the patient, the Yorùbá medical practitioner (onísègùn[a]) will also be interested in finding the spiritual causes of illness (if there are any), just as much as he or she will be interested in restoring spiritual balance in the patient (if necessary).

Restoring spiritual balance is important for two main reasons. First, in Yorùbá thought the human being is made up of four main components: (i) ara, the body, i.e. the skeleton created by Ògún (a Yorùbá divinity), and the form moulded by Obàtálá (another Yorùbá divinity); (ii) èmí, that aspect of the soul which is imparted by Olódùmarè (the High God) (note that the word 'èmí' is also the Yorùbá word for 'breath'); (iii) Orí, the principle of material success; and (iv) ese, which introduces the principle of individual effort, strife or struggle before the potentialities encapsulated in one's Orí can be actualised. Ese, in short, represents the idea that, ultimately, success is up to the individual. Note that Èmí, ese and Orí (in this context) are all spiritual, while Ara is corporeal. So, strictly speaking, one should say that the person has two parts: ara (the body) and the soul complex (èmí, Orí and esè).

Ifá divination is one important means of diagnosis employed by the medical practitioner. In the divination process, the priest establishes a link among the client, the client's Orí (i.e. each person's personal divinity) and Ifá (the God of wisdom) in a series of steps. So as to protect the integrity of the divination act, the priest is not informed about the nature of the client's complaint until after the divination.[b] (The client will simply whisper his or her concerns to the divination instruments.) After a series of invocations, the priest divines to determine the Odù (book) of the Ifá Literary Corpus from which to select a poem. The priest then explains and interprets the message of the poem. Although there might be variations in the depth of knowledge the priest brings to bear on his or her interpretation of a poem, every specific poem has a specific message.[4]

If, after divination, the onísègùn determines that the source of the disease, illness or affliction is spiritual, then, in addition to herbs and medications designed to treat and repair the body, the onísègùn will also prescribe something for spiritual repair. Sacrifice is compulsory after every divination. But the onísègùn's prescription may include incantations and/or Ifá (Ifá here meaning special herbal talismans, the recipes of which are contained in Ifá poems). Indeed, it is precisely because of this that we have the Yorùbá saying: 'ebo gíńgín, òògùn gíngín níí gba aláìkú là' ('it is a little bit of sacrifice and a little bit of medication that saves the patient who is not going to die').

The role of the Ajogun called Àrùn is very significant for our current discussion. Àrùn has at least two layers of meaning in the Yorùbá cosmos. First, it refers to an anti-God (one of the Ajogun's warlords). In Yorùbá theology, the Ajogun are completely evil and as such they have no redeeming virtues whatsoever. The avowed aim of all the Ajogun, including Àrùn, is the complete ruination of humankind. Only sacrifice and special pleading to Èsù by one's individual Orí can save one from the powers of the Ajogun. And, indeed, all the divinities in the Yorùbá pantheon can be afflicted by the Ajogun.

In addition to Àrùn as an evil supernatural force, the word 'àrùn' also means 'illness' or 'disease'. Àrùn, as a biological defect in a human being, can be caused by natural causes or by Àrùn (the malevolent supernatural force). This explains why divination and sacrifice are important in Yorùbá medicine. It is only through divination that a medical practitioner can determine whether the cause of an illness is natural or supernatural. Illnesses caused by natural causes require herbal and pharmacological remedies. But illnesses caused by supernatural forces require the offering of sacrifice, the use of talismans and amulets, or the recitation of incantations. The practice of medicine is, therefore, not merely homeopathic in the sense that it relies only on physical wholeness, it is also interested in spiritual balance.

In many contemporary Western societies, patients who make use of Yorùbá medicine frequently go to onísègùn as well as Western medical practitioners. Oftentimes, the diagnosis and prescriptions of these two practitioners will not clash. But what if they do? Do we have to accept a multiculturalist relativist position in which there is no rational means of choosing between these competing options?

Transculturalism and medicine: some implications

The foregoing has various implications for the practice of medicine in Western societies. I will consider two of these

[a] It is important to note that traditional onísègùn are also diviners. There are two main inter-related methods of divination in Yorùbá culture: divination with the Ifá Literary Corpus in which there are 256 books and hundreds of poems within each book, and the éérìndínlógún (sixteen cowries) divination system, a system which condenses the 256 books of the Ifá Literary Corpus into sixteen. The traditional onísègùn will be competent in at least one of these two divination systems. I should also point out that there are other traditional methods of divination (for example, kola-nut divination). Also, in contemporary Yorùbá societies, there are now many healers whose methods are not based on traditional Yorùbá medicine. These would include: Christian healers who eschew almost all forms of medication and concentrate on the power of prayers and the holy water; and Islamic healers who make use of the power of words derived from the Qur'an. Islamic healers also depend heavily on talismans and amulets. My assertions here apply only to the healing techniques of those healers who derive their methods from traditional Yorùbá conceptions. I should also add that there are some traditional Yorùbá healers who do not divine at all. They are, however, not called onísègùn, they are called adáhunse (a term which means something like 'he or she who does it alone').

[b] Even this is not mandatory. It is not uncommon for clients to choose not to reveal the precise nature of their problems to the diviner. The client might, therefore, decide to listen to the priests' chants, and interpretations of the poems chanted, and then ask that the appropriate sacrifice for a particular poem be performed.

implications: implications of alternative medicine on medical ethics vis-à-vis the patient–client relationship and implications on the problem of relativism.

Consider first, the context of medical ethical issues. In contemporary Western conceptions of ethics, ethical and moral issues arise within the context of interaction and contact among natural beings. That is, issues of ethics come into discussion when we consider the implications of human and/or animal actions vis-à-vis other humans and animals. In Yorùbá medicine, however, ethics is a three-way relationship among: (1) natural beings and other natural beings; (2) natural beings and spiritual beings; and (3) spiritual beings and other spiritual beings.

What does this tell us about the nature of ethics generally, and medical ethics in particular? One crucial point to emphasize here is that evil in Yorùbá culture (and in Yorùbá medicine) is concrete in the sense that the anti-Gods can manifest themselves as tangible, real or natural effects. This is precisely why the most important warlords of the Ajogun are Ikú (Death), Àrùn (Disease), Òfò (Loss), Ègbà (Paralysis), Òràn (Big Trouble), Èpè (Curse), Èwòn (Imprisonment) and Èse (Afflictions). The consequence of this is that, although the Yorùbá distinguish between natural and moral evil, both types of evil can be the handiwork of natural and supernatural beings.

In relation to Àrùn, sacrifice is believed to be the only effective means of warding off this anti-God. Hence, in relation to diseases caused by the anti-God, regular medication alone will not suffice as sacrifice would also be prescribed. It should be noted that sacrifice is not merely meant for the Gods and anti-Gods. Sacrifice in Yorùbá culture is also a social act. This explains why, when asked to offer a sacrifice to either a God, an anti-God, or, as redemption for sin, a person will invite friends and neighbours to a feast. The person will explain the reason why he or she is offering the sacrifice, and his or her invitees will offer prayers and blessings for that person. In the case of sacrifice as redemption for moral evil, someone who has not truly changed his or her ways is unlikely to receive prayers and blessings from friends and neighbours.

The foregoing has major implications for the health professional/patient relationship. What sort of duties, responsibilities and rights attach to the roles of the onísègùn and the client? Is the onísègùn ethically bound to tell the whole truth to the patient even if this might be inimical to a speedy recovery? The Hippocratic oath, which has traditionally been the basis for Western medical ethics, is silent on the issue of truth. In fact, with this oath doctors merely pledge to 'apply dietetic measures for the benefit of the sick according to [the doctors'] ability and judgment'.[5] Above all, doctors promise to protect their patients from 'harm and injustice'.

Based upon the Hippocratic oath in which protection against harm is paramount, the traditional model of responsibility that emerged within the practice of Western medicine was that of paternalism in which the physician's duty to tell the truth was subordinate to that of not harming the patient. In contrast to paternalism, many have argued that patient autonomy should be the basis of the physician–patient relationship. Neither of these models suits the onísègùn–client–divinities relationship because even the onísègùn is an interpreter who is decoding or attempting to decipher the messages of the Gods. The Yorùbá medical practitioner is not being paternalistic because, as an interpreter, her prescriptions and directions cannot be based on the hierarchical structure of a family-based patriarchy – a structure in which the *pater* (or father) is the person at the apex who is making the decisions on behalf of his 'children' for their own good, even if this is contrary to their wishes. Nor can the Gods be regarded as the *pater* at the apex of the Yorùbá hierarchy because the anti-Gods are often the ones in control.

Autonomy as the basis of the patient–client relationship does hold some promise in Yorùbá medicine. After all, the client, even in Yorùbá medicine, in some sense exercises some level of freedom in choosing between Yorùbá and Western medicine, in the decision to accept and perform the prescribed sacrifice. So within the contexts of this-worldly choices vis-à-vis action in relation to the illness, the client can to some extent be regarded as having the capacity, as an individual that makes rational, individual, informed and uncoerced decisions. However, this autonomy is severely diminished by the supernaturalistic dimensions of Yorùbá medicine. For, given the avowed enmity between Gods and anti-Gods, anti-Gods and humans, and indeed the occasional scuffles between Gods and Gods, humans can never truly be free.

Let us now address the issue of relativism. The problem is this: in a society where there are competing (and often conflicting) paradigms, should the physician always accept and respect contradictory choices (made from within other paradigms) as equally valid? Although a lot of confusion has been wroth on the issue of multiculturalism and relativism, I think this is the least problematic of the problems of cross-cultural comparisons in medical decision-making. As I have already argued above, medicine is a cultural good in any culture. That is, medicine is about the use of exemplary techniques that have been learnt, nurtured and transmitted in a society in such a way that these exemplary techniques become part of the community and individuals' methods for the moderation, regulation and control of action and inaction in issues of health, wholeness and wellness.

Differently put, medicine is not an end in itself – it is a means to an end and as a result of this, different paradigms of medicine can be evaluated in two ways: internally and externally. Internally, we can ask whether the methods and heuristic action-guiding principles adopted by a paradigm are consistent with the goals of that paradigm. Moreover, the methods adopted by each paradigm must be internally consistent (i.e. they must be free of contradictions); they must be realizable or achievable within the confines of that paradigm; these methods must also be in congruence with the values implicit in the communal practices that give rise to them. This is of course an instrumentalist justification of medical decision-making.

Consider, for instance, the following example of the switch from single-blind techniques to double-blind ones in clinical trials. Until relatively recently, double-blind trials were not part of the 'methodology' of Western clinical trials. This switch could be stated as the following prescriptive rule:

> If you want to determine whether a drug genuinely has specified physiological effects, prefer double-blind clinical trials to single-blinded ones.

This instrument justification of double-blind methodology in Western medicine is justified on the grounds that the advancement of knowledge has made scientists realize that the reassuring act of receiving medication and medical attention often has curative effects on patients – even when they have been given pharmacologically inert drugs. This is the placebo effect. To control the placebo effect in the testing of drugs, controlled experiments are performed on a group of patients. The group of patients on which the clinical trial is to be performed is subdivided into two groups: the test group and the control group. Patients in the test group are administered the drug under test, while patients in the control group receive a pharmacologically inert drug which looks like the true drug. But as patients in either group will not know to which group they belong (i.e. patients will not know whether they are receiving the real drug or the dummy drug) the problem of the placebo effect was regarded as eliminated. This is the single-blind test.

But as we learn more about therapeutic effects, we come to realize that in single-blind tests, researchers can, and often do, convey their own therapeutic expectations to the test patients; hence, the placebo effect could still recur in single-blind tests. Moreover, doctors' expectations might affect their judgement as to whether a patient had benefited from a certain treatment. So it becomes preferable to perform clinical trials double-blind. In double-blind trials, neither the patients nor those who conduct the experiment know which patient receives the genuine drug and which the dummy drug. As double-blind trials eliminate a possible source of error which single-blind tests do not, double-blind tests are a more effective means for determining whether drugs genuinely have the therapeutic effects they are said to have.

The use of double-blind techniques in Western clinical trials is obviously desirable, but in Yorùbá medicine, it is not applicable. The method that is applicable at the diagnosis stages of Yorùbá medicine is a single-blind method in which the client does not disclose her concerns to the onísègùn. In the diagnosis stages of the divination process, the client does not divulge her concerns to the diviner directly. Rather she whispers her concerns to the instruments of divination, and the diviner has to continue interpreting poems until the client is satisfied that she has acquired the appropriate level of guidance required.

Conclusions

I have maintained that instrumental efficacy, consistency and achievability within the confines of specific paradigms, and congruence with the values implicit in communal practices that give rise to methods, provide us with a set of criteria for evaluating, by the effectiveness of means in bringing ends, the realization in the practice of medicine. This is because rationality is to a large extent agent- and context-specific. When we evaluate an action or inaction of an individual as rational, we are at the very least claiming that the actor acted in ways which she believed would promote her ends. It should be noted, however, that while an instrumental mean-ends assessment of actions may be necessary for rationality, it may not be sufficient.

Doppelt,[6] for example, identifies the following three circumstances in which instrumental efficacy are insufficient for assessing the rationality of human conduct (and choices):

1. [An] act *A* violates powerful social standards of conduct embedded in the judgements of [a person] *P*, as well as the community or group(s) in which *P*'s activity is embedded;
2. *P*'s subjective ends *E* are so bizarre, idiosyncratic, incoherent, illegitimate or misguided by reference to powerful social norms of conduct embedded in the judgements of *P*'s community of peers, as to make *P*'s action *A* seem senseless, incoherent, mad or otherwise inappropriate; and
3. *P*'s background of beliefs *B* is itself so inconsistent, irrational, idiosyncratic or unstable relative to epistemic standards embedded in the judgements of *P*'s community or peers, as to make *P* an irrational agent, no matter how effective *A* is, to the realization of *E*.[6]

The point is that we can have situations of instrumental efficacy (hence, mini-rationality) which violate any of the three (especially 2 and 3) circumstances above. Irrespective of whether the action or choice was instrumentally efficacious in bringing the actors' goal to fruition, we will still pronounce such actions and choices maxi-irrational.

But this brings us back to the transcultural cultural goods of medicine: implicit in the five cultural goods I have identified is a more fundamental good about the need to maintain health and wholeness. And as such, even when paradigms of medicine adopt methods that are in conflict, they are mostly still concerned with an attempt to deliver good health, wellness and wholeness. Of course, people (from within the same paradigm and from different paradigms of medicine) have disagreed and will continue, hotly, to disagree about how to correctly and exactly characterize good health, wellness and wholeness. Nonetheless, this super-value of health, wellness and wholeness can function as a transcultural, but external, benchmark against which the delivery and practice of medicine in any specific culture can be assessed. Transculturalism, therefore, avoids the pitfalls of relativism (and multiculturalism) because of its reliance on internal and external criteria in the evaluation of medicocultural paradigms.

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