ON THE CREATION AND DISSOLUTION OF ETHNOMEDICAL SYSTEMS IN THE MEDICAL ETHNOGRAPHY OF AFRICA

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Between the mid-1970s and the mid-1980s a number of publications appeared in which earlier ethnographies of illness and misfortune in Africa were criticised for placing too much emphasis on supernatural causation and neglecting natural causation and practical medical behaviour. Indeed, following Warren’s (1974) first criticism of Field, there was what almost amounted to a crusade to prove that Africans have traditionally recognised a separate medical domain in which they interpret illness primarily in empirical and practical rather than in social and moral terms (see, for example, Fortes, 1976; Loudon, 1976; Gillies, 1976; Prins, 1981; Warren, 1974, 1979a, b, 1982; Yoder, 1981, 1982).

In this article I question this attempt to recast African aetiologies. Proceeding from a discussion of the distinction between naturalistic and personalistic aetiologies, around which the whole issue revolves, I examine the critics’ claim that ethnographers have placed too much emphasis on supernatural causation in African aetiologies and that once these aetiologies are viewed more broadly they can in fact be seen to be largely naturalistic. As Janzen (1981: 188) has pointed out, the discussion leads, as all discussions on causality in African thought must eventually lead, to Evans-Pritchard’s Witchcraft, Oracles and Magic (1937). The critics claim that one of the reasons for this bias is that earlier ethnographies, in particular Witchcraft, Oracles and Magic, have been wrongly interpreted. In order to examine the validity of this claim I examine Evans-Pritchard’s description of Zande aetiology in some detail.

This leads to the conclusion that the ‘revisionist’ interpretations of Zande aetiology are in fact mistaken. The question then arises: why the sudden desire to delineate discrete medical systems, and why so much emphasis on natural causation and practical activity? Following a discussion of Wimbum aetiology and the concept of ‘medicine’, based on my own fieldwork in Cameroon, I argue that the emphasis on naturalistic causation and practical activity in the definitions of African medical systems does not make them broader, as the protagonists claim but, rather, narrower, and that descriptions of ‘medical systems’ are not more accurate representations of how Africans interpret and cope with illness but biomedically determined constructs which are imposed on African culture in medical ethnography. I conclude with a plea for the dissolution of the concept of ‘ethnomedical systems’.

CRITICISM OF THE EMPHASIS ON PERSONALISTIC AETIOLOGIES

The re-evaluation of African aetiologies is based on a distinction which is often drawn between naturalistic and personalistic aetiologies.

A personalistic medical system is one in which disease is explained as due to the active and purposeful intervention of an agent, who may be human (a witch or
sorcerer), non-human (a ghost, an ancestor, an evil spirit) or supernatural (a deity or other very powerful being). The sick person is literally a victim, the object of aggression or punishment directed specifically against him, for reasons that concern him alone. Personalistic causality allows little room for accident or chance… naturalistic systems explain illness in impersonal, systemic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, heat, winds, dampness, and, above all, by an upset in the balance of the basic body elements. [Foster, 1976: 775, emphasis in the original]

Foster sees aetiology as the key to cross-cultural comparison of non-Western medical systems; as the independent variable which determines other elements of the medical system (p. 776). He also distinguishes between comprehensive and restricted aetiologies. Personalistic aetiologies are usually part of more comprehensive explanatory models, and illness is seen as being just one form of misfortune. Naturalistic aetiologies, on the other hand, are limited to explaining illness (pp. 776–7). So, for example, in India the hot–cold theory is used only to explain illness, whereas in Africa witchcraft explains not only illness but all kinds of misfortune.

It is an emphasis on comprehensive personalistic aetiologies in medical ethnography that some authors see as a problem. Fortes (1976) and Yoder (1982) trace the problem back to W. H. R. Rivers, who was one of the first medically trained anthropologists to make a systematic study of what was then referred to as primitive medicine. In Medicine, Magic and Religion (1924) Rivers claims that aetiology is the central element of medical systems, and that the study of aetiology naturally leads on to the study of diagnosis and treatment. This explains his focus on indigenous theories of disease causation. He distinguishes between three main kinds of cause: human, supernatural and natural. He states that all three are also recognised in Western societies, but that in the West natural causes are by far the most important, and it is on the notion of natural causation of disease that people base their attitude to disease. Among ‘savage or barbarous people’, on the other hand, beliefs about disease causation fall mainly into the first two categories, and natural causes are hardly recognised at all (1924: 7–8). Human and supernatural causes correspond to the domains of magic and religion respectively, and as a result the distinction between ‘primitive medicine’, magic and religion becomes blurred. Because of its mainly magical and supernatural nature, Rivers concluded, primitive medicine was fundamentally different from Western medicine.

The focus on aetiology as a basis for indigenous illness classification and the emphasis on comprehensive personalistic aetiologies was common in many other early studies (e.g. Clements, 1932; Field, 1937: 114–20, 135–60). It is also found in more recent ethnographic studies (e.g. Beidelman, 1963; Price-Williams, 1979; Ngubane, 1976), as well as in attempts at a more general synthesis: G. P. Murdock’s world survey of theories of disease (1980) is based on a twofold distinction between natural and supernatural theories of causation. Referring to Africa, he states that ‘a disproportionate number of societies emphasising witchcraft theories were found’ (p. 42).

The question now is: what is wrong with this emphasis on comprehensive personalistic aetiologies? And why so much trouble to prove that Africans traditionally explain most illness in naturalistic terms?
Fortes (1976) claims that the gap which has been described between Western and non-Western medicine is a result of the influence of early twentieth-century medical science on such early medically qualified anthropologists as Rivers and Seligman (pp. xii–xiii). Fortes claims that they were ‘obsessed with native theories of magical causality’ (p. xiii) and as a result they ‘reduce the study of health and disease to studies of witchcraft, sorcery, magic and in general curative or socially re-adjustive ritual practices, with herbalist and empirically rational diagnoses, treatment and prophylaxis as residual categories’ (pp. xiv–xv, my emphasis). Yoder (1982) agrees with Fortes, though he avoids the latter’s archaic scientism and explicit biomedico-centrism. Yoder points very explicitly to some of the more important problems in ethnomedical studies in Africa: anthropologists ‘have tended to accept uncritically biomedical definitions of what is relevant in the study of health care and medicine’; they have accepted a dichotomy between biomedicine and other medical systems, and there have been variations in the way the limits of medical systems are established (pp. 1–2).

But, in spite of this perceptive criticism, Yoder agrees with Fortes on the negative influence of Rivers’s conclusions about ‘primitive medicine’ on later generations of anthropologists. As a result, he says, referring to Evans-Pritchard and Turner, ‘the study of medical beliefs and practices became subsumed under the rubric of magic, witchcraft and religion’ (Yoder, 1982: 4, my emphasis). In particular:

Their emphasis upon belief and etiology has led them to neglect other crucial aspects of medical systems, in particular nosology, prophylaxis, and the patients’ choice of medical practitioners. Indeed, there has been little interest in the study of medical systems per se. [Ibid., my emphasis]

The issues raised by Fortes and Yoder can be summed up as follows: the focus on aetiology, and in particular on comprehensive personalistic aetiologies in the medical ethnography of Africa, has led to a blurring of the distinction between the domains of medicine, magic and religion. Anthropologists have been too eager to relegate indigenous disease theory to the realms of religion and magic by describing witches or supernatural beings as the most important, or the only, aetiological agents recognised by Africans, who are seen as interpreting disease primarily in social and moral terms. This has led anthropologists to accept (implicitly or explicitly) that there is a fundamental dichotomy between Western biomedicine on the one hand and all other medical systems on the other. The focus on aetiology accentuates the contrast between biomedicine and other medical systems. This has led in turn to the neglect of the practical, behavioural aspects of non-Western medical systems, and therefore to a neglect of medical systems as such.

But Yoder notes with apparent satisfaction that ‘Recent research, with a broader focus on medical ideas and practices in Africa, presents a rather different picture of both disease aetiology and medical knowledge in general’ (1982: 13, my emphasis). Here he is referring to the work of a number of anthropologists who have made the medical system their object of study and who ‘conclude that people regard most illnesses as having natural
causes’. Because of their ‘wider’ research interests, which include ‘all aspects of medical systems in Africa’ they provide a ‘more reliable data base from which to generalise’ (*ibid.*).

Bibeau, for example, claims (1982: 45) that ‘many studies of African traditional medicine are fragmented, ... breaking up reality’, which is in fact continuous. Indigenous pharmacopoeias, psychopathology, anatomo-physiological knowledge, etc., should be viewed holistically as aspects of a medical system (*ibid.*). He considers it necessary to analyse Ngbandi medicine by establishing the boundaries of the medical domain: defining the ‘semantic domain covered by Ngbandi medical terms, such as care, heal, drug, disease’, identifying medical behavioural settings in which these terms are used and observing the behaviour of ‘the actors of the medical scene’ (1981: 297, 1982: 49).

Both Fortes and Yoder trace the whole problem largely back to Evans-Pritchard, as does Janzen (1981), though Janzen absolves Evans-Pritchard of blame by claiming that later writers have quoted him selectively and out of context (though he refrains from mentioning names). He thinks that Evans-Pritchard’s discussion of natural and other non-witchcraft causes of misfortune in *Witchcraft, Oracles and Magic* has been passed over. Gillies (1976) also thinks that Evans-Pritchard is to blame, and to prove it she quotes his well known statement that the ‘Azande attribute sickness, whatever its nature, to witchcraft and sorcery’. She thinks that, because ethnographers have tended to follow Evans-Pritchard, their conclusions about ideas relating to disease causation have been too sweeping and have not taken account of people’s distinctions between different kinds of illness and different levels of causation (p. 377), and as a result they have ignored or neglected naturalistic explanations.

On the basis of her fieldwork in Ogori village, in Kwara state, Nigeria, she describes Ogori aetiology as ranging from natural illnesses, which Ogori see as part of the normal order of things, to the anti-natural death of a young adult, which they explain by witchcraft (p. 376). She states that this is very different from Evans-Pritchard’s (1937) and Turner’s (1964) claims that all illness is attributed to witchcraft (p. 377). Gillies feels that a similar situation can be shown to exist among other peoples as well, ‘on the evidence of their own conscientious ethnographers’ (p. 378). She points out that Evans-Pritchard, Turner and Horton (1967) mention common ailments which do not require divination and are easily cured with herbal remedies, which suggests that they are probably explained in naturalistic terms (p. 380). She distinguishes between the levels of immediate cause and distant cause, and states that a naturalistic explanation on the former level does not necessarily preclude a personalistic one on the latter (p. 384). This explains Evans-Pritchard’s observation that people’s belief in witchcraft does not contradict their empirical knowledge of cause and effect (p. 387). But she thinks that he was insufficiently interested in the latter: he directed his attention to theoretical aetiology rather than commonsense pathogenic explanation, and unfortunately others have followed him in this (though who these ‘others’ are is not clear) (p. 387). She concludes that the Azande do not, in fact, attribute all illness to witchcraft and sorcery, as Evans-Pritchard claims, but that they have a causal spectrum which resembles that of the
Ogori, containing a number of substantial categories of disease which are not attributed to witchcraft (pp. 391–2).

**EVANS-PRITCHARD AND ZANDE AETIOLOGY**

In his discussion of witchcraft as a cause of misfortune Evans-Pritchard does indeed begin with a bold generalisation—'Witchcraft is ubiquitous. It plays a role in every activity of Zande life'—and he goes on to sum up these activities (p. 63). He continues: 'if, in fact, any failure or misfortune falls upon anyone at any time and in relation to any of the manifold activities of his life it may be due to witchcraft' (p. 64). For the Azande witchcraft is commonplace and normal (ibid.), it is 'not less anticipated than adultery. It is so intertwined with everyday happenings that it is part of a Zande's ordinary world' (p. 65). It 'participates in all misfortunes and is the idiom in which Azande speak about them and in which they explain them' (p. 64). Misfortune can be explained fully only by taking witchcraft into account (p. 71).

But does he really mean that the Azande see witchcraft as the sole cause of all misfortune, as he could be interpreted as saying in the quotations above? No, I do not think that he does. He says that misfortune may be due to witchcraft, and he immediately goes on to say that misfortunes are attributed to witchcraft unless there is good reason to attribute them to other causes, such as sorcery, other evil agents, incompetence, breach of taboo or moral failure (p. 64). And further on he states that 'we shall give a false account of Zande philosophy if we say that they believe witchcraft to be the sole cause of phenomena' (p. 68). What witchcraft does is to bring people into contact with events in such a way that they are injured (ibid.). What the Azande explain by witchcraft is 'the particular conditions in a chain of causation which related an individual to natural happenings in such a way that he sustained injury' (p. 67). Witchcraft explains why two causal chains intersect in time and space (p. 70).

So witchcraft in no way excludes the role of natural causes (pp. 66, 79), it merely explains an unexpected sequence of events. He gives the following well known example:

A boy knocked his foot against a small stump of wood in the centre of a bush path, a frequent happening in Africa, and suffered pain and inconvenience in consequence. Owing to its position on his toe it was impossible to keep the cut free from dirt and it began to fester. He declared that witchcraft had made him knock his foot against the stump... I told the boy that he had knocked his foot against the stump of wood because he had been careless, and that witchcraft had not placed it in the path, for it had grown there naturally. He agreed that witchcraft had nothing to do with the stump of wood being in his path but added that he had kept his eyes open for stumps, as indeed every Zande does most carefully, and that if he had not been bewitched he would have seen the stump. As a conclusive argument for his view he remarked that all cuts do not take days to heal but, on the contrary, close quickly, for that is the nature of cuts. Why, then, had his sore festered and remained open if there were no witchcraft behind it? [pp. 65–6]

Witchcraft does not exclude 'real', i.e. natural, causes but is superimposed on them (p. 73). Azande express the relation between natural and mystical causes by using a hunting metaphor. They call witchcraft the 'second
spear'. When Azande kill game they divide meat between the man who first spear the animal and the one who thrust the second spear. They are both considered to have killed the animal. If a person is killed by a wild animal, then the animal is the first spear and witchcraft the second, and together they killed the person (p. 73–4).

Azande do not attribute all their troubles to witchcraft, and they often recognise laziness and incompetence as causes of misfortune (p. 78). Not even all deaths are caused by witchcraft, and certain deaths may be attributed to breach of taboo, sorcery, or the supreme being (p. 77).

The Azande recognise a plurality of causes, and it is the social situation which determines which one is relevant in a particular context (p. 74).

It sometimes happens that the social situation demands a commonsense, and not a mystical, judgement of cause. Thus, if you tell a lie, or commit adultery, or steal, or deceive your prince, and are found out, you cannot elude punishment by saying you were bewitched. Zande doctrine declares emphatically, 'Witchcraft does not make a person tell lies; witchcraft does not make a person commit adultery.' [p. 74]

In practical situations like this, natural rather than mystical causes are selected because they are socially relevant. Here witchcraft is irrelevant, but it is not totally excluded, either (p. 75). And when Azande say simply that someone was killed by witchcraft they are not excluding natural factors but merely shortening the causal chain and only mentioning the ultimate cause (p. 71), the socially relevant cause in that particular situation (p. 73).

Serious misfortune, especially when it results in death, is almost always attributed to witchcraft, no matter how much incompetence or lack of self-control the individual has shown (p. 78), but trivial failure will be attributed to witchcraft only if all possibility of technical error has been excluded (p. 80). (But what does he mean here by 'attributed'? Does he mean that Azande will speak of witchcraft as a cause of trivial failure only if technical error has been excluded, i.e. that they apply a shortened causal chain, or does he mean they will consider only the possibility of witchcraft in such cases?)

Let us turn now to Evans-Pritchard’s discussion of medicine and disease. He begins his chapter on Azande ‘witchcraft’ in the same way as his chapter on witchcraft as a cause of misfortune, which I have discussed above. He opens with a bold generalisation, only to qualify it immediately in the next sentence.

Azande attribute sickness, whatever its nature, to witchcraft or sorcery. This does not mean that they entirely disregard secondary causes but, in so far as they recognise these, they generally think of them as associated with witchcraft and magic. Nor does their reference of sickness to supernatural causes lead them to neglect treatment of symptoms any more than their reference to death on the horns of a buffalo to witchcraft causes them to await its onslaught . . . they possess an enormous pharmacopoeia . . . and in ordinary circumstances they trust to drugs to cure their ailments and only take steps to remove the primary and supernatural causes when the disease is of a serious nature or takes an alarming turn . . . the notion of witchcraft as a participant in their origin [i.e. the origin of diseases] may always be expressed, and if Azande do not always and immediately consult their oracles to find out the witch that is responsible it is because they consider the sickness to be of a minor character and not worth the trouble and expense of oracle consultations. [p. 479]
Evans-Pritchard's statements about Zande aetiology seem frustratingly inconsistent, and when key statements are placed next to one another he appears to be constantly contradicting himself. Do Azande attribute all sickness to witchcraft and sorcery or not? What he seems to be saying in the passage quoted above is that the Azande recognise a plurality of causes of disease and have a hierarchy of resort to treatment, but that witchcraft is always present as the underlying or ultimate cause. But uncertainty lingers, as he will not always commit himself to a categorical statement. For example, when he says, 'the notion of witchcraft as a participant in their origin may always be expressed' (p. 479, my emphasis) or 'In Zande notions about disease we find that the ideas of witchcraft and sorcery may always be present' (p. 505, my emphasis) what does he mean by 'may always'? Half-way through the chapter I begin to suspect that the presence of witchcraft is never completely excluded as a possibility, but neither is it a necessary condition. This suspicion is to be confirmed when, at various points, he mentions diseases which the Azande do not associate with witchcraft.

The only serious illnesses which are, to my knowledge, not attributed in any degree to witchcraft or magic are two diseases of infants. ... Azande ... have no very definite notions concerning them, though the Supreme Being is vaguely supposed to permit them. [p. 479, my emphasis]

Azande recognise congenital abnormalities and certain diseases such as smallpox, sleeping-sickness and cerebrospinal meningitis as incurable, and attribute them to 'Mbori, the Supreme Being, a word that accounts for whatever cannot be explained by other Azande notions and indicates their incomprehensibility' (p. 489, my emphasis). Azande often see European doctors as the cause of sleeping-sickness, or dysentery, and this would also seem to exclude the possibility of witchcraft (p. 490).

They also attribute some diseases to natural causes by analogy. For example, ringworm resembles fowl's excrement, so fowl's excrement is seen as both the cause and the cure of ringworm (p. 487). But Evans-Pritchard immediately qualifies the suggestion that such analogies entail a category of naturally caused illnesses by distinguishing between 'possible associations in the mind of individuals and collective associations which enunciate formally a mystical connexion between the two' (p. 487). He concludes, 'In my experience a Zande, when he feels the need to attribute sickness to anything, will always put it down to some mystical entity like witchcraft or magic' (pp. 487–8, my emphasis). But then he mentions, on two occasions, that the Azande claim that cupping will cure headache, 'if it is not a headache caused by witchcraft' (p. 508, my emphasis; see also p. 496), i.e. there are some illnesses which are not caused by witchcraft.

The inconsistencies continue. In connection with the distinction between immediate and ultimate cause he states that:

Azande conceive of witchcraft as something distinct from the primary and visible cause of calamity with which it co-operates in inflicting pain on particular persons. But when the misfortune is sickness the two causes tend to fuse. When a lion kills a man the lion and the witch are observably distinct and only participate in calamity to a particular person in a particular situation, whereas disease can be observed only in situations in which it is the ally and tool of witchcraft. Azande do not, therefore,
make any very clear division between the action of drugs in attacking the disease and their action in attacking witchcraft. [pp. 491–2, my emphasis]

But then a little later he appears to contradict this when he claims, 'In disease they also conceive of the disease and witchcraft as separate interacting causes' (p. 508, my emphasis). 'This very naming and identification of disease objectifies it and gives it a reality of its own, independent of witchcraft, just as an animal which has wounded a man has an independent existence of its own' (p. 509, my emphasis). Are the two causes fused and indistinguishable, or are they separate and independent? And do drugs have an effect on witchcraft as well as on the disease, as he suggests above, or do drugs have no effect on witchcraft, as he suggests when he says that cupping will cure headache if there is no witchcraft, or when he states, in referring to chronic illness, 'there is no question of immediately applying an antidote because there are no drugs against witchcraft' (p. 507).

At the end of the chapter he attempts to draw all these loose strands together. He states:

mystical notions are functions of the greater or less danger in which a patient stands. In Zande notions about disease we find that the ideas of witchcraft and sorcery may always be present, and that in their notions about drugs there may always be present the idea of mystical force in the drugs. . . . But these notions are not always of the same intensity. In some cases the disease and the mystical cause form an ideological unity. In others this unity is broken up and we find a belief in dual causation by two distinct forces, the disease itself and the witchcraft which conditions its occurrence and continuance in the organism. Lastly, we find in many cases belief in witchcraft as a causative agent in disease sinking into the background and what we call natural causation dominant. This separation tends to take place when the disease is slight in its organic effects. [p. 505, my emphasis]

Here we finally discover that he has been talking about three distinct ways in which Azande speak about aetiology, depending on the situation and the seriousness of the illness. Witchcraft or sorcery are present in all three, only sometimes the mystical element is more prominent in discourse about illness, depending on how serious it is thought to be. This is confirmed when he states:

in serious illness there is always a tendency to identify the disease with witchcraft or sorcery, and in less serious complaints to identify it with its symptoms which are participating with witchcraft to cause pain. . . . At death the thoughts of a dead man’s kindred are directed only toward witchcraft and revenge, to purely mystical causation, while in minor ailments or at the early symptoms of an illness from which a man may be expected to recover without difficulty they think less of witchcraft and more of the disease itself and of curing it by the use of drugs. [p. 509, my emphasis]

But even here [he continues, still referring to minor ailments], when supernatural causation ceases to be explicit . . . if you were to question a Zande he would certainly insist that he would not have been sick unless some mystical power, normally witchcraft, was against him. Ultimately witchcraft or some other mystical power is the cause and background to all misfortune. But here it is a distant cause, a vague background. . . . Supernatural causes are never excluded entirely from Zande thought about sickness, but they are sometimes more, sometimes less, prominent. [pp. 509–10, my emphasis]
Evans-Pritchard’s conclusions about the role of witchcraft in the genesis of misfortune also apply to illness: witchcraft is always present, but the seriousness of the misfortune and the social situation determine whether or not it will be explicitly mentioned, and that its ubiquity does not exclude natural causes but links unexpected sequences of events. When critics state that Evans-Pritchard has been misinterpreted by those who claim that the Azande explain illness and misfortune primarily in terms of witchcraft, or that he was simply mistaken, on the evidence of his own ethnography, in his conclusions about the ubiquity of personalistic aetiology among the Azande, they are wrong. It should be clear from the discussion above that the ‘traditional’ interpretation of Zande aetiology, as it is described in Evans-Pritchard’s ethnography, is the most acceptable one.

The critics are also wrong when they suggest that their naturalistic/practical interpretations of their own ethnographic data apply to African medical systems generally. In what follows I briefly consider my own ethnography of the Wimbum of the Grassfields of western Cameroon, in order to illustrate that the primacy of personalistic aetiology is not limited only to Evans-Pritchard’s Azande. There follows a discussion of the concept of ‘medicine’, which leads on to a critique of the idea of ethnomedical systems in Africa.

WIMBUM AETIOLOGY 3

When I asked Wimbum about the causes of illness they were often bewildered. Were they doctors? How were they to know what caused illness? Wasn’t that what I should be telling them. They did sometimes have commonsense explanations for simple ailments: they said that backache was caused by hard work, headache by drinking too much alcohol, or coughs by inhaling dust. The degree of elaboration in these explanations varied, depending on a number of factors such as education, knowledge of traditional medicine, knowledge of biomedicine, etc. But when I asked people about the causes of various common illnesses they almost always replied that they ‘just happened’, that they were ‘natural’ or that they ‘had no cause’.4 As a result my interviews on aetiology were always short, and although people were always very busy buying aspirins, nivaquine and ‘capsules’ (tetracycline), I never heard them discussing naturalistic causes of their ailments. I was puzzled by this and mentioned it to my assistant, Lawrence.

‘It’s interesting that people don’t seem to have any idea about the causes of their illnesses. When they tell me that they have backache or cough and I ask what’s causing it they just say they don’t know.’

Lawrence looked surprised. ‘But how do you expect them to know the cause? Do they know about the causes in other countries?’

‘Well,’ I said, ‘if someone in Holland has backache, and you ask him what’s wrong, he’ll generally have some theory about it. I found the same thing during my research in India. People always had some idea of what was causing their illness.’

‘What kind of theory would they have in Holland?’

‘I have a friend in Amsterdam who’s troubled by backache. He says that
it's caused by a draught of cold air coming through his bedroom window and reaching his back under the blankets when he turns in his sleep and his back becomes bare. He says that the cold enters his muscles and that it's that which causes the pain the next morning.

Lawrence burst out laughing. ‘That's all lies,’ he cried. ‘He's just lying because he can't know the cause.’ He went on laughing, until tears rolled down his cheeks.

I was surprised at this outburst. ‘But most people in Holland would have at least some explanation of the cause of their illness,’ I said.

‘Oh, no!’ Lawrence said, still chuckling. ‘White men are very funny, just inventing stories like that about things they can't know about.’

Lawrence didn't think this apparent lack of aetiological knowledge was unusual. In fact he found the idea of elaborate explanations for simple ailments amusing. Maybe he was right. Maybe our obsession with finding elaborate causal explanations for even the most minor ailments, while at the same time shrugging off major disasters and unexpected fatal accidents as coincidence, is a rather strange, culture-bound preoccupation. This is supported by the fact that people who did give elaborate explanations of minor ailments were usually relatively well educated and westernised, and their explanations were strongly coloured by biomedical idiom.

In practice, in the treatment of disease, Wimbum healers did not draw a distinction between what we would call disease and other non-disease misfortune. For example, in an early interview I asked Pa TaKwi, a medicine man, to tell me what he treated. He answered (and here I condense a very extended account):

I fix ngang [a children’s illness resembling kwashiorkor], twins, rib pains, headache, burns. When a person commits suicide I fix the place where it happened. I treat heart pains. If a person can't sleep I give medicines [mcep]. If a woman doesn't menstruate for a long time I give medicine. If you build a new house and can't sleep in it I give you medicine. If you want to marry a girl but she doesn’t love you I can make her love you. If you have a child at school who doesn’t do well because of witchcraft then I will give you medicine.

This was a typical answer. When I asked medicine men what sort of conditions they treated or fixed (kubci) they would mention, in addition to various diseases, all kinds of misfortune, from failure in love or business to motor accidents and poor performance at school.

In discussions about such misfortunes, as well as in the practical activity aimed at preventing them or countering their effects, witchcraft was never far away. In the days following some misfortune or serious accident I would hear people discussing the event everywhere: in the bars in the market square, in the men's societies, along the road where people happened to meet and stop to chat. It was in these settings that I heard numerous discussions of witchcraft. I also had occasion to witness divination sessions in which relatives of the afflicted attempted to discover the identity of the witch responsible, the punishment of suspected witches and rituals aimed at countering the activities of witches or curing witchcraft-related afflictions.

In one case the crops of certain farmers in one quarter of the village had been destroyed or damaged on a number of subsequent occasions by cows.
insects and wind. A meeting of the whole quarter had been organised to discuss the matter, and at the meeting the farmers in question had accused other women of being witches and transforming themselves into cows, insects and wind to destroy their crops out of spite. This was a topic of discussion in the village for a number of days.

In another case, a woman had been seriously injured when a granary under which she had been sheltering from the rain collapsed on top of her. As in Evans-Pritchard's (1937) well known example, everyone agreed that the granary had probably been in need of repair, and that the rain had been very heavy, but they were also convinced that the fact that it had collapsed on her and she had been seriously injured meant that there was 'something wrong in her compound', i.e. that witchcraft was involved.

There were also a number of cases of fatal illness in which a member of the deceased's family was accused of being a witch and causing his relative's illness and subsequent death by delivering him to a cannibalistic society to be eaten by witches. In one case a young man died after a long illness (liver cancer had been diagnosed at the local hospital). At the funeral his brother, who had been accused of cannibalistic witchcraft by a diviner (and who had actually admitted to the accusations in public), was attacked and almost lynched by the mob.

In a similar case a woman in her forties was accused of having killed her brother (who had dropped down dead one day after just recovering from a serious illness) and was banished to another village.

Then there was the case of the taxi driver who survived a serious crash in which all his passengers were killed. Everyone was convinced that he was a member of a kupey society, a modern, urban version of the cannibalistic societies mentioned in the two previous cases, in which a person can offer non-relatives to his witch society for financial gain.5

There were also cases of chronic illness. During a visit to Simon Ngeh, a traditional healer, I noticed that one of the patients in his crowded consulting room, a young woman, had large, open wounds on both feet and ankles. They were so deep that I thought I could see the bone. I asked what had happened to her and Simon said that she had been burnt when she tripped and fell into the kitchen fire more than a year ago. Since then she had been to two hospitals and a string of traditional healers for treatment but the wounds had refused to heal.

Because the wounds had not healed, despite a year of treatment, Simon had immediately suspected witchcraft. He had divined and discovered that one of the girl's uncles was responsible. He visited the uncle and told him that he was aware of what was going on and that if the man did not halt his nefarious practices immediately then he, Simon, would reverse the witchcraft and make it attack its perpetrator, afflicting him with the same wounds. The witch had become scared and agreed to desist. Simon had then begun to treat the wounds and they were responding.

The burns were the result of an accident, and the normal, expected course of events would have been herbal or hospital treatment leading to reasonably rapid recovery. The illness had not followed that course, however, and this led to the consultation of a diviner and accusations of witchcraft. It was only when this the ultimate cause had been eliminated that a cure could be effected.
Wimbum do not discuss minor self-limiting or easily treatable ailments in aetiological terms. When I push them for an explanation they say that they 'have no cause' or 'just happen'. They do spontaneously attribute unexpected fatal illness and chronic illness to witchcraft. They draw no distinction between the (unexpected) death of an individual resulting from serious illness, death caused by accidents which are not related to disease, and other serious forms of non-illness misfortune. My interpretation of Wimbum aetiology is similar to Evans-Pritchard's description of Zande aetiology: in the final instance everything boils down to witchcraft (see Pool, 1993).

WIMUM MEDICINE

Bibeau, whom I have already cited, claims that studies of African traditional medicine break up reality, which is in fact continuous, and that indigenous pharmacopoeias, psychopathology, anatomo-physiological knowledge, etc., should be viewed holistically as aspects of a medical system (1982: 45). He considers it necessary to establish the boundaries of the medical domain by defining the semantic domain covered by medical terms (such as 'care', 'heal', 'drug', 'disease'), identifying medical behavioural settings in which these terms are used and observing the behaviour of the actors on the medical scene (1981: 297, 1982: 49). The problem here, however, is that if, as medical anthropologists, we should direct our attention to the medical system or the medical domain, whose criteria are we to use in defining that domain? Are we to proceed uncritically from Western biomedical categories and terms such as 'medicine', 'disease', 'drugs', 'healing', or should we concentrate on native categories and terms? In this connection I will briefly consider the use of the term 'medicine' in Wimbum discourse.

'Medicine' is the term which people use, in both English and Pidgin, to translate the Limbum mcep (sing. ncep). But the term mcep has a much broader meaning than we assign to 'medicine', so when people speak English or Pidgin they use the term 'medicine' in a much wider sense than we would. In what follows I will briefly mention some of these meanings.$^6$

Firstly, people use the term mcep to refer to more or less the same things we would call medicines: both Western pharmaceuticals and local herbal remedies for illness. They extend this meaning by also referring to herbs and other substances or combinations of substances used to 'fix' or prevent various non-illness misfortunes, or to enhance the chances of success of various undertakings.

Secondly, they call certain objects mcep. A ncep may be a bundle of leaves, feathers, porcupine quills, a mixture of powders, contained in a small leather pouch or other package or container, or some other object, black and shiny from layers of sacrificial blood and soot and encrusted with beads or cowrie shells. The house in which I stayed in the village had been abandoned by the owner because witches had continually tried to harm him there. Throughout my stay I kept discovering the anti-witchcraft medicines which he had hidden in almost every nook and cranny: bundles of porcupine quills and feathers stuck in holes in the wall, a small leather package in the crevice above the door, bottles containing leaves, buried near the entrance, with only the
opening visible. These *ncep* are what used to be called ‘fetishes’ in the older literature.

Thirdly, in some compounds an oval stone or other object which symbolises the unity of the compound or the lineage is kept in a separate room or corner. This object is also called a *ncep*. The compound head makes regular sacrifices to the *ncep*, performing a ritual which is referred to as *kubci ncep* (fixing the *ncep*). This *ncep* unites the whole family or lineage around it and binds them to their ‘old compound’, giving the compound head who looks after the *ncep* power over those who leave the village to work in the city or the plantations in the south. These migrants are supposed to maintain contact with their village and their home compound, coming home regularly to *kubci ncep*, to perform the ritual and sacrifice a fowl on the compound *ncep*. Failure to do so can lead to all kinds of misfortune, from illness and accidents to failure at school and lack of promotion at work or low profits in business. The urban *évolué* who consults a diviner because he has been meeting with one misfortune after another is likely to be told that he has been neglecting his contacts with the village, that the *ncep* is vexed and he should return as soon as possible with fowls or a goat and calabashes of palm wine in order to *kubci ncep*. Diviners often trace illness, not only of migrants but also of those who remain behind in the villages, back to the sufferer’s neglect of the family *ncep*.

Twins, particularly so-called ‘single twins’ (*rfar mo’sir*) are referred to as *boo ncep* (*boo*, children; sing., *muu*). Single twins are children who are born with the umbilical cord around their shoulder and under the opposite arm, or wrapped around their neck, or who are born feet-first or already have teeth when they are delivered. They are very active children whom it takes a lot to satisfy. They are said to become great leaders, good musicians and renowned medicine men if they are treated properly. If they are not they go mad or, according to some, become witches. They are called *boo ncep* because they have a special relation to certain kinds of *ncep*, and neglect of rituals which are part of this relationship will affect the child adversely.

*Jujus*, masked figures belonging to the secret societies, are also referred to as *mcep* in Limbum. It is worth noting that although people use the English ‘medicine’ to refer to all the kinds of *ncep* mentioned above, they would never refer to a *juju* as medicine.

Finally, there are various objects which come from outside local society and which are also considered to have mystical power. Some old men still have knives or bugles which they received as gifts when they worked for the Germans in pre-World War I days, and many of the chiefs and sub-chiefs have collections of Toby jugs which they cherish even more than their masks, elephant tusks and carved wooden stools. Like the masks and other important *mcep*, these objects are only brought out on special occasions. When elderly chiefs persuaded me to take an official photo of them in full regalia, their courtiers had to employ all the rhetorical skills at their disposal in order to get them to display their bugles and Toby jugs.

More recently there are the new forms of medicine described by Probst and Bühler (1990) which are related to improved communication and increasing literacy: *The Great Napoleon Book of Faith, The Sixth and Seventh Book of Moses* and the ‘powerful Hindu talismans, rings and preparations capable
of solving all your life problems' which are imported from Nigeria (p. 453; see also Probst, 1989).

What these kinds of *mcep* have in common is that they possess the power to influence people, events, outcomes, and this power and these effects cannot be readily explained in terms of observable connections. Geschiere (1983) calls the Maka equivalent of *mcep* 'charged objects', i.e. objects which are charged with some kind of (supernatural) power, and this does indeed seem to be their essence.

Thus when Wimbum use the term 'medicine' it refers to a much wider range of meaning than we would associate with the same term. This has consequences for the attempt to identify and delineate an 'ethnomedical system' and would seem to suggest that it is impossible to describe and analyse such systems while proceeding from biomedical assumptions about the nature of medicine.

THE DISSOLUTION OF ETHNOMEDICAL SYSTEMS

I now return to the issues raised by Fortes and Yoder with regard to the distinction between naturalistic and personalistic aetiologies, and consider them in the light of my own findings. These issues can be summed up as follows: the focus on aetiology, and in particular on comprehensive personalistic aetiologies in the medical ethnography of Africa, has led to the blurring of the distinction between the domains of medicine, magic and religion. Anthropologists have been too eager to relegate indigenous disease theory to the realms of religion and magic by describing witches or supernatural beings as the most important, or only, aetiological agents recognised by Africans, who are seen as interpreting disease primarily in social and moral terms. This has led anthropologists to accept (implicitly or explicitly) that there is a fundamental dichotomy between Western biomedicine on the one hand and all other medical systems on the other. The focus on aetiology accentuates the contrast between biomedicine and other medical systems. This has led in turn to the neglect of the practical, behavioural aspects of non-Western medical systems, and therefore to a neglect of medical systems *per se*. Yoder (1982: 13) notes that more recent studies with a broader focus on medical ideas and practices present a different picture of aetiology and medical knowledge.

When Yoder claims that anthropologists have uncritically accepted biomedical definitions of what is relevant in the study of health care and medicine, he is right. But his advice does not seem to have been heeded. By trying to bridge the gap between biomedicine and other medical systems the critics make use of the very biomedical categories they explicitly reject, and the broader view they claim to have is in fact narrower: they select certain elements from that continuous whole constituted by indigenous discourse and behaviour and use them to construct a medical system. The criteria and assumptions employed in this selection are ultimately biomedical. After all, why study *medical* systems? All this talk of medical systems, medical knowledge, medical behaviour, medical situations, behaviour related to health and illness (Yoder, 1982: 8) flows from a biomedically determined and basically practical interest in disease and health
care. That health workers in Africa focus their attention on such matters is understandable, but why should ethnographic enquiry be limited to a domain which has been defined beforehand: a medical system, consisting of naturalistic aetiology, disease and health care behaviour (rather than, say, witchcraft, motor accidents, crop failure and an unsatisfactory love life)?

Not only is the object of medical anthropology, the medical system, created as a separate domain by the very attempt to study and describe it as something discrete (though that creation is concealed by the assumption of its prior existence), it is also—and this is more problematic— surreptitiously created in the very image of biomedicine, from which the authors explicitly distance themselves. By focusing on the 'practical', 'natural', 'empirical' and 'behavioural' aspects of disease they automatically exclude the 'supernatural' and 'ritual' aspects of illness (which Rivers and Evans-Pritchard did include, even if they considered them to be less 'real') as well as other non-illness misfortunes, thus not only creating an indigenous medical domain but also reducing it to a somewhat inferior version of biomedicine.

Indigenous conceptions of illness, and concomitant practical behaviour, are thus narrowed down (naturalised and separated from other non-disease misfortune, their 'supernatural' aspect being either purged or socialised). This thereby brings them into line with biomedical conceptions of disease, based ultimately on positivistic assumptions about the nature of physical reality, thus making anthropological interpretations more acceptable to biomedical health workers.

It is assumed that the 'supernatural' aspects of indigenous culture are somehow less real or less important than the 'natural' aspects. Even when witchcraft is recognised as an important part of the medical system it is socialised, i.e. it is transformed from a 'supernatural' phenomenon into a social phenomenon. When Africans refer to witchcraft as a cause of illness this is not interpreted literally, as it is often intended, but as a metaphorical statement about social conflicts and moral issues (see, for example, Taussig, 1980).

What are we to make of the explicit criticism of biomedical hegemony and the commitment to discovering the native's point of view, which is so subtly combined with the projection of the dominant definitions and categories of this very same hegemonic system on to indigenous culture, followed by the 'discovery' that Africans really have a medical system and that it looks basically just like ours: naturalistic, empirical, pragmatic, disease-oriented? Here medical anthropologists may be repeating the surreptitious appropriation of indigenous discourse that certain scholars of religion perpetrated before them when they 'discovered' that the pagans had believed in one 'High God' all along (see Smith, 1950; Parrinder, 1963; Mbiti, 1970), thus reducing indigenous tradition to the shape and interest of Western biomedical and anthropological discourse. Like kinship, religion and witchcraft, medicine has become one of the topoi of anthropological discourse (see Fabian, 1983).7

In his critique of the use of the concept of witchcraft Crick (1982: 346) claims that it has probably become a separate topic for anthropological study because of its role in our own history. It is a ready-made concept which can easily be applied to other cultures and leads to the translation
of domains of meaning in those cultures in terms of our own categories. Through the work of Evans-Pritchard the concepts of witchcraft and sorcery have 'tended to become frameworks into which ethnographers could fit their own field material instead of paying more attention to the particularity of the culture they happen to have studied' (p. 351). Concepts such as witchcraft form part of a wider conceptual field and can be understood only when they are placed in the context of the other concepts which make up that field. When the conceptual field is so different that we could not reasonably expect to find the same phenomenon, then we should not use the same term (pp. 346–7).

Crick therefore appeals for the analytical dissolution of witchcraft, claiming that:

our understanding will advance when 'witchcraft' is analytically dissolved into a larger frame of reference. Some still argue that our first task is to define witchcraft, and then by comparison to see what the phenomenon really is. . . . But it is vital to locate the nature and dimensions of the field by which 'witchcraft' is constituted. Such a location can then define the phenomenon away. Studies of witchcraft—let alone comparative studies—would then appear a semantic nonsense, and the mark of our better comprehension would be a decreasingly frequent employment of the term. [p. 346]

This critique could be extended to include many of the general terms that anthropologists use to describe and analyse other cultures, in particular to the idea of a medical system.

The problem here is not that biomedical categories and concepts are being adopted into local discourse (thus 'contaminating' indigenous conceptual structures). People are inventive and use these categories creatively, as my brief description of the Wimbum use of 'medicine' shows. The problem is rather the surreptitious incursion of these categories into anthropological discourse, through ethnographic descriptions and analyses which, explicitly or implicitly, pose as neutral representations. It stems not from any sinister attempt to impose biomedical categories but from the very attempt to avoid these categories through the use of an 'emic' perspective to reveal the native's point of view more accurately (usually on the basis of some form of ethnoscience methodology). The ideology which has to be opposed here is not blatant cultural imperialism but rather liberal humanism.

After all, why should we want to bridge the gap between traditional medicine and biomedicine? Why do we find it necessary to identify and delineate indigenous medical systems and show that they are naturalistic, practical, etc.? The idea that non-Western cultures are inferior to ours because they are different is reprehensible, but is the only alternative to reduce them to variations on some putatively universal theme (which on closer inspection usually turns out to be a Western theme) in order to be able to take them seriously or treat them equally?

One of the reasons why non-Western medical systems are constituted in this way may well be the assumption, underlying much (applied) medical anthropology, that medical anthropology should make some contribution, directly or indirectly, to 'development'. This is seen as a one-way process the outcome of which for non-Western societies is that they resemble
contemporary Western society, or some variation of Western conceptions of
the ideal society (industrial, socialist, parliamentary democratic or what-
ever). As a result (applied) medical anthropology is in danger of becoming
‘a secular, scientifically neutral substitute for missionising or carrying out
an oeuvre civilisatrice’ (Fabian, n.d.: 4). Scholte has also pointed to the
continuity between Christian and scientific missions, which he traces back
to a Judaeo-Christian passion for transcending comparative history through
universal categories.

The Occidental Weltanschauung, however diverse its actual contents or concrete
historical manifestations, is ultimately guided by universal (hence abstract) and
teleological (hence judgmental) aims to be realised or realisable in history.
Western theologians, scientists, and others argued ad infinitum about the specific
nature of these ultimate aims, but the overriding anthropological consideration
is that all interested parties presuppose transcendental and prescriptive norms
by means of which concrete and diverse historical societies may be described,
analysed, assessed, and influenced. To the non-Western ‘beneficiaries’ of these
Occidental idées fixes, they must seem like so many exotic variations on an alien
theme: Christ’s Second Coming, the Proletarian Revolution, Rational Scientific
Closure. [1982: 45–6]

The conclusion from all this is perhaps not that the ‘medical system’ is wider
and more inclusive than some authors have recently claimed, but that there is
no medical system at all. The complexes of behaviour, sets of beliefs and
spoken discourses which we refer to as medicine can then be seen pragmatically,
‘not so much as a medical system but as part of the necessary cultural
camouflage, like clothing and food, that enables one to survive . . . ’ (Last,

NOTES

1 Here I must stress that I am referring to a specific discussion in the medical ethnography of
Africa. I am not referring to medical anthropology on Africa generally, nor to all the work of the
authors I discuss. I am also quite aware that there are many anthropologists who continue to
emphasise the personalistic nature of African aetiologies.


3 For a detailed consideration of Wimbum aetiology see Pool (1993).

4 In Limbump the term which is used as a translation for the English ‘to cause’ is rgee, which
means ‘to make’ or ‘to do’. When it is used in relation to illness causation the term implies the
active involvement of a personalistic agent, and in this it differs from the English ‘cause’, which
may refer to natural, impersonal factors. This explains why people can speak of natural illnesses
which have no cause, i.e. they have not been ‘made’ by anybody.

5 For a more detailed account of these cases see Pool (1993).

6 For a full discussion see Pool (1993).

7 Here I should not be misunderstood as accusing the authors I am discussing of blatantly
imposing biomedical categories. Indeed, their analyses are sophisticated and they are highly
sensitive to indigenous interpretations and categories. I am criticising the suggestion, often
implicit, that these interpretations apply to African aetiologies more generally rather than to
specific, limited contexts. Nor do I consider a biomedical approach to be ‘wrong’ in itself. It is
the universalising and objectivising tendency which is the problem.

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**ACKNOWLEDGEMENTS**

The research which underlies the discussion of Wimbum aetiology was undertaken between 1985 and 1987; it was made possible by a grant (No. WS2-370) from the Netherlands Organisation for the Advancement of Tropical Research (WOTRO).

**ABSTRACT**

Between the mid-1970s and mid-1980s a number of publications appeared in which earlier ethnographies of illness and misfortune in Africa were criticised for placing too much emphasis on supernatural causation and neglecting natural causation and practical medical behaviour. Indeed, following Warren's (1974) first criticism of Field, there was what almost amounted to a crusade to prove that Africans traditionally recognised a separate medical domain in which they interpret illness primarily in empirical and practical rather than in social and moral terms.

This article critiques the attempt to cast African aetiologies in a new light. Proceeding from a discussion of the distinction between naturalistic and personalistic aetiologies, around which the whole issue revolves, it examines the critics' claim that ethnographers have placed too much emphasis on supernatural causation in African
aetiologies, that once these aetiologies are viewed more broadly they can in fact be seen to be largely naturalistic, and that one of the reasons for this bias is that earlier ethnographies, in particular Evans-Pritchard’s *Witchcraft, Oracles and Magic*, have been wrongly interpreted. A discussion of Evans-Pritchard’s own description of Zande aetiology leads to the conclusion that the recent reinterpretations of Zande aetiology are mistaken. This raises the question: why the sudden desire to delineate discrete medical systems, and why such emphasis on natural causation and practical activity?

Following a discussion of Wimbum aetiology and the concept of medicine, based on fieldwork in the Grassfields of Cameroon, the author argues that the emphasis on naturalistic causation and practical activity in the definition of African medical systems does not make them broader, as the protagonists claim, but narrower, and that the ’broader’ descriptions of medical systems are not more accurate representations of how Africans interpret and cope with illness but biomedically determined constructs imposed on African culture through medical ethnography. The article concludes with a plea for the dissolution of the concept of ’ethnomedical systems’.

**RÉSUMÉ**

Entre le milieu des années 1970 et le milieu des années 1980, il est apparu un certain nombre de publications qui critiquaient les premières ethnographies de maladies et de misfortunes d’avoir attacher trop d’importance à la causalité supranaturelle et d’avoir négligé la causalité naturelle et le comportement médical pratique. En effet, à la suite de la première critique de Field par Warren (1974), il y eut ce qui équivalait presque à une croisade visant à prouver que les africains reconnaissaient traditionnellement un domaine médical séparé, dans lequel ils interprétaient les maladies surtout en termes empiriques et pratiques plutôt qu’en termes sociaux et moraux.

Cet article critique les efforts qui ont été fait pour jeter une lumière nouvelle sur les étiologies africaines. Poursuivant la discussion de la distinction entre les étiologies naturalistes et personnalistes, autour de laquelle toute la question pivote, cet article examine les critiques qui reprochent aux ethnographes d’avoir attacher trop d’importance à la causalité supranaturelle dans les étiologies africaines; qui revendiquent que tandis que ces étiologies sont perçues de façon plus générale elles peuvent en fait être vues comme étant en grande partie naturalistes; et qui revendiquent que l’une des raisons pour cette tendance est que les ethnographies précédentes, en particulier celle d’Evans-Pritchard, *Witchcraft, Oracles and Magic*, n’ont pas été interprétées correctement. Une discussion de la description de l’étiologie des Zande par Evans-Pritchard lui-même, nous amène à la conclusion que les réinterprétations récentes de l’étiologie des Zande sont erronées. Ceci soulève la question: pourquoi ce désir soudain de délimiter des systèmes médicaux discrets? et pourquoi attacher tant d’importance à la causalité naturelle et l’activité pratique?

Faisant suite à une discussion au sujet de l’étiologie des Wimbum et le concept de médecine, basé sur des recherches dans les Grassfields au Cameroun, l’auteur arguements que l’insistance sur la causalité naturaliste et l’activité pratique dans la définition des systèmes médicaux africains ne les font pas s’élargir davantage comme les protagonistes le prétendent, mais les font au contraire se rétrécir davantage, et que les grandes descriptions des systèmes médicaux ne sont pas des représentations plus exactes de la manière dont les africains interprètent et affrontent la maladie, mais des constructions déterminées de manière biomédicale, imposées à la culture africaine à travers l’ethnographie médicale. Cet article se termine par un argument en faveur de la dissolution du concept, “systèmes ethnomédicaux”.