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The Nature, Goal, and Core Business of African Traditional Medicine:
An Account for the Southern African Context

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Abstract

In this paper, I argue that African traditional medicine (ATM), as practiced in a southern African context, involves a relational and interconnected inquiry into conditions of disease, and this investigation is grounded in an African philosophical worldview that integrates human, environmental, and spiritual dimensions (relational and interconnected thesis). Second, its goal is healing, rather than curing, particularly as healing encompasses not only the relief of disease symptoms but also the restoration of a person's social and spiritual relationships (healing thesis). Finally, its core business is to understand and explain the circumstances and cause(s) of pathological conditions, often through methods such as divination (understanding and explanation thesis).

1. Introduction

Fundamental questions about the nature, goal, and core business of medicine have recently become central to debates in contemporary philosophy of medicine (Broadbent 2019; Varga 2024).[1] The question of the nature of medicine explores its fundamental essence, such as whether mainstream medicine is a scientific enterprise that tries to provide a biomedical understanding of medical conditions, or a different inquiry from science. On the other hand, the question about the goal(s) of medicine concerns identifying its aim(s), such as whether its proper objective is merely curing disease.

Furthermore, closely related to the goal(s) of medicine is the core business of medicine.[2] This refers to what medicine does successfully. In other words, medicine's core business is defined by its competencies, focusing on what it efficaciously performs, rather than merely attempts, such as understanding and prediction (Broadbent 2019).

[1] I use the terms "nature," "goal," and "core business" consistently throughout this paper to avoid any confusion. Furthermore, these questions serve as a broader demonstration of *what medicine is*.

[2] The questions about the goal(s) and core business of medicine are closely related, but they should not be conflated. According to Broadbent (2019, 34): "It would be odd if goals and activities were not related, but there is no reason to assume that the activities (of medicine) can be 'read off' the goals."

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Importantly, the questions on the nature of medicine are typically articulated in a descriptive sense—that is, scholars aim to describe the nature, goal(s), and core business of medicine. Benjamin Smart (2023) illustrates the descriptive approach within the context of the conceptual analysis of disease. According to Smart, "descriptive accounts of disease provided by Christopher Boorse (Boorse 1977), Rachel Cooper (Cooper 2002), and Jerome Wakefield (Wakefield 1992) can help us identify conditions that are mistakenly considered diseases" (Smart 2023, 194).

A similar point can be made about descriptive accounts of medicine, which likewise help us identify its nature, goal(s), and core business. Following this descriptive approach, this project offers a philosophical analysis focused on explaining *what are,* rather than prescribing *what should be,* the nature, goal, and core business of medicine.

In this paper, I aim to discuss the following question: What are the nature, goal(s), and core business of African traditional medicine (ATM) as practiced in the southern African context? I argue that its nature is a relational and interconnected inquiry into medical conditions (relational and interconnected thesis).[3] It recognizes the existence of multiple dimensions—namely, human beings, nature, environment, and spirits—as fundamentally linked. Secondly, its goal is to heal a person (healing thesis). Healing is not limited to the individual in isolation; it occurs within the context of the person's relationship with the family, community, and spirits. Finally, and closely related, its core business is to understand and explain the circumstances and cause(s) of pathological conditions (understanding and explanation thesis).

I focus specifically on ATM as practiced in a southern African context; in particular, by the Nguni subgroup, which represents the southern extension of Bantu speakers, and it "includes three clusters: the Nguni proper (including the Zulu, Swazi, and Xhosa), the Ndebele, and the Ngoni" (Green 1999, 24).[4] Given the vastness of the African continent, it is impractical to cover every form of ATM practiced across all regions, such as in northern, western, and eastern Africa contexts. Despite this, I believe that the proposed account for ATM in the southern African context opens opportunities for further dialogue and research with other African regions where ATM is also practiced, especially since they all involve several and sometimes overlapping indigenous belief systems, knowledge traditions, and medical traditions, developed and transmitted across different generations (Ngubane 1977).

Why is it important to provide an account of ATM? From my perspective, clearly articulating its nature, goal, and core business is increasingly necessary in the literature, especially since scholars like Somogy Varga and Alex Broadbent have offered their accounts of mainstream/Western medicine and all forms of medicine, respectively. Similarly, there is a pressing need for such an account of ATM, which, as noted earlier, is one of the objectives of this paper. The other aim of this paper is to demonstrate that Broadbent and Varga's accounts fall short of capturing ATM's distinct character, particularly its relational and interconnected, healing-oriented, and context-sensitive nature.

Likhwa Ncube has recently contributed to the debate on the nature of medicine, particularly concerning its main goal(s) and core business. He rejects the distinction between these, arguing that "the idea of a core business is conceptually superfluous and

[3] In this context, the term "medical condition" refers broadly to both physical and mental health issues.
[4] Although there may be some subtle differences in knowledge and practices among Bantu speakers, there are core shared rituals, beliefs, and values across these communities that we can observe and appreciate, such as spiritual rituals (Ndlovu 2025).

unhelpful" (Ncube 2026, 412). I engage with this argument in light of my central claim, since leaving it unaddressed would undermine the overall objective of my project.

This paper is structured as follows: First, I critically examine the accounts of medicine offered by Broadbent and Varga. Second, I present and defend my own account of ATM in the southern African context, focusing on its nature, goals, and core business; thereafter, I examine some of the differences between this account and Broadbent's and Varga's accounts. Third, I address Ncube's claim that separating the aim and core business of medicine is conceptually unhelpful and argue instead that this distinction is useful in the context of this paper.

2. Broadbent's and Varga's Analyses of Medicine

Broadbent and Varga each offer analyses of medicine. Broadbent presents a broad account, which includes mainstream, alternative, and traditional forms of medicine (including ATM), while Varga focuses specifically on mainstream medicine, which is practiced globally despite some "variation in local features of institutions and practices" (Varga 2024, 12). Thus, Broadbent's analysis is broad in scope, whereas Varga's is more narrowly focused but, considered together, they aim to offer a comprehensive understanding of medicine across its various forms.

2.1 Broadbent's Analysis of the Forms of Medicine

It is important to note from the outset that Broadbent presents the goal and core business of medicine as sub-questions that define the nature of medicine (Broadbent 2019). In other words, these sub-questions reveal the essential features of medicine across various medical practices and traditions. His motivation for proposing such an account is clearly summarized by Ncube (2025, 492): "While much has been written about medical ethics, epistemology, and methodology, Broadbent contends that the very nature of medicine itself has been comparatively neglected."

Broadbent argues that the goal of medicine is to cure disease—a view he formally calls the "curative thesis."[5] According to this thesis, "medicine is the sustained and organized effort to heal the sick, or prevent them from getting sick in the first place" (Broadbent 2019, 35). This means that medicine seeks to heal those with diseases, such as cancer, using the available tools and interventions. It also includes preventive measures aimed at avoiding the onset of illness. In contemporary mainstream medicine, vaccination, such as the flu vaccine, is a common example of such a preventative measure.

Medicine is thus oriented toward both curing and preventive interventions, which play a fundamental role in the broader medical profession. Broadbent views cure and prevention as part of a unified goal, noting that both "have the same effect if they are achieved—that is, the removal of disease. The only difference [between them] is when the intervention takes place. A preventive intervention takes place before disease; a cure, after its onset" (Broadbent 2019, 53).

Closely related to the goal of medicine, Broadbent argues that its core business is to provide understanding and make predictions about health and disease—what he terms the

[5] Broadbent uses "heal" and "cure" interchangeably. This suggests that these refer to the same thing with respect to the goal of medicine.

"understanding thesis" and "predictive thesis," respectively. For Broadbent, understanding is demonstrated empirically through prediction. For example, to predict the cause and course of a disease (a prognosis), a doctor must first have an understanding of the condition. He thus sees understanding and prediction as interconnected core competencies of medicine. Together, they form what he calls the "inquiry thesis," which holds that "medicine is an inquiry into the nature and causes of health and disease, for the purpose of cure and prevention (that is, for the purpose of removing disease in favour of health)" (Broadbent 2019, 64).

Broadbent's account offers a compelling view of medicine's goal as "cure," which, in my view, applies across all forms of medicine—that is, mainstream, alternative, and traditional medicine. The goal of all forms of medicine is to eliminate disease, whether minor or major. Furthermore, all have preventive measures to stop illness before it even occurs.

However, I believe Broadbent's formulation of cure as the goal of medicine does not fully capture the goal of ATM, especially in a southern African context, where a relational ontological worldview shapes the understanding of health and disease. I am sympathetic to the argument that the goal of medicine is cure; however, in a southern African context, with its interconnected worldview, this view is insufficient. Here, the goal extends beyond merely removing the symptoms of disease. For example, southern African ATM practitioners aim not only to alleviate symptoms but also to restore the harmonious relationships disrupted by the pathological condition, as will be seen later.

I do not entirely reject Broadbent's claim about medicine's core business. I agree that medical practitioners are skilled in understanding and predicting pathological conditions—a competency evident across various medical systems, including ATM in southern Africa. For instance, a *sangoma* can explain the nature of *amafufunyana* and predict their possible outcomes if left untreated.[6] Nevertheless, I endorse a slightly nuanced position regarding southern African ATM's core business. I elaborate on these arguments later, with the objective of demonstrating that Broadbent's formulation of core business overlooks the essential spiritual feature of ATM in the southern African context. For now, let me move to another account of medicine, particularly mainstream medicine, which advances its nature and goal.

2.2 Varga's Analysis of Mainstream Medicine

Varga argues that mainstream medicine is a form of systematic inquiry, which he terms the "systematicity thesis." He claims that medicine meets "a crucial, necessary criterion for science" (Varga 2024, 58). To support this, he draws on Paul Hoyningen-Huene's account (2013, 2019),[7] which holds that systematicity—an essential characteristic—is required for any discipline, such as medicine, to be considered a science.

Hoyningen-Huene (2019) identifies nine dimensions of systematicity that distinguish science from other forms of knowledge: descriptions, explanations, predictions, defense of knowledge claims, critical discourse, epistemic connectedness, an ideal of completeness,

[6] A *sangoma* is a diviner and healer in southern African ATM medical practice; *amafufunyana* are culturally bound mental health disorders found in southern African contexts (Ngubane and De Gama 2024).

[7] It is important to note that Varga expands his support by also drawing on Alexander Bird's (2019) account, which emphasizes the defense of knowledge claims and uses historical medical examples to demonstrate the link between medicine's scientific nature and systematicity.

knowledge generation, and knowledge representation. According to Varga (2024), medicine exhibits systematicity across all nine dimensions, both synchronically and diachronically,[8] thereby fulfilling a necessary condition for being considered a science.

Finally, it is important to ask: What is the goal of scientific inquiry? Varga argues that its aim is understanding, what he calls the "understanding thesis." He explains: "If [scientific] inquiry in medical science has a scientific character (Systematicity Thesis) and aims at providing understanding (Understanding Thesis), then it seems safe to assume the working thesis that medicine aims to understand pathological conditions" (Varga 2024, 106).

These pathological conditions, which are negative physical or mental states (Reznek 2022 [1987]), such as cardiovascular diseases, harm human agency. Thus, the motivation behind this scientific understanding is to intervene through curing, predicting, preventing, and controlling these conditions to promote human agency (Varga 2024).

From my perspective, Varga's account of mainstream medicine—especially his view of its nature—does not adequately capture ATM in southern Africa if it is transposed analyze it.[9] ATM in this context cannot be confined to the systematic inquiry that defines mainstream medicine. While it shares some features of systematicity, such as description, explanation, prediction, and knowledge generation—for example, a southern African ATM practitioner seeks to describe and explain pathological conditions to patients—it does not fully conform to the rigorous model of systematic inquiry characteristic of mainstream medicine. ATM in southern Africa has a distinct character, which includes spiritual and communal dimensions, among other things. These aspects are overlooked by the systematicity thesis, which does not recognize their significance. For instance, this limitation is evident in the nine dimensions that Varga uses to substantiate his account of medicine. Therefore, I argue for a fundamentally different thesis of ATM in the southern African context, which is non-systematic.

Additionally, Varga's view of the goal of scientific inquiry offers only a partial understanding of the core business of ATM, rather than as a goal. The core competency to understand pathological conditions is reasonable and shared across all forms of medicine—for example, understanding why a person is ill—a core competency also reflected in Broadbent's account. As a result, I propose a core competency of southern Africa ATM aligned with these understandings of disease but different in subtle and important ways.

3. The Nature, Goal, and Core Business of African Traditional Medicine as Practiced in Southern African Context

So far, I have examined two existing accounts of medicine in the literature that address its nature, goal, and core business. I have also critically assessed these accounts to demonstrate their relevance to ATM as practiced in a southern African context. In what follows, I propose

[8] Systematicity includes both synchronic and diachronic claims. The synchronic claim states that "knowledge produced in the sciences and in medicine is more systematic than other kinds of knowledge, particularly its everyday counterpart." The diachronic claim holds that the "development of a scientific discipline is accompanied by an overall increase in systematicity" (Varga 2024, 72).

[9] Some may argue that Varga's account, being proposed for mainstream medicine, cannot be faulted on this ground. That may be so, but it is still worthwhile to explore transposing this framework to ATM, particularly to highlight points of convergence and divergence between mainstream medicine and ATM.

and defend an account of ATM in this context that outlines its nature, goal, and core business in detail.

3.1 Nature

ATM is a form of relational and interconnected inquiry, and I refer to this as the "relational and interconnected thesis." It recognizes multiple dimensions as fundamentally linked in a metaphysical sense, such as human beings, the environment, and spirits.[10] Below, I briefly outline these dimensions to illustrate their interconnectedness. While existence may encompass more than these three dimensions, I focus on these three to highlight a worldview that is prevalent across southern Africa. I acknowledge that these may overlap significantly with other regional African metaphysical perspectives.

In southern Africa, a human being is understood as inherently interconnected with others and embedded within the community. They are not viewed "as the singular, personal and impenetrable entity, living in glorious isolation" (Van der Walt 2006, 108). It is impossible, in this context, to conceive of a person apart from their relationships with family, neighbors, and the broader community.

A human being, on this view, thus attains personhood through the ability to form and sustain meaningful relationships. Personhood refers to living a life that is considered "morally flourishing" (Molefe 2020, 194).[11] Maintaining good and stable relationships—especially with immediate family and community members—reflects a morally flourishing life and, therefore, the attainment of personhood in the southern African context.

Furthermore, a southern African conception of the human being and personhood is grounded in the philosophy of *Ubuntu,* which emphasizes communality. *Ubuntu* holds that a person exists within a continuous flow of interactions, particularly with others (Ramose 1999).[12] To explain this in more detail:

> In Ubuntu, to be human one must practice giving, receiving, and passing on the goods of life to others. This worldview takes the ethical position that to be a human being is to care for oneself and others. *A person is a person through other persons*, is the motto of Ubuntu. A human is being and becoming in relation to and interdependence with others. (Ramose 2014, 212; emphasis in original)

Secondly, and closely related, the environment in a southern African context is understood as an interconnected and interdependent space that includes material and nonmaterial entities—namely, plants, animals, human beings, spirits, and other forms of life. For instance, African environmental philosophy outlines principles governing the relationship between human beings and other intrinsically valued entities (Okpe and Oti 2019), such as what one may or may not do to other beings within the shared environment. As C.J. Ekwealo

[10] I am aware that in the African philosophy literature, particularly metaphysics, this is usually referred to as a holistic metaphysical worldview. However, in this paper, I intentionally refrain from using the term "holistic" inquiry. The principal reason for this is that using "holistic" can be confusing within the discourse of philosophy of medicine, especially as other forms of medicine interventions can be labeled "holistic medical interventions," including acupuncture, food therapy, and herbal medicine of Chinese alternative/complementary medicine (Fenech 2024).

[11] The idea of personhood in African philosophy has been discussed extensively, particularly as an ethical idea and its implication (Masolo 2010; Behrens 2013; Tshivhase 2013; Matolino 2014).

[12] Others can include the environment, community, and spirits.

(2011) notes, "there is a culture of respect, dignity, and accommodation for all beings, such that before you invade another's space, it must be based on necessity" (in Okpe and Oti 2019, 106). In essence, respect for all spaces is essential, and any disruption must be justified by necessity, such as ensuring long-term sustainability.

Finally, spirits are part of the invisible realm, described as the "world of the spirits which has the Ultimate Reality (God) at its head and then followed by the divinities, ancestors and other uncountable spirits" (Ugwu 2017, 77). God is seen as the source of all existence, including other spirits, human beings, and the environment. Among the other spirits are mediators, such as ancestors, and harmful or malevolent spirits often associated with witchcraft. This invisible realm contrasts with the visible realm, which consists of entities perceivable by the human senses, such as trees, mountains, the moon, and so on. Despite this distinction, the two realms are deeply interconnected and coexist "in an organic unity with no sharp distinction between the two" (Ebelebe 2009, 1).

This overview clearly illustrates an interconnected and relational worldview held in southern Africa, where events in one dimension can affect the others. This supports the view that ATM in this context is a form of relational and interconnected inquiry. It draws on this worldview to inform its medical knowledge and practices, meaning that any inquiry in ATM, such as in the development of medicinal knowledge and related healing practices, involves examining all dimensions of existence. The following proposed goal and core business of ATM in southern Africa are anchored in this nature.

3.2 Goal

The goal of ATM is healing, what I formally call the "healing thesis." It encompasses medical knowledge and practices that address physical, psychological, social, and spiritual causes of a disease. As Peter White (2015, 3) explains, a traditional practitioner "deals with the complete person and provides treatment for physical, psychological, spiritual, and social symptoms [of disease]. [They] do not separate the natural from the spiritual, or the physical from the supernatural."

This interconnected approach means practitioners treat both visible and invisible causes of disease (physical and supernatural causes, respectively), without drawing a sharp distinction between natural and supernatural factors.

The treatment interventions offered by traditional practitioners depend on whether the causes of pathological conditions are spiritual, physical, or both. White (2015) outlines a range of tailored interventions for each. Spiritual interventions may include protection rituals, sacrifices, spiritual cleansing, and appeasing the gods, while physical interventions involve herbal prescriptions, clay applications, and counseling. In other cases, these interventions are combined, especially when a condition is believed to have both spiritual and physical causes.

This demonstrates that the medical knowledge and practice of healing in ATM in southern Africa follows a relational and interconnected inquiry to diagnosis, prognosis, and treatment. It considers multiple aspects of a person's existence—physical, psychological, social, and spiritual. This aligns with Robert J. Thornton's (2017, 2) observation that, for traditional practitioners, the treatment of a disease involves "not simply the person—as body, spirit, or soul—that the healer attempts to work on and thus to heal, but rather the network of influences that affect the life of the person." In other words, healing is never

isolated from the broader context of a human being, particularly their social and spiritual environments. In southern African ATM, it is not possible to heal someone without acknowledging these dimensions.

Later in this paper, I outline the subtle but important distinction between healing and curing, particularly in relation to Broadbent's account of the goal of medicine. This clarification is essential to support my claim that the goal of ATM in southern Africa is to heal, rather than cure. It also aims to enhance the reader's understanding of my perspective, which is rooted in the rich context of African medical knowledge and practice.

3.3 Core Business

Closely related to its goal, the core business of ATM in southern Africa is to understand and explain the circumstances and cause(s) of pathological conditions,[13] which I formally refer to as the "understanding and explanation thesis."[14] In practice, this involves traditional healers engaging with individuals to gain insight into their experience of illness, including the symptoms they report. This process may also involve the patient's family. Such interactions occur with both types of traditional healers: herbalists (*inyanga*) and diviners (*sangoma*). These "are the two main types of indigenous or traditional healers in South Africa" (South African History Online 2011) and they are regarded as key figures in healing in southern Africa, particularly in Bantu societies (Ozioma and Chinwe 2019).

The understanding gained from this interaction helps determine the appropriate intervention for the condition. In other words, the treatment is contingent on the nature of the complaint, particularly in the case of an herbalist. For example, if a person presents with persistent headaches, the herbalist may prescribe snuffing or inhaling burning medicinal herbs.

However, in the case of a diviner, the initial interaction may provide important insights into the illness but is often insufficient to determine the appropriate intervention. This is where additional methods, such as divination, are employed to gain a deeper understanding and to enable the diviner to explain the causes and circumstances of the pathological condition to the patient and their family:

> Divination means consulting the spirit world. It is a method by which information concerning an individual or circumstance of illness is obtained through the use of randomly arranged symbols in order to gain healing knowledge. It is also viewed as a way to access information that is normally beyond the reach of the rational mind. It is a transpersonal technique in which diviners based their knowledge on communication with the spiritual forces, such as ancestors, spirits, and deities. (Ozioma and Chinwe 2019, 198)

This means that when divination is used to understand and explain the circumstances and causes of a pathological condition, a *sangoma* may throw bones to receive ancestral

[13] The system of causation is indispensable to the practice of African traditional healing, especially for patients and traditional practitioners (Ashforth 2002; Green 1992; Wreford 2005).
[14] The understanding and explanation thesis also has a prediction of the course of a pathological condition—a prognosis of a disease.

guidance and insight into what has led to the affliction, such as *amafufunyana*. The ultimate goal of this process is to facilitate healing and restore social harmony.

The core business of ATM in southern Africa demonstrates that the understanding and explanation at stake are directed toward the restoration of the patient's health. Through practices such as divination, an ATM practitioner identifies the factors contributing to disease, including biological, social, psychological, and spiritual dimensions. In the literature, this is commonly described as a holistic approach to disease, since the ultimate aim of the core business is to develop a comprehensive understanding of these interacting factors in order to contribute to the healing process, which is the goal of ATM in this context.

Furthermore, the medical knowledge and practice of divination serve the core business of understanding and explaining the circumstances and causes of disease, particularly those regarded as primarily spiritual. This does not mean that divination is an adjacent religious practice; interpreting it in this way would distort its role within southern African ATM. Divination is understood as a means of discerning nonphysical causes of disease, which may manifest biologically, socially, psychologically, or spiritually. The spiritual dimension is regarded as populated by the living-dead (the departed), who continue to exert considerable influence on the lives of the living (Teffo and Roux 2003), including contributing to illness and misfortune, and who are consulted through divination. In the southern African context, however, this does not necessarily make divination a religious exercise, even though it involves consultation with ancestors who "fall beyond the range of modern scientific, evidence-based, medical logic" (Tosam 2021, 256).[15]

My formulation of the goal and closely related core business of southern African ATM may raise a significant question: Why is the core business of ATM's understanding and explanation of the circumstances and causes of a disease, rather than healing, especially given that ATM appears to be primarily directed toward healing patients?[16]

Although healing appears to be a successful and central practice of ATM in southern Africa, with understanding and explanation serving as instrumental to its occurrence, I argue that this is not always the case in practice. Practitioners are not invariably competent in healing every disease condition. This can be seen in cases such as *amafufunyana,* where a practitioner may be able to understand and explain to the patient that their condition has a spiritual cause—namely, an ancestral calling—and that they must undergo initiation to become a diviner. However, this does not mean that the practitioner has healed the patient. The condition lies beyond the practitioner's healing capacities because recovery requires direct ancestral intervention through the initiation process, rather than the practitioner's own healing activities.

Accordingly, this is illustrative of my formulation that healing is a goal of ATM, as it is not defined by what practitioners are competent in doing successfully, a fact that patients are also aware of. In other words, healing is an objective they have in mind when they are consulted by a patient or family members. Furthermore, it can be granted that understanding and explaining the circumstances and causes of a disease seems to be instrumental in the healing process, but I believe it is a constitutive part and forms a core business of ATM—it is what southern African ATM practitioners do competently when consulted by patients.

[15] This is a subtle but important distinction on why the method of divination, as instrumental in the core business of ATM, cannot be reduced to a religious activity.
[16] I appreciate an anonymous reviewer for directing me to this question.

In short, the proposed account of ATM in the southern African context presents it as a relational and interconnected inquiry into medical conditions. Its goal is to heal negative health conditions, and its core business is to understand and explain the circumstances and cause(s) of pathological states. In the following section, I examine how this account relates to Broadbent's and Varga's analyses, especially their subtle differences. This exercise aims to situate my account within the broader literature on the nature, goals, and core business of medicine, regardless of its form.

4. Differences Between an Account of African Traditional Medicine and Broadbent's and Varga's Accounts

4.1 African Traditional Medicine and Broadbent's Account

As previously noted, Broadbent's account analyzes all forms of medicine in terms of their goal(s) and core business. The proposed account of southern African ATM asserts that its goal is healing. Also noted earlier, Broadbent uses the terms "cure" and "heal" interchangeably, treating them as equivalent medical activities. However, in the southern African ATM context, these terms carry distinct meanings. Specifically, the understanding of healing and curing in ATM differs significantly from that in biomedicine or Western medicine (Wreford 2005).

"Curing" refers to the process of eliminating the symptoms of a disease, with a focus on the individual's condition; specifically, whether they are in a healthier state following treatment. For example, a patient is considered cured if they no longer exhibit symptoms of a particular illness; thus, the patient is restored to good health (Buse et al. 2009).

However, healing differs subtly from curing in terms of ATM practice. While healing may involve alleviating symptoms of a pathological condition, it also considers the patient's broader context, particularly their spiritual, familial, and community relationships. In this view, the absence of symptoms alone is not enough to declare someone healed. Healing occurs when the individual is restored within the interconnected social and spiritual fabric of their life. For example, a patient diagnosed with alcohol use disorder may also be causing familial and spiritual disharmony. Therefore, healing in this situation occurs when these relationships are repaired and restored, and not just the elimination of alcohol use disorder symptoms. The difference between curing and healing is succinctly demonstrated by Nokwanda Ndlovu's assertion that "studying *izangoma* [diviners] through an integrated lens requires us to see healing as more than symptom reduction, instead focusing on restoring balance across individuals through awareness of community, spiritual, and environmental dimensions" (2025, 22).

In my view, Broadbent's failure to recognize the subtle but important distinction between curing and healing—treating them as identical activities pursued by all forms of medicine—creates a shortcoming in his account when applied to the analysis of ATM in the southern African context. This distinction is crucial for analyzing different forms of medicine, and its neglect reveals a key flaw in Broadbent's account.

The distinction between curing and healing may invite an important question, which, if left unaddressed, could undermine my attempt to conceptually separate these medical and

epistemic activities: Why should healing be understood in ATM terms, as proposed in this paper, rather than through a biopsychosocial approach?

According to the biopsychosocial approach, understanding health and disease requires accounting for biological, social, and psychological factors (Bolton 2023). These factors can each contribute to disease through their interaction, as in cases such as major depressive disorder. Disease conditions, therefore, should not always be understood as arising from a single causal factor but rather from a complex interplay of biological, social, and psychological influences.

Granted, this approach offers a valuable perspective on disease, particularly in its emphasis on the interaction of multiple causal factors. However, I argue that it overlooks an important causal dimension—the spiritual—which is accounted for within ATM terms. In southern African ATM, healing aims to address spiritual, communal, and familial relations in order to restore a patient's health. Put simply, for an ATM practitioner, healing involves not only addressing biological, psychological, and social factors, but also engaging with spiritual causes, particularly in cases where disease is attributed to witchcraft.

Moreover, I believe the proposed core business of southern African ATM extends to encompass the core competencies of its practitioners, particularly their ability to understand and explain the circumstances of a pathological condition. This suggests that ATM practitioners focus not only on understanding and predicting a disease but also on understanding the surrounding circumstances that led to its onset—for example, what prompted a person to commit an action they know is considered wrong by societal norms?

In other words, there is an important distinction between providing "understanding and prediction" and "understanding and explaining the circumstances and cause(s)" of a pathological condition. I argue that the latter more accurately captures the core business of ATM in southern Africa, reflecting practitioners' ability to offer deeper insight when consulted. This is precisely what I mean when I claim that ATM's core business is to provide understanding and explanation of the circumstances and cause(s) of disease, distinct from Broadbent's formulation of medicine's core business, the inquiry thesis.

In justifying my argument about ATM's core business, I draw on Ncube's rejection of Broadbent's inquiry thesis as a universal account of medical traditions. Broadbent proposes the inquiry thesis to ensure that the definition of medicine is "less parochial, avoiding a model that privileges only Western biomedicine" (Ncube 2025, 492). However, Ncube argues that the roles of understanding and prediction in ATM are far more complex than Broadbent suggests. In other words, these competencies are not exercised in ATM in the same way that Broadbent conceives them, and the recognition of core competency in this medical tradition operates differently.

Ncube challenges the inquiry thesis by examining three key elements: inference to the best explanation, the logical primacy of prediction over cure, and the understanding thesis.[17] First, when applying inference to the best explanation to southern African ATM, several challenges arise. In Western medicine, a patient's recognition of a physician's competence is typically based on their ability to understand and predict the persistence of illness. In contrast, patients' recognition of ATM practitioners' competence depends on attributing the persistence of illness to other factors, such as the "lack of improvement to:

[17] Broadbent (2019) offers an argument for the inquiry thesis by resting it on the inferences to the best explanation and the logical primacy of prediction over cure.

- the superior spiritual power of an adversary;
- ancestral displeasure or unmet ritual obligations; [and]
- the healer's misalignment with certain spiritual forces or the need for a more powerful healer." (Ncube 2025, 497)

Second, when applying the logical primacy of prediction over cure, predictive explanations in ATM are not expressed conditionally, as Broadbent proposes. In Western medicine, a cure demonstrates competency through predictions about outcomes with or without treatment—for instance, what happens to a patient's organs when medication is taken versus when it is not. In contrast, ATM embeds predictions within a spiritual framework. As Ncube (2025: 498) explains, "a *sangoma* might say that an illness will improve if the patient performs certain rituals or makes offerings to appease the ancestors."

Finally, Broadbent's understanding thesis poses challenges when applied to ATM. In Western medicine, understanding health and illness depends on explanatory causal mechanisms, such as identifying specific disease agents. In contrast, ATM approaches understanding differently; for instance, in trance-healing, the "healer's role is not to demonstrate mechanistic comprehension but to act as a conduit for knowledge from spiritual agents" (Ncube 2025, 498).

Therefore, Ncube's rejection of the inquiry thesis shows that ATM's core business cannot be limited to the competencies of prediction and understanding (inquiry thesis), as Broadbent contends. It involves more than these epistemic and practical skills. I believe my formulation of the core business captures the complexity of ATM in the southern African context, particularly the significance of the spiritual dimension and the role of knowledge from spiritual agents in healing, understanding, and explaining the circumstances of pathological conditions.

If we consider the distinctions I have drawn between ATM and Broadbent's account, particularly between the medical practices and knowledge of cure and healing, as well as their respective core businesses, it becomes clear that Broadbent's account overlooks several essential features of ATM. These include its relationality, its emphasis on healing, and its explanatory engagement with the patient's disease condition. Broadbent may respond that his account is intended as an abstract and general account of the nature of medicine. However, I argue that its inability to adequately represent these central features of ATM suggests that it cannot, or should not, be regarded as an account of *all* forms of medicine. Admittedly, providing a single account that captures every form of medicine is a demanding task. Nevertheless, it has to be said that the limitations of Broadbent's account mean that ATM is not adequately appreciated in a way that reflects its nature as it is practiced in the southern African context.

4.2 African Traditional Medicine and Varga's Account

There is little to add about Varga's account compared to the preceding examination of Broadbent's account. However, as noted earlier, Varga's account analyzes Western medicine in terms of its nature and goals as a scientific inquiry. In contrast, the proposed account of southern African ATM asserts a fundamentally different nature: it is a relational and interconnected inquiry into medical conditions.[18] This account departs from the idea of

[18] I make this claim based on the view that Varga's analysis of Western medicine cannot be transposed onto the analysis of ATM in the southern African context, as pointed out earlier.

systematicity, which Varga sees as central to the nature of medicine, characterized by description, prediction, knowledge generation, and so on. Instead, ATM in this context considers the diverse dimensions of human existence as understood in many African worldviews, including the spiritual realm, the environment, and social relationships—all of which shape both the life and the health of a human being. Overall, this implies that Varga's account overlooks the non-systematic nature of other forms of medicine (if his account is transposed to other forms), which may be relational and interconnected, such as ATM.

5. A Response to Ncube's "Cure as Medicine's Constitutive Aim: A Defence of the Refined Curative Thesis"

Ncube (2026) has recently raised important points in the debate on the nature of medicine that bear directly on this paper's central argument. It is therefore necessary to engage with his claim that the distinction between the main goal and the core business of medicine is conceptually redundant,[19] so as to ensure the paper's philosophical robustness.

Broadbent (2019) advances the Argument from the Persistence of Ineffective Medicine (APIM) in response to the question: Why has medicine persisted for millennia despite long periods of failure to reliably cure diseases? APIM can be briefly stated as follows:

1. If curing were the core business of medicine, long-term failure to cure would have undermined medicine's persistence.
2. Medicine has persisted despite prolonged and widespread therapeutic failure.
3. Therefore, curing cannot be the core business of medicine. (Broadbent 2019, 59–60)

As noted earlier, Broadbent characterizes medicine's core business as what it is actually competent to do, arguing that curing is not something medicine has reliably achieved; yet, despite this limitation, medicine has persisted over long periods. He labels the first premise of this argument the "No Bullshit" premise, which Ncube critically examines. Ncube's objection is twofold:

> Firstly, I oppose the framing that underpins both the Curative thesis and the Inquiry thesis, especially the distinction between the main goal and the core business of medicine. I believe the idea of a core business is conceptually superfluous and unhelpful. Secondly, I reject the "No Bullshit premise" as simply wrong. It is factually inaccurate, even assuming, for discussion's sake, that the distinction between the main goal and core business holds. It isn't accurate to claim that professions that fail to consistently perform their core business (whatever that may be) should eventually disappear. (Ncube 2026, 412)

All the points raised in this argument are important. However, for the purposes of this paper, the most crucial is the first: the claim that separating the main goal from the core business of medicine is conceptually unhelpful. Ncube says that the reason for this is not difficult to identify nor it is "straightforward: 'what medicine actually does' can vary significantly over time, yet medicine remains recognizable. If so, then 'core business' cannot be the basis of medicine's identity'" (Ncube 2026, 414).

[19] I assume that Ncube uses "medicine" to include all forms of medicine, consistent with Broadbent's usage.

Despite this compelling reason, the distinction matters because I rely on it in analyzing ATM, where the aim is healing, and the core business is understanding and explaining the circumstances and cause(s) of a disease. I maintain that this separation is valuable for descriptive philosophical analysis, as it helps clarify what differentiates ATM in southern Africa from other forms of medicine, particularly Western medicine. It provides a framework for identifying the defining features of ATM.

Furthermore, Ncube identifies Broadbent's proposal of medicine's core business of understanding and explanation as playing instrumental roles in his Refined Curative Thesis (RCT),[20] "rather than the definitional roles assumed by the Inquiry thesis" (Ncube 2026, 417). This means that, in Broadbent's inquiry thesis, understanding and prediction are central to medicine, particularly in illuminating its persistence over time. However, in the RCT, their significance does not imply that we must "regard them as the defining features of medicine. They are vital tools, but their importance lies in their role in achieving the ultimate goal of curing" (2026, 418).

However, in ATM, the core business is not merely instrumental but constitutive of the healing process. In other words, the practitioner's competence in understanding and explaining the circumstances and cause(s) of a pathological condition, such as familial or spiritual disharmony, is not simply a tool for healing but the primary mechanism through which healing occurs. Without this competence, the restoration of harmony (central to healing) cannot take place. This approach extends beyond symptoms to the patient's broader context, including spiritual, familial, and community relationships.

Ultimately, I argue that distinguishing between the aim and core business of medicine captures the distinctive, relational, and interdependent nature of ATM in the southern African context. It also respects epistemic diversity by recognizing the importance of family, community, and spiritual dimensions within medical practice and knowledge of ATM.[21]

6. Conclusion

In this paper, I advance an account of ATM in southern Africa, focusing on its nature, goal, and core business. I argue that it is a relational and interconnected inquiry into medical conditions (relational and interconnected thesis). Its goal is to heal a person who has a pathological condition (healing thesis). Its core business is to understand and explain the circumstances and cause(s) of a disease (understanding and explaining thesis), often through the use of methods such as divination in the case of a *sangoma*.

I also highlight key differences between my account and those of Broadbent, who addresses all forms of medicine, and Varga, who focuses on mainstream medicine. My main concern with these accounts lies in Broadbent's curative thesis, which defines medicine's goal. I argue that when this thesis is applied to ATM, it overlooks an essential aspect—ATM practitioners aim not only to remove disease symptoms but also to restore a person's social and spiritual relationships. Moreover, I express dissatisfaction with Broadbent's

[20] The RCT says: "Medicine is the socially organised, institutionally legitimised, and morally structured effort to restore, maintain, or improve human health through interventions directed at beneficial change, even when such interventions do not reliably or consistently result in cure" (Ncube 2026, 416).

[21] Epistemic diversity is "both the existence of a diversity of knowledge [and practice], and the recognition of and respect for such diversity" (Xu 2022, 36).

formulation of medicine's core business, which restricts it to understanding and predicting pathological conditions.

On the other hand, Varga's systematicity thesis explains the nature of mainstream medicine. I demonstrate that when this thesis is applied to ATM, it overlooks key aspects of the African worldview, particularly its spiritual and relational dimensions. This reveals the limitations of existing accounts of medicine in engaging with the African context and weakens their contribution to the philosophy of medicine, particularly in the Global South.

The account of the ATM in the southern African context proposed in this paper offers an alternative way of understanding medicine. Existing accounts in the literature may not adequately explain or capture the diversity of medical practices across different traditions. Therefore, my proposed account should not be seen as universally applicable to all forms of ATM across Africa, but rather as specific to the sub-Saharan African context. Nevertheless, this account opens a valuable space for further exploration of ATM practices in other regions and for comparative analysis with the framework I have developed.

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