The Continuing Allure of Cure: A Response to Alex Broadbent's "Prediction, Understanding, and Medicine"

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In "Prediction, Understanding and Medicine" Alex Broadbent rejects the curative thesis, the view that the core medical competence is to cure, in favour of his predictive thesis that the main intellectual medical competence is to explain and the main practical medical competence is to predict. Broadbent thinks his account explains the phenomenon of multiple consultation, which is the fact that people persist in consulting alternative medical traditions despite having access to mainstream medicine. I argue that Broadbent's explanation of multiple consultation makes sense only from the perspective of patients who migrate from mainstream to alternative consultation. His explanation is not as convincing when we consider alternative-to-mainstream migration. I also provide an argument against Broadbent's view that prediction is medicine's main practical competence and argue that when it comes to explaining most cases of multiple consultation the curative thesis provides a more convincing explanation than the predictive thesis.

Keywords: *alternative medicine, cure, medical competence, prediction, non-western medicine, traditional medicine*

I. INTRODUCTION

In "Prediction, Understanding, and Medicine" (PUM) Alex Broadbent (2018) argues in support of his predictive thesis, which is the view that the main intellectual medical competence is to explain and the main practical medical competence is to predict. He wants this thesis to replace the incumbent curative thesis, which is the established view that the core medical competence is to cure. While his conclusion is strikingly counter-intuitive at first glance, it is defended through a persuasive analysis of medical competence premised mainly on the fact that mainstream medicine, both currently and historically, largely lacks good cures.

Broadbent has an additional argument for the superiority of the predictive thesis over the curative thesis: that it explains another problematic fact pertaining to healthcare, namely multiple consultation. This phenomenon is the fact that large numbers of people persist in consulting traditional and alternative medical traditions in conjunction with consultations and treatments from mainstream medical doctors. In PUM this line of argumentation is advanced by means of a proposed explanation of the continued popularity of *sangoma*[1] consultation in the South African context. Broadbent's points made regarding *sangoma* consultation are then extended to other alternative traditions such as homeopathy. Broadbent argues that it is the pursuit of understanding, not cure, that motivates the people

[1] *Sangoma* is a word in the Zulu language describing traditional African healers and diviners. Some writers separate the functions and use the term *sangoma* for diviners and *inyanga* for traditional doctors, but not much hangs on this distinction for now.

in these contexts to act the way they do in consulting multiple traditions. His examples are thus meant to demonstrate the superiority of his predictive thesis over the curative thesis.

In this response I argue that while Broadbent's comments about mainstream medicine's disappointing curative track record hold true, his discussion of multiple consultation is less convincing. I argue that multiple consultation, as illustrated in the South African context, rather demonstrates that the curative thesis is more recalcitrant than PUM makes it out to be. The crux of my disagreement with Broadbent pertains to what he takes for granted about the motivation for migration across traditions and the persistence of simultaneous consultation of different healing traditions.

I demonstrate why I consider "bet hedging," or the attempt to access multiple cures in the hope that one will take hold, to be a more plausible explanation as to why multiple consultations persist. I am not arguing that other factors besides multiple consultation could not provide a good reason for dropping the curative thesis for the predictive thesis. My aim is only to show that the phenomenon of multiple consultation is not as convincing as Broadbent makes it out to be in terms of motivation for his predictive thesis.

I make the following objections to Broadbent's theory. First, I make an objection based on the incompatibility of the types of explanations provided by mainstream and traditional medical practitioners respectively (the *Incompatibility Objection)*. My *Asymmetry Objection* is premised on Broadbent's lack of a decent explanation for migration from traditional to mainstream medicine, although he purports to explain multiple consultation. The *No Useless Predictions Objection* and the *Probabilistic Prediction Objections* are responses to his

finger example, which is meant to illustrate his view that medicine's main practical competence is to predict.

I start by looking at Broadbent's argument about how the search for understanding or explanation motivates people to consult multiple traditions. I counter that his argument makes sense only from the point of view of someone migrating from mainstream to traditional medicine, and that if we change perspectives his proposed explanation for the motivation behind migration across traditions is no longer convincing. I then discuss Broadbent's argument about why prediction is the main practical medical competence before showing why the kinds of prediction on offer from the mainstream tradition would not be a good motivating factor for a traditional-to-mainstream migrant. I conclude that when it comes to explaining most cases of multiple consultation, the curative thesis still provides a more convincing explanation than the predictive thesis.

II. EXPLANATION AS THE MAIN INTELLECTUAL COMPETENCE

In PUM one of Broadbent's contentions is that, despite what the curative thesis would lead us to believe, people are motivated by the search for a different type of understanding rather than just the prospect of a cure when they seek out alternative medical traditions. He argues that people are motivated by wanting to understand their ailments and afflictions, and this desire to "make sense of things" is what leads people to consult outside of the mainstream medical tradition because the explanations on offer from mainstream doctors are limited in important respects.

Broadbent's point is that given this limitation in what mainstream doctors are able to provide in the way of understanding, it is no surprise that people seek the opinions of healers in alternative traditions. He explains:

> I will argue that Mainstream Medicine is limited in the scope of explanations that it can offer, and that this is why people persist in consulting homeopaths, *sangomas*, and a multitude of other practitioners of various disciplines, usually alongside consulting Mainstream Medicine—much to the frustration of the latter. There are questions that Mainstream Medicine cannot answer, even if it does have better curative powers than other traditions. (Broadbent, 2018, ??)

Broadbent's argument for explanation as the main intellectual medical competence is thus two-pronged: on the one hand he points to the shortcomings of the type of understanding delivered by mainstream medicine, and on the other he argues that the attraction of what the traditional healers have to offer can be understood in terms of their explanations, not their cures. He does this to support his claim that the key motivating factor for people who consult multiple traditions is the prospect of procuring a different type of understanding, not just another type of cure. I will next evaluate each aspect of his argument in turn.

The Shortcomings of Mainstream Explanation

First, there is the point about the shortcomings of the explanations provided by mainstream explanation. The key consideration Broadbent introduces here is the idea of contrastive causal explanation. As he explains:

> A contrastive explanation answers a contrastive question, such as "Why did you arrive late rather than on time?" The two go together nicely, because many ordinary explanations do seem to cite causes, but ordinary events have far too many causes for them all to count as informative explanations. To provide a good contrastive causal explanation, I must cite a causal difference between the history of the fact and the history of the foil with which it is contrasted (Lipton, 2004: 42). The birth of your grandmother does not count since she is born in the case where you arrive late and the case where you arrive on time. However, your tarrying to knock back another glass of sherry when you should have been filing into the auditorium is a cause of your late arrival *and* a difference from the case where you arrive on time. (Broadbent, 2018, ??)

His contention is that the system of explanations mainstream medicine offers people is impoverished in the sense that it refuses to countenance entities and events that cannot be accommodated within a narrowly materialistic or "Vitruvian" worldview. This means that its pool of contrasts available as foils for causal explanation is quite limited. The mainstream doctor can ask, for example, whether this or that bacterium could be causing your symptoms. But she has to leave out spiritual, social and other factors as legitimate possibilities. Broadbent suggests that it is exactly these types of explanations that people are after when they seek further consultation from traditional and alternative healers. According to Broadbent, what makes traditional consultations attractive is the fact that while both the mainstream and alternative traditions provide explanations about health and disease, *sangomas* can include non-natural causes while mainstream doctors are restricted to natural causes.

I think there is some ambiguity about exactly what Broadbent is saying here. To say that alternative healers can "countenance contrasts" that mainstream medicine cannot, can mean two different things. Either it means that the traditional healer will have a completely different set of contrastive foils from which to pick out the cause, in which case the cause alighted on by the traditional healer, and by extension the explanation provided, will be completely different in kind from the cause (and explanation) proffered by the mainstream doctor. These will be different explanations that emerge from two entirely different causal fields, or explanations from separate paradigms, if you prefer. Alternatively, it means that while the explanatory models may differ, there can be some overlap between the two. In other words, certain events in the set of contrasts could be applicable in both domains, or could be relevant possibilities in both paradigms. Understanding this distinction is important because it makes a difference to any purported explanation of the motivations of patients migrating across traditions.

Getting at the correct interpretation Broadbent's meaning about this issue is difficult because he never explicitly states the conditions he thinks would motivate someone to explore ulterior traditions. One of the things he says, for example, is: "One need not accept a paradigm to recognise the crisis within the dominant paradigm that makes it attractive to seek alternatives" (2018, ??). That is, for Broadbent it would make sense for someone to, for example, consult a *sangoma* out of frustration with mainstream doctors even though she does not "buy into" traditional medicine, or accept the type of explanatory contrasts provided by traditional healers. But then the question is what would motivate such a person to seek out and even pay for explanations from a tradition she does not accept? The answer

to this question will become clearer after looking at the alternative interpretations of what could be meant by “countenance contrasts.”

On the first possible interpretation, we have a situation where the *sangoma* has a set of contrasts such as “the ancestors are upset with you,” “person X is bewitching you,” “person Y is bewitching you,” and so on. From this set the *sangoma* explains by selecting the appropriate cause from the set of alternatives. The mainstream doctor likewise has a completely different and non-overlapping set of contrasts from which to pick the relevant cause as the explanation. On the latter picture, while the set of mainstream contrasts stays the same, the *sangoma*’s set of foils would now include such contrasts as “you have a bacterial infection” or “you are deficient in Vitamin B.”

If the former alternative captures Broadbent’s meaning, then it’s unclear how his argument would navigate concerns about the desirability of seeking more than one kind of explanation for the same ailment or event. I am not saying there is necessarily something incoherent about accepting more than one explanation emerging out of more than one independent causal field, and thinkers such as Godwin Sogolo (1998) make the case that access to more than one causal explanation for the same event can deepen our understanding of that event. It does deepen my understanding to identify, for example, the child who started the fire as the cause, as well as the sociological factors in his neighbourhood that left him alone with a box of matches and no supervision.

The problem is that this is not always the case. Consider a scenario where the explanation I am given by the *sangoma* is outright incompatible with the mainstream doctor’s. Consider,

for example, being told by the mainstream doctor that I am suffering from an odious contagious disease and should avoid contact with other people for a few weeks. The *sangoma*, in contrast, advises that my ailment is a result of neglecting my father's relations and I should travel immediately to their village and pay them a visit. Here, there is no deeper understanding gained, and it is impossible to reconcile the two explanations. In cases like these where one must accept either the mainstream diagnosis or the alternative diagnosis (or reject both), being apprised of both explanations leaves one more confused, not more informed. This result is inconvenient for Broadbent, who wants to put forward the quest for improved understanding as a motivating factor for those who consult more than one tradition. This is the crux of my first objection to Broadbent, and can be described as the *Incompatibility Objection*.

Accepting the latter of the two interpretations (that the set of foils available to the traditional healer is a larger, more inclusive set than mainstream medicine's set, and includes the material causes that the mainstream practitioner would consider) also leads to problems. I want to explain these problems and give my full response to this view about explanation after I have filled in some more detail about what I mean by approaching the issue from a change in perspective, specifically from that of mainstream-to-alternative "migrants," to that of alternative-to-mainstream "migrants."

What the *Sangoma* Offers

I want to briefly look at the other aspect of Broadbent's argument, namely his attempt to demonstrate that what people get from *sangomas*, and other "alternative" healing

traditions, is not mainly curative. In this regard he discusses two of the main activities associated with *sangomas*, namely divination and herbal remedies.

First, I want to look at the comments aimed at showing the act of divination delivers explanation, not cure. He asks us to consider Robert Thornton's (2009) account of divination, from which he argues there is a clear suggestion of shared inquiry meant to deliver understanding:

> This practice involves the release from cupped hands of a set of objects (*tinhlolo*) onto a grass mat that is situated between the diviner and the client. …When these are thrown onto the mat, the objects land in a configuration that is "read" through a rhythmic verbal interaction between client and healer concerning the meanings of the *tinhlolo*. A diagnosis or possible solution to the problem that is being addressed gradually emerges through the interaction between client, healer and the pattern of the objects. (Thornton, 2009, 24–25)

I grant the point that there is some sort of joint inquiry going on here and it is difficult to characterize the process of divination as predominantly curative. Broadbent is correct that this description of divination presents it is an activity aimed at understanding, and that considered from this perspective the cure is a secondary issue.

I think it is illuminating, though, that Broadbent separates the diagnostic and curative function in this discussion of traditional medicine, but not in his discussion of mainstream medicine. Given that diagnosis and cure can be seen as separate medical competences, a

direct comparison of the respective diagnostic and curative abilities of alternative and mainstream medicine would have been more appropriate for an explanation of why people consult multiple traditions.

This would have made for a more convincing explanation of why someone dissatisfied with the diagnoses on offer from a mainstream practitioner would find a *sangoma*'s explanations attractive. Under that scenario we would be comparing apples with apples, so to speak. But we are never invited to separate the functions in this respect and compare them across traditions. Instead we are encouraged, against the background of the knowledge of the relative failure of the cures provided by mainstream medicine, to accept that what is attractive about alternative traditions is the species of explanation they provide, considered in isolation as diagnoses.

Finally, I think it is telling that Thornton couches his explanation of the understanding on offer from traditional healers as equivalent to "possible solutions" to the problem being addressed by healer and patient. This implies that what the patient is after is more than simply an explanation or diagnosis. It implies that the motivation for consulting the healer is the quest for a solution to the problems. In short, the purpose of the visit is the search for a cure.

So much for divination. Broadbent makes a similar argument regarding herbal remedies. He argues that while on the face of it herbal remedies may be construed curatively, this turns out to be false on closer inspection. Broadbent points out that according to what Thornton

says, herbal remedies are not typically intended to be pharmacologically active, as one would assume from the perspective of Mainstream Medicine:

> Most of these are not used as pharmacological agents, but rather used in a ritual or for steam or smoke baths, inhaled as smoke or steam, applied as rubs, or worn as amulets. Herbs may be ingested orally, vaginally, anally via enemas, or through small cuts in the skin, but whatever the pharmacological activity the original herb might have (or might have had) is often not the goal or rationale of the treatment. (Thornton, 2009, 25)

I think that the case for the anti-curative claim isn't quite as evident in these remarks as Broadbent makes out. My gripe with his interpretation of these comments is that they shift the goalposts from a discussion about whether the interventions (herbal remedies) are meant to be curative (in the sense of therapeutic), to a discussion about whether these herbs are pharmacologically active. This is not the same thing, and just because herbal remedies are not supposed to be pharmacological does not mean they are not meant as interventions to alleviate ailments. They could be meant as solutions to some spiritual malaise, for example, and the way they function could be through some spiritual agency.

I also find it unconvincing to construe herbal remedies as mere attempts at explanation. Granted in the African tradition there are non-material "back stories" for the functioning of these herbs, this still does not mean that the core purpose of providing herbal remedies is explanatory rather than curative. Consider the explanation that the herb works by purifying

your environment and chasing away evil spirits. Believing this does not commit one to accepting pharmacological effectiveness. But buying into this supernatural account of the herbal remedy does imply one's belief that the herb will result in one's ailment being alleviated or cured.

Why Seek Mainstream Consultation?

In framing my main response to the account of explanation in PUM I want to first suggest a change of perspective. This is because I am of the view that Broadbent's explanation of why the phenomenon of multiple consultation persists only really makes sense from the perspective of a patient whose default position has been mainstream medicine. In other words Broadbent's argument about multiple consultation only makes sense if we are considering the perspective of patients who start off consulting exclusively mainstream doctors but who afterwards broaden out and consult traditional and alternative healers. His explanation for what it is that lures people from mainstream doctors to *sangomas*, namely the prospect of a more holistic type of understanding, makes it difficult to explain the motivation for someone to move in the opposite direction, from traditional to mainstream consultation. This objection can be described as the *Asymmetry Objection.*

The problem with focusing exclusively on mainstream to traditional migration is that in most cases, including the South African context, the movement is mostly in the opposite direction. In most developing countries, individuals and communities who have always consulted traditional healers have only recently begun to consult mainstream doctors in conjunction with those healers.

As Stokes Jones (2006) points out, the overarching trend in the South African context is that increasing numbers of people have been exposed to mainstream medicine since 1994 and the advent of democracy. The corollary of this is therefore that before ’94 traditional healing was the dominant tradition in much of the country. In fact contrary to the PUM assumption that mainstream consultation is the default position for most people, Jones’s research suggests that the typical South African healthcare consumer can best be described as a “DIY Pluralist.” What this means is that the first port of call for medical treatment is not a specialist, either of the mainstream or alternative variety, but rather one’s own previous experience of what worked in the past.

According to Jones:

> What animates this approach (and influences these township dwellers views on medicine overall) is a vigorously pragmatic orientation to healthcare that values only what works and whatever works without bias. This almost “empirical” attitude based on trial and error (and the accumulated experience of others) means that our informants took a non-ideological approach to medicine. Just as they would play one institution off against another; going to the clinic only if OTC or “home remedies” failed; then escalating to a private doctor (or considering a healer) if relief was not forthcoming; so they were also playing one “tradition” off against another to get the most effective treatment (again showing little ideological or cultural preference relative to their own background). This was results-driven healthcare with the main basis of “preference” being outcomes (always really the perception of outcomes. (Jones, 2006, 180–81)

I think that, if true, the empirical findings demonstrated in the quote above are inconvenient for the predictive thesis, mainly because of what they imply about the motivating factors the typical South African finds convincing. Even if we assume that the "DIY" picture is not completely accurate, it is still the case that considered from the perspective of someone for whom an exposure to mainstream medicine is newer than her exposure to traditional medicine it is more difficult to make the case that the motivating factor for the migration is the prospect of a different explanation rather than another possible cure. My reason for asserting this can be seen if we reverse Broadbent's question: "Accepting, then, that the *sangoma* is not wholly engaged in healing, and at least partly engaged in offering understanding, what are the questions that the *sangoma* can answer that the Mainstream Medicine cannot?" and ask instead: "Given the *sangoma* is not wholly engaged in healing, what are the questions the mainstream doctor can answer that the *sangoma* can't?"

If Broadbent's contention is that what the traditional healer offers is mainly one type of explanation, then his answer to the flipped question would have to involve the traditional-to-mainstream migrant's unhappiness with the explanation on offer. What this new question demonstrates is that Broadbent's attempt to strip traditional medicine of its curative import ends up working against his own argument if considered from the reverse perspective of someone moving from traditional to mainstream medicine. The problem becomes even more acute if we also accept his story about the impoverished nature of the mainstream explanatory framework and his statement that the *sangoma* can countenance causal contrasts that mainstream medicine is unable to countenance.

In other words, if the traditional healer offers explanations that are more in sync with the worldview of the people seeking consultations, then what else besides the prospect of another cure could lure someone away from that traditional perspective to seek interaction with a different medical tradition? I think the most plausible answer, and the simplest way of cutting through all these issues, is that the mainstream doctor holds the promise of an effective cure, and it is this prospect that motivates the exploration of the mainstream tradition by the "alternative" patient. The upshot is that we have to foreground the prospect of a cure as a motivation for patients migrating across traditions, and by extension patients who consult multiple traditions at the same time.

III. PREDICTION AS THE MAIN PRACTICAL COMPETENCE

The previous section dealt with Broadbent's discussion of multiple consultation as it pertains to his conclusion that explanation is the main intellectual medical competence. In this section I evaluate his claims about the main practical medical competence. Broadbent's argument that prediction is the main practical medical competence is influenced by another principle he endorses, namely that prediction is the best empirical test of an explanation. In this regard he uses the following example to make his point about medical competence:

> Consider a case where a medical professional is unable to cure, but is considered a competent medical professional nonetheless. Suppose you have a sore finger. The doctor recognises the disease and gives you a detailed explanation of what is going on. She regrets that she can do nothing, but tells you that in three days it will turn green, and then fall off two days after that. (Broadbent, 2018, ??)

Broadbent argues that in this case it is obvious that the consultation has been ineffective in terms of saving the finger, but it is still the case that the doctor displays medical competence. This is because the competence of the medical practitioner is manifested through the prediction the doctor gives, which comes out true. As he explains: "In a case like this, the patient's health may be little better off before he sought medical help. What he has obtained is not cure, but some degree of *understanding*" (Ibid.).

But why should we accept that medical competence is displayed in this case? Remember that Broadbent has already delineated a weaker standard for cure than the requirement of an outright removal of, or solution for, the ailment. As he explains: "I am happy to count as a cure any intervention that is reasonably effective at alleviating the ill-effects of a disease, incapacity, reduced lifespan, and suffering" (Broadbent, 2018, 4). Given this softer account of what counts as cure, I want to make what can be called the *No Useless Predictions Objection* and argue that in this case, if no attempt at some sort of amelioration was made, then we should not be so ready to grant that medical competence is displayed. The doctor could, for example, at the very least suggest painkillers, or a course of anti-bacterial topical treatments so that the rest of the hand isn't affected by the finger falling off.

Furthermore, I would assert that this curative criterion should trump any considerations of understanding. In cases like this, if no attempt at cure in the weaker sense is evident then the quality of the explanation given to the patient is irrelevant, and no medical competence was forthcoming. That is, I submit that, even in this case, some sort of curative intervention has to be a necessary component of any display of medical competence.

But my main response to Broadbent's views on prediction is directed at another aspect of the example, and can be described as the *Probabilistic Prediction Objection*. My argument is that the scenario painted in this example is not representative of the type of predictions medicine is able to provide. Typically, medical predictions are almost always more tentative and probabilistic in nature than the prediction in the example. In the normal case what we get, and expect, from a mainstream medical diagnosis is something like: there is a 70% chance of your finger falling off. But one implication of this is that whenever a doctor, using the best evidence available to her, predicts a probability short of 100% that a certain outcome will occur, that doctor would have displayed medical competence whatever outcome occurs.

A good analogy is to consider the case of a weather forecast that predicts a 70% chance of rain the following day. If a rainless day were to follow, this could still demonstrate competence in forecasting the weather despite the fact that the prediction turned out false. The same is true in the case of medical predictions that turn out false. They could still demonstrate medical competence.

The problem, therefore, is that the link between the competence displayed by a prediction and the fact of its turning out true is more tenuous than Broadbent makes out. For example, he says: "The plausibility of the proffered explanation, and of the doctor's claim to understand what is going on, is hugely bolstered by the fact that the predictions she makes come true. Conversely, if they do not, the claim to understanding is weakened" (Broadbent, 2018, 23). My point is that this is not necessarily true. So, while Broadbent asserts that the

best empirical test of an explanation is prediction, my point is that we don't have a very convincing answer for what the best empirical test of a prediction is.

The significance of this point about the nature of prediction for my argument can be understood when considered in the light of multiple consultation, specifically the motivation for a patient who consults more than one tradition. Consider again my point about changing perspective to consider what the lure of mainstream medicine could be for someone with a history of consulting traditional healers. On Broadbent's account, the allure of mainstream medicine has something to do with the predictions it offers, and this is part of the reason he identifies prediction as the core practical medical competence.

But given prediction's fickle relationship with the truth, it becomes more difficult to make the case that the attraction of mainstream medicine could be in its predictions. Broadbent cannot claim that it is mainstream medicine's true predictions that lure traditional patients because, as I have established, it is not necessarily the truth of the prediction that makes it a competent medical prediction. It is also not clear how Broadbent could explain the allure of mainstream medicine's false predictions to the traditional patient. This leads me to conclude that prediction is not a central concern in explaining migration across medical traditions and the persistence of multiple consultation.

IV. CONCLUSION

To summarise what I have established in previous sections and to conclude, I want to draw our attention one more time to the question that points to my core disagreement with Broadbent: what would motivate someone who has only ever consulted traditional healers

to consult a mainstream medical doctor? I have given four reasons to question the plausibility of Broadbent's view that the prospect of the mainstream doctor's explanations or predictions could provide the required motivation, namely the *Incompatibility*, *Asymmetry*, *No Useless Predictions* and *Probabilistic Prediction* objections. A more plausible explanation of the persistence of multiple consultation is that people consult multiple traditions for reasons having little or nothing to do with the explanations or predictions on offer from mainstream doctors, but rather having to do with the patients' attempt to "hedge bets" in the hope that one of the cures they pay for will be effective. And if this is the primary motivation for multiple consultation, then it casts doubt on Broadbent's argument that his predictive thesis provides a better explanation for multiple consultation than the curative thesis.

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