The Contribution of African Traditional Medicine For a Model of Relational Autonomy in Informed Consent

Peter Ikechukwu Osuji

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THE CONTRIBUTION OF AFRICAN TRADITIONAL MEDICINE FOR A MODEL OF RELATIONAL AUTONOMY IN INFORMED CONSENT

A Dissertation
Submitted to the Center for Health Care Ethics
McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

By
Peter Ikechukwu Osuji, C.S.Sp. M.A.

May 2013
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OF RELATIONAL AUTONOMY IN INFORMED CONSENT

By
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ABSTRACT

THE CONTRIBUTION OF AFRICAN TRADITIONAL MEDICINE FOR A MODEL OF RELATIONAL AUTONOMY IN INFORMED CONSENT

By

Peter Ikechukwu Osuji, C.S.Sp. M.A.

May 2013

Dissertation supervised by Gerard Magill, PhD

The Western liberal approach to informed consent defines autonomy as an independent choice or decision made by an individual as the final authority in medical decision-making. This approach is so dominant that one can fail to see the merits of other traditional and cultural perspectives. In this dissertation, another approach to informed consent is considered - that of communal culture of Africa, a process used in African traditional medicine (ATM) wherein patients make medical decisions and give consent in consultation with the members of their community and the ATM doctor. Often, but not necessarily, the final consent rests on the consensus reached in consultation with the group rather than on that by the individual patient alone.

This dissertation argues that the ATM form of consent constitutes legitimate informed consent based on the concept of relational autonomy, commonly called
relational autonomy in informed consent (RAIC) in this dissertation. To interpret and
enlighten the significance of the ATM approach to RAIC, the analysis in this dissertation
examines the ethics of care movement in Western bioethics which also advocates a
relational approach to informed consent. This movement presents a concept of persons as
relational beings who are socially embedded, thereby interpreting patient autonomy in
their relationships with others. This movement provides the hermeneutic to enlighten the
significance of the ATM approach as a legitimate model of RAIC.

By comparison of the ethics of care approach with that of ATM to RAIC, this
dissertation further provides a relational approach to informed consent in order to inform
the restrictive emphasis on individual autonomy practiced in Western bioethics, all with a
view towards fostering current discourse on global bioethics. The dissertation also
provides an applied example of the contribution of ATM’s RAIC approach to ethics
committees in Africa, focusing in particular, on the decision-making process for patient
informed consent.

This dissertation is distinct insofar as it focuses on informed consent in ATM,
employs ethics of care as a hermeneutic to interpret ATM, advocates integrated model of
healthcare ethics committees in ATM. Because ATM forms a large portion of the
healthcare systems in Africa, it follows that ATM and its practices should receive more
attention in bioethics in the present global era.
DEDICATION

To my late parents Elizabeth and Leonard Osuji for their loving care,
and
to all practitioners of African traditional medicine and African bioethicists.
ACKNOWLEDGEMENT

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To Henk ten Have PhD, the director of the Center for Health Care Ethics and a member of my dissertation committee, I deeply appreciate your invaluable comments about my proposed topic and your continued support of my academic pursuits. I am looking forward to working under you.

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<td>African Traditional Medicine.</td>
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<td>ATR</td>
<td>African Traditional Religion</td>
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<tr>
<td>CPHA</td>
<td>Centre for Psychic and Healing Administration</td>
</tr>
<tr>
<td>DFLST</td>
<td>Deciding Forego Life-Sustaining Treatment</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>HCE</td>
<td>Health Care Ethics</td>
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<tr>
<td>HEC</td>
<td>Hospital Ethics Committee</td>
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<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<tr>
<td>JCAHO</td>
<td>Joint Commission for Accreditation of Healthcare Organizations</td>
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<td>RAIC</td>
<td>Relational Autonomy in Informed Consent</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
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CHAPTER ONE

INTRODUCTION: INFORMED CONSENT IN A COMMUNAL CULTURE

In traditional African society, it is a duty to help those who are in need or are sick—family, relatives, and clan, all members of the community. Whoever fails to render such help incurs a reprimand. Despite urbanization and movement of people to cities, this obligation to help has survived in various ways. Community members—family, relatives, and clan—continue to regard it as a duty to take care of a sick member. It has remained an enduring feature of the family in particular and of African society in general. Hence, the sick (the patient) rarely goes unaccompanied to consult the African traditional medicine (ATM) doctor. In some cases, the patient does not have to go at all. Instead, relatives go on the patient’s behalf. Generally, when an adult becomes ill, the head of the family and relevant community members consult among themselves to decide on a common course of action. If, however, the ill person is able, the group will discuss practical matters regarding the situation at hand with this person. Such practical matters may include: which ATM doctor to consult, how to finance treatment, whether the patient will be brought to the ATM doctor’s place, or whether the doctor will be invited to attend to the sick person within the family setting. The decision is reached by consensus. If the consensus is to take the sick person to the ATM doctor’s place, the group will proceed further to decide the following: who will accompany the patient, who will take care of the house as well as the children of both the patient and of those accompanying the patient. Some members of the community (relatives or elders) will sit in with the patient as the ATM doctor is consulted. If need be, they will help to describe or explain the history of the patient’s illness and what the sick person has experienced. If, on the other hand, the patient is seriously ill and weak, it is customary for community members to respond to
questions on behalf of the patient. Although consent may be given within this context, final approval for decision-making is made by group consensus rather than by the individual patient alone. The family, relatives, and elders continue to remain available for further meetings or consultation throughout the treatment period in order to assess the patient’s progress and continuing needs.

The ATM practice described here differs markedly from the model of informed consent, practiced in the Western world which typically and legally gives full authority and responsibility for decision-making to the individual patient. Even though an individual patient may reach consent by consulting a clinician and, at times, close family, he/she has the final authority to decide and give consent in accordance with his/her own values and interests.

Thus, the issue in this dissertation is whether the African practice described herein constitutes legitimate informed consent in biomedical ethics or whether it is paternalism. This problem is made even more complex by the fact that the Western liberal concept of informed consent is a perspective that dominates informed consent in bioethics.

1. A. Dominant Cultural Perspectives of Informed Consent

The various cultural regions of the globe, -- Asia, Africa, America, and Europe -- have their own long standing rich moral values, cultural norms, belief systems, and healing traditions. These cultural regions tend to approach the concept of informed consent -- and, indeed, bioethics --from the perspective of their moral and cultural traditions. For example, the Euro-North American tradition (Western cultures), which places more emphasis on individual and personal values, approaches informed consent
from the perspective of patient self-determination, or individual autonomy. On the other
hand, the Asian tradition, which places more emphasis on family, approaches informed
consent from the perspective of family-determination.¹

Ruiping Fan observed that although the Western model of patient autonomy has
been introduced into East Asian countries, it has hardly been generally accepted.²
According to Fan, the reason is that there is implicit in the cultural and ethical traditions
of East Asian countries a different principle regarding the form of autonomy. Though this
East Asian model -- “family-determination oriented principle” -- is not yet clearly
articulated, it differs from the Western, patient self-determination model. This “family-
determination oriented principle” governs clinical ethics in Asia.³ Thus, the family rather
than the individual patient has the final authority to make medical decisions. In other
words, the care of the sick person is a family matter.⁴ The decision is made based on an
objective concept that is supported by the “family-determination oriented” autonomy
model, namely, what constitutes the greater good or the good objectively defined. Yet it
is vital that one’s medical decisions “are made for one’s long-term good impersonally
understood.” One’s medical decisions do not have to be made “by oneself in conformity
with one’s present desires.”⁵

African tradition, however, lays more stress on communal values (communal-
determination) and relationships. African tradition approaches informed consent from the
perspective of a relational autonomy. A similar approach to ATM can be found in the
Western bioethics understanding of the ethics of care. The ethics of care movement,
although of Western cultural origin, canvasses for some communal values and
relationships. For example, it advocates relational autonomy in keeping with African
practice. Nevertheless, of all these different models of autonomy as well as of informed consent, the Western liberal approach, which is personal rights oriented, is so dominant in bioethics that other practices and perspectives of informed consent are at risk for being lost. Furthermore, this dominance so overshadows alternative models that it tends to cast doubt and raises questions as to whether alternative practices constitute a legitimate form of informed consent or whether they constitute paternalism. Yet, one such alternative form of informed consent, namely ATM, is found in communal culture.

1. B. Informed Consent in a Communal Culture

In the present age of global bioethics, (as a global field of inquiry) a concept of autonomy and informed consent from a communal cultural perspective can only enrich current ideas of bioethics principles of autonomy and informed consent. Global bioethics requires that care be taken not to silence ethical impulses and thereby constrict the moral life of other cultures. Rather, it necessitates that bioethics embraces or, at the least, respects the legitimate rich moral traditions, cultural norms, belief systems, and healing traditions of the various cultural regions of the world. Consequently, therefore, this dissertation examines one of the alternative approaches to informed consent arising from a communal culture. This approach is a process used in African traditional medicine (ATM) wherein patients make medical decisions and give consent in consultation with both the members of their community and the ATM doctor. Typically, the final consent in their decision-making process rests on the consensus reached in consultation with the group rather than by the individual patient alone. While the Western model also typically arrives at consent by the patient after consulting the clinician and, at times, close family, this model places the responsibility for decision-making on the individual patient. By
contrast, the process of consultation in ATM gives much more substantive weight or authority to the consensus decision-making process. This dissertation argues that the ATM focus on consent based on consensus constitutes legitimate informed consent. This approach is based on the concept of relational autonomy. Hence, the dissertation adopts the phrase relational autonomy in informed consent (RAIC). To interpret and enlighten the significance of the ATM approach to RAIC, the analysis in this dissertation examines the ethics of care movement in Western bioethics insofar as the latter also advocates RAIC. The ATM approach advocates relational autonomy from the perspective of African communal values and relationships adopting RAIC. With ethics of care as a hermeneutic to interpret and enlighten ATM, this dissertation argues that ATM practices RAIC in so far as the ethics of care practice of relational autonomy and interdependence are similar to those of ATM. If such is true, then, RAIC of ATM is a legitimate practice of informed consent and deserves recognition in bioethics on its own merits.

Incorporating the ATM RAIC perspective into (Western) bioethics can only enrich the meaning and the practice of both autonomy and informed consent in the context of global bioethics.

Yet, both the ethics of care movement and the ATM approach have been overshadowed by the dominance of the autonomy model in Western bioethics. However, by comparing the ethics of care approach with the ATM approach to RAIC, this dissertation aims to inform the restrictive emphasis upon individual autonomy in Western bioethics, to provide a relational approach to informed consent with a view to fostering and enhancing current discourse on global bioethics.

1. C. Focusing on ATM
To date, there is no known work done on the practice of informed consent in ATM. Some studies have been done on autonomy, and an unpublished MA thesis by Christopher Agulanna, have related autonomy to informed consent. Most of these works deal with informed consent in research and clinical trials in Western style medicine in Africa, but not in clinical or medical treatment in ATM.

Ifeanyi Menkiti asserts that, in African thought, it is not some isolated static quality of rationality, will, or memory that defines a person qua person; rather, the community defines a person qua person. The individual is accompanied by a process of incorporation and assisted transformation into personhood. The individual is, therefore, embedded within the community by relationships with others. Community, Menkiti explains, is not an additive group, but a thoroughly fused group because of the existence of an organic relationship between the component individuals. He contrasts it with the Western notion of community, wherein community is understood as a non-organic atomic assemblage of individuals as a group that resembles more an association than a community. Menkiti’s assertion highlights the contrast between the Western view of person, as represented by Gert, and the African understanding of persons as relational and social beings, defined in relationship with the community.

Kwame Gyekye in his work, Tradition and Modernity: Philosophical Reflections on the African Experience, takes issue with Menkiti’s thoughts on the determination of the individual. Gyekye concurs that the community helps to define the individual. However, Gyekye observes, and rightly so, that the individual plays a part in defining and determining the self. It is not the community alone that determines the self. Thus, Gyekye sees the individual as possessing some capacity for self-assertion as a result of which
individuals can and do sometimes critique and reevaluate communal as well as inherited values and practices. Polycarp Ikuenobe, tries to explain and resolve the conflict between Menkiti and Gyekye on the metaphysical concept of the person. Ikuenobe concludes that Menkiti’s notion of communitarianism leaves itself open to radical or strict communitarianism and that is why some people, such as Gyekye understands him as implying that the community vitiates the autonomy and freewill of the individual.

Agulanna’s work is the only other research related to the topic under study in this dissertation. He begins with a brief history of the principle of informed consent in the Western world, and he concentrates on informed consent in research and clinical trials in Sub-Saharan Africa. He surveyed the traditional methods of decision-making in three representative ethnic groups in Africa (Hausa-Fulani, Yoruba, and the Igbo) as well as the role of the individual in communal culture. In dealing with the communal nature of African culture, He provides a summary of the relationship between the individual and the community.

Agulanna, however, focuses mainly on informed consent in the context of biomedical research in allopathic or Western-style medicine. His application of both the decision-making in African societies in Sub-Saharan Africa and of the relationship between the individual and the community is also in the context of biomedical research, with particular reference to HIV/AIDS. This section, which is the main thrust of his work, considered what he called a “multi-step” approach to informed consent in research and clinical practices in Sub-Saharan Africa.
In contrast, this dissertation will utilize the history of Western informed consent which emphasizes individual rights-oriented autonomy in order to establish a basis for comparing the ethics of care movement in Western bioethics and ATM, both of which emphasize relational autonomy in informed consent (RAIC). Furthermore, the dissertation will focus on informed consent in the context of African traditional medicine and not on allopathic medicine or medical research. Overlapping in both works is the exploration of decision-making and the relationship between the individual and the community in traditional African society. However, contrary to Agulanna’s work, this dissertation will focus on ATM and its practices and argue that consent arising via consensus constitutes a legitimate decision of informed consent based on the concept of RAIC. Thus, this dissertation can be said to extend Agulanna’s work to the area of ATM.

In addition, furthering Agulanna’s work, this dissertation clarifies certain facts and conclusions incorrectly perceived by Agulanna in his study. For example, with respect to decision-making in an African communal culture, Agulanna writes

But in my opinion, … collective decision in a communal culture is more often than not, the decision of a few elders who have appropriated for themselves authority to legislative rules for other members of the community who have been rendered helpless by the sleight-of-hand methods of the elders.¹⁶

This dissertation hopes to show that Agulanna’s position is a misunderstanding or an exaggeration of the traditional decision-making system in Africa. In the first place, the elders do not abrogate powers unto themselves. They are either chosen or emerge through a culturally defined system. Secondly, there is a broad consultation (of men and women alike) in traditional decision-making. Thirdly, decisions are made by consensus often only after lengthy discussion.
Moreover, in speaking of women in traditional African societies, Agulanna glosses over matriarchal societies where women are chiefs, queens, and even military leaders of men. Scholarship bears testimony to the active role of these women: N’Dri Thérèse Assie-Lumumba, Ivan Van Sertima and F. C. Steady. Moreover, Joseph Thérèse Agbasiere, Kamene Okonjo, and Harry A. Gailey all show that, in pre-Colonial African society, women had economic, socio-political and religious powers and functions similar to those of their male counterparts. Women were in the forefront of opposition to the colonialists and, in many cases, they championed the revolt. The Baoulé of the Ivory Coast, the Igbo, and the Ibibio women of Nigeria are typical examples. One can argue that the inferiority of women or the mistreatment of women as second-class citizens reflected the colonial values of Europe rather than those of Africa. Assie-Lumumba asserts, therefore, that it was transmitted by colonial masters, their women, and through the religious and education system as well as the policies of the Colonial Era.

Effectively, the area of African traditional medicine has been ignored in these studies. Yet, ATM forms a large portion of the health care delivery in Africa. World Health Organization statistics show that as much as 80% of the population in Africa uses traditional medicine for primary health care. With such a large constituency, it follows that ATM and its practices should receive more attention in bioethics. This dissertation argues that, based on the concept of RAIC the ATM focus on consent via consensus constitutes legitimate informed consent.

It has been valuable to apply the work of these African scholars to various aspects of informed consent in ATM. This dissertation utilizes the insights of Menkiti and Gyekye to understand and interpret the norms and practices of ATM, the nature of
person, relationships with the community, and autonomy. By bringing the works of Menkiti and Gyekye to bear on ATM, the dissertation extends their findings, and proposes a relational autonomy in informed consent (RAIC) model from the perspective of ATM.

1. **D. Scope of the study**

   In setting the historical context, the dissertation concentrates on the Western liberal idea of informed consent, especially as practiced in the USA. Also arising from the Western ethos is the ethics of care movement and its concept of informed consent, the understanding of human person, and autonomy. In the discussion of ATM and African cultures regarding the constitutive concept of person, decision-making, autonomy, and informed consent, the dissertation focuses on four representative ethnic groups in African continent: the Akan, the Hausa-Fulani, the Igbo, and the Yoruba. The dissertation acknowledges that both ATM and allopathic or Western-styled medicine exist in Africa. The aim of the dissertation is neither to compare both strands of healing nor to seek which is superior.

1. **E. Focusing on Ethics of Care**

   The dissertation focuses on ethics of care rather than communitarianism proposed by scholars such as Ezekiel Emmanuel, Michael Walzer, and Alasdair MacIntyre. Communitarianism, like ethics of care, makes a similar contrast between individual and community, emphasizes communal values, personal relations and communal ties, including particularism as opposed to universalism. Likewise, both ethics of care and communitarianism assert that we forge relationships --personal relations and communal ties-- and we experience ourselves more as related and interdependent beings.
above scholars also propose an alternative form of autonomy, namely, relational autonomy, which differs from the liberal individualistic autonomy of the Western model.  

However, ethics of care goes beyond relational autonomy to consider the relation between reason and emotion, a contrast that is not made by communitarianism. Because the proponents of ethics of care consider this relation between reason and emotion, ethics of care scholars such as Virginia Held, Jennifer Nedelsky, and Grace Clement reject the liberals’ overemphasis on impartiality and reason over emotions in moral decision-making. This consideration of the relation between reason and emotion in moral decision-making draws ethics of care closer than communitarianism to African morality. An early advocate of ethics of care and feminist ethics, Carol Gilligan articulated this close connection by noting that African men showed some of the same tendencies—caring, in interpreting moral problems as the women she studied. Gilligan, a psychologist and one of the prominent figures in the history of feminist ethics and ethics of care, hypothesized that women speak in a voice different from that of traditional moral theories, namely liberal, Kantian, and utilitarian. She maintains that the moral development of women is different from that of men. According to her, while men tend to understand morality in terms of reasoning, impartiality, and justice, women tend towards caring and empathy. She also indicates that African men share this caring and empathy but with less emphasis on reasoning and justice.

1. F. Focusing on Ethics Committees

The final chapter of this dissertation focuses on ethics committees rather than on research committees. The rationale is that the dissertation considers ATM as a form of
clinical care and does not address research, research ethics committees, or institutional review boards. The goal is to focus on consent of the patient for medical treatment, which is the purpose of ethics committees, and not consent of subjects for research. Consent of subjects for research and clinical research in general is dealt with by research ethics committees or institutional review boards, and, therefore, they are not within the scope of this dissertation.

Finally, the dissertation is divided into four major chapters. The analysis begins with an historical overview of informed consent in Western bioethics, followed by a systematic analysis of the ethics of care, a comparative analysis of ATM and ethics of care, and last, an applied analysis to ethics committees in Africa. Thus, the analytical progression moves from a discussion of the historical context to a systematic analysis, a comparative interpretation, and an applied example (historical, systematic, comparative, and applied analyses). More specifically, the chapters discuss the following points. Chapter One provides a brief Introduction to the dissertation. Chapter Two presents the historical context by discussing the liberal approach to informed consent in Western bioethics which emphasizes individual and rights-oriented autonomy. Chapter Three presents a systematic analysis of ethics of care as a hermeneutic to interpret ATM. The discussion examines the emphasis in ethics of care upon relational autonomy as a foundation for enlightening the meaning of relational autonomy in informed consent (RAIC). The discussion also considers the emphasis in the ethics of care movement on relationships by presenting a concept of persons as relational beings who are socially interrelated, thereby interpreting patient autonomy in relationships with others. Chapter Four provides a comparative interpretation of ATM with ethics of care. The overall
analysis provides an explanation of ATM as adopting a relational approach to informed consent (RAIC). In this discussion, the ethics of care movement provides the hermeneutic to enlighten the significance of the ATM approach as a legitimate model of RAIC. That is, ATM exhibits practices similar to those of ethics of care, these include focusing on relationships, and also maintaining that persons are relational beings who are socially interrelated in a community, and exercising autonomy in relationships with others in the community. Chapter Five presents an applied example that discusses the contribution of the ATM RAIC approach for ethics committees in Africa, focusing especially on the decision-making process for the informed consent of patients. Finally, Chapter Six provides a brief conclusion to the dissertation.
1. **G. Endnotes**

15. Ikuenobe, *Philosophical Perspectives on Communalism*, 77.
22. Held, *Feminist Morality*, Ch.3; Held, *The Ethics of Care*, Ch.3; and Clement, *Care, Autonomy, and Justice*, Ch.2.
23. Held, *Feminist Morality*, Ch.3; Held, *The Ethics of Care*, Ch.3; and Clement, *Care, Autonomy, and Justice*, Ch.2.

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CHAPTER TWO

HISTORICAL CONTEXT OF THE WESTERN BIOETHICS APPROACH TO AUTONOMY

The principle of informed consent, which includes informed refusal (hence both will be represented in this dissertation as informed consent), is a vital principle in biomedical ethics. In Western bioethics, the emergence of this principle has been influenced by the concept of autonomy that is grounded in rights-oriented liberal individualism. Such an understanding of informed consent has served American society well. However, in other continents, for example Africa, informed consent is used with less success and raises more questions than in Western medical practices. In other socio-cultural groups, alternative approaches to informed consent emerge. These alternative forms of informed consent are based on how socio-cultural groups understand the human person and on how they traditionally make decisions. They are also influenced by how much emphasis a group places on communal culture. This is evident in, but not restricted to, the ethics of care and to African bioethics.

This chapter examines the history of the liberal approach to informed consent in Western bioethics. It shows that this approach emphasizes individual rights-oriented autonomy and advocates a subjective concept of the greatest good. Using the historical analysis of informed consent in Western bioethics as a starting point brings the entire discussion into context and helps to underscore the contrast in various approaches to informed consent --liberal, ethics of care, and ATM. The discussion begins with the history and origin of informed consent.
2. A. History and Origin of Informed Consent

There is some argument as to when critical discussion of informed consent began. However, there is a consensus that informed consent became an issue in the American medical practice in the late 1950s and early 1960s. It was at about this time that the expression “informed consent” became more widely use. In their study of the history of informed consent in the USA, Ruth R. Faden, Tom L. Beauchamp, and Nancy M. P. King used the following criteria to determine whether or not informed consent existed in a particular era: a) a patient or a subject must agree to an intervention based on an understanding of (usually) disclosed relevant information, b) consent must “not be controlled” by influences that would engineer the outcome, and c) the consent must involve the intentional granting of permission for an intervention. For Faden, Beauchamp, and King, the three conditions combined specify what they called “informed consent” as they examined historical evidence for the practice, policy, and theory of every era. If any of the three criteria was lacking in a particular situation, depending on the circumstance, Faden, Beauchamp, and King considered such a practice or policy an example of consent or refusal of disclosure, but not informed consent.

The three conditions are reminiscent of Beauchamp and Childress’ elements of informed consent: competence, disclosure, understanding, voluntariness, and acceptance. While Faden, Beauchamp, and King adduced three conditions or criteria for informed consent, Beauchamp and Childress set out five. Faden, Beauchamp, and King were constrained by their bid not to employ over demanding criteria in identifying informed consent in their interpretation of historical writings and practices. Thus, they limited the criteria to three. They argue that employing over demanding criteria “would render it
impossible to find any theory or practice of informed consent at any time.” Moreover, Faden, Beauchamp, and King are open to more criteria or elements of informed consent. They considered the three points necessary for informed consent but they do not commit to their sufficiency. A closer look at the wordings of the three criteria reveals a much closer similarity to the Faden, Beauchamp, and King’s. One can deduce the following criteria from Faden, Beauchamp and King’s three elements: understanding, voluntariness, intentional or acceptance, disclosure and permission. For instance, their first criterion reads thus, “the patient or subject agreeing …based on understanding of (usually disclosed relevant information) ….” It embodies acceptance, understanding and disclosure of information. Then the second element would be voluntariness etc. What appears to be missing in their criteria is “competence.”

Bernard Gert, Charles Culver, and K. Danner Clouser like Faden, Beauchamp and King, discussed three conditions or criteria of informed consent in their book. These are adequate disclosure of information, competence and absence of coercion. They do not disagree that understanding the information is necessary to informed consent even though it is not a heading or sub-title in their book. However, Faden, Beauchamp, and King emphasize the degree of autonomy, understanding, coercion etc. more than Bernard Gert, Charles Culver, and K. Danner Clouser.

In their project, Faden, Beauchamp, and King discovered that from 1930-1956 there were only nine articles published on the issue of consent in the American medical literature. They drew the following conclusions: first, that informed consent did not become an issue in American medicine until the twentieth century; and second, that, even though in the nineteenth century there was some evidence of seeking consent as well as
respect for a patient’s refusal, prior to the mid-twentieth century, the beneficence model trumped other principles. Thus, before the widespread adoption of informed consent, the principle of paternalism was dominant. The principle of paternalism presupposed that, because of experience and expertise, the physician knew best what the patient needed. However, Jessica W. Berg, Paul S. Appelbaum, Charles W. Lidz, and Lisa S. Parker found two medical instances where consent and disclosure of information regarding the risks and benefits of the treatment or trial were operative. The first was in Prussia in the 1890s, after public outcry about trials on unsuspecting patients inoculated with the spirochete which causes syphilis. As a result, the government of Prussia required consent for further experimentation involving human subjects. The second was in Cuba where Walter Reed carried out a research on yellow fever. He devised a contract similar to the modern consent form for the volunteers to sign. In addition to the contractual form, there was a discussion, about the risks and benefits to volunteers. However, public outcry in Germany led to development of guidelines requiring “clear explanations of innovative treatment.” Albert Jonsen appears to support Faden, Beauchamp, and King’s view. Jonsen noted that it was only in 1957 that informed consent, emphasizing the relevance of information to consent, was given “judicial blessing.” It has both legal and bioethical origins. Its emergence was, in part, a reaction to paternalism.

2. A. 1. Legal Origin

Based on the above, it is evident that informed consent was solicited long before it was legally required in the physician-patient relationship. The legal origin of informed consent was precipitated by various litigations and court decisions over the years. Although there are some early court cases dealing with consent and privacy, these cases
were not strictly about informed consent. Nevertheless, they helped in its development. Such cases include the 1767 English decision, Slater v. Baker and Stapleton,\textsuperscript{16} Mohr v. Williams 1905\textsuperscript{17} and Pratt v. Davis 1905/06. The first legal case involving informed consent \textit{per se} was the 1914 landmark opinion of Justice Benjamin Cardozo’s opinion in the Schloendorff v Society of New York Hospital case.\textsuperscript{18}

**Slater v. Baker and Stapleton 1767**

Doctors Baker and Stapleton were hired by Slater to remove a bandage from a partially healed leg fracture. Doctors Baker and Stapleton therapeutically re-fractured the leg and inserted an experimental apparatus to promote stretching and strengthening it during the re-healing process. They did it against Slater’s protest. Mr. Slater sued, claiming that the doctors breached the contract by “ignorantly and unskillfully” fracturing his leg thereby injuring him. Other physicians testified that both the medical approach and the apparatus used were unorthodox and contrary to standard practice. Because Slater’s complaint was that his leg was re-fractured without his consent and without regard for his protests, the defendant argued that the case was brought under the wrong “writ” (contract writ) or liability theory. It should have been brought under \textit{trespass} \textit{vi et armis}, that is, what today is called “battery” especially in the USA. The court did not want to dismiss the case because of being brought under the wrong “writ.” Consequently, it held the doctors liable under the contract writ, just as Mr. Slater prayed. The court explained its ruling as follows:

\begin{quote}
In answer to this, it appears from the evidence of the surgeons that it was improper to disunite the callous [bony material in healing] without consent; this is the usage and law of surgeons: then it was ignorance and unskillfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done; and indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation.\textsuperscript{19}
\end{quote}
One of the ancient presumptions of English law is that individuals should be secure in their bodies against unauthorized touching by others. In the Magna Carta of June 15, 1215, there is a prescription offering individuals a general protection against unwarranted use of force by the government, “No freeman shall be taken or imprisoned, or disseised, or outlawed, or banished, or any ways destroyed, nor will we pass upon him, nor will we send upon him, unless by the lawful judgment of his peers, or by the law of the land.”

The law or the right to be free from others’ molestation is rooted in “ancient pagan Germanic traditions.” In Germanic law free individuals were immuned from torture which were regularly used in the Mediterranean world. This torture was later used in the famous Spanish Inquisition of western Christendom. It was, therefore, a crime to use violence against a free person.

It is this unconsented touching as unlawful or battery that is exemplified in Slater v Baker and Stapleton. The 1767 decision given above, namely, that it is reasonable that a patient should be informed of what is to be done to him or her, was to enable the patient to take the necessary courage to undergo the surgery. Engelhardt is of the opinion that the ruling is not necessarily grounded in a view of the patient as the source of authority. It is rather grounded in concerns regarding the reason “why it would be useful to gain consent.”

**The Mohr v. Williams 1905**

The second case that was not strictly about informed consent but helped in its development is found in Mohr v Williams 1905. This case is intertwined with Pratt v Davis 1906 in reasoning and chronology. Even though Mohr was the first of the two to
make it to the lower courts, the final opinion of Pratt comes before that of Mohr. The ruling in Mohr cites Pratt extensively. Mohr consented to her physician, Dr. William to perform surgery on her right ear. Williams later discovered that the left ear is actually the one that needed surgery. He went on to perform the surgery on Mohr’s left ear without additional consent from her. When the hearing in Mohr’s left ear later became further impaired by the surgery, she sued Williams for battery. Because the original impairment to the left ear was not life threatening, the court ruled that Dr. Williams should also have obtained his patient’s (Mohr’s) consent to the surgery on her left ear.

If a physician advises a patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, the patient thereby, in effect, enters into a contract authorizing the physician to operate to the extent of the consent given, but no further.

When a physician obtains consent for a specific treatment or surgery the physician may not treat or perform additional or different surgery on another body part without the patient’s consent. A consent may be implied or applied to another part in case of emergency in the course of the treatment/surgery, that is, if the new issue is life threatening. In general, however, the patient had the right to bodily integrity without unauthorized intrusion. Violation of this right was viewed as justification for liability for battery.

In the case of Mohr v Williams, the court made two assumptions about valid consent: first, that valid consent requires knowledge about risks and dangers; second, the opportunity to weigh knowledge about risks and dangers in the course of decision-making is necessary for a valid consent. As Faden et al. noted, the court in Mohr’s case examined consent not simply as a simple permission to touch but as a “full decisional process,” even though the facts in the case required the court to decide only whether a
patient had given consent to the medical procedure performed.\textsuperscript{28} This point was supported by the sources that the court utilized in arriving at its decision, namely the torts treatise which recognizes that the essence of requiring consent “is not simply to authorize what would otherwise be a battery,” but rather to ensure that patients make effective treatment decisions. The patient must be “the final arbiter” as to whether or not one shall take one’s chances with the treatment.\textsuperscript{29} The court also showed that, like contracts, consents are products of informed consideration and reflection. The court did that by drawing an analogy between consent in the patient-physician relationship and the entering into contracts in other professions or trades.\textsuperscript{30} Finally, the last case that was not on informed consent \textit{per se} but which helped in its development is that of Pratt v Davis of 1905/06.

\textbf{Pratt v. Davis 1905/06}

This is a case of hysterectomy without consent. Kelly Pratt had been told that she required only medical treatment, and not surgery, for her care. Eventually, the surgeon Susan Davis, removed Pratt’s uterus while Pratt was under anesthesia. Thus, the hysterectomy was performed without obtaining consent prior to surgery from the woman herself or, if necessary during the surgery from the husband. Pratt sued. The surgeon’s attorney argued that, when a patient consents to (or places oneself in) the care of a surgeon for treatment without instructions or limitations, the patient by law implicitly consents that the surgeon may during surgery carry out any such surgery or treatment as in the surgeon’s best judgment is deemed proper and essential to the patient’s health and survival.\textsuperscript{31}
In its judgment, the court rejected the defendant’s argument that the patient could not give consent because of her epilepsy. And because of the lower court’s decision regarding Mohr v Williams in 1906, which had just discussed at some length the requirement for consent, the higher court followed Mohr v Williams and specifically restricted “implied consent to emergencies” as well as to situations where the patient knows and understands the consequences of yielding to “the physician’s exercise of professional judgment.”

The cases of Mohr v Williams and Pratt v Davis are not only intertwined in reasoning and in chronology, but they are also memorable for other reasons as Faden, Beauchamp, and King have shown. According to them, Mohr v Williams, and Pratt v Davis are significant because they required “physicians to obtain consent to particular procedures.” These cases are also important for restricting “implied consent” to “limited exceptional circumstances” such as emergencies. Finally, they are memorable for their strong language about “the nature and importance of self-determination.”

Historically, more recent legal cases which further advanced and directly impacted the development of informed consent are those of Schloendorff v Society of New York, Salgo v Leland Stanford Jr. University Board of Trustees (1957), and Canterbury v Spencer a Washington, D.C.

**Schloendorff v Society of New York**

In the case of Schloendorff v Society of New York, Mrs. Mary E. Schloendorff consulted a physician in a New York hospital in January, 1908 for some stomach disorder. After some weeks of treatment, the house physician, Dr. Bartlett, found a lump which proved to be a fibroid tumor. Dr. Bartlett consulted Dr. Stimson, the visiting
surgeon, who advised surgery. According to Mrs. Schoendorff’s testimony, the physicians informed her that the character of the lump could not be determined without examination under ether. She consented to such an examination, but notified Dr. Bartlett that she did not want surgery. However, on the following day she was anesthetized, and the tumor was removed. Following surgery she developed gangrene in her left arm, and some of her fingers had to be amputated. She suffered intensely. She sued the hospital for the wrong. She testified that the surgery was done with neither her consent nor her knowledge. She was contradicted by Dr. Stimson, Dr. Bartlett, as well as by many of the attendant nurses. Justice Cardozo stated that “her narrative, even if improbable, must be taken as true” because the verdict issued in her favor, concluded that the complaint was not merely negligence, but trespass. Justice Cardozo ruled that every adult human being with sound mind has a right to determine what shall be done with his or her own body. If a surgeon performs an operation without the consent of the patient, the surgeon commits an assault, for which the surgeon is liable in damages.36

The consent requirement here is justified on the grounds of the right of self-determination. The right is the equivalent of the moral principle of respect for autonomy.37 The case focused on the liability of the New York hospital as defendant for torts committed by surgeons using its facilities. Consequently, the court did not find that there was a violation of informed consent or that the hospital intentionally withheld information that the patient might need to exercise the right of self-determination.38 However, the opinion of Justice Cardozo is considered as a “classic statement” of the right of self-determination of a patient.39 It draws great attention to the fact that patients have “the right to protect the inviolability of their persons” by deciding and dictating their
medical treatment. Any interference with this right may be considered unauthorized bodily invasion or battery, notwithstanding both the skill with which the treatment was administered and the ultimate benefits of the intervention.\(^{40}\) The court also held that it is the responsibility of the patient to solicit information relevant to consent. It meant that a physician is negligent only when he performs a procedure against the express wishes of the patient. The physician was not under obligation to communicate all the risks and benefits in advance.\(^{41}\) Most legal cases hinged on this landmark case, Schloendorff v Society of New York. However, the judicial “blessing” began with the California Supreme Court ruling in Salgo v Leland Stanford Jr. University Board of Trustees (1957).

**Salgo v Leland Stanford Jr. University Board of Trustees**

Martin Salgo had undergone translumbar aortography without being told that paralysis was a risk, which in fact he did suffer as a result of the surgery. In granting relief to Martin Salgo, the court ruled that physicians “have the duty to disclose any facts which are necessary to form the basis of an intelligent consent.”\(^{42}\) The Salgo v Leland Stanford Jr. University Board of Trustees (1957) case is the first to use the term “informed consent.” Salgo began the long effort to establish precise disclosure and other requirements that physicians are required to provide to patients.

Three years later, the Kansas Supreme Court, in Nattanson v Kline, weaved a new concept of informed consent into the legal framework, namely, the negligence theory instead of the battery theory.\(^{43}\) The battery theory or a tort is the unlawful touching of another person, unconsented physical contact even if the contact is nonviolent. It had been the legal basis for enforcing informed consent requirements until the case of
Nattanson v Kline. The decision in this case also impacted on informed consent theory by establishing that true informed consent required a “thorough-going self-determination” instead of a reasonable physician standard that had been in use. The reasonable physician standard was defined by the court at Schloendorff v. Society of New York, as noted above. The first expanded description of the new legal requirement of informed consent was not to come till 1972 in the case of Canterbury v Spencer a Washington, D.C.

Canterbury v Spencer a Washington, D.C.

Mr. Canterbury, a 19-year-old male with severe back pain, underwent a successful laminectomy without complications. Later, while voiding, he fell off his hospital bed and developed severe paralysis from the waist down. To remove pressure on the spinal cord, surgery was again performed but was only partially successful in restoring movement to his legs. It also resulted in urinary incontinence. He sued his surgeon to court for failure to inform him of the possibility of paralysis. Ruling in Mr. Canterbury’s favor, the court noted that such information was material to Mr. Canterbury’s decision to have the surgery. The court observed thus,

True consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.

The court argued that, because the typical patient has little or no comprehension of the science and art medicine, one ordinarily has only one’s physician to consult for information and explanation which will assist in making an intelligent decision. In light of this, the patient’s dependency on the physician for enlightenment, the court concluded that this compels the physician to make reasonable divulgence of risks to a patient in order to arrive at as informed a decision as possible. What this ruling recognized is that
the amount of information to be disclosed is established not by medical practice or standards but by the patient's need to know.

Supporting this point of view, Jerry Menikoff argues that the patient’s right of self-decision should shape the boundaries of the duty to reveal. The scope of the physician’s communications to the patient must be measured by the patient’s need. That need is the information material to the decision. It means then that the test for determining whether a particular danger should be disclosed or not is its materiality to the patient’s decision rather than standard care. All risks that potentially affect the decision must be divulged. The law must itself set the standard for adequate disclosure in order to protect the patient’s interest, instead of leaving it to the practice of medical community.50

Menikoff further observes that the Canterbury v Spencer case in addition to establishing adequate information as per the need of the patient, demonstrates how physicians or professionals can define for themselves the standard of care. The court, by basing the standard of disclosure of information required by the patient on the standard of care, or on good medical practice, or what a reasonable physician will do, was leaving it to the physicians or professionals to define for themselves the standard of care. Menikoff suggests that, rather, the scope of the standard should not be subjective as to either the physician or the patient; it should remain objective with due regard for the patient’s informational needs and with suitable leeway for the physician’s situation.51

The fruits of these legal wrangling in the area of (battery) malpractice and negligence were not only incorporated into the statutory laws of many states in the United States of America, but they also helped in the development of informed consent and its requirements in the realm of bioethics. Barring a few exceptions, the law currently
requires informed consent before any medical intervention and requires physicians, as a professional duty, to notify their patients of the following: the nature of the intervention, the condition and its expected course, the benefits and risks of any proposed treatment, and alternative treatment or non-treatment. In addition to its contributions to legal history, the development of informed consent was enhanced by the introduction of language regarding patient’s rights.

**Patient’s Bill of Rights**

In 1973, the American Hospital Association was instrumental in publishing a patient’s Bill of Rights which was adopted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Commenting on the American Hospital Bill of Rights, Faden, Beauchamp, and King noted that it “was one of the earliest signals of the place of an autonomy model in medical practices.” This Bill of Rights introduced the language of “rights” into the discourse and practice of patient autonomy. It became the most influential of several patients’ rights statements to appear in the 1970s. The Patient’s Bill of Rights incorporated and strengthened some of the fruits of previous legal wrangling. For example, it endorsed the patients’ rights to obtain from their physicians information necessary to give informed consent before any procedure or treatment. It also recognized the individual patient’s right to refuse medical treatment to the extent permitted by law and to be informed of the medical consequence of his action. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned.

Prior to the adoption of Patient’s Bill of Rights, medical codes and didactic writings had traditionally emphasized the physician’s obligations or virtues. Trust rather than commerce was the theme of the doctor-patient relationship. As a result, the language of rights suddenly shifted the focus in a different direction. Right, for example, is about
entitlement, that is, a demand made by someone regarding the conduct of others. When rights are turned in the direction of medical decision-making, they literally invite or, at least, encourage the replacement of the beneficence model with the autonomy model.  

2. A. 2. Bioethical Origin

While the legal formulations were in process, the importance of informed consent was also being critically examined and discussed from a moral perspective in the area of medical experiments and research. There were, for instance, events at Nuremberg, Helsinki, the National Institutes of Health (NIH), and the Federal Drug Administration (now known as Food and Drug Administration) that began to have a cumulative ground-breaking effect on medicine, especially on research ethics. According to Faden, Beauchamp, and King, these events, more than anything drew and directed the attention of scholars in law, theology, history, and biomedical and behavioral sciences to the subject matter of informed consent.

The Nuremberg code declared consent “absolutely essential.” It insists that the patient or the subject who is giving consent must not only possess sufficient knowledge of the intervention but must also sufficiently comprehend the information in order for that patient or subject to make an “enlightened decision.” In view of this insistence, Jonsen surmised that consent was required to go beyond mere permission. In 1972, the year several courts in USA included informed consent in medical practice, the Tuskegee syphilis study scandal occurred. Shockingly, it was discovered that the subjects of the Tuskegee syphilis study were not fairly consulted, not given information regarding the study, nor were they asked to give consent to the study. For example, they were not furnished with the reason why the government doctors were collecting their blood
samples. Dr. Jay Katz, a member of the Tuskegee panel, noted that “the most fundamental reason for condemning the Tuskegee Study … [is that the subjects] were never fairly consulted about the research project, its consequences for them and the alternatives available to them.” Bioethicists of the time held that consent to therapy or experimentation “is the external manifestation of the moral values of freedom and loyalty” that makes the relationship between doctors and patients (and or subjects) a moral one. The Tuskegee Study showed that doctors in USA as well as Nazi war criminals could disregard the Nuremberg code requirement for voluntary consent.

Finally, there was the study of informed consent to experimentation initiated by the National Commission for the Protection of Human Subjects. The study led to the production of the Belmont Report which classified informed consent under the general topic of “Respect for Persons.” One of the contributing essays to this project was from Robert Veatch. His article, “Three Theories of Informed Consent: Philosophical Foundations and Policy Implications,” set the path for an in-depth exploration of informed consent. He posited three possible philosophical grounds for informed consent: one, that the beneficent duty of physicians requires them to warn patients of possible harm associated with treatment; second, that “the utilitarian principle recommends consent as a means of maintaining the general trust between the scientific profession and society;” third and last, that possible philosophical grounds for informed consent is the right to self-determination. Veatch was critical of the first two although he approved the third. In defense of the right to self-determination, Veatch argued that an informed consent that is grounded in the right to self-determination means a standard of disclosure that is centered on the need of a reasonable person for information to make a decision and
is not based on professional judgment. Veatch’s exposé shaped the Belmont’s commission Report on informed consent.

Later, in November 1978, the Congress in the USA asked the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to examine the issue of informed consent. As a result, in 1980, the Commission was convened and informed consent was its agenda. In its study, the commission chose to go beyond the legalistic scope of informed consent in order to consider how to nurture a relationship between patients and medical personnel “characterized by mutual participation and respect and by sharing decision-making.”

The Commission published its study as: Making Health Care Decisions: the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship and Deciding to Forego Life-Sustaining Treatment. Its appendices contain two volumes of documents, scholarly papers, and empirical research.

In the Report, the Commission observed that, in spite of the fact that the concept of informed consent is a product of legal history; the requirements are not legally-oriented. Rather, they are basically “moral and policy-oriented.” Emphasizing self-determination, the Commission further noted that informed consent is ultimately founded on the principle that competent adults are entitled to make their own decisions in keeping with their own values and goals; that the context of informed consent and any claim of valid consent must derive from active, shared decision-making. The report supported its statements with “a philosophical argument based on the principle of autonomy…” that is, that persons have an intrinsic right to direct their lives; and on the principle of beneficence, that is, that care is improved when patients collaborate in their...
care. Although the primary goal of health care, in general, is the maximization of each patient’s well-being, to act simply in a patient’s best interest without recognizing the individual as the essential decision-maker would fail to respect each person’s interest in self-determination.”

In its later report, the Commission concludes that “the right to autonomous choice” implies the choice to forego life-sustaining treatment. This conclusion contradicts the usual “presumption in favor of sustaining life,” and the Commission recognized that this fact could have “a pervasive and unsettling effect” on medical facilities, where such practices are generally looked at “as suspect and disruptive.” According to the Commission, such a view undermines patient self-determination. These public discussions about the moral and legal obligation to obtain consent for therapeutic interventions have shaped the private discourse that is supposed to take place between physicians and patients. What should be an improvised interaction tailored to suit each situation and the personalities involved has been usurped by legal and moral obligations. Moral and legal obligations require a conversation about certain elements prescribed that have been dictated by the public discourse which took place in commissions and in courts. All these bioethical and legal insights, especially those regarding self-determination directly helped the development of the informed consent theory and indirectly raised awareness and re-evaluation of paternalism in the physician-patient relationship.

2. A. 3. Reaction against Paternalism

Finally, informed consent emerged, in part, because of a reaction against paternalism. Paternalism is the intentional overriding of an individual’s known wishes
and choices or actions by another person. The one overriding justifies the action by arguing that it is to benefit or to prevent harm to the one whose preferences or actions are overruled. In healthcare, paternalism was based on the view that, because a health professional has superior training, knowledge, and insights, that authoritative position is used to determine what is in the patient’s best interests. Throughout the history of medical ethics, both principles of beneficence and nonmaleficence have produced a basis for paternalistic actions towards patients. Joel Feinberg distinguishes between weak (soft) and strong (hard) paternalism. In weak paternalism, an agent intervenes on grounds of beneficence only to prevent substantially nonvoluntary conduct, that is, to protect a person against his or her own substantially nonautonomous action(s). Substantially nonvoluntary or nonautonomous actions include cases of consent or refusal that are not adequately informed, severe depressions that preclude rational deliberation, and addictions that prevent free choices and actions. In weak paternalism a person’s ability is compromised in some way.

Mill, despite his stringent opposition to paternalism, considered temporary beneficent intervention in a person's action to be justified on certain occasions. An example is a person who is ignorant of a significant risk such as starting to cross a dangerous bridge. It is justifiable to restrain the person in order to ensure that he or she is acting intentionally and with adequate knowledge of the consequences of this action.

In fact, in ancient Greece, a patient’s participation in medical or treatment decision-making was seen as undesirable. It was accepted practice not to disclose possible risks or difficulties of treatment or procedure to the patient because such disclosure was believed to erode patient trust. Physicians were required to stimulate and
foster patient confidence in the treatment.\textsuperscript{77} According to Albert Jonsen, Plato noted that, when a free physician attended to patients who are free citizens, the physician conversed with them and attempted to understand their problems. Then, having gained their confidence, he went on to administer the prescription or the treatment. On the other hand, when treating slaves, the physicians dispensed with the conversation and went directly to prescription, giving orders like tyrants.\textsuperscript{78} The distinction between the treatment method for slaves and that for free citizens melted into Hippocratic aphorism: if a patient is under orders, that patient will not stray; whereas, if the patient is left to his or her own discretion, that patient will give up the struggle and die. Hippocrates advised, therefore, that the physician should take the patient in hand. They (physicians) should “assume authority,” “give orders firmly,” “urge obedience” and reproach the “delinquent.”\textsuperscript{79} For example, Hippocratic ethics required physicians not to reveal anything of the patient’s future or current condition. The reason was that, on learning the prognosis, patients would take a turn for the worst.\textsuperscript{80} These practices of the beneficence model of Hippocratic medicine encouraged and fostered beneficence and paternalism. Consequently, by following this beneficence model of Hippocratic medicine, physicians traditionally took the general view that disclosing certain forms of information can cause harm to patients under their care and that medical ethics obligates them not to cause such harm. The principle of autonomy is more a product of the traditions of Kant and the Liberal political philosophy than of the Hippocratic tradition.\textsuperscript{81}

According to Peter Murray, in medieval times physicians were encouraged to utilize their conversations with the patients to foster “comfort and hope while emphasizing the need for the doctor to be manipulative and deceitful.”\textsuperscript{82} In Medieval
Europe, Henri de Mondeville (1260-1325), a French surgeon and teacher of anatomy, upheld the Hippocratic beneficence model of medicine and ethics. In truth-telling, for example, beneficence was the criterion. He encouraged physicians to promise a cure to all patients and to tell patient’s relatives or friends if there is any risk. The prevailing view of medical moralists supported that sort of therapeutic privilege, namely, paternalism, which is an offshoot of beneficence. Physicians and medical professionals directed the conversation and sanctioned what today would consider to be ethically suspect, such as the withholding and distortion of truth.

Later, in the Eighteenth Century, in reaction to such paternalism, medical opinion was divided with some in favor of disclosure and patient participation in medical decision-making, others were not. Some medical moralists of the time, for instance, the Rev. Thomas Gisborne and Samuel Johnson contested the practice, arguing that physicians should tell patients the truth unless, of course, a patient demanded not to be told. Subsequently, medical ethicists and moral philosophers joined to condemn the practice of medical paternalism. They argued for the respect of the autonomy and wishes of the patient. Others such as Dr. Percival strongly contested the idea of abandoning paternalism. Ultimately, the advocates of ending paternalism triumphed, thanks to the influence of the self-determination and informed consent theory championed by both the legal and the bioethical sectors. Through these combined three-pronged forces of legal, bioethical events, and reaction against paternalism, the principle of informed consent gradually emerged.
2. B. Autonomy and Informed Consent

There are four commonly used principles in bioethics: autonomy, beneficence, non-maleficence, and justice. They were principally formulated by Beauchamp and Childress. Informed consent was, however, anchored in self-determination, especially in autonomy. Autonomy became the driving force. To understand informed consent better, therefore, it is necessary to take a hard look at autonomy.

2. B. 1. Meaning of Autonomy

Autonomy, one of the four principles of bioethics, is the driving force of informed consent in Western liberal society. Etymologically, the word “autonomy” has its origin in two Greek words: *autos* meaning self, and *nomos* meaning, rule, governance, or law. Autonomy stands, therefore, for self-rule or self-governance of independent city-states.\(^86\) It was originally advocated in the context of states being sovereign. Personal autonomy, by analogy, is said to be self-rule that is free from both coercion and controlling interference by other people, and from limitations such as inadequate understanding or illness that mitigates meaningful choice. Liberty and agency have been posited as the two essential conditions for autonomy. According to Tom Beauchamp and James Childress, while there is agreement on the necessity of the two conditions, there are disagreements about the meaning of the two conditions and about whether or not more conditions are required.\(^87\) The understanding of autonomy in Western thought has been greatly influenced by the Kantian and liberal rights moral theories.\(^88\) In the USA, it has also been influenced by Amendments to the national Constitution. It has been noted, for example, by J. B. Schneewind that Kant devised the conception of morality as autonomy, partly in support of conceptions of morality as self-governance that developed in competition with
conceptions of morality as obedience. Human beings are self-governing because they are autonomous. They legislates the moral law themselves. It is only because of the legislative action of the human will that human beings are subject to the moral law, and it is the same action that “always enables everyone to be law-abiding.” Consequently, Kant focused on autonomy of the will, which is a property the will has as being a law unto itself. This property of being a law unto oneself is referred to by Kant as the “dignity of man as a rational creature.”

While Kant spoke of autonomy, John Stuart Mill adopted individuality rather than autonomy. For Mill, in possessing “individuality,” human beings are autonomous in a very strong sense. They reflectively choose their own plans of life and make their own decisions without coercion or manipulation by others. They exercise certain “firmness and self-control in acting on their decisions.” For Mill, to do something because it is the custom is to make no choice. Although autonomy is very important to Mill and the Utilitarians, their interest in autonomy varies from the Kantian. For the Kantian, respect for autonomy of the rational agent “serves as a limiting criterion for all moral conduct.” It puts limits on what a person can do to another without behaving immorally because one cannot use another person as a means to an end. One cannot use another as a subject in medical studies without one’s consent, irrespective of the potential benefits for society. In the case of Utilitarians such as Mill, however, respect for individual autonomy possesses “utility value.” A society that encourages respect for individuals as autonomous agents will be a more progressive and, on balance, a happier society because the citizens will possess opportunities to foster their capacities in order to act as rational, responsible moral agents.
On the other hand, Thomas E. Hill, Jr., argues that the following notions of autonomy are not Kantian. The notion of autonomy as a particular feature of psychological maturity possessed by some people and not by others, is seen as a trait attributable to people in various degrees and circumstances on the basis of empirically discernible evidence. Thus, according to Hill, autonomous persons are understood as possessing independence of judgment which others, such as children, unthinking conformists, compulsive gamblers, do not have; or that autonomous persons are understood as being emotionally independent of other people, being self-reliant and secure in their own self-esteem. Hill maintains that blindly following one’s parents’ wishes, peer pressures, traditional norms, church authorities, for example, is regarded in this psychological notion of autonomy as lack of autonomy. For Hill, Kant sees autonomy as an “idea of reason, attributed on a priori grounds to all rational wills.” It is for Kant an “all-or-nothing trait” that grounds a basic respect due to all human beings, as opposed to an exclusive respect earned only by the most conscientious, human beings. Because human beings possess autonomy of will, “all (minimally) rational human beings have basic moral obligations.” Being under moral obligation (at all) “presupposes autonomy as a universal condition of moral agency” and “not as the special achievement of the few.”

Likewise, Hill believes that the notion of autonomy as a right, that is, to have a moral right to make certain decisions for oneself, to control certain aspects of one’s life without interference, rather than autonomy as an empirical trait, is not Kant’s. Autonomy as a moral right arose from the concept of the autonomous states. Hill argues that, even though Kant believes in rights, especially as being grounded in human autonomy,
autonomy itself is not a right but a property of all rational wills. A convicted murderer on
the gallows, for example, may have lost most of his rights to determine his future;
nevertheless, he has not, therefore, lost his Kantian autonomy. Whatever the case, and
as Hill himself admits, even if the aforenamed concepts of autonomy are not Kant’s
concept of autonomy, they must have been inspired by Kant’s concept of autonomy. In
other words, they have roots in Kant.

2. B. 2. Informed Consent and the Principle of Respect for Autonomy

The understanding of autonomy as an empirical trait, and as a right, that is, to
have a moral right to make certain decisions for oneself, without interference, have been
said to have roots in Kantian thought. Similarly, the Kantian thought influences the way
the principle of respect for autonomy and therefore informed consent is understood in the
USA and in the Western bioethics.

a) Informed Consent

Informed consent is a legal doctrine with an ethical foundation. It is based on
values such as dignity, individualism, respect for autonomy, and beneficence in the
liberal societies of the USA and Europe. There are, therefore, two meanings of “informed
consent:” the first sense and the second sense. The first sense can be analyzed in terms of
an individual’s autonomous authorization of a medical treatment or of participation in
clinical research. This first sense requires a substantial comprehension, absence of
substantial external control, intentionality, and authorization of a professional to do or not
to do something. It is, therefore, a particular kind of action by an individual or a subject.
The second sense of informed consent involves the social rules of consent practiced in
institutions that have to obtain consent that are “legally or institutionally valid” from
individuals before performing medical intervention or before allowing a subject to become involved in medical research. According to this second sense, the informed consent may not necessarily be an autonomous act or a meaningful authorization. It mainly requires satisfying the institution’s prevailing policy or legal criteria. It is policy-oriented in the sense that conditions are neither derivable solely from analysis of autonomy and authorization nor even from broad concepts of respect for autonomy. Every consent is informed consent in this second sense provided it satisfies the operating rules used by the institution in question in its practice of informed consent. For example, according to a North Carolina statute, a signed consent form constitutes a “valid consent” in the second sense provided a reasonable person would have comprehended the information provided in the consent form, even if the individual involved did not understand. An individual can autonomously authorize a medical treatment and give informed consent in the first sense, while not effectively authorizing the treatment and without giving an informed consent in the second sense. Likewise, informed consent obtained in the second sense may not satisfy the criteria of informed consent in the first sense. Informed consent in both senses is acceptable within certain limits, namely, where the purpose is to offer the patient or the subject the opportunity either to grant or to refuse authorization for medical treatment or research.

Besides these two senses, Franklin Miller and Allen Wertheimer have proposed a third sense, the Fair Transaction (FT), which is another context in which consent is morally transformative. This form requires going beyond valid consent. In other words, it requires going beyond the first two senses discussed above. The central concern for Miller and Wertheimer is whether a consent transaction between x and y is morally
transformative, and specifically whether a consent transaction makes it permissible for x to proceed. Miller and Wertheimer assert that the informed consent commonly used in bioethics is quite special. They argue that while valid consent as given in the two senses above captures much of what is important, and is an eminently serviceable notion for most purpose; it is not quite right. In addition, Miller and Wertheimer believe that the view of consent embraced by bioethics is a parochial one. The reason, according to them, is that bioethics has been under the clutches of “a specific historical legacy and an associated set of canonical statements and legal doctrines.” Consequently, bioethics has not been able to locate its own principle of informed consent within the more general field or contexts in which people alter their moral and legal status by consent. Moreover, the idea that morally transformative consent needs to be “informed” is very unique to the context of medicine. After all, in other aspects of life where people make decisions, we speak of “consent” and not of “informed consent,” and the standard for a consent transaction is an intercourse between two people x and y with y pledging consent to x to do something. Often times and in most aspects of life, the two people or group will mutually consent to an interaction. The two become both consenters and recipients of the consent.

Continuing, Miller and Wertheimer argue that a theory of consent transaction has got to account for both standard consent transactions as well as flawed ones, wherein it is reasonable and fair for x to believe that y has pledged consent despite the fact that y has not actually given consent. In other words, Miller and Wertheimer’s contention is whether the consent transaction makes it permissible for the recipient of consent to go on, or continue even when an examination of the transaction would show that valid consent
was not given. Their contention is not about whether the consenter gives valid consent. Likewise, Miller and Wertheimer contend that there are situations where even though a valid consent is given, the consent transaction may turn out not to be morally transformative. However, according to Miller and Wertheimer, both moral transformation or permissibility to proceed and valid consent should go pari passu or hand-in-hand. When they do not go pari passu, moral transformation rather than valid consent should be of fundamental moral importance. Using the example of the lock-and-key/autonomous authorization (LK/AA) model of consent transactions, Miller and Wertheimer explain that lock-and-key asserts that valid consent is the key that opens the lock of moral transformation. Identifying what constitutes a valid consent, Miller and Wertheimer posit the Theory of Faden, Beauchamp, and King as one possibility. That is, where valid consent is defined by the concept of autonomous authorization. Here consent is valid provided it reflects the consenter’s autonomous will and the consenter is substantially voluntary, competent to make such choices, is well informed, and comprehends what is being consented to.

Furthermore, Miller and Wertheimer contend that the lock-and-key/autonomous authorization model of consent has serious practical and theoretical difficulties. For instance, they assert that lock-and-key/autonomous authorization makes an excessively narrow conception of the values at stake by tying morally transformative consent to the consenter’s autonomous choice. Specifically, they stress that a morally defensible theory of consent transactions has to account for the interests of the consenter as well as the interests of those soliciting consent in possessing “clear, practicable, and fair standards by which recipients can determine when they are entitled to proceed with cooperative or
transactional activities.” Thus, Miller and Wertheimer propose an alternative: the “fair transaction” model (FT) of consent transactions. This model holds that x is morally permitted to proceed on the basis of a consent transaction if x has treated y fairly and responds in a reasonable manner to y’s voluntary expression of consent or that which x reasonably believes is y’s expression of consent. Miller and Wertheimer believes too that fair transaction model of consent is a more superior moral conception or paradigm of consent transaction than others; that it (fair transaction) serves both to protect and promote the interests and autonomy of the consenter. For them, any approach which makes valid consent central fails to do justice to the bilateral nature of consent transactions.

b) Elements of Informed Consent

As was mentioned above, the following elements have been identified in informed consent: competence, disclosure, understanding, voluntariness, and acceptance. That is to say that one has to be competent; one has to receive a detailed disclosure; one has to understand the disclosed information; and one has to voluntarily accept or refuse the intervention in question.

i. Disclosure

Physicians are required to divulge the following: those facts that patients normally consider material in deciding whether to consent or to refuse the proposed intervention. These include the nature and purposes of the intervention, risks and benefits involved, diagnoses, prognoses, and alternative interventions available as well as their risks and benefits. Other requirements are information the physician believes to be material, the
physician’s recommendation, the purpose of seeking consent, as well as the nature and limits of consent as an act of authorization.\textsuperscript{111}

Bernard Gert, Charles Culver, and K. Danner Clouser agreeing that there is a need for adequate disclosure of information to patients identified two sets of information: morally required and morally encouraged information disclosures. According to them, at least three kinds of information are morally required to be divulged to patients. These are: of significant benefits and harms that might occur or result from the planned treatment and tests; plausible alternative treatments possible in the current situation, as well as their benefits and harms; and the nature of the patients’ sickness and the risks and benefits of not taking any action or intervention.\textsuperscript{112} Gert, Culver, and Clouser believe that these sets of information should essentially always be disclosed in the consent process. However, the inclusion of the other sets, the morally encouraged, which they did not enumerate, in the information to be disclosed, is not morally required but encouraged. Gert, Culver, and Clouser argue that physicians who fail to disclose such information have not acted immorally but they “have failed to act as helpfully and virtuously as they might.”\textsuperscript{113} Believing that most physicians want to know and disclose information critical to patients’ medical decision-making, Gert, Culver, and Clouser observed that the problem is that all health care codes of ethics do not make distinction between information that is morally required and information that is morally encouraged. Therefore, Gert, Culver, and Clouser agree with Clarence H. Braddock III, Kelly A. Edwards, Nicole M. Hasenberg, et al.,’s empirical research evidencing that vast majority of physicians and health care practitioners do not conduct adequate consent process, and even sometimes they carry out
medical interventions and diagnostic tests with “almost no accompanying information” and disclosure.\textsuperscript{114}

\textbf{ii. Understanding}

Informed consent requires that the patient understands the information disclosed, at least the essential information. Such understanding does not have to be complete since a grasp of the central facts is generally sufficient. A patient or the surrogate usually ought to understand at least what a healthcare professional considers as relevant to authorize an intervention.\textsuperscript{115} These include the nature and purposes of the intervention, risks and benefits involved, diagnoses, prognoses, and available alternatives.

\textbf{iii. Competence}

Competence to consent to or refuse medical intervention is a central concept in health law and bioethics in the USA. It encompasses being legally of age to exercise a legal right including rights to make healthcare decision and decisional capacity. The person needs to have the ability to communicate choice, understand relevant information, appreciate the situation as well as possible consequences, and manipulate information. Thus, when individuals “lack the ability to make decision that promotes their well-being in keeping with their own previously expressed values and preferences,”\textsuperscript{116} we say they are incompetent. Being competent to make a decision is different from willingness to make a decision. Being competent or having the capacity enables, but, it does not obligate a patient to act autonomously or independently. Besides, a person can be competent in one thing and not in another. It is task specific. For instance, a patient may be competent in deciding what to drink or wear but not in making medical decision.
Thus, lacking the ability to make medical decision does not mean that one is incompetent in other things.\textsuperscript{117}

Furthermore, even though Gert, Culver, and Clouser assert that there are various definitions of competence, they agree that the various definitions have in common the stipulation that one necessary element of competence is that the patient must comprehend at least the minimal amount of factual information that would count as adequate information for validly consenting to or refusing the proposed medical treatment. Otherwise, the patient is considered incompetent to make medical decision.\textsuperscript{118}

iv. Voluntariness

While Beauchamp and Childress speak of voluntariness, Gert, Culver, and Clouser talk of coercion/ absence of coercion or according to Faden, Beauchamp and King, acting without controlling influences.\textsuperscript{119} Voluntariness or acting without coercion or controlling influences, entails that after the patient has received the information and understood the core message, one “acts voluntarily to the degree that one wills the action without being under the control of another’s influence.”\textsuperscript{120} Sickness, psychiatric disorders, drug addiction or substance abuse can diminish voluntariness. Nevertheless, this analysis is restricted to control by other human beings. For instance, if a doctor instructs a reluctant patient to undergo dialysis and coerces the patient to comply by threatening to abandon that patient, then the doctor’s influences appear like control. While, if a doctor persuades the patient to undergo the procedure when the patient is at first reluctant to do so, then the doctor influences, but does not control, the patient.\textsuperscript{121} According to Gert, Culver, and Clouser, the doctor can justifiably influence a patient to consenting or refusing an intervention when the patient is in a situation when acting
paternalistically towards that patient is justified. Otherwise, it is neither morally nor legally justified to coerce a patient even if it is done by the patient’s family.

Finally, Beauchamp insists that voluntariness and autonomous choice rather than disclosure of information are the central elements to the notion of consent. Because of the name, “informed consent” the understanding of consent has been skewed towards providing information and being informed. Thus, the legal system emphasizes the supreme importance of disclosure of information to patients and subjects.” In fact, he thinks that disclosure is not a necessary condition of informed consent, “and is only remotely connected to consent per se.”

v. Acceptance

After receiving and comprehending the disclosed detailed information, the competent patient is expected to voluntarily either decides in favor of the planned intervention and authorizes it or refuses to go on with it and, therefore, declines to authorize the proposed intervention.

c) Respect for Autonomy

Respect for autonomy involves recognizing that individuals have the freedom to make choices based on personal values and beliefs and to accept or refuse medical treatments that affect their life as well as their well-being. It is embedded in common morality that one ought to respect the autonomous choices of individuals even if there is little or no agreement about the nature, scope, or strength of this respect for autonomy. Respect for autonomy arises in part from a special fiduciary obligation between the patients and the health care professional. As a positive obligation for autonomy, respect for autonomy includes enabling individuals to act autonomously, and in some contexts it
involves the obligation to build peoples’ capacities for autonomous decisions and choices. It also involves the duty to assist in preventing and warding off conditions that might mitigate or destroy autonomous choices or actions. It requires healthcare professionals to assist the patients to overcome their sense of dependence and achieve as much control as possible as they desire.

The obligation to respect autonomy does not extend to those individuals who are unable to act in a manner which is sufficiently autonomous or individuals who cannot be made to be autonomous, because of their immaturity, incapacitation, or ignorance. An example of such persons includes infants, irrationally suicidal individuals, as well as those dependent on drugs. These people are psychologically or legally incapable of giving valid consent. They are unable to communicate preferences or choices, to comprehend information, their situation and its consequences. In addition, they are unable to give reasons, to risk benefit-related reasons or to reach any reasonable decision.

Immanuel Kant offers us a reason to respect autonomy, namely, because autonomy is the basis for a human being’s moral standing as a rational being. Every person has unconditional worth and the capacity to determine his or her own moral destiny. As free moral agents, individuals have the capacity to choose and to act in accordance with their own reasons and motives without external constraints and manipulative influences. For Kant, to contravene a person’s autonomy is to treat that person merely as a means, without regard to that person’s own goals or end, that is, to treat the person in accordance with someone else’s goal or end. Kant requires that one
rationally and impartially evaluate one’s choice. He noted that decisions based on particular relationships or emotions are not autonomous but heteronomous.129

However, even some liberals believe that respect for autonomy is not absolute; rather, it has only a *prima facie* standing. Sometimes it can “be overridden by competing moral considerations.” Beauchamp and Childress offer the following considerations which can override the principle of respect for autonomy: 1) when one’s choice will endanger the public health; 2) when respecting one’s autonomy can harm others; 3) when it requires scarce resources for which no funds are available; and 4) when for any of these reasons others can justifiably restrict a competent adult from exercising autonomy.130 In her own critique of autonomy and informed consent, Onora O’Neill introduces the issue of trust in the discussion. The next sub-section presents O’Neill’s thoughts on the issue of autonomy and trust.

2. B. 3. Autonomy and Trust

O’Neill opines that the conceptions of individual autonomy which is widely relied on in bioethics are philosophically and ethically inadequate, and that they undermine relationships based on trust instead of supporting them. In her books *Autonomy and Trust in Bioethics*, she acknowledges that much of medical ethics has very much emphasized individual patient autonomy and rights.131 On the contrary, she thinks that literatures on the second principal domain of bioethics --environmental ethics-- (for her, the two principal domains of bioethics are medical and environmental ethics), have focused more on public benefits and public harms wherein individual autonomy is taken as source of harms. For instance, environmental ethics hardly see autonomous life-style choices of individuals as adequate for the protection of the environment. Rather it increasingly accentuates the importance of stewardship of the environment advocating local or
international public regulation and enforcement. Consequently, it emphasizes the need to limit individual autonomy. However, medical ethics and environmental ethics have recently found a convergence and common language by concentrating on rights, thus bracketing issues of agency and obligation in favor of a primary focus on recipience and entitlement. Thus, medical ethicists consider human rights including patients’ rights, as securing the right kind of respect for human agents and their autonomy, environmental ethicists view the rights of animals, plants ecosystems, landscapes and etc. as safeguard, protection, and respect for the non-human world.\textsuperscript{132}

Juxtaposing autonomy and trust, O’Neill notes that while it might be expected that the increasing emphasis on individual rights and autonomy would have increased public trust, rather it undermined it as well as the relationships based on trust.\textsuperscript{133} O’Neill believes that trust is a major theme in sociology, but a minor theme in ethics. Consequently,

a large amount of discussion of trust focuses on empirical studies of perception of others as trustworthy or untrustworthy, and rather little addresses the practical demands of placing trust. The topics are connected, but they are not the same. The connection is that those who see their world as a ‘risk society’ often find placing trust problematic: but it does not follow that they do not place trust, or even that they place no trust in those whom they claim to think untrustworthy.\textsuperscript{134}

Continuing O’Neill rightly argues that people do place trust on others in various cases. Sometimes only with respect to a specific range of action, especially actions for which those people have explicit responsibility. For instance, patients may trust their physician to act in their best interests in deciding on their treatment, while they might not trust the physician to drive safely. Other times trust is unrelated to role as in trusting strangers in giving us reliable information. Likewise, people cannot avoid placing various sorts of trust in others with whom they have close and complex relationships. Other times trust is
often reciprocal in personal relationships. From all this, O’Neill concludes that we often trust others to play by the rules and to “do something properly without the slightest assumption that they have any good will towards us” or even knowing that they do not have any good will toward us.135

O’Neill also believes that just as there are various cases on which people place trust on others, there are various conceptions of both autonomy and trust. Some conceptions of trust and of autonomy are compatible, and even mutually supporting, while others are not. While all these conceptions of autonomy and trust do not have to be adopted, however, embracing conceptions of autonomy and trust that cannot be reconciled will result in inability to have both. In other words, to have and enjoy both conceptions of autonomy and trust, reconcilable conceptions of each of them must be adopted. For O’Neill, the physician-patient relationship presents a paradigm of a relationship of trust. A patient goes to the physician being aware that the physician is bound by professional oath and integrity to act in the best interests of the patient. She thinks that this physician-patient relationship ought to trump any other considerations of self-interest and gain, in spite of the contractual and financial benefits connecting physician and patient, or physicians and their employers or medical institutions. The physician-patient relationship is supposed to last long, be intimate, trusting, and disinterested.136

O’Neill observed that some scholars criticize the physician-patient relationship as not being of reasonable trust because patients placed their trust on physicians as children blindly put trust on parents. It is based on lack of an alternative and on inability to distinguish and to discriminate between well-placed and misplaced trust. It was
paternalistic initially. However, the realization of the defects of paternalism of the physician-patient relationship, for instance, that it could not offer an adequate context for reasonable trust. The idea that relations of trust are in themselves enough to safeguard a weaker, dependent was declared naïve. A more adequate basis for trust was explored, a model where the patients were on a more equal footing with professionals/physicians, hence, patients have to be better informed and less dependent. In other words a well-placed trust is only the one “given by those who understand what is proposed, and who are in a position to refuse or choose in the light of that understanding.”  

Consequently, there is the need for informed consent, and autonomy. In this model, autonomy is believed to be a pre-condition of genuine trust, and informed consent “a ritual of trust that embeds it in properly institutionalized respect for patient autonomy.” This model is seen as a relationship between equals and trust is properly combined with patient autonomy. Legal developments and abuse of research subjects by Nazi and Nuremberg code helped to bring about this model.

Nevertheless, with recent developments and changes in health care technological developments, there arose many teams of professional in the hospitals most of whom are not a known and trusted face, but are what some have called “strangers at the bedside.” To the patient these are powerful strangers, and functionaries of medical facilities whose structures are opaque to most patients, even though they ought to look out for the best interests of the patients, preserve confidentiality, and to respect privacy. The change for the patient is loss of trust even though autonomy and respect for autonomy was emphasized. From the patient’s point of view every development in the post-World War II period distanced the physician and the hospital from the patient, disrupting social
connection and severing the bonds of trust.\textsuperscript{140} Conversely, viewed from the physicians and practitioners’ side, there is increase of codes, complex professional codes, more formal certification of competence to perform specific medical interventions, audits, patients’ rights to complain and sue in case of mistakes or improper treatment.\textsuperscript{141} These new relationships may yield better billing by replacing traditional forms of trust with a new and better basis for trust. The new structure may afford reasons for patients to trust even though they do not know their physicians personally, and even though they do not understand the details of the rules and codes that constrain physicians’ action. O’Neill reinforces and re-iterates her basic argument: that implementation of the kind of principled autonomy she derives from Kant must be complemented by considering a social context of trust. Employing the use of human tissue in medical research as an example, O’Neill contends “that emphasis on informed consent can hardly be sufficient without a more general contextualization of those principles alongside the obligation not to deceive and the need for a context of trusting relations between medical professionals and those with whom they interact.” \textsuperscript{142} In this way, an ideal of trust and autonomy might be achieved, reshaped and made compatible.

But in a situation where patients have limited options, and where cognitive and decision-making capacities are limited, and the healthcare professionals, strangers at bedside who “certainly do not seem to be exercising a million autonomous experiments in living,” and “a medical system that increasingly presents itself to its consumers as an industrial process,” makes it seem a façade.\textsuperscript{143} Thus, informed consent procedures might seem a burden or a ritual. In such a situation, ideas of patient autonomy might become “more inflationary than liberating.” The physician would set out the options and show the
patients to sign and where to sign, while at same time the patient is still being told that s/he is autonomous, and an equal partner in treatment and that s/he is about to give free consent, while the reality is virtually different. This model shows neither traditional trust nor newer and better grounded trust with respect and autonomy, rather it depicts semblance of trust, and autonomy.¹⁴⁴

Finally, the following conclusions can be drawn. O’Neill reinforces the argument of this dissertation, which is that there is too much emphasis on individual patient autonomy to the near exclusion of family and community contribution. It is a call to balance the emphasis on individual patient rights and autonomy with some communal values.

Likewise, O’Neill makes a significant contribution to the understanding of the most important task confronting those responsible for the National Health Service (NHS) and medical practice to maintain and strengthen trust where it exists and to restore and foster trust where it has atrophied. Finally, it calls for the recruitment and training of more and better health care professionals, instead of the tendency to quick fix issues by setting up more regulatory bodies.¹⁴⁵

The concept of “person” in liberal thought impacts on the way the principle of respect for autonomy and informed consent is understood. It will be seen in subsequent chapters that this concept of autonomy differs from the understanding of autonomy in African thought. It has also been challenged by the Ethics of Care Movement. However, this dissertation will first explore how Western liberal notions of person influence the concepts and practice of autonomy and informed consent in Western bioethics.
2. C. The Concept of Person and Autonomy

There are various ideas of what constitutes a human person in Western culture. For instance, the existentialists\textsuperscript{146} believe that human beings are relational, that \textit{to be} is to be in relationship. They also believe that human beings are co-existent and interdependent beings and not independent isolated beings. There is no statement that one can make about a person that is not referential.\textsuperscript{147} “Existence is co-existence,” one’s being is a “being-through-others.” “Making-one-another-be is the indispensable condition for an authentic, personal existence.”\textsuperscript{148} Aristotle too held that human beings are by nature social and political animals. “A social instinct is implanted in all men by nature.”\textsuperscript{149} The state or society is a creation of nature and it precedes the individual. Aristotle argues that the proof that the state or society is prior to the individual is that the individual is not self-sufficient when isolated. An individual who is unsocial (has no state or society) naturally and not accidentally, is either a bad person or above humanity. An individual who is either incapable of the common life or is so self-sufficient as not to need to live in society, is either a beast or a god.\textsuperscript{150}

However, rather than existentialist understanding, it was the Kantian and liberal Protestant concept of the human person that laid the ground and very much impacted the concept of the human person that is at the root of autonomy in the USA and in Western tradition in general. Kant, for instance, was influenced by Aristotelian tradition. Aristotle’s ideas correspond to the Judeo-Christian tradition that described human beings as sacred, possessing dignity and the sanctity of life which are derived from our being created in the image and likeness of God. This notion also maintained the idea of a
divinely inspired universal hierarchy, with man at the top. The Judeo-Christian Scripture proclaims thus:

Then God said: “Let us make man in our image, after our likeness. Let them have dominion over the fish of the sea, the birds of the air, and the cattle, and over all the wild animals and all the creatures that crawl on the ground.” God created man in his image; in the divine image he created him; male and female he created them.\textsuperscript{151}

Then God ordered them to be fruitful and multiply, filling the earth and subduing it.\textsuperscript{152}

The book of Genesis does not necessarily give a historical account of creation. Rather it is a symbolic or theological history that requires interpretation. Ancient readers and the Fathers of the Church have their interpretations of the account of creation. Origen, for example, using his “allegorical” method of interpretation, takes the two accounts of the creation of man and woman together and understands them as representing the “dual structures of human existence,” that is, the “incorporeal, rational nature” possessing the ability to entertain perfect infinity, and as “embodied physical beings” who must strive in life to satisfy their needs and fulfill their desires.\textsuperscript{153} For Origen, man and woman created in the image and likeness of God means that they received the honor of God’s image in their first creation while the perfection of God’s likeness is reserved for them at the consummation.\textsuperscript{154} Created in the image of God depicts the “intrinsic spiritual dignity” that God has conferred on humanity; however, that dignity awaits perfection as the “likeness.” Thus, Origen sees in the “image” and “likeness” an eschatological salvation. He finds support for his point in the First Letter of John:

Beloved, we are God’s children now, what we shall be has not been revealed. We do know that when it is revealed we shall be like him, for we shall see him as he is. (Jn 3:2)

Though modern biblical scholars\textsuperscript{155} may neither use the same vocabulary as Origen nor read the salvation motif into the phrase created in the “image and likeness of God,” their interpretation of the creation of man and woman is similar to Origen’s. Like
Origen they parse the two accounts of the creation of humanity but, unlike him, they identify them as belonging to two different traditions: the “Priestly” known as “P” and the “Yahwistic” known as “J.” For modern biblical scholars, the account of the creation of man and woman in Genesis, Chapter 1 belongs to “P,” whereas the account in Genesis Chapter 2 comes from “J.” Modern biblical scholars such as R. R. Reno, Robert Jenson, Robert Wilken, Ephraim Radner, Michael Root, George Sumner, Bruce K. Waltke, and Cathi J. Fredricks agree with Origen that being created in the image of God seals man and woman, that is, human beings, as those destined for communion with God. The image of God is engraved into our human nature, which is precisely why human beings experience their desires and capacities as fit for more than animal survival.156

Commenting on the image of God, Waltke and Fredricks noted that the expression “image of God” is used in a unique way in reference to human beings.157 This image set human beings apart from other creatures who are created according to their own kind. Being created in the image of God facilitates the role of human beings as rulers of the Earth in place of God. “Likeness” depicts that humans are distinct from God; “humanity” is a facsimile of God. Image of God is equated with God alone.158

In the Ancient Near East it was widely believed that a god’s spirit lived in any statue or image of that god, with the result that the image could function as a kind of representative of or substitute for the god wherever it was placed. It was also customary in the ANE to think of a king as a representative of a god; obviously the king ruled, and the god was the ultimate ruler, so the king must be ruling on the god’s behalf. It is, therefore, not surprising that these two separate ideas became connected and king came to be described as an image of a god.159

The passage (Genesis 1:26-27) lends credence to the idea of the dignity of the human person as a derivation of being created in the image and likeness of God. It (Genesis 1:26-27) further supports an idea of a divinely inspired universal hierarchy with human beings (man) not only being at the top of the ladder but also possessing a divine
mandate to subdue and dominate all other creatures. Some commentators such as Francis of Assisi, Albert Schweitzer, Darryl C. Macer, and Thomas More give a nuanced interpretation to this passage by de-emphasizing the subduing and domination of creation by humans. They, rather, emphasize stewardship and care for creation, in which case, humans are required to treat creation and other creatures as fellow creatures of God and worthy of some respect.160

Aristotelian tradition maintained the universal hierarchy, although it incorrectly taught that women, children, and slaves were inferior and lacked immortal souls. Those who cannot participate in a rational principle to apprehend it sufficiently are by nature slaves and inferior, almost equal to tamed lower animals. The lower animals cannot apprehend a principle; they use their instincts.161 The Fathers of the Church saw the divine element in human beings as rationality, hence the “rationality thesis.”162 Human beings are special because they are rational. Augustine of Hippo asserts that human reason is the essence of the soul.163 In relating the rationality thesis to the image of God thesis, and the importance for the idea of the human dignity, for example, Thomas Aquinas argues:

Of all parts of the universe, intellectual creatures hold the highest place, because they approach nearest to the divine likeness. Therefore, a divine providence provides for the intellectual nature for its own sake, and for all others for its sake.164

Borrowing from this tradition, Kant believed not only that human beings occupied a special place among other creatures, but that they also have intrinsic worth or dignity that “makes them valuable above all price” or end.165 This dignity, according to Kant, derives from a person’s ability to be an autonomous, rational agent able to make his or her own decisions.166 Kant believes that God owns human beings, and because human beings are God’s property, they are bound to regulate their activities in conformity with God’s
intention to preserve life. He also saw the secular idea of human beings as rational beings closely linked to the religious idea that they are made in the image of God. These are evident in his discourse on suicide. Kant noted thus:

But as soon as we examine suicide from the stand point of religion we immediately see it in its true light. We have been placed in this world under certain conditions and for specific purposes. But a suicide opposes the purpose of his creator; he arrives in the other world as one who has deserted his post; he must be looked upon as a rebel against God.\(^{167}\)

Like Aristotle and Plato, Kant believed that animals (non-human animals) and plants are not rational beings and, therefore, they are not worthy of any moral status or respect. They are there just as means to an end, especially as means to serve the ends of human beings.\(^{168}\) In other words, animals may have rights in so far as they are at the service of human beings, for example, in research. Otherwise, in and of themselves, animals and plants have no worth. They are outside the realm of the rights and responsibilities that define our moral order. Thus, in defining a human being, Kant exalted reason and autonomy. One of the disadvantages of emphasizing reason in defining a human person is that individuals such as newborn infants, and the severely mentally challenged who are incapable of exercising rational thought or making choices, would not be considered within such a notion of “human person.” Furthermore, Julia Tao Lai Po-wah, in contributing to the critique of the Western notion of person, notes that it is not appropriate “to delineate descriptive properties of individuals in order to draw conclusions about moral standing.” To be rational and to act freely and purposively is insufficient “for establishing any form of moral standing.” Po-wah’s reason is that “capacities of rationality, self-consciousness, and the like” do not possess any inherent “connection to moral properties such as moral agency, moral judgment and moral accountability.”\(^{169}\) Po-wah thinks emotions are very much involved because thinking
rationally bears on moral decision-making. If one is only rational or only emotional, one can arrive at different moral decisions on the same subject.\textsuperscript{170} Po-wah’s comment, especially the latter, is in keeping with recent research results on emotions and moral decision-making. That emotions play roles in moral decision-making will be demonstrated later.

It is, however, in the Eighteenth Century and during the Enlightenment, that the full emergence of the autonomous self-determining individual as an ideal in Western culture took place. John Christman, for example, noted that placing moral weight on an individual’s ability to govern oneself, independent of one’s position in the metaphysical order or one’s function in social structures and political institutions was produced by the “Enlightenment humanism of which contemporary liberal political philosophy is an offshoot.”\textsuperscript{171} According to Robert Veatch, the full emergence of the autonomous self-determining individual was enhanced mainly by the writings of David Hume (1711-1776), Rousseau (1712-1778), and Immanuel Kant (1724-1804), and, to some extent, by John Locke (1632-1704) as well as Thomas Hobbes (1588-1679). The latter were the precursors of the former. Some of these men, such as Kant, were nurtured by Protestant thinkers including Martin Luther and John Calvin.\textsuperscript{172} The Founding Fathers of USA, Thomas Jefferson, James Madison, and Alexander Hamilton, in addition to crafting the Declaration of Independence and the Constitution, expressed in a general way the spirit of Liberalism. They also integrated the language of rights into the American ethos and strengthened the importance of the individual as decision-maker as an American ideal.\textsuperscript{173} We have, therefore, the Patient Self-Determination Act whereby the wishes of a competent individual patient override every other person’s. Furthermore, the notion of
person that emerged emphasizes individual independence. It emphasizes reason as opposed to emotion, individual patients’ rights, individual autonomy, and a subjective conception of the good (life).

2. C. 1. Individual Independence

When one comes to the issue of who decides treatment in a liberal society, it really depends on the individual and on the values that shape and give meaning to the life of the individual in question.\(^{174}\) Two reasons offered for this are the lack of a common understanding among individuals and across communities, and a lack of one authoritative view of what constitutes the “good life” or a concrete goal of medicine.\(^{175}\) At the heart of Liberalism is the belief that the individual is the seat of moral judgment as opposed to the community or family. This means that one has to recognize much more diversity of views concerning moral issues. One has to adopt a political structure that is neutral among the diverse views regarding moral questions, irrespective of whether one or more of those views is correct. A plurality of values co-exists. No one of these values is, for social purposes, given a privileged position.\(^{176}\) Thus, liberal societies promote a social system that delineates value as determined in substance or content by individuals in that society. Thus, Thomas May concludes that it is only by accommodating this plurality of moral views that individual’s unique value system will be respected and protected within a liberal constitutional framework. May, however, does not think that societies such as those in Russia and in Africa which emphasize communal values more than individual values are wrong or uncaring. On the contrary, he sees them as portraying a different political perspective centered on collective good rather than on individual good.\(^{177}\)
The liberals, especially the Utilitarians, advocate for individual interest, desire, and happiness as the good. There is, for instance, the notion of aggregate individual happiness as the good (utility) to be maximized by utilitarianism. Individuals are allowed to construct their own life plan independent of family or society and, by so doing, their happiness is maximized. John Stuart Mill justifies this by arguing that, even though individuals may sometimes make poor decisions, it is still the individual who is in the best position to judge what constitutes one’s own good.  

Mill rejects paternalism. However, he concedes that prevention of harm to others may be sufficient justification for interfering with an individual’s autonomy. Nevertheless, an individual’s own good is never a justification for interfering with that individual’s autonomy, because individuals are better judges of their own interests more than anyone else. The high utility value Mill ascribes to individual autonomy leads him to reject paternalistic interventions.  

This line of thought is supported by Kantian liberals who believe in broad rights of individuals such as broad rights of non-interference or privacy, free speech, and association. May substantiates this assertion with the example of the situation in his country, the United States of America. He writes that the “cultural history and political institutions of the United States are decidedly focused on liberal individualism.” This liberal political framework, May insists, is vital, and nonnegotiable, as a starting point in our discussion of bioethics decision making in the United States. Be we liberals, communitarians, communists, or other in ideology, we find ourselves in a liberal constitutional society. This context governs our social relations. Healthcare as a social practice is bounded by the fundamental political context within which it exists. In short, the role moral beliefs play in bioethics will be limited, in a social context, by the political rights of individuals.
There is little wonder, then that the Western liberal individualism has a concept of autonomy that places much emphasis on rational and individual self-determination, thus, leading to the individual right-oriented concept of informed consent in liberal societies, especially in the United States of America today. In a clinical setting, the tradition of medical ethics in Western liberal society emphasizes the individual. It focuses on the patient and on the patient’s interests and autonomy as isolated from the patient’s social context such as family or relationships that may not count as families, but yet, count as intimate. These, as described by James Lindemann Nelson, are lasting relationships in which the interests of the people are complexly intertwined, and in which people care intensely about each other.182 Families and enduring relationships tend to offer the contexts that support “moral values of intimacy,” and tend to be the spot at which medicine often encounters intimacy.183

The resultant effect of this emphasis on reason and individual rights-oriented autonomy and informed consent is that not only is the patient as an individual the best judge of these needs, but also the patient is expected to be strong and independent even in illness or vulnerability in order to make sound decisions in healthcare situations. Likewise, the patient is expected to make choices according to one’s own interests and preferences. John Hardwig rightly observed that, in another aspect of life, no one would argue that a family man should decide to take a sabbatical or a new job solely on the basis of what he wants for himself, or to make the decision alone, no matter how responsible he is.184 The question is: Why it should be different in making medical treatment decisions?

It could not be because medical decisions are matters of life and death because most or many of the medical treatment decisions are not matters of life and death.185
Perhaps part of the reason for the difference in medical treatment decision-making is the misconception and preoccupation with the biophysical model of disease. This probably has led people into thinking that and acting as illness is something that happens simply within the patient’s body and does not affect their relatives and other people except for contagious disease. Consequently, healing and treatment has come to be seen in the same manner as taking place simply in the patient’s body.

Of course, this is not the reality because sickness as well as cure and care of the patient can and do affect the family members and others. More often than not, family members, relatives, or close friends who have deep concern for the patient’s health are suspected as interfering in the patient’s autonomy or self-determination. The Western clinical milieu overlooks the fact that self-determining patients exist basically in relation to others. Their interests involve a dynamic balance among interdependent people who possess overlapping considerations; rather, the healthcare setting appears to consider illness as a problem of a particular patient. It neglects the disruptive effects the patient’s illness may have on family members especially close members who are expected to provide diverse forms of care. In patient care, for now, basically, families are only a means to patient’s ends. They (families) “may be important as sources of information about the desire” and wishes of incompetent patients’ or as “reservoirs of emotional support.” Likewise, as Susan Sherwin rightly observed, individual patient self-determination oriented medicine as well as bioethics requires health medical personnel to “ensure that individual patients have the information they need to make rational decisions about their healthcare, yet it does not ask the necessary questions about the circumstances in which such decisions are made.”
There is a need, therefore, to broaden the understanding of the effects of illness, its medical care and practice of ethics of medicine. There is a need to look beyond the medical personnel and the patient to family members, those involved in other intimate and enduring relationships with the patient as well as their interests. Lawyers and teachers, as Hardwig noted, consider more than the legal and educational consequences of their actions respectively.\textsuperscript{190}

Furthermore, proffering an answer to why decision-making is different in clinical situation, Nelson points to the peculiar situation of patients. Because they are ill, patients are vulnerable; and, being in healthcare facilities such as hospitals, means being displaced, plucked from their homes and placed into an unfamiliar milieu --hospital. They are in a weak position to guide and protect their own interests fairly. Moreover, patients will directly suffer if denied medical attention in favor of other family needs.\textsuperscript{191} Hardwig agrees that these considerations highlight the importance and implications of “fairly and fully representing” the interest of patients in decision-making. Yet, Hardwig doesn’t think that attending to patient’s interests “disenfranchises” the interests of the relations of the patient and other people. Nelson responded that it does disenfranchise the family or others.\textsuperscript{192} Following the points made above, this dissertation agrees with Nelson that attending exclusively to patient’s interests can and does disenfranchise the interests of the families, those involved in other intimate and enduring relationships with the patient and others.

Certainly, the sick are vulnerable and do not lose their autonomy, thus, should be dully cared for, respecting their interests and wishes. Granted that the need to defend the vulnerability and privacy of patients is a powerful reason; yet, the interests of the patients
should not always be considered exclusively over those of their families, those involved in other intimate and enduring relationships with them and other peoples. The idea of treating patients, their autonomy, and their interests in isolation from their social context needs to be re-examined. Equally requiring re-examination is the Western liberal understanding of the role of emotion in decision-making and, thus, in informed consent.

2. C. 2. Reason as Opposed to Emotion

René Descartes, Immanuel Kant, and John Stuart Mill ennobled reason over emotion in moral decision-making. Kant and the Kantian moral theory, for instance, emphasize abstract reasoning or rationality over emotions and desires. For Kant, reason is the arbiter of truth in all judgments. Reason is the faculty of principles or the faculty of unity of the rules for understanding principles because reason is the source of certain concepts and principles. Kant holds that, for one to act morally, one ought to be able to recognize sufficient reasons for action. These reasons are supposed to arise from the will and not from one’s desires, or needs, or inclinations, or from what Kant calls heteronomy of the will. This recognition of sufficient reasons for action is accomplished through the exercise of pure practical reason. This is the idea of the Categorical Imperative, that is, the law of reason which commands unconditionally, necessarily, and universally, requiring human beings to act in ways consistent with reason and logic, devoid of emotions, wishes, and feelings.

Thus, for Kant and Kantian moral theory, emotions and desires do not play a positive role in moral decision making; emotional inclinations and desires are in conflict with our rational wills and are not conducive to moral analysis. They are not able to function as a foundation for moral laws. Consequently, Kant defends the stoic
principle of apathy and detachment. “The prudent man must at no time be in a state of emotion, not even in that of sympathy, with the woes of his best friend.” As a result of this, Kantian moral theory requires us to divest ourselves of passion and emotions, and instead, arm ourselves with abstract reason, which Kant calls pure practical reason, in order to act as reason recommends in moral decision-making or moral analysis. For Kantians, reason should help people resist yielding to emotional inclinations and desires that are in conflict with their rational wills. Yielding to them is not autonomy but heteronomy, which is unacceptable to Kant. One acquires the impression, therefore, that a person is just a rational being who is unfortunately saddled with emotions, and to be autonomous is not to be a slave of one’s emotions and passions but a slave of one’s reason.

Kant’s thoughts and his repudiation of emotions very much affected Western “philosophical tradition of moral decision-making.” Tristram Engelhardt, Jr., for example, argues that affirmations of one’s feelings are “irrational,” people should strive instead to become an impartial reasoner “whose only interests are in the consistency and force of rational argument.” He does not, however, believe that this is achievable. In view of the fact that in moral judgment, people are supposed to be impartial, which is a critical component of justice, Rawls proposed that a judgment in the name of justice be made behind the “hypothetical veil of ignorance.” Beneath this veil of ignorance, emotional attachment and personal relationships do not affect deliberations and conclusions. Within this reasoning, emotions are said to be events that occur or happen to people, events that are experienced passively. Their influence on judgment lies outside the sphere of voluntary control. Therefore, their influence over judgments or behavior
cannot be regarded as assisting in moral reasoning.\textsuperscript{202} The underlying assumptions here, as David Pizarro indicated, are: first, that there can be a thorough detachment of reason from emotion; second, that reliably objective reasoning is only a detached reasoning; and, third, that emotions will “only bias, cloud, and impede moral decision-making.” Contrary to such assumptions, as will be discussed below, emotions, passions, and empathy can help in moral decision-making or moral judgments.\textsuperscript{203}

Joel Feinberg, for his part, appreciates moral emotions seeing them as essential to our culture, “but only if they are always and everywhere evaluated, monitored, and tutored by reason.”\textsuperscript{204} This is an improvement of Engelhardt’s position. There is an acknowledgment of the importance of emotion in moral decision-making even though Feinberg subsumed emotion under reason.

The Utilitarian moral theory, like the Kantian, depends entirely on reason in its process of determining what we ethically ought to do or not do. It presents a similar understanding of a person, as an abstract rational, self-sufficient individual who is, nevertheless, endowed with emotions. There is no doubt that this understanding colors the concept of Utilitarian autonomy, that is, individualistic autonomy that is independent of others. The Utilitarian approach, like ethics of care, acknowledges that persons have desires, interests and reasons. However, unlike ethics of care, the Utilitarian proffers rules of rational choice for maximizing the satisfaction of these desires and interests. Utilitarianism begins with the assumption that morally relevant things are the gains and losses of utility to theoretically isolated individuals. In such a case, it is a rational calculation about an outcome that will make moral recommendations available to steer all our choices.\textsuperscript{205} It, thus, relies on abstract general principles and sets of laws to be applied
to particular cases. What is more, even though the Utilitarian moral theory recognizes that emotion is the font of our desires for some objectives, Utilitarianism still requires us to disregard emotional attitudes towards moral issues because, according to Utilitarian moral theory, such attitudes interfere with the pursuit of rationality, which is the ultimate objective. Accordingly, morality is supposed to teach us how to seek objectives rationally and abstractly. Thus, Utilitarianism presents an understanding of the person similar to the Kantian: an abstract, rational, self-sufficient individual, albeit endowed with emotions.

In following the thoughts of Aristotle and Plato, as shown above, Kant held that non-human animals are not worthy of any moral status because, although they possess emotions, they are not rational beings. Thus, because they possess no dignity, they, therefore, command no respect. If non-human animals are not rational beings, they are not autonomous agents capable of making their own decisions. Human animals, however, because they possess the faculty to reason, occupy a special place among other creatures. They possess an intrinsic worth or dignity that makes them valuable above any price or end. This dignity derives from their ability to be autonomous rational agents who are capable of making their own decisions. The worth of non-human animals is predicated to humans. Otherwise, non-human animals are outside the realm of rights and responsibilities that define the moral order. Thus, Kant and liberal secular morality exalted reason and autonomy. Individuals, such as newborns infants, and the severely mentally challenged who are seen as incapable of making rational thoughts or choices, would not be recognized according to such a concept of the human person defined mainly
by rationality. Kant, of course, was influenced by Descartes and his “cogito ergo sum” meaning “I think, therefore, I am.”

Scholars are increasingly recognizing that emotions, passions, and empathy are responsible for arousing partial moral judgment. Contrary to the belief of the Kantian and liberal secular common moralities that emotions and desires do not play any positive role in moral decision-making, it is known that emotions can direct or alter reasoning, just as reasoning or reasons can inform and modify emotional responses. Emotions shape thinking/reasoning and “information processing.” “Thinking about death may activate sad feelings, but feeling sad may also activate thoughts of death.” When one is happy, one recalls happy things and makes optimistic predictions regarding the future and other people. Emotions are consciousness, and are interwoven with self-consciousness and moral thinking. They provide people with personal and social values that offer directions and purpose to rational thinking. In reference to emotion in ethical decision-making, the French philosopher-mathematician Blaise Pascal (1623-62), remarked that “The heart has reasons that reason knows not of.” Moreover, emotional responses reflect internalized past choices and the use of attention. Being able to listen to and read our emotions as well as those of others involved in a case aid moral decision-making. These ideas are also echoed by David Pizarro. In his research, Pizarro surveyed the psychological literature on emotions and emotional processes and he concluded that the belief that emotions are antagonistic to moral judgment is untenable. He presents “a theoretical model of emotive moral judgment that takes a closer look at how emotions,” empathy in particular, “play an integral role in the process of moral judgment,” or moral decision-making.
John Christman also recognizes the importance of emotions in moral decision-making. He noted that in generalizing one’s judgment in accordance with the Categorical Imperative, one needs not commit oneself “to valuing only the cognitive capacities of humanity but also its (relative) subjective elements,” that is, emotions, desires, affect, felt commitments, sense of attraction and aversion, alienation and comfort. He goes on to assert that emotions and desires are objects of our judgments and partly constitutive of them. It makes sense, then, to recognize with Callahan that “emotions, reason, and intuition should be fully integrated and engaged to produce a complex approach to moral decision-making. We need to make decisions in a holistic way that does justice to all our moral resources.”

From his own study, J. J. Gross observes that human beings are endowed with the capacity to regulate their emotions and that, most of the time, they effectively induce or suppress emotional reactions through various tactics; and, in doing so, people are able to engender and employ emotions, such as love, when appropriate, thus, providing “flexibility to their emotional lives.” Pizarro agrees with Gross and offers an example of such regulation of emotion. One’s “underlying beliefs moderate the very presence of emotion” and make one’s emotional reactions a reflection of earlier cognitive deliberations. He concludes that emotions “are not vacuous reflexes devoid of rational influences.” Rather, they “reflect our pre-existing concerns, such as our moral beliefs and principles, making them less capricious than may appear.” Even if sometimes emotions really arise for arbitrary reasons, Pizarro believes that one’s ability to control these emotions is to a large extent what makes one responsible for one’s emotional reactions. Thus, it makes one an active agent in one’s emotional life. It means that people are not
“merely passive recipients of reflexive emotional responses.” The control people possess over their emotional reactions permits them to make use of the influences of those emotions as source of energy for actions such as moral decision-making, and thus serves our “higher-order moral belief.” This brings out the advantage of a human being as “a complicated multisystem organism.” In this multisystem organism, a system is able to correct, check, supplement, and compensate for another. Therefore, human beings can and do suppress, shape, control, direct, and produce emotions by all the other functioning subsystems available to the self as a self-conscious agent.

Modern psychological research shows that the emotional system interacts with other “specialized human subsystems” meant for perception and thinking, for drives and physiological maintenance, as well as for motor activity. Emotions have come to be regarded as “the primary motivating system for all activity.” Interestingly, Callahan reckons that, if there are no “emotions or affects to amplify physiological drives and infuse cognitive processing with subjective meaning,” human beings will not feel interested or concerned enough to stay alive, not to talk of mating, nurturing offspring, creating kinship bonds, or pursuing art and music, politics, science and technology, and moral philosophy.

Emotions, especially empathic arousal are a “first alert” that signals moral relevance. When someone feels empathy in the presence of a person in anguish, the empathic response draws one’s attention to the possibility that an event of moral relevance is taking place. The arousal might even be able to inform the person that something is wrong, in which case one can use emotional arousal as a source of information for subsequent appropriate judgment regarding the situation.
Pizarro further notes that emotions can assist reasoning by “acting as a centralizing agent, focusing our attention and cognitive resources on the problem at hand,” instead of defeating or destroying the reasoning process.\textsuperscript{225} It is the “very negative and extreme intense or regressed affective states” such as “extreme depression, extreme panic, or extreme rage” that disable as well as impair reasoning and appropriate actions.\textsuperscript{226}

Such focusing of attention and acting as a centralizing agent characteristic of emotions allow one to pay attention to the features of a situation that may otherwise have been missed. Pizarro concludes that these characteristics, in combination, “make emotions desirable for the process of moral decision-making.”\textsuperscript{227}

2. C. 3. \textbf{Individual Patient Rights}

Besides the emphasis on reason over emotions and desires in moral decision-making, the liberals emphasize also individual rights in their understanding and practice of autonomy leading, therefore, to individualistic right-oriented informed consent. Liberty of the individual has dominated the philosophy of Western liberal thought since the Eighteenth Century. From the time of Thomas Hobbes, liberal individualists have used the language of rights to buttress moral and political arguments. Likewise, the Anglo-American legal tradition relied heavily upon rights language. Robert Veatch noted that, since the 1970s when the radical rethinking of medical ethics began, liberal political philosophy has, in turn, dominated medical ethics in the USA as well as in the rest of the Western world.\textsuperscript{228} Liberalism, which embodies within it a respect for liberty, utilizes and promotes the language of rights: whether it is natural rights or human rights or economics and social rights. Rights are central to the liberalist and to libertarians.
Rights are defined as justified claims made by an individual or a group against other individuals or upon society. Human rights flow from nature. To claim a right is a rule-governed activity, whether it involves legal, moral, or institutional rules. Whereas legal rules and principles justify legal rights moral rules and principles justify moral rights. In other words, moral rights are justified claims or entitlement defensible by moral principles and rules. Liberal Individualism holds that rights provide important protection of life, liberty, expression, and property, as well as protection against oppression, unequal treatment, intolerance, and arbitrary invasion of privacy. Some scholars, such as philosophers and framers of political declarations, see rights as the basic language for expressing the moral point of view. For instance, the language of rights has served to oppose the status quo, to assert claims that call for recognition and respect, to promote social reforms which aspire to gain legal protection for individuals such as freedom of religion, freedom of expression, and freedom of the press. The concept of rights can be traced back to the ideas of Natural Law seen in the ancient Greek, Roman, and Judeo- Mesopotamian traditions, for example the *lex talionis*, the right to retaliation.

When one make claims against other people or against society, the rights-claims place corresponding duties or responsibilities on those other people or on society. For instance, Mrs. A’s claim against Mr. B for non-interference places a burden of duty on Mr. B not to interfere in her business. Because rights-claims attach corresponding duties in such a way as this, a liberal society faces great difficulty in safeguarding autonomy through rights. For any right granted to protect the autonomy of one individual, the autonomy of another individual is limited through corresponding duties. As a result, Mrs.
A’s claim to non-interference restricts Mr. B from acting in ways towards Mrs. B that would constitute interference, irrespective of Mr. B’s views regarding the justifiability or desirability of such interference.\(^{233}\) To balance these rights-claims under which autonomy is protected, the liberals often distinguish between two types of “liberty” namely, positive and negative liberty.\(^{234}\)

In emphasizing the freedom and rights of the individual, liberals give primacy of place to individual rights to life, liberty, and property. Rights can be either negative (such as rights to non-interference, individual rights to life, liberty, and property) or positive (entitlement rights). Autonomy is chiefly related to negative rights.\(^{235}\) The negative rights theory posits that the overriding moral principle is noninterference,\(^{236}\) a right to be left alone, not to interfere with one’s liberty of thought, or action. It requires people or the State not to deprive one of life, property, or the free use of property.\(^ {237}\) Thus, in healthcare, the individual has the right to autonomy and/or self-determination. The individual, not the family or the community, is invested with the authority to make one’s own medical decisions.

In making individual liberty central to their political theory, liberals advocate that democratic political institutions include a set of basic civil rights in order to limit the powers of the government by Constitutional means.\(^ {238}\) More so, the language of rights has, among other things, served as a vehicle to fight any unjust status quo and to affirm and defend claims that demand recognition and respect. It has also served as a means of promoting social reforms that aim to secure legal protections for individuals, in particular, protecting individuals from governmental and societal intrusions.\(^{239}\)
In a liberal rights framework such as the one described here, the issue of who makes medical decisions is not only contingent upon the individual; it is, in fact, the individual’s right. The principle of autonomy in Western liberal culture upholds the patient as the final authority in medical decision-making. This claim is made clear in Justice Cordozo’s 1914 ruling on Schloendorff v Society of N.Y. Hospital. The law insists that every human being of adult age and sound mind have a right to determine what shall be done with his or her own body. If a physician treats a patient without the patient’s consent, that doctor commits an assault and is liable for damages. The President’s Commission for the Study of Ethical Problems in Medicine, and in Biomedical and Behavioral Research supports the idea that the patient has the final authority to decide.

Moreover, among individuals and across communities in a liberal society, there is no common understanding of the good life. Similarly, one authoritative view of the good life or a concrete goal of medicine is non-existent. Thus, liberal societies promote a social system that delineates value as determined in substance or content by individuals in that society. This upholds a climate of self-interest for all citizens in society. For example, for a liberal rights theorist, the collective goal is not enough justification for denying individuals their rights or denying people what they wish, as individuals, to have or to do. Likewise, the collective goal is not enough justification for imposing some loss or wrong upon individuals. A liberal negative right theory tends to discourage community and interrelationship; it is mostly about what is good or best for the individual irrespective of others’ needs, provided that individual does not interfere in theirs.
Autonomous choice is then a right, and for the liberals it is more about individual rights protecting individual autonomy.

2. C. 4. Individual Autonomy

From René Descartes to contemporary theorists, many philosophers consider the self as individualistic, isolated, and ahistorical. As demonstrated above, the Western liberal tradition emphasizes individual independence, and individual patient rights. Consequently, these lead to their understanding of autonomy as individual autonomy, which is contrary to family or relational autonomy practiced in other cultures. According to the Western liberal tradition, to act autonomously is, first and foremost, to act independently of other people and/or their interference. It is to isolate oneself even, as it were, from family or close friends because of any suspicion that they are interfering or manipulating the individual. Secondly, it is to be free of any external influences, interests, or coercion. Such influences, it is thought, mitigate autonomy.

In the USA this concept of autonomy is strengthened by the Patient Self-Determination Act.

The Patient Self-Determination Act (PSDA) is a measure passed by Congress in 1991 to amend the Omnibus Budget Reconciliation Act of 1990. The Patient Self-Determination Act requires many healthcare facilities (Medicare, Medicaid providers, hospitals, nursing homes, hospice programs, home health agencies, and HMOs) that receive federal funds to give adult individuals, at the time of inpatient admission or enrollment, certain information about their rights under state laws governing advance directives, including the following: the right to participate in and direct one’s own health care decision; the right to accept or to refuse medical or surgical treatment; the right to
prepare an advance directive; information on the provider's policies that govern the utilization of these rights. The Patient Self-Determination Act further requires institutions to document patient information and provide community education about advance directives. The intent of the Act is to protect and promote autonomy and self-determination in medical decision-making. The Act also prohibits institutions from discrimination against a patient who does not have an advance directive. Even though informed consent is often classified in law under the right of privacy, “the leading legal decisions in informed consent tradition appeal fundamentally to the right of individual self-determination.” Thus, it boosts autonomy and informed consent.

Autonomy so understood is self-sufficient, self-directed, and rationally controlling. It is based on the model of an independent rational will that is inattentive to emotions, communal life, reciprocity, and the development of a person over time. The liberal tradition suggests, therefore, that the most perfectly autonomous person is the most perfectly isolated person, and that what enables the individual to be autonomous is this isolation from others. However, it is in relation to others that one develops one’s autonomy. In health care or within a clinical setting, the Western liberal tradition gives the individual patient the final authority to make decisions according to his or her own values and interests. The patient is not necessarily required to consider others’ interests or the common good in making any personal medical decision. The emphasis on individual autonomy or patient autonomy in clinical care assumes that patients consider family involvement or their respective interests as being in conflict. The reason is that the wide acceptance of patients’ interests as priorities has marginalized the concerns and well-being of relatives and families as morally irrelevant. The healthcare setting, as Susan
Sherwin noted, appears to consider illness as a problem of particular patients and neglects the disruptive effects a patient’s illness may have on family members especially close members who are expected to provide different forms of care. The Western clinical milieu overlooks the fact that self-determining patients exist basically in relation to other people. Their interests involve a dynamic balance between mutually dependent people who possess overlapping considerations. Rather, the focus of autonomy in contemporary Western bioethics, especially in the USA, is “on the autonomy of patient to the exclusion of the interests of anyone else.”

Reacting to this sort of overemphasis on patient autonomy, Carl Schneider remarked that autonomists are more concerned with what patients “should want” from the patient’s understanding of autonomy than what patients “do want.” Based on his medical sociology and psychological research, Schneider concludes that although patients largely wish to be kept abreast of their medical circumstances, a considerable number of them such as the elderly and the very sick, do not want to make or wish even to participate in their own medical decisions in any considerable way. Moreover, as Sherwin rightly noted, the emphasis on traditional individualistic understandings of autonomy reinforces the healthcare providers as well as ethicists’ tendency to pay less attention to the “exploration of the deep social causes and conditions that contribute to health and illness.” Similarly, an emphasis on traditional individualistic understandings of autonomy encourages patients to consider their own healthcare decisions in isolation from those of other people, including their relatives, thereby “increasing their sense of vulnerability and dependence on medical authority.”
It is true that self-determination and patient autonomy were aimed at eliminating the image of patients as passive care receivers and at curbing paternalistic influences on patient decision-making processes especially from family members who might have values and priorities other than those of the patient. It was also aimed at curbing paternalistic influence of coercion of patients by healthcare personnel. However, self-determination and patient autonomy have gradually led to suspicion of family members who are heavily involved in a competent patient’s decision-making. Any semblance of a patient deferring to the family or giving any weight to family preferences is sometimes considered as undue family pressure and is, therefore, frowned upon. When family is allowed to become involved in a patient’s medical decision-making, medical personnel tend to be cautious regarding boundary-crossing, both in the way of challenging professional authority and intervening in patient decision-making. The role of family is restricted often to assisting the patient in enduring the healthcare experience, in relaying patient information to medical personnel, and in providing long term care if the patient returns home. In this case, family members are viewed as a means to the patient’s medical or clinical ends.

Thus, because the Western liberal concept of autonomy is focused narrowly on self as independent and self-sufficient being, the concept leads to individualistic autonomy. This Western liberal approach to informed consent privileges the independent decision of the individual patient and defers to subjective concept of the good.

2. C. 5. Subjective Conception of the Good

The idea of a common good goes back as far as Plato and Aristotle. It has been understood and formulated in various ways by various scholars. Plato, for example,
identified the common good with the total virtue of the citizenry. Society is natural and 
the polis, or city/state has primacy over the citizen because the polis is divinely 
“sanctioned by Hermes’ gifts of justice and reverence.” The worth and dignity of 
individual citizens are ensured by virtue of their living within a political community that 
is intrinsically just. Thus, the “common good is the virtuous life of the entire 
community,” a set of conditions for individual self-fulfillment. “A virtuous life is the end 
of man.”

Plato also envisaged human beings as citizens, social and political animals, whose 
worth as individuals is to be subordinated to the good of the community. Based on 
Plato and Aristotle, the common good was defined in the Middle Ages as “a good proper 
to and attainable only by the community, yet individually shared by its members.” This 
definition establishes the common good as both individual and communal. It, however, 
exceeds inter-individual transactions and does not coincide with the aggregate of 
particular goods. The question has been raised as to the possibility of identifying the 
common good or the public interest in contemporary historical and cultural conditions. 
It is the issue that Robert Bellah, Richard Madsen, William M. Sullivan, Ann Swidler, 
and Steven Tipton explored in their book, the Habits of the Heart. The book calls for a 
revival of a strong commitment to the common good in USA while not losing or giving 
up the commitment of modern freedom and rights. Louis Dupré in his article The 
Common Good and the Open Society, proposes, more or less, the same idea as Bellah et 
al.: the restoration of the notion of the common good incorporating “individual rights 
without separating them from their social context.” These scholars are not alone in the 
call for the revival and adoption of the common good in Western society and especially
in the USA. Besides the incorporation of the modern individual rights and freedom, the communitarians of Western society hold dearly the idea of the common good, as is the case with the Ethics of Care Movement. Daniel Callahan, while retaining common good and community, calls for the eradication of rights, especially, in the enactment of public policy.

Bellah and his colleagues argue that there is a growing tide of individualism emanating from both the traditional style of entrepreneurship and the therapeutic models of self-realization. This rising tide of individualism has suspended communitarian ideals. It has also suspended the emphases embodied by the biblical religion of the early Puritan settlers and the classical republican commitments of some of the founders and framers of early American institutions. Bellah et al. call for immediate recovery of the emphasis on community and the common good contained in both biblical and republican traditions. They contend that Americans have lost the ability to talk to one another in a public way regarding the public moral good, the common good, even though they (the Americans) retain some sense of the importance of these goods. There is a need to recover the language and the tradition of the common good latent in cultural memory for precisely and clearly expressed public use. Bellah et al. further note that individual rights and freedom have made major moral contributions that need to be preserved. The problem, according to Bellah et al., is that “when liberated and autonomous ‘selves’” are severed from any connection to the larger public or common good, society tends to move toward anarchy or some form of “authoritarian tyranny.” In cases where citizens “lack the vision and virtues” required to sustain a genuine human community, the end result is either Hobbes’s state of nature, where life is solitary, poor, nasty, brutish, and short,” or a
situation ruled by Hobbes’ sovereign Leviathan. In retrieving the common good or its language and tradition as well as in preserving individual freedom and rights, Bellah et al. suggest that it is not simply recovering past traditions but having a “hermeneutic suspicion” toward “the oppressive power” exhibited by such traditions. It also calls for the exploration and adoption of new meanings of community and common good made possible by experience of other traditions and cultures. Caution should be taken not to identify the common good with military victory, and virtue with military might as had been done in the past.

As indicated above, Western liberal societies promote a social system that delineates value as determined in substance or content by individuals in that society. According to John Stuart Mill, even though sometimes individuals may make poor decisions, the individual is, nevertheless, in the best position to judge what constitutes one’s own good. Mill taught that the good consists of human “happiness,” and it requires the maximization of the aggregate happiness of individual living in a society. To achieve this aggregate happiness of the individuals in society, individuals, not the community, are allowed to construct their own life plans. The emphasis here is on individual good and not on communal or common good. In the framework of a liberal society, there is a lack of agreement about what constitutes the good life or the common good among individuals and across communities. Likewise, there is no one authoritative view of the good life or of a uniform concrete goal of medicine. In such a situation, a plurality of values co-exists. No single one of these values for social purposes is given a privileged position; hence, there is a subjective conception of the good and the good life. Moreover, in societies such as the USA, both the political institutions and the cultural
history are “decidedly focused on liberal individualism.” It is the framework which
governs the social relations and its understanding of the good. The good is subjectively
defined according to values each individual defines for oneself.\textsuperscript{272} The basis for
individual self-decision-making follows, therefore, the principle of autonomy in Western
liberal society and advocates a subjective conception of the good. One is considered as
having made a good decision if that decision satisfies one’s prudent desires, preferences,
and expectations. It does not matter whether the individual’s desires and preferences are
or are not in conformity with a set of impersonal values objectively defined.\textsuperscript{273} Allen
Buchanan and Dan Brock explored this issue in their discussion of medical decisions
made for children in relation to the good of these children. They observed that the goal of
a child’s development into adulthood is to equip the child with the necessary
opportunities and required capability to exercise self-determination as an adult in
choosing and pursuing one’s own view of values. It is not to foster a child to lead a life in
accordance with a certain notion of the good life objectively understood or communally
defined. Even when we think an individual’s decision-making is defective, our basis of
making such a judgment is that the individual’s choices are incompatible with his or her
settled aims and values.\textsuperscript{274} Our basis is hardly a common good or a concept of a good life
objectively understood.

2. D. Summary

In order to lay out the historical context of the discourse on autonomy and
informed consent, Chapter Two undertook the examination of the history of the liberal
approach to informed consent. The Western liberal concept of autonomy and, thus,
informed consent has served Western societies and bioethics well so far. The liberal
tradition (individualism) emphasizes individual independence, individual rights and autonomy, autonomy understood as non-interference from others in one’s self-determination, self-rule, and rational control. Furthermore, the liberal tradition emphasizes reason over emotions in moral decision-making; and upholds a subjective concept of the good or the good life. The Ethics of Care Movement, which also arose from the Western traditions, has a different position and emphasis on the understanding of the human person: namely, that of a relational and interdependent being. Consequently, it proposes a different concept of autonomy -- relational autonomy and informed consent --, what in this dissertation is referred to as RAIC.

Therefore, the Western liberal approach to autonomy and informed consent which privileges the decision of the individual patient sharply contrasts with the concept of autonomy and informed consent in ethics of care which advocates relational autonomy. This contrast will become the focus of the next chapter as this dissertation progresses from a discussion of the historical context to a systematic analysis of ethics of care.
Endnotes

1 See disagreements of Jay Katz, Martin S. Pernick, and John Fletcher as discussed by Faden, et al., History and Theory, 56-60.
2 Faden, et al., History and Theory, 86.
4 Faden, et al., History and Theory, 54.
5 Faden, et al., History and Theory, 54.
6 Beauchamp and Childress, Principles of Biomedical Ethics, 120-1; and Beauchamp, “Autonomy and Consent,” 56.
7 Faden, et al., History and Theory, 54.
8 Faden, et al., History and Theory, 54.
10 Faden, et al., History and Theory, 86.
11 Faden, et al., History and Theory, 100-101.
14 Berg, et al., Informed Consent, 250.
17 95 Minn.261.104 N.W. 12 (1905).
18 Jonsen, the Birth of Bioethics, 355-56; and Engelhardt, Jr., The Foundations of Bioethics, 303-304.
19 Faden, et al., History and Theory, 117.
21 Engelhardt, Jr., The Foundations of Bioethics, 361.
22 Slater v Baker and Stapleton. 2Wils 359, 95 Eng. Rep. 860 (King’s Bench 1767); Engelhardt, Jr., The Foundations of Bioethics, 303.
24 Faden, et al., History and Theory, 120.
26 Faden, et al., History and Theory, 121.
27 Cf. Faden, et al., History and Theory, 121.
30 Faden, et al., History and Theory, 122.
31 Pratt v Davis, 118 Ill. App.161 (1st Dist 1905), aff’d 224 Ill.300, 79 N.E. 562 (1906); In: Johnson, “The Emergency Exception,” 2; and Faden, et al., History and Theory, 122.
32 Pratt v Davis, 118 Ill. App.161 (1st Dist 1905), aff’d 224 Ill.300, 79 N.E. 562 (1906); In: Johnson, “The Emergency Exception,” 2; and Faden, et al., History and Theory, 122.
33 Faden, et al., History and Theory, 122.
34 Faden, et al., History and Theory, 122.
35 Schloendorff v. The Society of the New York Hospital, 105 N.E. 92 (1914); In Opinion by Justice Cardozo: http://www.lawandbioethics.com/demo/Main/LegalResources/C5/Schloendorff.htm In Law and Bioethics, Court Cases; Accessed 02/21/2012. Also in Mary E. Schloendorff, Appellant, v. The Society of the New York Hospital, Respondent, 211 N.Y. 125, 105 N.E. 92 (1914); University of Buffalo Center for Bioethics, http://wings.buffalo.edu/bioethics/schloen0.html Accessed 02/21/2012.
36 Schloendorff v. The Society of the New York Hospital, 105 N.E. 92 (1914); In Opinion by Justice Cardozo: http://www.lawandbioethics.com/demo/Main/LegalResources/C5/Schloendorff.htm In Law & Bioethics Court Cases. See Engelhardt, Jr., The Foundations of Bioethics, 303-4.
37 Faden, et al., History and Theory, 120.
38 Faden, et al., History and Theory, 123.
39 Faden, et al., History and Theory, 123.
40 Faden, et al., History and Theory, 123.
41 Bennett, “A History of Informed Consent,” Online. Dr. Bennett is a staff of Ventana Center for Psychotherapy, Santa Barbara, CA, USA.
45 Bennett, “A History of Informed Consent,” Online.
50 Menikoff, Law and Bioethics, 163-64.
51 Menikoff, Law and Bioethics, 157-164.
52 Faden, et al., History and Theory, 94.
53 Faden, et al., History and Theory, 93.
54 Hospital 47 (February 1973): 41. Cited by Faden, et al., History and Theory, 94.

56 Faden, et al., History and Theory, 92-94.

57 Faden, et al., History and Theory, 94-95.


59 Faden, et al., History and Theory, 91.


62 Jonsen, The Birth of Bioethics, 357.

63 Jonsen, The Birth of Bioethics, 356.

64 Jonsen, The Birth of Bioethics, 357.


66 Faden, et al., History and Theory, 96.

67 Jonsen, The Birth of Bioethics, 357.

68 Faden, et al., History and Theory, 97.


71 President’s Commission, Deciding to Forego Life-Sustaining Treatment, Ch. 2, p.44. See Faden, et al., History and Theory, 98.

72 President’s Commission, Deciding to Forego Life-Sustaining Treatment, 2-4, Chs. 1-2. See Faden, et al., History and Theory, 97.

73 President’s Commission, Deciding to Forego Life-Sustaining Treatment, 2-4, Chs. 1-2. See Faden, et al., History and Theory, 97.

74 Jonsen, The Birth of Bioethics, 358.

75 Beauchamp and Childress, Principles of Biomedical Ethics, 208.

76 Beauchamp and Childress, Principles of Biomedical Ethics, 209-110.


79 Hippocrates, Precepts, IX. Cited by Jonsen, The Birth of Bioethics, 354.


81 Veatch, The Basics of Bioethics, 72.
82 Murray, “The History of Informed Consent,” 104. See also Faden, et al., History and Theory, 63.
83 Faden, et al., History and Theory, 63.
84 Murray, “The History of Informed Consent,” 104. See also Faden, et al., History and Theory, 63.
86 Beauchamp and Childress, Principles of Biomedical Ethics, 99.
87 Beauchamp and Childress, Principles of Biomedical Ethics, 99.
88 Beauchamp and Childress, Principles of Biomedical Ethics, 103-104; and Mappes, and Degrazia, Biomedical Ethics, 45.
89 Schneewind, The Invention of Autonomy, 3. According to Schneewind, Kant’s Proposal, Morality as Self-Governance, is a Revolutionary Rethinking of Morality. The Invention of Autonomy, 6.
90 Schneewind, The Invention of Autonomy, 6.
91 Kant, Groundwork of Metaphysics, 105, and 108; see also Mappes and DeGrazia, Biomedical Ethics, 45.
92 Mappes and DeGrazia, Biomedical Ethics, 46.
93 Mill, Utilitarianism, On Liberty, 185, 187. Also Mappes and DeGrazia, Biomedical Ethics, 46.
94 Mappes and DeGrazia, Biomedical Ethics, 46.
99 Beauchamp and Childress, Principles of Biomedical Ethics, 119. See also Faden, et al., History and Theory, 278.
100 Faden, et al., History and Theory, 280.
102 Beauchamp and Childress, Principles of Biomedical Ethics, 119; and Faden’ et al., History and Theory, 280.
103 Miller and Wertheimer, The Ethics of Consent, 79.
104 Miller and Wertheimer, The Ethics of Consent, 79.
105 Miller and Wertheimer, The Ethics of Consent, 80.
106 Faden, et al., History and Theory.
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108 Miller and Wertheimer, The Ethics of Consent, 81.
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110 Beauchamp and Childress, Principles of Biomedical Ethics, 120. See also Osuji “Informed Consent,” 133.
111 Beauchamp and Childress, Principles of Biomedical Ethics, 121.
112 Gert, et al., Bioethics, 214.
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193 Williams, “Kant's Account of Reason.” Online.
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207 Kant, *Fundamental Principles*, 60-61; Rachels, *Created from Animals*, 87; and Rachels, *The Elements*, 132.
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Carl Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions*, (New York: Oxford University Press, 1998), xi, cited by Beauchamp & Childress, *Principles of Biomedical Ethics*, 105. See also, Wolpe, “The Triumph of Autonomy in American Bioethics,” 38-59; Beauchamp and Childress, *Principles of Biomedical Ethics*, endnote 11, page 142. Beauchamp and Childress support a principle of respect for autonomy with a corresponding right to choose and not a mandatory duty to choose; that the right to choose or to decide is the individual patient’s prerogative, 105.


Ho, “Relational Autonomy or Undue Pressure?” 128-9.

Nelson, “Taking Families Seriously,” 6-12. See also Ho, “Relational Autonomy or Undue Pressure?” 129.


Nemetz and Massaro, “Common Good,” 17.

Nemetz and Massaro, “Common Good,” 17; Mahowald, “Person,” 1934-1941.


270 Mill, On Liberty, Ch.1, 111; and May, Bioethics in a Liberal Society, 2-3.


272 May, Bioethics in a Liberal Society, 2-5.

273 Fan, “Self-determination vs. Family-determination,” 314-315; Fox and Swazay, “Medical Morality is not Bioethics,” 354. Fox and Swazay assert that liberal individualism sees the common good atomistically and arithmetically as the sum total of the rights and interests, desires and demands of an aggregate of self-contained individuals, 354.

CHAPTER THREE
SYSTEMATIC ANALYSIS OF ETHICS OF CARE

In Chapter Two, a historical analysis of informed consent in Western bioethics was presented with a discussion of the liberal approach to informed consent which emphasizes individual and rights-oriented autonomy. In this Chapter, the discussion now considers a view opposing liberal individualistic rights-oriented autonomy in informed consent. It presents a systematic analysis of the ethics of care as a hermeneutic used to interpret African Traditional Medicine (ATM) and its practices. The chapter also explores the emphasis in the ethics of care movement on relationships that posit a concept of persons as relational beings who are socially interdependent, thereby interpreting patient autonomy in relationship with others. The analysis further considers the emphasis in ethics of care on relational autonomy as a foundation for enlightening the meaning of Relational Autonomy in Informed Consent (RAIC). And in turn ethics of care forms a hermeneutic to interpret ATM in the next chapter. However, to facilitate the analysis of ethics of care, this chapter has been divided into three sections. Section A traces and delineates the origin of ethics of care from the works and activities of feminist movements, some male ethicists, and the alternative feminist moral theories. Section B explores the meaning of ethics of care, identifying care as labor, practice, value, caring relations, and as justice. Section C considers the ethics of care concept of person, or human being, and autonomy in informed consent, noting the essence of both emotion and reason in moral decision-making, the place of rights and of relational autonomy arising from human relatedness, and the interdependent nature of human beings.
3. A. The History and Origin of Ethics of Care

Howard Curzer, a professor of philosophy at Texas Technical University in Lubbock, attempted in his paper to identify some germs of ethics of care in the works of Aristotle. He observed that Aristotle uses the Greek terms *philesis* and its infinitive, *to philein*, to express caring and care. For Curzer, the meaning of these terms approximates the way the scholars of ethics of care understand care and caring today.\(^1\) *Philein* includes substantial familiarity with the other person. This familiarity is gained through meaningful personal interactions with the person. The interactions imply compassion and sympathy which are the essential elements of care.\(^2\) Aristotle’s discourse on friendship contains much of his thoughts on care. Mutually caring relationships are friendships although not all mutually caring relationships are friendships. For Aristotle, friendships are wider than our notion of friendship. Aristotle’s understanding of friendship includes families. He does include some “significant portion” of care within his list of virtues although care and its components such as sympathy, empathy, and compassion are not listed as virtues.\(^3\)

Aristotle, according to Curzer, expounded ten core doctrines of ethics of care which are also stated by moderate modern proponents of ethics of care. Aristotle proposes that ethics of care is particular, passionate, partial, etc.\(^4\) He argues that human beings are and should be partial with relationships because individual responsibilities grow from these relationships.\(^5\) However, while it is interesting to identify some similarities between Aristotle’s works and the modern proponents of ethics of care, it does not necessarily mean that ethics of care originated from Aristotle’s thoughts. The origin of ethics of care has not been traced to Aristotle, but, and rightly so to the
revolutionary critique of dominant moral theories: Kantian, Utilitarian and deontological, as well as liberal individualist moral approaches advanced by women and feminist movements. This strand helped to bolster the development of alternative feminist moral theories through which contemporary ethics of care emerged. It is these last two sources of origin that will be discussed in detail in this work. From these simple beginnings, ethics of care has developed as a promising alternative to the dominant moral approaches utilized in the last two centuries. Today, ethics of care has emerged in the public forum, in medical practice, law, political life, organization of society, and in international relations.

3. A. 1. Feminist Movement and Some Male Voices

Feminist movements generally promoted gender equality and rejected the perpetuation of gender discrimination in all its forms, and in all areas of life -economic, legal, political, and social. The ideals of feminism inspired a series of women’s world fairs (1925-1928). In these fairs, women exhibited their achievements in science, literature, arts, and industry. The fairs also served as loci where women shared information regarding jobs and career opportunities. The feminist movement is a concern for justice and a celebration of the ordinary lives of women, children, and men from all races, religions, and “ethnic backgrounds.” It has been a part of a global wave of movements for liberation that marked the second half of twentieth century.

However, morally and academically, the feminist movement was a revolution against the hierarchy of gender and a rethinking of practically all disciplines. Part of the aim was to include and establish that the experience of being a woman is as important, pertinent, and as philosophically motivating as the experience of being a man.
experiences of women, just as those of men, are what literature, art and science are currently concerned about. Feminist experience is the lived experience of feeling as well as thinking of performing action and receiving impressions and awareness of our connections with other persons as well as our own sensations. It is the experience of actual women in all their racial, cultural, and other diversity.¹⁰ The validation of women’s experiences by feminists led to the fundamental critical assessment of the moral theories that were dominant at the time. Eventually it culminated in calling into question the adequacy of dominant moral theories and the emergence of a feminist approach to morality. The dominant moral theories were seen as having been fashioned according to men’s experience in public life and in the market arena.¹¹

Some male voices joined women’s movements in questioning the adequacy of dominant moral theories. Among these voices were those of Lawrence Blum, Bernard Williams, Alasdair MacIntyre, and Michael Slote.¹²

Lawrence Blum showed how the dominant theories neglected friendship. Friendship, according to Blum, is an altruistic phenomenon, and an atmosphere in which altruistic emotion occurs.¹³ Friendship is also a relationship founded solely on mutual advantage. Because one is another’s friend, one desires and acts for the good of the friend, not simply because the friend is a human being but because the friend is a particular person: a friend. Friendship, therefore, is “personal” and altruistic. For this reason, Blum criticizes Kant’s concept of morality wherein impersonality and impartiality are central notions. In Kantian morality, taking a moral point of view in one’s action and judgment means looking at issues from an impartial perspective, giving equal
weight to the interest of all, without partiality. To act beneficently towards one’s friends, one does not typically violate a duty of impartiality.  

Bernard Williams raised serious doubts as to how such dominant theories could have handled some of the most vital questions human beings faced. He questions:

How could it be that a subject, something studied in universities (but not only there), something for which there is a large technical literature, could deliver what one might recognize as an answer to the basic questions of life? It is hard to see how this could be so, unless, as Socrates believed, the answer were one that the reader would recognize as one he might have given himself. But how could this be? 

Alasdair MacIntyre laments and criticizes the deterioration of Western morality with its subsequent fragmentation and rising incoherence of ethical theory. He observed that moral crisis springs from the historical rejection of an Aristotelian morality wherein the function of virtues is dominant, thus, representing a society of shared goods. This society of shared goods has been supplanted and replaced by individualism -liberal individualism- where people are seen as atomistic individuals with private desires and objectives. According to MacIntyre, virtue has dwindled and is fast disappearing. Honesty, truthfulness, and loyalty barely form part of people’s pattern of living. Shared goods are replaced by the development of the individual as a social institution, and life has become competitive. The self has come to lack any inherent moral ties or social relations. This idea and critique of liberal individualism spurred the emergence of an ethics of care that values relationships.

Like MacIntyre, Michael Slote laments the disparaging of virtues in contemporary philosophers’ works. He argues that, when confronted with actual phenomena of the moral life, it becomes clear that the ideal of personal goods and virtues proffered in some current works of philosophers is wanting. He advocates that virtues be understood as more relative and dependent as goods than they have been in recent works on ethical
theory. Furthermore, Slote criticizes dominant moral theories for placing much emphasis on reason, universality, impartiality, and absolutes in morality. Slote also criticizes the stoic presumption that the best way to decide what is good for human beings is by reference to the measure of an ideal being who is self-sufficient, independent, and free from human limitations. Slote’s critique of the morality of impartiality, universality, absolutes, and reason links him with the ethics of care advocate whose thoughts his writings propagated and encouraged. In this way, he is a significant contributor to the development of the ethics of care.

Through their works, these male voices not only led the renewal of the virtue theory that had been largely obscured, but they also assisted in the development of the ethics of care movement. Therefore, while the ethics of care movement emerged and progressed in the late 1980s, in part, through the activities of the feminist movement, it was also advanced through the works of some male ethicists described above, and, in addition, by alternative feminist moral theories.

3. A. 2. Ethics of Care and Alternative Feminist Moral Theories

From the feminist movement and critique of dominant or traditional moral theories emerged alternative moral theories such as feminist ethics, feminist contractualism, a feminist form of liberal individualism, Kantian, and Utilitarian moral theories. Although the feminists supported some form of these moral theories, they adapted them to include feminist thinking and ideology. The proponents of these alternative moral theories applied the perspective of women, caring for minorities, and families to these theories while focusing on justice, equality, and freedom. They argue, for instance, that the principles of justice should be met in the division of labor and
availability of opportunities within the family, not only in public life. This implies an end to domestic violence, marital rape, and patriarchal dominance. On the other hand, non-feminist proponents of dominant moral theories had paid little or no attention to the perspectives the feminists were raising. The alternative moral theories only extended the traditional moral theories in non-traditional ways. However, another form of alternative moral theory, namely ethics of care, emerged taking a distinctive direction.22

Held specifically locates the beginnings of ethics of care with the pioneer essay “Maternal Thinking” by the female philosopher, Sara Ruddick, in 1980.23 Ruddick showed that giving attention to the experience of women in a caring practice not only could change how people think about morality, but could also alter people’s views of the values appropriate for the given activities.24 Women possess maternal power, yet, at the same time, they are powerless. They are powerful in two ways. First, for example, for a child, the mother is the primary and uncontrollable source of goods, love and affection. She is also a judge and a disciplinarian. Therefore, she is the one to be placated and her approval must be secured. Second, she possesses power that comes from her capacity to give birth and nurse babies. Ironically, women are powerless, especially in the very reproductive capacities that also hold the key to their being powerful. They often stand powerless before the husband, physicians, judges, the landlord, and the world.25

Continuing, Ruddick maintains that “maternal” is a social category, and maternal thinking emerges from actual child-caring practices, that is, mothering. Therefore, women possess maternal thinking, which is a way of thinking that is different from reasoning that arises from other contexts. Even though some men may express maternal thinking, in various ways of working and caring with others, Ruddick believes that
maternal thought “does exist for all women in a radically different way than for men.” According to her, the reason is that women are daughters who early in life receive maternal love with special attention to its implications for their bodies, their passions, and their ambitions. They are alert to the values and costs of maternal practices whether they are determined to engage in them or to evade them. “Thinking is governed by the interest of the practice out of which it arises.” “Maternal practice” responds “to the historical reality of a biological child in a particular social world.” For her, out of practice of mothering come values such as humility -“a metaphysical attitude one takes toward a world beyond one’s control”- and cheerfulness. From the resilience of good humor and humility, maternal thought is critical of dominant moral theories for their use of principles in moral justification. Ruddick’s work forms and fosters strong association between motherhood and care ethics. Like Ruddick, Held utilizes a maternal perspective to espouse care ethics as a moral political theory.

In 1982, Carol Gilligan published In a Different Voice which lent great impetus to the development of ethics of care. Gilligan explored the various social scientific studies and concluded that men tend to adopt a different perspective in morality, than women. She argues that men are more likely to take a ‘justice-based’ approach to ethics, whereas women tend to adopt a “care-based” approach. Men’s moral thinking is described in terms of justice, right, abstraction, rationality, and impartiality. On the other hand, women’s moral thinking is characterized in terms of care, relationships, and particularity, focusing on particular cases instead of on abstract general principles. However, Gilligan does not maintain that all men think or reason in one way while all women think and
reason in another way. For her, then, although there are different styles of moral thinking, there is none which is exclusively male or female.  

Other significant works that spurred the development of ethics of care include Nel Noddings’ book, *Caring*; the collection of papers: *Women and Moral Theory*; and *Science, Morality and Feminist Theory*. Noddings who is the first to use the term “ethics of care,” concurs with Gilligan that caring involves an emotional or motivational sensitivity to particular other people. It focuses on the individual herself or himself and not just “on any abstract or general moral principles that someone might want to consult in order to determine how to act towards that individual.” For Noddings, one is not simply concerned but actually engrossed in the particular other person. She explains engrossment as “thinking about someone in order to gain a greater understanding of the person.” According to her, engrossment is necessary for caring because an individual’s personal and physical situation must be understood before the one caring can determine the appropriateness of any action. Michael Slote agrees with this view, but he observes that the same idea of weighing the personal and physical situation of the one cared-for applies to the Utilitarian or Consequentialist. The difference between the Utilitarian or Consequentialist, on one hand, and ethics of care, on the other, is that “any ethics of care will be avowedly partialistic in a way that Utilitarianism or Consequentialism, more generally, decidedly are not.”

Discussing the particularity and the partiality of the ethics of care, Noddings argues that one cannot have an attitude of caring towards people one is likely never to meet. Likewise, David Hume believes that a person’s generosity seldom extends beyond one’s native country. He questions the existence of such a thing as the love of
These views reflect the way that ethics of care emerged, developed, and grew through the ideas and activities of the Feminist movement, those of some male ethicists, alternative feminist moral theories, and the works of early scholars like Ruddick, Noddings, Gilligan, and later scholars like Slote, Grace Clement, Tronto, and Held.

Initially, ethics of care was confined to the private sphere and care was regarded as a morality for women. Currently, not only has it been brought to the public sphere by the analysis of ethicists such as Tronto and Held, but another form of ethics of care has also emerged, namely a narrative ethics of care by Jens Erik Paulsen, for example.\(^{38}\)

**3. B. The Meaning of Ethics of Care**

Ethics of care is a form that constructs an entire approach to ethics based on one’s daily activities and universal experience of care or caring. For Tronto, to change the moral boundaries and the unjust and unbalanced moral ideals they include, one must account for a moral life that should provide people with a means “to respect and deal justly with others.” According to Tronto, the way to achieve that is to “honor what most people spend their lives doing: caring for themselves, for others, and for the world.”\(^{39}\)

Therefore, in ethics of care, the moral point of view is the caring point of view. Care encompasses caring for somebody, caring about somebody, or being concerned about somebody; in which case, one does something about what one cares for. In all these cases, care or caring involves some form of activity or work and expenditure of energy on the part of the one caring.\(^{40}\) Care also involves empathy. Slote speaks of empathic caring. Diemut Bubeck defines caring as the meeting of the needs of one person by another person, where face-to-face interaction between the one caring and the one cared for is the crucial element of the overall activity. The need is of such a nature that it cannot possibly
be met by the person in need him/herself.\textsuperscript{41} For Bubeck and for most ethics of care advocates, care almost always entails addressing or meeting a need which the particular others are incapable of fulfilling by themselves as well as a face-to-face encounter between the carer and the cared-for. Bucbeck’s definition makes the interaction between the carer and the cared-for central, even though the interaction may or may not cover the whole activity or set of activities that is or are described as caring. For Tronto, the definition of care is more embracing: “a species activity that includes everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.”\textsuperscript{42} Like Slote, and Bubeck, Tronto speaks of care in the context of human beings, but she also extends caring to the environment and to non-human beings. While Tronto’s definition is broad, leading Ruth Groenhout, to observe that it “is so extensive that it does not provide much specificity in thinking about care;”\textsuperscript{43} Bubeck’s definition is dependent on the function of the activity concerned. That is, the delineation of an activity as caring depends on the function the activity performs, not on the activity itself. This definition is, therefore, said to be functional. In “caring for others” and in a “daily caring of people for each other is a valued premise of human existence.”\textsuperscript{44} “Caring for others” clearly suggests that the “degradation” of caring activities is a problem not only of sexism, but includes that of racism as well as classism, all of which can occur among women or men alike.\textsuperscript{45} Tronto goes further to identify four phases of care as follows:

i. ‘Caring about’: this consists in recognizing the need and necessity of care.
ii. ‘Taking care of’: this involves taking some responsibility for the recognized need and deciding how to respond to it.

iii. ‘Care giving’: this is the stage at which the need is met.

iv. ‘Care receiving’: this is the stage where the recipient of the care begins to respond to the care received.\(^{46}\)

Tronto translates these four phases of care into what she sees as the elements of ethics of care that she and Fisher had identified, namely, attentiveness, responsibility, competence, and responsiveness of the being cared-for and integrity of care, which requires that the four moral elements of care be integrated into an appropriate whole.\(^{47}\)

Furthermore, the particular other is important to ethics of care, and thus particularity is a central feature of ethics of care and an essential element of the ethics because it defines the distinctiveness of interactions in close personal relationships. Relationship confers particularity on those involved in the relationship.\(^{48}\)

The face-to-face aspect of caring is also central to care and makes it difficult to imagine caring for more distant others.\(^{49}\) However, contrary to the emphasis on face-to-face meeting as a necessary part of care, or Hume’s belief that a person’s generosity seldom extends beyond one’s native country, Bubeck thinks that the face-to-face encounter does not restrict care to the context of the relatively personal. The reason is that she understands face-to-face interaction in a broad sense. It includes “ear-to-ear” telephone conversations, letter writing and reading, “eye-to-eye” or similar cases based on modern means of telecommunication.\(^{50}\) She asserts that care can and should be publicly provided, as in public healthcare and in activities of the welfare state - childcare centers and centers for the elderly- which can but may not involve face-to-face
encounters. Similarly, she thinks care should be widely spread beyond face-to-face
encounter because that is the way ethics of care can offer just political and social
programs. The problem with Bubeck’s idea is that, although ethics of care can offer just
political and social programs by not requiring the second aspect of caring, namely face-
to-face encounters, it advocates a generalization of the moral principle of meeting needs.
And if Bubeck is advocating a generalization of this moral principle (of meeting needs),
it means that Bubeck rejects the particularistic aspects of ethics of care. Bubeck also
does not think that care requires an emotional bond between the caregiver and the one
cared-for. Caring need not be an expression of love or friendship. If caring is
accompanied by or creates an emotional bond and attachment, that is acceptable, but, in
her view, the most important aspect of caring is that needs are being met. This suggests
that she sees care as almost entirely composed of the objective fact of needs being met,
rather than as the attitude of the caregiver. According to her view, if a caregiver is
meeting the needs of a hungry child, but, at the same time, is wishing that the child be
sold into slavery, the caregiver would still be engaged in caring. Held disagrees with
Bubeck, and rightly suggests that a strict Utilitarian might agree with Bubeck’s idea in
the sense that, if the child is fed, clothed, and hugged, the intention behind the acts may
not be morally significant. Held believes that intentionality (intention) should be of moral
significance. Of course, intentionality is significant in morality. Denying intentionality
and simultaneously rejecting particularity in ethics of care as Bubeck advocates, detracts
from and misrepresents ethics of care. For Held, the denial of intentionality and the
rejection of particularity in ethics of care is tantamount to “collapsing the ethics of care
into Utilitarianism.” The reason is that in ethics of care, “care” involves meeting
objective needs, attitude, motive, and value. In caring, one focuses on the situation of the individual in question, on relationships, and on particular cases, not just on abstract or general moral principles which one would like to consult in order to establish how to act towards that other person. Likewise, caregivers also care for themselves to maintain their own capabilities. If they do not care for themselves and no one takes care of them, then, they will be unable to continue to offer care. Thus, care requires that one attend to the needs of both oneself and others. To attend to one’s needs while not excluding others is to be honest to oneself. One is, as such, able to take responsibility for one’s decisions. This issue of particularity involves relationship with the other and, therefore, it will be further discussed below, under Section B. 3. Caring Relations.

Continuing, Bubeck makes a distinction between caring for and providing a service. Held illustrates this by explaining that to prepare food for a child is care, whereas it is not care if a man cooks a meal for his wife when she could well do so herself. A man cooking a meal for his wife who is capable of doing it herself is not providing care but a service, because the wife can meet the need herself. Care is, therefore, a response to human need that the one cared-for cannot meet. As seen above, Noddings would say that, in caring one is not simply concerned but actually engrossed in the particular other person. For Noddings, engrossment is thinking about someone in order to gain a better understanding of the person. The caregiver receives the ones being cared for on their own terms, without projecting oneself onto the cared-for. In outlining the moral values, virtues as well as dilemmas arising from caring, Noddings focuses on caring in the psychological-moral sense and acknowledges caring more as an attitude than as an activity. She insists that care-taking given grudgingly is not care. It would seem that
she sees caring as attitude as distinct from caring as activity, both being independent of each other. In this case, Noddings’ views would seem to conflict with Bubeck’s understanding of care as an activity. However, as Bubeck notes, it is not a serious issue because both aspects of care --as activity and as attitude-- go together and are present in most typical cases. Moreover, in those typical cases, “the attitude of care is systematically related to the activity.”

Like other ethics of care advocates, she rejects universal principles for prescribed action and judgment, and insists that care must always be contextually applied.

Gilligan divides ethics of care into three levels in accordance with their increasing order. At the first level, one cares for oneself to make sure one survives. The second level begins with one’s realization of the connection between oneself and others. One begins to shift the center of attention more to others and less to the self. Thus, one realizes that one’s actions under level one were selfish and, therefore, begins to eliminate actions that hurt other people. Gilligan also believes that in this second stage people adopt a feminine conception of goodness as self-sacrifice. Care is, therefore, essentially a relationship, and ethics of care focuses on relationships and communal ties. Furthermore, care can be seen as labor, as relational, as practice, as value, and in relationship to justice.

3. B. 1. Care as Labor

Caring in ethics of care involves labor or at least implies an activity such as taking care of someone. However, an activity has to have purpose to be considered labor or work. Most scholars writing on care, among whom are Held, Ruddick, Slote, and Eva F. Kittay, concur that care involves work, labor, or some form of work or activity and the expenditure of energy on the part of the one providing the care. For Ruddick, care is work or labor, and inasmuch as care is labor, it is a relationship: “Caring labor is
intrinsically relational.” According to Kittay, ethics of care “develops and refines the normative characteristics in the labor, the attitude and the disposition.”

Thus, the moral subject is understood as the relational self, embedded in relationships, and moral relationships are not necessarily among equals but also among unequals. Similarly, moral deliberation is understood as involving not just reason alone but, in addition, emotional responsiveness, empathy, and perceptual attentiveness. Moral harm is seen more as the consequence of failures in responsibility and responsiveness and less as an issue of the violation of rights.

3. B. 2. Care as Practice and Value

Care, which is the central value in ethics of care, is both a practice or a cluster of practices and a value or a cluster of values. Care as well as ethics of care is a practice and not a set of rules or principles. That is why the moral qualities of care take a more ambiguous form than a list of carefully designed moral precepts. As a practice, care involves both the work of care-giving and the standards of evaluating the practices of care. It is important to evaluate care because, according to Held, care ought to be concerned with both the effectiveness of its efforts to provide needs as well as the motives for providing care. Care as practice not only draws our attention to the reason for responding to these needs, but it also demonstrates to us how to respond to such needs. It promotes trust and mutual concern and, thus, leads to connectedness between people; in other words, it leads to interrelationships. Care as practice involves more than good intention. It requires a deep thoughtful knowledge of the situation, including the situation of all the actors: care givers and care-receivers, their needs and competencies. In fact, care as practice assists us in avoiding over-idealizing care. Caring is so much a matter
of the relations between persons and refers to the disposition of individual persons. By thinking of care in both ways we resist the tendency to limit care to a virtue.\textsuperscript{70}

Practices of care are not devoted solely to the values of care. Most often, they require justice. As Held observed, parenting is the ultimate practice of caring because the emotional tie between the care-giver and the care-receiver is very strong. The primary value of this practice is caring well for the child. The adequate understanding of practice of care should include normative guidance, such as how to avoid tendencies that parents may have to unduly interfere and control justice in requiring the fair treatment of multiple children in a family and in fairly distributing the burdens of parenting. Thus, justice and care complement each other. Responding to needs, as economic and social rights do, is part and parcel of the concerns of justice. The difference between economic and social rights of meeting basic needs is that of motive. If the motive of meeting needs is care, then the needs are responded to because the persons with these needs are cared for.\textsuperscript{71} For instance, a social program may fulfill the requirements of justice and equality but still be lacking in caring if it does not seek the actual well-being of the one cared-for that the program was meant to provide.

Values provide normative standards which can be utilized in the evaluation of practices. Just as justice is needed as a value to help evaluate actual practices of justice, care as a value is needed to isolate the appropriate cluster of moral considerations, such as sensitivity, trust, and mutual concern with which to evaluate or assess actual practices of care.\textsuperscript{72} To think of care only as a work describable empirically as using “good” and “right” providing all the normative evaluation of actual practices of care is general and insufficient. The reason is to say that Mr. X is a caring person ought to include that Mr. X
has a characteristic that is morally admirable (honesty, trust, sensitivity). It includes a
normative judgment, just as when a virtue like generosity, trustworthiness, etc., is
attributed to a person. This not only expresses a disposition, but, also makes a normative
judgment. According to Held, caring instead of merely identifying the characteristics of
persons or societies as good or bad, and as morally admirable or not, identifies a more
specific value to be found in the characteristics of persons and societies, for example,
trust, sensitivity, and mutual concern. Furthermore, Held asserts that the relevance of care
to ethics of care is that one incorporates values which feminists decided to find
acceptable. Ethics of care evaluates practices of care in the way they “evolved under
actual historical conditions of patriarchal and other dominions.” The aim of the
evaluation is to recommend what the practices of care ought to be like morally rather than
simply to accept and describe such practices of care as they originated and evolved.\(^73\) It
follows, then, that care is seen as both practice and value.

3. B. 3. Caring Relations

Besides being purposeful, labor, practice, and value, care is intrinsically a
relationship.\(^74\) There are relationships with the particular other, within the family and
relatives, and between friends. As Gilligan’s stages of care show, one advances from the
first stage to the second level on realization of the connection between the self and others.
The self is seen as “responding to perceptions, interpreting events, and governed by the
organizational tendencies of human interaction and human language. It is not so much
“self” as “self-governed.”\(^75\) The values of caring are best expressed by caring relations,
instead of in persons as individuals. Caring relations establish small societies of family
and friendship. Larger societies, including the state and nation, rely on these small
societies created by caring relations. Likewise, caring relations between more distant others, albeit weak but evident, enable those involved to develop trust in one another. It is a trust that is enough to enable them live in peace and respect each other’s rights. This trust is seen also in relationship between mother and child. As Held noted, these kinds of relationship, especially the relationship between a mother and a child, can hardly be comprehended in terms of their respective individual states taken in isolation. Again, the reason is that the self is connected to others. They are interdependent. In this context, detachment, isolation from self or from others poses a problem morally because it generates moral “blindness or indifference” which is a failure to determine and respond to need. For Carol Gilligan and Nel Noddings, however, detachment is a moral concern for ethics of care and caring does not permit the termination of a relationship. For instance, Noddings argues that, it is not caring or moral to terminate a relationship. Ending a relationship may be required for one’s physical or psychological well-being. Grace Clement disagrees with both Gilligan and Noddings. She argues that “the view that sustaining one’s relationships is the top priority of an ethics of care is based on faulty reasoning. It is based on a conflation of a relational ontology with a relational ethics.” In addition, she notes that the focus on sustaining one’s relationships creates an impediment to autonomy. For her, autonomy requires that one critically examine one’s choices. Thus, if an ethics prevents one from critically examining a relationship in order to decide whether to remain in the relationship or to leave it, such an ethics does not provide for autonomy. She, therefore, concludes that because ethics of care or feminist ethics of care do not permit a critical perspective on relationships, then “the care orientation seems to rule out autonomy.”
If the feminist ethics of care prevents women from taking a critical look at their relationships and from terminating harmful relationships, it is not acceptable. However, while ethics of care places emphasis on relationships, it does not insist that one always remain in a relationship that is deleterious, for example, an abusive relationship. This idea is supported by Noddings’ response to Sarah Lucia Hoagland, who believes that the ethical self is improved when one withdraws from relationships in which one’s partner is guilty of gross wrong-doing. Her reason is that, because one would not commit such an offence, one should show one’s superior morality by withdrawing from the guilty other. Noddings responds that such a divorcing of oneself from the guilty other does not help much to alleviate the evil, even though it tends to make the one withdrawing feel righteous. Noddings believes that “at every level -personal, group, nation- it is better to saturate the alleged evil-doer with our presence than to withdraw” because withdrawing often aggravates the evil as the guilty other “is left to find companionship and support among like-thinkers.” However, for Noddings withdrawal from the wrong-doer is permitted in instances of “direct personal abuse where physical withdrawal is necessary for self-protection.”

The comprehension of one’s interconnectedness helps one to realize that the apparent conflict between oneself and others comes from “a faulty construction of reality.” Gilligan advises, then, that a right understanding of our connectedness leads one to reconstruct reality such that, caring for self and caring for other people are connected rather than disconnected. Recognizing the depth of one’s interdependence to other people can also help overcome the apparent conflicts between self and others. One establishes a relationship in caring for a particular other. Held speaks of caring relations
especially when it comes to forming a political entity and developing civil society.\textsuperscript{83} She compares relations of care and of justice as discussed in the next section.

\textbf{3. B. 4. Care as Justice}

Care, namely responding to human needs, is justice. For Michael Slote, caring or “empathic caring” as he prefers to call it, is the parameter or criterion for evaluating the justice/injustice of actions, law, institutions, etc. Ethics of care pertains to an evaluation of the actions or situations in terms of whether or not they express, exhibit, or reflect empathically caring motivation.\textsuperscript{84}

Held has discussed how the feminist understanding of care and justice shows that both are different values and each involves different ways of both “interpreting moral problems and expressing moral concern.”\textsuperscript{85} However different they are, both are values that are important and needed for morality. The value of either justice or care may be primary in a given situation, depending on the need of the situation and the practices involved. For instance, the primary value in the practice of childcare by employees in an orphanage is caring even though justice --treating the children fairly and with respect-- should be involved. Or, as Ruth Groenhout noted, caring parents are expected to be just and seen as doing justice if they are to be caring parents. Adequate caring requires a strong sense of justice. However, without room for care, “or a caring concern for the well-being of those affected by the principles of justice, the principles become harsh, unforgiving, and frequently misapplied.”\textsuperscript{86} In the distribution of amenities in society, justice value is primary, but care value should not be absent or neglected. A program may accomplish the requirement of justice without meeting the demands of caring. Take, for
example, when people offer somebody what is due to him/her, but, the offering is made with disdain and grudge.\textsuperscript{87}

Both care and justice are appropriate for the public sphere of the political as well as the market domain. Contrary to what is often expressed, justice is required in the public domain as well as in families in the same way as care is required in both spheres. It is erroneous to limit justice to the public domain only, whereas care is required only in the family sphere. Justice is needed in the family domain for a more equitable division of labor between women and men, for the protection of vulnerable family members from domestic violence and abuse.\textsuperscript{88} In a state, for example, it is needed in the distribution of amenities, in protecting the citizens from government, and the weak from the strong and the rich. Care is needed in the public sphere and in welfare. As a criterion, care works in both the individual or private sphere of life as well in the social, public, political, and international sphere. Both care and justice are required in society as two different values and ways of interpreting and dealing with a moral situation. Thus, they need not be regarded as two polar opposites, even though when justice is the guiding value, it requires deferment to or respect for individual rights.\textsuperscript{89}

Similarly, ethics of care deals with personal morality and relationships, be they social, legal, political, economic, and distributive justice, each on its own terms. It is not confined only to personal morality and relationships.\textsuperscript{90} Ethics of care evaluates the actions of individuals, society, groups, or a nation in terms of how their actions exhibit or reflect caring motivation. For example, the actions of an individual person reflect the motives and/or belief of the person as an agent. Similarly, the laws, customs, practices, and institutions of a given society, groups, or nation reflect the motives and belief of that
society, groups, or nation because these laws, customs, practices and institutions resemble the actions of that society, groups, nation.\textsuperscript{91} Therefore, a society is just to the extent that its laws, customs, practices, institutions, and attitudes are just; that is, they reflect and express caring motivations (or “empathic caring” motivation, according to Slote). A society or community with just laws and institutions will not be indifferent to the interests and good of people in other countries, just as caring individuals are not hostile to the interest of others. A society that upholds justice and expresses caring or empathy will consider the well-being of other people and countries in its legislative institutions, practices etc.\textsuperscript{92}

Comparing relations of care with those of justice in the formation of political entity and the development of a civil society, Held believes that it is on the basis of care rather than on that of justice that people can sufficiently identify with others to form a political entity and develop a civil society.\textsuperscript{93} She further observes that relationships of care are wider and deeper than relationships of justice. Her reasoning is that, within relationships of care, people can treat others justly, as if they were liberal individuals agreeing on mutual respect. It is seen in more personal contacts as when parents care for their children equally or when friends compete fairly in games they seek to win. In public, political, and social contexts, relationships of care occur when people see each other as fellow affiliates of a group that is forming a political body which acknowledges a legal system. Contrarily, if justice is the guiding value, it requires that people defer to or respect individual rights.\textsuperscript{94}
3. B. 5. Criticism of Ethics of Care

Nevertheless, ethics of care has been criticized, in particular by proponents of the justice-based moral theory and by some feminist ethicists themselves. Some find the paradigm for mothering a limited and problematic framework. Ruddick proposes that mothering is logically peaceful even though some mothers support military undertakings and tend to undermine peace movements. Some critics reject Ruddick’s idea of mothering asserting that it can require “violent protectiveness and fierce response.” Other critics see the motherhood paradigm as “a too narrowly dyadic and romantic paradigm,” because the model “mistakenly implies that characteristics of a mother-child relationship are universal worldly qualities of relationship.”

The motherhood paradigm may be limited and involves unequal relationships, namely those of mother and child. However, if the mothering context offers an appropriate and acceptable context to investigate and explore moral values, as both feminists and ethicists of care are doing, then a different moral voice may emerge, a voice worth listening to, as Held noted:

If such valuations emerge from mothering, and if on reflection they are endorsed as evaluations appropriate to mothering, we can assert that moral understanding of persons who mother, and not only their attitudes and activities, is different from that of persons who do not mother, because such values are the values of a distinct practice. And if we acknowledge that a mothering context is an appropriate one in which to explore moral values --an acknowledgment only prejudice could lead us to deny-- then paying attention to this context, as feminist moral philosophy does, can lead to different moral theories than ignoring it.

Moreover, as has been noted above, moral relationships are not always between equals. Sometimes, they are between unequals, and, therefore, the mother-child relationship of the mothering paradigm reveals an unrecognized alternative valid moral relationship.
Furthermore, some female ethicists have questioned the validity of an ethics arising from the very work or labor commonly attributed to women only, works that have been associated with or are part of female subjugation; that ethics of care neglects the oppression of women and emphasizes women’s experiences as caregivers in traditional roles of self-sacrifice. Kittay provides a good answer to this criticism. She insists that, if an ethic emerges from the work and activities of subjugated people, it means that the subordinated “do have a voice.” That voice needs to be heard because it can indicate value where none was previously recognized. It can also assist a newly empowered group to avoid colliding with or playing into the hands of values that formed the very basis of their subjection.

Finally, Per Nortvedt observed that the hallmark of ethics of care is its insistence on the interdependence of all humans and that relationships make them vulnerable and dependent. “Relationships can fail and they can be oppressive, but they are also the only way through which we can shelter and protect our human vulnerabilities. To live in a web of significant relationships is for many persons the central part of human flourishing.” Consequently, Noddings concludes that, although justice-based ethics, which is supposed to be more masculine, is a genuine alternative to ethics of care, however, ethics of care, which she refers to as “relational ethics” and describes as “caring, 'rooted in receptivity, relatedness, and responsiveness,'” is a more basic and preferable approach to ethics.

3. C. The Concept of Person and Autonomy

As noted in Section 2. C, Kantian philosophy greatly influenced the Western concept of the human person that shaped the concept of autonomy and informed consent in Western bioethics. However, although ethics of care has its origin in Western society,
it rejects and challenges some aspects of the concept of the human person in relation to autonomy and informed consent found in Western concepts. Whereas Western dominant moral theories -Kantian, Utilitarian, Liberal Individualism- emphasize the human person as a rational, independent, self-sufficient, autonomous individual, ethics of care acknowledges the rational character, and in addition, highlights the relational and emotional aspects of a human being. Persons are in relationship with others and are constituted to large extent by their social ties. Human beings are not fundamentally separate and isolated individuals.

Consequently, ethics of care characteristically views persons or human beings as relational, interdependent, rational, and emotional beings who are historically situated. Ethics of care maintains a conception of the human person wherein human lives are “grounded in a web of care with other people, so that each person is able to give care to and receive care from others.”102 The care is for the comprehensive well-being of the particular other, the one cared-for -physical, spiritual, emotional and intellectual. Ethics of care draws from our experience of caring to give a better account of persons as related, interdependent beings who make moral decisions by taking into consideration both their emotions and their reason.103

Ethics of care also emphasizes the notion of personhood as being dependent merely upon connectedness in particularistic relationships, instead of being dependent merely upon the capacity for rationality. Part of the intrinsic notion of personhood includes particularity. Every person is unique and particular, not just rational or autonomous. In other words, for ethics of care, the intrinsic conception of personhood includes particularity, autonomy, rationality, and emotions. Julia T. L. Po-wah notes that
the idea of particularity means that *individuals* are unique and that *particular* implies that a person is irreplaceable. Essentially, one cannot be substituted. Po-wah, therefore, argues that, because particularity implies irreplaceability and non-substitutability, ethics of care scholars are, in effect, establishing that persons possess value simply because of their irreplaceability. ¹⁰⁴ However, Kant proposed that human beings are an end-in-themselves possessing dignity by virtue of their rational will or law-making capacity (i.e., autonomy). Beyond the dominant moral theories or principle-based approaches that follow Kant’s thoughts, ethics of care questions whether rationality is sufficient in defining personhood.

Held understands persons as moral subjects who are capable of action, and shaping their lives, institutions, and societies over time. She sees persons achieving this shaping by cultivating in themselves as well as in others certain characteristics, practices, and values. Persons are to experience themselves or have the self-awareness of being expected in order to possess moral responsibility, a moral agency, namely, relational agency. To be a moral person “is a status conferred on human beings as biological entities, by law, morality, as well as by other different human practices.” ¹⁰⁵ For Held, children are potential moral subjects. When children do not behave as they should, adults tend to disapprove of their actions with the intention of gradually “steering” or directing them to comprehend the moral significance of their action. This understanding is not quite different from the Western understanding of person. However, Held upholds, as do other ethics of care advocates, the relational and interdependency character of the human person.
In ethics of care, the concept of person wherein every person is particular implying irreplaceability and non-substitutability, and the concept of person as relational, both help to bring to the fore that the fact a “patient’s autonomy does not have to be the overriding principle to guide ethical and bioethical decisions;”\textsuperscript{106} that long after one’s capacity for autonomy has waned or disappeared, “relationship ties continue to exert a normative force.”\textsuperscript{107} This highlights the need to understand autonomy in the context of relationships. Besides emotion, dependency, interdependency of person, and human existence, ethics of care also emphasizes family as the unit of society, and relational autonomy which is considered below.

3. C. 1. Relational Being, Family, and the Patient

By contrast with the Liberal emphasis on the individual as a self-sufficient, independent being, ethics of care centers on personal relations, family, and communal ties. Based on the experience of care being relational, our experience of caring and being cared for, that is, ethics of care, identifies the idea of persons as relational and interdependent, as well as emotional and rational beings. It maintains that human beings experience themselves as relational and interdependent beings. Persons are involved in relationship with other persons and are very much affected by these relations. Indeed, to be a person is to be in relationships. Each person enters into a complex web of relationships, ranging from family, friends, neighbors, community members, and fellow citizens. These social relationships help to shape, develop, and constitute the human. Persons are constituted to a large extent by their social ties.\textsuperscript{108} Marilyn Friedman summarized the description of humans as relational beings thus: being relational beings means that persons
are fundamentally social beings, who develop the competency of autonomy...in a context of values, means, and modes of self-reflection that cannot exist except as constituted by social practices... It is now well recognized that our reflective capacities and our very identities are always partly constituted by communal traditions and norms that we cannot put entirely into question without at the same time voiding our very capacities to reflect. We are each reared in a social context of some sort, typically although not always that of a family itself located in wider social networks such as community and nation. Nearly all of us remain, throughout our lives, involved in social relationships and communities, at least some of which partly define our identities and ground our highest values.109

Held commends Friedman’s idea as a more developed conception of the human person. However, some other scholars criticize Friedman for interpreting social relations as merely causal instead of being constitutive elements.110 Of course, social relations are both causal and constitutive. Persons are causally affected and partly and importantly constituted by social relations.111 Diana Meyers describes various influential conceptions of the relational self as

the interpersonally bonded self... As relational selves... people share in one another's joys and sorrows, give and receive care, and generally profit from the many regards and cope with the many aggravations of friendship, family membership, religious or ethnic affiliation, and the like. These relationships are sources of moral identity, for people become committed to become central moral concerns.112

It follows that a relational self or selves-in-relation cannot adequately be described as independent, isolated entities and their states. Similarly, contrary to what the communitarian view would have people believe, relational selves are what they are not simply because of the communal, class, or historical context in which they are embedded. Rather, relational selves can radically change. They can make their own changes for better or for worse. It is insufficient to value relational beings in terms grounded only in the values of independent, isolated individual or in terms of values grounded only in the social entireties with which communitarians are concerned -nations, ethnic groups, or local communities, and in terms of changes which occur at these levels. The “values of the relation must not be reducible to the values of individuals in the relation” -as claimed
by individualist. Additionally, the claim that persons have value only in so far as they contribute to the value of communal relations can be rejected as untrue. Both persons and relations can have value.\textsuperscript{113}

Contributing to the discussion, Tronto identifies three implications of care as a fundamental aspect of human life: Dependence and autonomy, needs and interests, as well as moral engagement which emphasize the social nature and relatedness of human beings.\textsuperscript{114}

Explaining the first implication, dependence and autonomy, Tronto argues that one of the implications of care being a fundamental aspect of human life is that “humans are not fully autonomous.” They must always be understood in the context of interdependence. It is part of the human condition that our autonomy occurs only after a long period of dependence, and, in many ways, we remain dependent upon others throughout our lives.”\textsuperscript{115} At the same time, we are often called upon to help others, as well as to care. She, therefore, concludes that because “people are sometimes autonomous, sometimes dependent, sometimes providing care for those who are dependent, humans are best described as interdependent.” Dependence implies that those who care for those who are dependent can exercise power over them. For her, this is why we speak of relational autonomous persons.\textsuperscript{116} Slote thinks it is reasonable to hold that the mere fact that one has been influenced in one’s thoughts or decisions does not demonstrate a lack or absence of autonomy. Obviously, it can sometimes be reasonable, for example, to take someone’s advice, but there is a difference between taking advice and feeling compelled to do or to think whatever a certain other person or institution
advises you to do. To freely take someone’s advice can be an exercise of autonomy, whereas being compelled to follow someone’s or an institution’s wish is not.\textsuperscript{117}

Proceeding to implications of care, Tronto criticizes liberal theories that do not see dependency as a natural part of human experience. These political theories see and emphasize dependence as a character-destroying condition. For liberals, to be dependent is to lose one’s autonomy. It is to “lose the ability to make judgments for themselves, to end up at the mercy of others on whom they are dependent.”\textsuperscript{118} She thinks that, when liberal political theorists such as Jean Jacques Rousseau and Adam Smith, condemned dependence, they did so because of their understanding of dependency. Rousseau believed dependence to be a threat to human authenticity.\textsuperscript{119} Similarly, Smith sees dependence as a danger to citizenry virtues. He asserts that factory work dulled workers, making them less willing to serve in citizen armies.\textsuperscript{120} Other liberals say that dependence allows the powerful to have undue influence over other people.\textsuperscript{121} However, dependence does not necessarily imply loss of autonomy, as will be discussed later in Section 3.C.3.

Relational Autonomy in Informed Consent (RAIC)

Furthermore, in looking at the second implication, “needs and interests,” Tronto notes that, while interest connotes and depicts \textit{human activity} in terms “either logically or culturally individualistic,” \textit{needs} “is necessarily inter-subjective.” The way someone arrives at a need is an issue of social concern because it evokes dependence. Both need and its fulfillment imply dependency and vulnerability. On the other hand, how someone comes to an interest is not a matter of social concern, at least, not as need.\textsuperscript{122}

Finally, addressing the third implication, “moral engagement,” Tronto notes that, from the perspective of care, individuals are seen as being in a state of moral
engagement, rather than as being in a condition of detachment. If people’s activities of care are taken as instances of moral action, it, then, means that everyone engages in moral actions a lot of the time. For Tronto, understanding “moral engagement” in this way, namely, from a care perspective, changes our political ideas of persons and relationships.123

In evaluating and valuing relations of care, especially relations between persons, ethics of care rejects some of the theses of the social contracts, for example, that relationships relevant to morality have been entered into voluntarily by free and equal individuals.

i. Ethics of Care Critique of the Social Contract Theories

Before further addressing ethics of care criticisms of the social contract theory, a brief description of the thoughts of the social contract theorists is in order. The social contract theory states that human beings originally were isolated individuals in the state of nature. Later, these individuals came together and made a pact or a contract to live together as a society and as citizens with some form of government in authority. In a sense, the social contract theory can be traced to Socrates who employed it in his argument to convince Crito that he, Socrates should remain in prison and embrace the death penalty.124 As a modern theory, the social contract theory is very much associated with Thomas Hobbes, John Locke, and Jean-Jacques Rousseau.125

ii. The Social Contract Theories

Hobbes hypothesized the state of nature where persons exist as self-interested individuals. The individuals are reasonable and possess the rational capacity to pursue their desires and individual interests efficiently and maximally. In Hobbes’ State of
Nature everyone is equal, and there are limited resources. There is no power to force people to cooperate. Hobbes foresees a brutal State of Nature, where everyone is afraid of losing one’s life to another. He, therefore, proposes a justification for individuals to surrender to form a society or government. Hobbes reasoned that humans can and need to enter a social contract that will offer them a life better than the one available in the State of Nature. To form such a society, they must agree collectively and reciprocally to renounce the rights they had in the State of Nature. They also have to confer on some person or group of persons the authority to enforce the initial contract.

Unlike Hobbes, however, Locke (1632-1704) does not see the State of Nature as utterly brutal. Consonant with other social contract theories, Locke uses Hobbes’ methodological device of the State of Nature but, to a different end. Locke’s State of Nature is a state of perfect and complete liberty to conduct one’s life as one best sees fit. One is free of interference from others. However, one is not free to do anything that one pleases and/or what one judges to be in one’s own interest. It is not a condition of individuals, but it is populated by mothers, fathers, and their children or families – a conjugal society. However, these societies are based on voluntary agreements to nurture and raise children together but not on a political society. Society will come into existence if individuals representing their families in the State of Nature assemble and agree to give up their executive punitive power to form a civil government. Although there is an absence of government, in the Lockean State of Nature there exist morals and the law of nature (law of nature is for Locke, the basis of all morality, liberty, health, or possessions). Likewise, for Locke, the State of Nature is not the same as war, but war can start especially because of disputes over properties. Should war begin, there is a
likelihood that it will not stop because there is no civil authority. That is why there is a need for social contract and civil government. A civil government is even more needed, because in Locke’s State of Nature, people have liberty. Locke can envisage conditions under which people would fare better rejecting a particular civil government by returning to the State of Nature to regroup and form a better civil government in place of that rejected.\textsuperscript{130}

Jean-Jacques Rousseau (1712-1778) posits a State of Nature in which people lived solitary, uncomplicated lives, with their needs easily satisfied. There would be reduced human population but an abundance of nature. Individuals would hardly see one another. Given this background, there would be neither competition nor reason for conflict or fear. However, with time and changes, human populations would increase and resources for satisfying the needs would also change. People would gradually begin to live together in small families, and then in small communities. Then, development and invention of private properties, greed, competition, inequality and vice would ensue. Rousseau sees the invention of property as the catalyst of “fall from grace out of the State of Nature.” Those who have property realized that it would be in their best interests to have a government, an authority that can protect private property from those who do not but might aspire to acquire it by force. “Man is born free and everywhere in chains.” This is the conceptual bridge between the two works of Rousseau in his search for a social contract wherein people can live together without yielding to the force and coercion of others. Rousseau determined that this kind of condition can be achieved by people submitting their individual or particular will to the collective or general will; that is, that, such a society would be created by agreement with other free and equal persons.\textsuperscript{131}
iii. The Critique

Advocates of ethics of care, especially Annette Baier and Held contend that social contract theory does not give an adequate account of our moral or political obligation.132 The Hobbesian society, for example, is composed of a number of relatively equal and self-sufficient adult individuals (males) entering into contract. First of all, as Baier points out, the “conditions of social cooperation, whether in families or in communal decision-making, are not always chosen. Such conditions of social cooperation are intimate and involve unequals in relational network.”133 Moreover, humans do not come into being as adults fully grown and competent to struggle against each other. They are born as babies and infants who are cared-for and who later care-for others. Infants and small children need and do take a very different type of context for survival and development. Usually babies are not born as Hobbesian individuals. Rather “they are born reaching out and expecting care, they continue to expect care even when raised by harsh or negligent parents.” Consequently, Baier concludes that the primary move in human life is not away from others but towards others.134

Thus, the social contractists and the dominant moral theories’ idea of person give and nurture the impression that society is “composed” of free, equal, and independent individuals who can choose to relate with one another or not. This idea does not ring true of the human experience wherein exists dependency for every human being when he or she is young, for most people who are disabled, old, ill, and infirm at various periods in their lives. Likewise, the social contract theory and the dominant moral theories’ ideas of equality obscure the very real facts about those involved in unpaid “dependency work.”135 Otherwise, people and groups are interdependent in society or in the world.
Different groups possess various levels of dependence, vulnerability, or special needs. Whichever ethical framework seeks to gloss over or assign uniformity to these differences should be regarded as irrelevant. Kittay asserts that a conception of society viewed as an association of equals hides inequitable dependencies, those of infancy and childhood, old age, illness, and disability: “While we are dependent, we are not well positioned to enter a competition for the goods of social cooperation on equal terms.”

Therefore, according to care ethicists, social contract theory goes only as far as distinguishing rights and obligations. They argue that this account is not enough to demonstrate adequately the full extent of what it means to be a moral person. Social contract theory also does not show “how fully to respond” to other people “with whom one interacts through relations of dependence.”

Not all morally important relationships can or are freely chosen and entered into. Thus, moral obligations do not always arise from freely chosen association or between equals. For example, “vulnerable future generations do not choose their dependence on earlier generations.” The unequal infant neither chooses its place in a family nor in a nation. Likewise, the unequal infant is not treated as one free to do as he/she likes until some association is freely entered into. Parents do not always choose their parental role or freely assume their parental responsibilities any more than people utilize their power to affect the conditions in which later generations will live.

For Baier, the work of social contract theorists, such as that of Gauthier, does not represent the fullness of human psychology and motivations because Gauthier portrays the affective bond between persons as voluntary and non-essential. Thus, Baier rightly observed that this leads to a crucial flaw in social contract theory. The affective bonds
between persons are not always voluntary and non-essential. She proposes that we defend the liberating idea of a society that does not impose affective bonds on its members, and, at the same time, she distinguishes this affective liberty from moral and political chaos, “and a free society from an all-embracing market.” Affective liberty in a free society is the pilgrim’s Promised Land.\(^{141}\)

Furthermore, ethics of care insists that human beings are relational beings, and people must first be in relationship, for example, a mother-child relationship, in order to develop the very capacities and qualities that liberal and social contract theory praises or exalts. Certain relationships of dependence or interdependence, is required, \textit{ab initio}, to become the very sort of persons who are capable of entering into famous contracts and agreements proposed by the social contract theorists.\(^{142}\)

Held observes that the ‘economic man” model presented by the social contract theorists does not “capture much of what constitutes meaningful moral relations between people.” Economics operates on the belief that people will decide what to do on the basis of self-interest. Studies show that being repeatedly and intensively exposed to such a model encourages economic students to be less cooperative and more inclined to free ride than students in other disciplines. To see human relations in purely contractual ways is to “hold out an impoverished view of human aspiration.”\(^{143}\) Thus, Held asserts that, other paradigms of human relationships should be explored. Like other advocates of ethics of care, Held proffers the model of the mother-child relationship suggesting that at least, the paradigm of this relationship will “supplement the model of individual self-interested agents that negotiate with one another through contracts.”\(^{144}\)
Finally and in conclusion, in their assessment of liberal and dominant moral theories, which include the social contract theory, Gilligan and Baier are critical of the relative weight that these moral theories place “on relationships between equals, on freedom of choice, and on the authority of intellect over emotions.” Gilligan and Baier argue that the dominant moral theories are primarily concerned with and tend to regulate relationships between equals or those thought to be equals in some important sense. They ignore other relationships such as those between parents and their children, earlier and later generations, states and citizens, doctors and patients, the healthy and the ill, as well as large states and small states. These are obviously unequals. To express some moral regulations for these unequals, the dominant moral theories find a way of making them equals: virtual equality. One way of achieving this is to categorize all of them as some types of weaker person or entity needing protection. As a result, citizens collectively become equal to states, children are described as adults-to-be, “the ill and dying are treated as continuers of their earlier more potent selves,” in order to portray their rights as “the rights of equals.”

Baier concludes, therefore, that this kind of virtual equality veils the issue of what people’s “moral relationships are to those who are their superiors or their inferiors in power.” Baier therefore declares:

> A more realistic acceptance that we begin as helpless children, that at almost every point of our lives we deal with both the more and the less helpless, that equality of power and interdependency, between two persons or groups, is rare and hard to recognize when it does occur, might lead us to a more direct approach to questions concerning the design of institutions structuring these relationships between unequals (families, schools, hospitals, armies) and of the morality of our dealings with the more and the less powerful.

Against this background, Baier argues that liberal rules or theories do not do much to protect the young, the dying, the starving, or any of the relatively powerless against neglect. Also the rules do little to insure that there is an education that will nurture people
to be “capable of conforming” to both ethics of care and responsibility. In other words, liberal theory may make people nothing but persons “who have no interest in each other’s interests.” Furthermore, she notes that the proponents of contract theory, especially of dominant theories, for example, Rawls, do not attend to or deal with wrongs to animals and wrongful destruction of the physical environment. In answer to this situation, Baier insists that any serious moral theory has to take interest in the next generation’s interests, that is, caring for the children and the weak, as well as caring for the environment. For Baier and other ethics of care advocates, the morality proffered by ethics of care fulfills these requirements. The experience of caring as typified in women’s traditional work of caring for the less powerful, such as the young and the sick, as well as the environment, is socially vital and a definite interest in the future generation’s interests.

For ethics of care, the family is the unit of society. It is the primary domain for teaching and understanding ethical behavior. The same is true of Asian society and similar in some way to African culture, as shall be explained later in Chapter 4. In health care decision-making, ethics of care gives much greater recognition to the place of family, friends, and professional care-givers than in the liberal individualist approach to ethics. Against the legal prescription supporting the patient’s independent decision in Western liberal moral theory, ethics of care argues for a relational autonomy whereby the family can morally and legitimately participate in and influence the medical decision-making process of the patient. Moreover, ethics of care is well-suited to discussions, disclosure, and beneficence in decision-making in health care “which typically becomes a family affair, with support from a health care team.” More still, one cannot assert too much independence from parents, family or community. “For many years in a person’s
life, years in which childhood experiences shape the adult person” the individual becomes, one does not exercise much independence. Even as adults, “it is part of what we are to be the children of given parents, with all the genetic and cultural history this involves, all the gender expectations or class advantage or racial disadvantage that attaches to it,” as well as all the obligations and moral sentiments that the relationship brings with it. Of course, this is not all that a person is. Individuals have their thoughts and capable of shaping their life amidst these external and biological influences. However, it is absurd to deny the dependency on one another.

3. C. 2. Dependency and Interdependency of Persons and Human Existence

Caring highlights the element of dependence that is in relationships and which is part of the human condition. In caring relationships, we are dependent on one another; that is, there exists interdependence. Each human being goes through a process of dependency according to age, physical or mental condition. One of the implications of care being a fundamental aspect of human life is that human beings are born into a condition of dependency. They stay dependent upon others throughout the course of their lives. In their interdependence, they manage to learn to become autonomous. Writing about people with disability who require care by others, who are dependent on their caregivers, Kittay insists that it is not abnormal but natural to all humans to be dependent on others in some stage of their lives.

If we conceive of all persons as moving in and out of relationships of dependence through different life-stages and conditions of health and functionings, the fact that the disabled person requires the assistance of a caregiver is not the exception, the special case. The disabled person occupies what is surely a moment in each of our lives, a possibility that is inherent in being human. From this perspective, we reason that our societies should be structured to accommodate inevitable dependency within a dignified, flourishing life—both for the cared for, and for the carer.
Likewise, defining human beings by their relationships implies that caring cannot be totally self-sacrificing. If one gives to one’s relationships, it can only be to one’s benefit. After all, if we are constituted by our relationships to one another, our well-beings “cannot be at odds.” One does not give and receive in kind as a totally separate individual. Rather, one’s individuality, one’s social self, is defined in relationships. Therefore, when one does something for someone else, one enhances oneself through the relation that defines one as well as the other.155

Tronto chides liberal theorists for holding that being “dependent is to be without autonomy” and for not seeing dependency as a natural part of human experience. For her, these liberals do not see that human beings remain dependent upon others throughout the course of their lives, and, simultaneously, other people depend on them. Often, people are beckoned to help and to care for others, to care for each other.156 In ethics of care, dependence is a “conviction that one is able to have an effect on others, as well as the recognition that the interdependence of attachment empowers both self and the other, not one at the other’s expense.157

Generally, the possibility of and presupposition for human life lies in the care and support human beings offer each other. Parents possess a moral responsibility to care for their offspring. Children, in turn, have a moral responsibility to care for the elderly. In this way, human beings exist in interdependent relationships that entail ethical responsibilities.158 Human interdependence is also highlighted in caring relationships of friendship. Here, friends voluntarily care for each other and, at the same time, they are dependent on each other.
Interdependence has to do with limitation. Human beings are finite and limited. They are not self-sufficient. As embodied beings, they enter into life as infants requiring great care. Throughout their lives, they require care, albeit of varying degree. They do not go through significant portions of their lives without some dependence on others for one thing or another. This dependence is not simply material or physical. It includes emotional, psychological, spiritual, and intellectual dependence. To be human, so to speak, is to be interdependent on all kinds of fellow human being for all sorts of things.\textsuperscript{159}

This notion of an interdependent being and moral agent in ethics of care contrasts markedly with the Kantian inspired moral theory or the dominant moral theories where the moral agent is like an isolated, independent (self-sufficient) individual. The human experience of life demonstrates that human beings are not isolated, independent, or self-sufficient individuals because they have and are dependent on others, and on one another through most of their lives for emotional, psychological and physical nurturing at various times.\textsuperscript{160}

This idea is at odds with the contractists’ theory. For example, as noted above under 3. C. 1a – c, Jean-Jacques Rousseau who wrote extensively about the danger of dependence, regarded dependence as a threat to the authenticity of human beings.\textsuperscript{161} He viewed dependence negatively and did not consider dependence or interdependence as being autonomous.

In conclusion, if humans are interdependent being rather than isolated, self-sufficient individuals by nature, then it does not make much sense to emphasize individual patient independence or autonomy as if patients are isolated, self-sufficient individuals. Furthermore, it does not make sense to expect patients who are in a weak
position not to seek the help of other people, especially, in treatment decision-making. If anything, patient circumstances, ill and weak, call for dependence on relatives, friends, and healthcare givers. Therefore, ethics of care values the ties people have with particular others, as well as the concrete relationships that partly constitute peoples’ identity. Ethics of care is hospitable to the relatedness of persons. It does not understand many of peoples’ responsibilities as freely entered into. Rather, ethics of care sees them as made manifest by the accidents of people being embedded in a familial, social, and historical context. People motivated by ethics of care will tend to seek to become more admirable relational persons in better caring relations, rather than seek to more closely resemble the unencumbered abstract rational self of the liberal political and moral theories described in Chapter Two above.162

3. C. 3. Relational Autonomy in Informed Consent (RAIC)

Having asserted the caring interdependence in human existence, Tronto argues that those who care for dependents can exercise power over them leading to temporary loss of autonomy. Thus, human beings are not fully autonomous. And because human beings are only sometimes autonomous, at times dependent, sometimes caring for the dependent, they are, therefore, best described as interdependent. Tronto suggests, then, that, in reconciling the caring interdependent relationships with self-determination, people temporarily lose their autonomy.163 In this way, she speaks of the relational autonomous person. Some other ethics of care scholars, such as Clement, Nedelsky and Held, develop more than Tronto this idea of relational autonomy. They proffer analyses to explain autonomy in the context of relationship. This dissertation will consider the
following two such scholarly views, namely, Grace Clement and the Jennifer
Nedelsky/Held attempts.

For Clement, because ethics of care holds that human beings are to a large extent, socially constituted, only a non-individualistic account of autonomy is compatible with ethics of care. Ethics of care must allow for the autonomy of both the care-giver and the cared-for. She argues that being socially constituted implies that autonomy is not simply an internal or psychological characteristic, but it also includes an external or social characteristic. She points out that this idea is contrary to most discussions on autonomy wherein autonomy is presented as a psychological attribute related to free will. Such discussions concentrate on impediments to psychological autonomy. She further notes that in the dominant moral theories people are asked to engage on critical reflection or rational reasoning, that is, higher-order desires. The primary reason for requiring higher-order desires, rational reasoning or critical reflection, is that our ordinary desires--the first order desires--are often socially determined. A critical reflection on these first-order desires reveals that they are not really our desires. That is why autonomy requires that people assume a critical perspective of their socialization. However, Clement argues that, when one reflects on the higher-order desires, one may realize that they too are not really one’s desires. One begins to recognize that, perhaps, it is not only the first-order desires that are socially constituted but the higher-order reflections as well. Thus, perhaps the critical reflection is itself a social product, just as the first-order desires are socially constituted. Should this be true, then, Clement concludes that there are no grounds to speak of a “true” self, because a “true” self is generally understood to mean an innate or “self-generated self.” If there is no true self, that is, no self which is not determined by its
social context, then, it would seem to follow that there is no autonomy. On the contrary, Clement regards critical reflection as allowing people to be more autonomous than usual. It attests to our “social constitutiveness,” that is, the fact that human beings are socially constituted. We, humans, learn to become autonomous from others, through relationship with them and not by isolation from them. A person’s autonomy is nurtured through other’s care. Isolation might nurture the negative component of autonomy, namely, absence of coercion in one’s decision-making. It, however, will not promote the positive component of autonomy which is critical thinking about one’s motive. The reason that Clement offers is that what fosters the skills of self-examination permitting us to be autonomous is the support and guidance of our family, friends, and teachers. Relationships with others teach us to be ourselves. Some relationships nurture skills better than others whereas some relationships even undermine the skills of autonomy. However, fundamentally, the fact is that relationships, especially caring relationships certainly, are a necessary precondition for autonomy. Relationships are the social conditions that make it possible for us to develop the capacity to be autonomous. In this case, autonomy is practiced in relationship; thus, the label “relational autonomy” is used for what Clement proposed, although Clement herself did not use the term.

Much in keeping with Clement’s thesis is Nedelsky’s proposal which Virginia Held adopted in her own work. Both Nedelsky and Held see relational autonomy as an effort to relate human beings’ experience of relatedness and being socially constituted in relationships to others with “the value of self-determination.” Nedelsky begins by asserting that the term “autonomy” is so linked to the liberal tradition that it seems to be synonymous with “individualism.” She speaks of “becoming autonomous,” or of
becoming able to find and live in accordance with one’s own law. She adopts the word “becoming” because autonomy is not a quality that can be simply imposed on human beings. It has to be developed and sustained. Everyone has to develop and sustain that capacity for finding one’s own law. One finds this law because one does not really choose or create it. Even what is truly one’s law, or autonomy, is shaped by the society in which one lives as well as by the relationships in which one engages in that society. Thus, autonomy may be one’s own, but it is not developed by the individual in isolation or without connection to others in the context of relationships. For these reasons, Nedelsky speaks of finding one’s law. Speaking of “finding” also allows the openness that an individual’s own law or autonomy might be revealed by spiritual sources, that the capacity to find one’s own law may arise from one’s spiritual nature. This idea of a transcendent source need not be like Kant’s Categorical Imperative with its exclusive reliance on human rationality. Nedelsky asserts, then, that the law may be one’s own, but not necessarily made or created by the person. The person concerned develops it, but in connection with other people. The capacity to find one’s own law can develop only in the context of relationships with other people. These other people include both an intimate and, more broadly, a social group. It is the relationship with others that nurtures this capacity. The content of one’s own law is understandable only in relation to shared social norms, values, and concepts. Thus, Nedelsky concludes that what really enables people to become autonomous are relationships and not isolation from others. It is relationship with friends, parents, teachers, and loved ones. This understanding is comparable to the African concept of person and the connection with humans and spirits, as is discussed in Chapter 4. These persons provide the support and guidance required for
the development and sustenance of autonomy. The implication of this proposal is that, in the emergence of autonomy in relationship with others, it becomes clear that relatedness is not the antithesis of autonomy as the liberal tradition asserts. Rather, relatedness is a literal precondition of autonomy, and interdependence is “a constant component of autonomy,” thereby fostering autonomy through relationships with others.172 Continuing, Nedelsky notes that autonomy is not a static quality that is or can be achieved simply in one day. Rather, it is a capacity requiring ongoing relationships that assist it to flourish. Autonomy can also wither or thrive at various times throughout a person’s adult life.173 As a result of this analysis of autonomy in the context of relationships, Clement, Nedelsky, Held, and other ethics of care scholars advocate a relational autonomy which, in this dissertation, is referred to as RAIC (relational autonomy in informed consent).174

Nedelsky also finds a dichotomy between autonomy and the collectivity or groups. The dichotomy is grounded in the deeply ingrained sense that individual autonomy is to be achieved by erecting a wall (of rights) between the individual and those around him. She sees the central symbol for this sort of autonomy as property. The reason is that property “can both literally and figuratively provide the necessary walls, of isolation.”175 Therefore, the most perfectly autonomous person is thus, the most perfectly isolated. This idea of the autonomous individual, as one perfectly isolated from one’s fellow human beings, has been promoted in Western society for many centuries.

In conclusion, by following these analyses of autonomy in relationships, one can infer that ethics of care adopts an RAIC approach; therefore, ethics of care does not place too much emphasis on the individual patient as the sole authority in medical decision-making or in the informed consent process. Ethics of care does not vest the individual
patient with the power to make medical decision based solely on his/her interests and needs.


Rather than reject or dismiss emotions in moral decision-making, ethics of care appreciates and gives passion and emotions a role. Virginia Held notes that caring relationships cannot be understood in terms of abstract rules or moral reasoning. Morality requires the development of moral emotions. It is a morally relevant factor to possess a certain emotional attitude as well as to express the appropriate emotion and passion in action. In the same way, it is morally relevant to possess an appropriate motive for an action. If one acts from rule-governed obligation and does not have appropriate feelings of emotions, such as in the face of a friend’s suffering, a dying son or daughter, one appears morally deficient. Ethics of care insists further that not only should people express their feelings in their responses, but they need also to attend to the feelings of persons towards whom they act, because “insight into the needs of others and considerate attentiveness to their circumstances” often arise more from emotions than from reason. This is exemplified in the relationship between parents and their children. Annette Baier argues that parents need to love their children and not just control their irritation when their children’s screaming enrages them. Parents and guardians need to develop desirable forms of emotions required for nurturing their children rather than simply harken to the Kantian emphasis on rational control of emotions. Another example is the assertion that, in the history of human experimentation, it was those who were able to feel compassion and empathy for human suffering who first recognized that the research subjects were subjected to misery or being brutalized. The people who were able to feel
disgust and outrage through insight into the situation of the research subjects were the ones who in their research challenged inhuman practices. Even the act of imagining someone else’s experience of suffering is capable of inspiring moral action. The resultant moral could be to respond to the suffering or to shy away. By no means does this emphasis on the emotional dimension and on the moral life convert moral response into emotional response. Rather, contrary to liberal theories, it brings out the importance of emotions in moral judgment. Philosophers of history, Plato, and Kantians argue that emotional attitudes towards moral issues themselves interfere with rationality and should be disregarded. “They encourage people to discipline themselves against desires, impulse, and inclination in order to ensure a more rational course of moral deliberation and action. For these philosophers, while decision and action based on emotions - impulse, inclination, and passion might be good, but they are not morally good because they are not based on an “appropriate cognitive framework.” Persons and emotions are, therefore, seen as impediments to moral judgment by Kant and these philosophers.

Because in a moral analysis, ethics of care embraces emotions, Held and scholars of ethics of care have a problem with the Kantian Categorical Imperative: the Law of Reason that requires us to act in a manner consistent with reason and logic, devoid of emotions, feelings, wishes, and circumstances in order to act autonomously. For ethics of care advocates, Kant’s Categorical Imperative suggests that every moral problem can be handled by applying an impartial, pure, rational principle to particular cases. One seeks the general features of the moral problem at hand and applies an abstract principle or rules derived from the Categorical Imperative to the issue. This procedure is supposed to be adequate for all moral decisions. In using the Kantian Categorical Imperative, one is
able to act as reason recommends and resist yielding to emotional inclinations and desires in conflict with our rational wills.\textsuperscript{182} Although Utilitarians recognize emotions as the source of human desires for certain objectives, they believe that the task of morality should be to instruct people on how to pursue those objectives most rationally. They suppose that one highly abstract principle, the principle of utility, can be applied to every moral problem no matter what the context. Having and exercising emotional attitudes towards moral problems interferes with rationality and should not be encouraged. Ethics of care advocates, such as Held, conclude, therefore, that both the Kantians and Utilitarians share a reliance on a highly abstract, universal principle as the appropriate source of moral guidance. Additionally, both the Kantians and Utilitarians hold the view that moral issues are to be resolved by applying such an abstract principle to particular cases.\textsuperscript{183}

Questioning this reason intensive method, ethics of care asserts that emotions provide, at least, a partial basis for morality itself and surely a basis for moral understanding.\textsuperscript{184} As was noted in Chapter Two above, this view is also supported by Callahan, Fritz, and Pizarro who maintain that emotions can direct or alter reasoning, just as reasoning or reasons can inform and alter emotional responses. Emotions are consciousness, and they provide people with personal and social values that offer directions and purpose to rational thinking.\textsuperscript{185} Emotions, especially empathy, play an integral role in the process of moral judgment or moral decision-making.\textsuperscript{186} Thus, emotions have come to be regarded as “the primary motivating system for all activity.”\textsuperscript{187} According to Martha Nussbaum, the “liberal tradition holds that emotions should not be trusted as guides to life without being subjected to some sort of critical scrutiny and
urges people to ask whether their emotions are appropriate.\textsuperscript{188} According to her, such critical scrutiny would help women avoid or end some of the injustices and oppression that follow excesses of emotional commitment; that love and deep caring are fine, so long as you think first. She is critical of Noddings’ view on caring for recommending emotional attitudes that are not sufficiently self-critical and for regarding the critical attitude recommended by liberalism as involving “one thought too many.”\textsuperscript{189} On the other hand, Slote does not believe that Noddings used that expression, “one thought too many” or that she made explicit reference to William’s view that certain attitudes involve “one thought too many.” However, some caring ethicists like Noddings idealize or command a critically unselfconscious form of love or caring.\textsuperscript{190}

Over and against liberal ideas about emotions and morality, ethics of care recommends a focus on relationships and on particularities of the context in which a moral problem arises, as well as its general context. In addition, ethics of care recommends that people pay attention to feelings of empathy and caring to help decide what is to be done (morally) rather than relying solely on abstract rules and reason. This implies a respect for emotions rather than a dismissal of emotion in the process of gaining moral understanding. It is a procedure that involves approaching moral consideration with “embodied, gendered subjects” who possess “particular histories, particular communities, particular allegiance, and particular visions of human flourishing.”\textsuperscript{191} However, caring can be said to possess a cognitive aspect because it “involves insights into and understanding of another’s circumstances, needs,” as well as feelings. While emotions motivate people, and reveal much about somebody’s character, human
understanding directs people in choosing a path of action. This means that both reason and emotion are necessary and play their part in moral judgment.

Similarly, while acknowledging the role of emotion in moral judgment, principles should not be rejected outright. They should be acknowledged while caution should be exercised in not using them in such an abstract way that neglects particular relations and personal moral judgments. Moreover, as Held rightly observed, the absence of principles can lead to a capricious and fickery moral situation. Consequently, caring may be a weak defense against arbitrary decisions. Perhaps then, if both the cared-for and care-giver, but especially the carer, “are guided to some extent by principles regarding rights and obligations,” the cared-for may find the relationship more satisfactory in several different aspects. Principles may be for the care-giver a reminder not to be capricious or domineering. Considering children and the disabled, Curtin noted that people, who are essentially defined as having an inborn defect, find it hard to challenge or contest the labels others especially their care-givers, have given them. Consequently, these children can come to the awareness of their disadvantage only if they can “make evaluative judgments based on the practices taking place out there” in the wide world and beyond dyadic caring relationships. Thus, Curtin concludes that principles or rule-based approaches offer helpful avenues for finding “elements of cross-situational identity.”

One can conclude with Beauchamp and Childress that “we should be prepared for situations in which our actions are overly partial and need correction by impartial principles. We are likely to treat more favorably persons who are close to us in intimate relationships; although on some occasions those who are distant from us deserve even more favorable treatment.” In addition, as Beauchamp and Childress point out, while
acknowledging the need not to place too much emphasis on justice, impartiality, rights, and obligations, ethics of care has to confront contexts wherein *bona fide* requirements of impartiality conflict with acting partially from care. Just as ethics of care demands that acting impartially gives way to acting partially, it has to admit that sometimes acting partially must yield to acting impartially. There are some occasions when impartial judgment is required to arbitrate between conflicting moral judgments or feelings.\textsuperscript{196}

3. C. 5. Individual Patient Rights

As seen in Chapter Two, in addition to the rejection of emotions in moral decision-making, the liberals define, employ, and emphasize rights, individual rights, in their concept of autonomy in informed consent and medical decision-making. Moral judgments in liberal practice follow principles defining rights and duties of the individual (sometimes without due considerations of specific circumstances, and costs particularly). Against this background, ethics of care advocates call for the evaluation of the concept of rights. They seek to understand rights from the perspective of caring relationships and connectedness. They also seek to delineate the value of rights in the context of family, friendship, and political or civic organizations such as the state, or communities. Recall from above that the ethics of care asserts that there are social relationships holding the individual person together, whether in a family, among friends, or in political entities. In these relationships and connectedness, there is a sense that what happens to others in the group (family, state, community) matters and that it plays important roles. The relationships or caring relationships and affection are, however, much stronger in the context of families and friends. Because of the greater affection, empathy, and caring relationships in family and among friends, ethics of care is more suited for family and
among friends than ethics of rights and justice or traditional ethics (including liberalism) which emphasizes justice and rights. Consequently, the value of rights is said not to be quite appropriate in relationships in family and among friends but is more suited for other civic or social groups such as the state, or communities. For example, Held thinks that it is appropriate and more sensible to have care as primary in the family, because the most important things are the caring relationships that nurture the family, seeing that the family is the provider of care, barring which infants will not survive or which children will not grow. Held further insists that there can be no human life or family in the absence of the actual practice of care. The issues of rights and justice should also be considered in caring relationships of the family, although this pursuit should not be done in such a way that it “sunders family relations.”¹⁹⁷ For instance, as Held rightly argues, girls should be supported in seeking equal and fair treatment in education, feeding, and freedom just as boys. Uma Narayan has an example of female infanticide in India introduced for the purpose of promoting the care of male children. But, as a result of the practice, female children compared to their male counterparts are unable to grow up and become bearers of rights.¹⁹⁸ Claudia Card speaks of possible instances where care-givers themselves are seriously abused by the cared-for as well as by members of the family who are neither care-giver nor cared-for.¹⁹⁹ This sort of practice is unjust and it leads to failure of care. Nevertheless, it is not always possible for a member or some members of the family to assert their rights and remain within relationships which form individuals into a family. For instance, when a parent threatens to cut ties with a son or a daughter who refuses to marry the spouse chosen by the parent, or when parents threaten to severe the ties if a child refuses to follow the career path chosen by the parents. The child in each case may
be morally justified to choose his or her rights over family ties. However, to expose a family member to such a situation where a choice has to be made between family ties and one’s rights is uncaring and unjust. In good caring relationships among family or friends, it should be possible to resolve such issues through civil discussion.200

Rights as non-interference can amount to neglect, especially for the powerless, and even among equals it can be isolating and alienating. Therefore, rights are not quite good for relationships of family, friendship and, to some extent, civic organizations.201 However, there can certainly be room for competition, the pursuit of self-interest, and for the assertion of rights requiring equal treatment and respect in the caring relationships of family and friends. The problem arises when this pursuit of self-interest and the assertion of individual rights overcome all interactions within the family. The group might disintegrate but, if it survives, the people will no longer be genuine friends or members of the caring families.202

Concerning rights in the context of civic or political organizations, that is, rights in the context of the state or society, there is a consensus that rights are suitable for caring relationships of these civic organizations. However, some care ethicists, such as Held and Joy Kroeger-Mappes, argue that caring relations and social connectedness are prerequisites and are required as both a base and a context for rights (ethic of rights). Other care ethicists, such as Nedelsky, proffers an understanding of rights as relationships and as a conditio sine qua non for rights in the context of caring relationships of civic or political entities as well as families and friendships. For Kroeger-Mappes, ethics of care and ethic of rights (as she prefers to call “rights”) are an integral part of one system of ethics wherein ethics of care is a necessary base or foundation for the “ethic of rights.”
Kroeger-Mappes argues that ethics of care being a necessary base for ethics of rights is a philosophical thesis which reveals “at a theoretical level, moral relationships within social reality.”

Held critically challenges the understanding of rights in liberal and dominant or traditional moral theories. She set out to delineate an account of rights that will fit within a globalized ethics of care. In the process she considers the preconditions of rights and what rights presuppose. She argues that to have respect for rights, especially human rights of all persons everywhere, first and foremost, there has to be a feeling or sense of social connectedness with other peoples whose rights are being recognized. Likewise, there is need for the development of the capacity for and the practice of caring about all other fellow human beings in order to recognize and respect their rights. Even to recognize others as members of a society or citizens, the members of the society have to trust each other and care enough about one another. Having recognized others as fellow citizens, as part of “the group of us,” the group can fight together for their rights. It follows, then, that for “a working legal system to protect their rights, citizens must acknowledge others as also citizens of the same system.” Held thinks that this has an analogy in normative priority and not simply a mere empirical pre-condition. If the members of society, or citizens, give priority to the assertion of individual rights against those of others, and to the pursuit of economic, political, and cultural interest, over and above the citizens’ interactions, that society will disintegrate. It will cohere no more. It is necessary, then, that the pursuits take place within social relationships of a sufficiently caring kind, as well as with enough recognition of the moral values of such relationships. A caring society creates practices that foster “caring activities, considerate discourse
throughout the society,” and reduces the “pressure for political conflict and legal
cohesion,” and the “commodification of and the commercial competition over much that
has value.” Thus, Held concludes that rights presume a background of social
connectedness or solidarity based on caring that has value.206

While Held asserts that rights and respect for rights work only in the context of
caring relationships or in the context of relationships of social connections, Nedelsky
goes beyond that. She calls for a rethinking of the concept of rights and of all rights. She
proffers the understanding of all rights as wells as the concepts of rights in terms of
relationship. She argues that seeing all rights and concepts of rights as relationship offers
a better way of solving rights problems.207 However, she does not advocate abandoning
the use of the term “rights.” Rather, she thinks that it is not only useful to continue using
the term “rights,” but that there is also an institutional commitment to use it. Nonetheless,
if rights were to be employed to constrain democratic outcomes, Nedelsky asserts that
people should use rights in a way that “is true to the essentially contested and shifting
meaning of rights.” She insists on the need to confront the history of rights and
acknowledge the depth of the changes that have occurred in both legal and popular
understandings of rights. These changes include the understanding of equality rights few
years ago wherein the great restrictions on both legal rights and actual opportunities for
women were taken to be consistent with the basic equality for all.208

Thus, a good working concept of rights is to encompass any ongoing
disagreement and discussion in a given society regarding the meaning of rights and its
concept; for instance, the meaning of equality and how it fits with the understanding of
property, contract, and the legal foundations of equality. According to Nedelsky, rights
always construct a relationship of power, of responsibility, of trust, and of obligation.

Similarly, rights as in property rights, contracts, and family law all structure relationships. She exemplified her assertion with property rights, arguing that they are about relations and limits on the use of things rather than about things. They draw attention to how people can use their power of ownership and their responsibilities with respect to others’ well-being. They define fiduciary relationships:

…property rights are not primarily about things, but about people’s relation to each other as they affect and are affected by things. The rights that the law enforces stipulate limits on what we can do with things depending on how our action affects others…and what responsibilities we have with respect to others’ well-being (for example, tort law and landlord-tenant law). In the realm of contract, the law takes account of relationships of unequal bargaining power, and it defines certain parameters of employment and of landlord-tenant relationships.209

Nedelsky admits that rights have been criticized as “undesirably individualistic,” as obfuscating “the real political issues,” and as serving “to alienate and distance people from one another.” However, because Nedelsky asserts that all rights -indeed, the very concept of rights- are best understood in terms of relationship, she, therefore, concludes that conceptualizing rights in terms of the relationships that they foster and structure will radically transform the problem of individualism and other criticism levied on rights.210

The problem with individualism which rights are accused is that “it fails to account for ways in which our essential humanity is neither possible nor comprehensible without the network of relationship of which it is a part.”211

Furthermore, Nedelsky continues to bring to bear on the concept of autonomy the idea of rights as relationships. The Anglo-American or Western liberals’ concept of autonomy and rights are such that they are described in terms that fits into the idea of autonomy as independence, requiring protection and separation from other people. Rights are seen as defining boundaries that other people cannot cross. These are boundaries that
are enforced by the law to guarantee individual freedom and autonomy. Nedelsky thinks that this is a misguided view of autonomy, because, as she noted above, 3. C. 5. Individual Patient Rights, what makes autonomy possible is not separation or isolation but relationships. Seeing rights as relationships shifts the interest from protection against other people to structuring relationships in order that they foster autonomy. “The human interactions to be governed are not seen primarily in terms of the clashing of rights and interests, but in terms of the way patterns of relationship can develop and sustain both an enriching collective life and the scope for genuine individual autonomy.” This means, therefore, that the constitutional protection of autonomy is no more an effort to carve out an area into which the collective other people cannot intrude. It becomes a means of structuring the relationship “between individuals and the sources of collective power” in order that autonomy be nurtured instead of undermined.

Although some theorists canvass for group rights, rights --legal or moral-- are “usually thought to attach to persons as individuals.” In liberal thinking, and in dominant moral theories, rights draw attention to individuals, albeit the respect for rights may presume a social context. Annette Baier testifies to this: “the language of rights pushes us…to see the participants in the moral practice as single, clamorous” individuals. Thus, there is emphasis on individual rights to decision-making in health care. Western liberalism privileges decisions of informed consent by the individual. Ethics of care on the other hand, focusing on caring relationships between persons and families instead of on individuals and their rights and possessions, questions the emphasis on the individual in decisions of informed consent. The legal system has used rights -
individual rights- to institutionalized power of men over women, and rights authorize the male experience of the world. As Catherine Mackinnon observed:

> In the liberal state, the rule of law --neutral, abstract, elevated, pervasive-- both institutionalizes the power of men over women and institutionalizes power in its male form ... Male forms of power over women are affirmatively embodied as individual rights in law ... Abstract rights authorize the male experience of the world.²¹⁷

> Rights are seen, especially, by some feminist ethics of care advocates, as “inherently abstract and reflective of a male point of view.”²¹⁸ They note that the law helps to build and enshrine rights. The law considers and treats persons as self-contained individuals rather than as the relational persons of ethics of care.²¹⁹ This is the type of person whose rights the law projects as reflecting social reality and which able to decrease actual oppression and injustice. This is seen in the elevation of the rights of women. However, rights are not fixed but are contested. Political and social “struggles” are often staged, rather well, around “indignation,” that is, dissatisfaction and widely felt over clear denials of rights and persuasive reasons to recognize new rights. Some of the rights guaranteed by law are yet to be granted or accorded to women, or minorities. While the discourse of rights, justice and equality should not be abandoned, it should be borne in mind that these form one framework among other frameworks of moral discourse. They should not be the privileged or the dominant framework because there is the caring relationship of ethics of care.

> The ethics of care concept of relational autonomy arising from the understanding of persons as relational and interdependent links it to the African understanding of autonomy and, thus, of informed consent. The next chapter examines this issue beginning with a general overview of African traditional medicine.
3. D. Summary

In view of the next section, Chapter Four, the systematic analysis of ethics of care as a hermeneutic to interpret ATM was undertaken in the present Chapter Three, beginning with the origin of ethics of care from the Feminist Movement, Male Voices of their supporters, and Alternative Feminist Moral Theories. The meaning of ethics of care was described paying special attention to its relation to labor, practice and value, relationships, justice and particularity. Caring is shown to create and fosters relationships, thus elucidating the concept of person as a relational being who is interdependent and particular. Because ethics of care emphasizes relationships and interdependence, it understands autonomy in terms of relationships wherein autonomy is developed and fostered in relationships with others. Consequently, ethics of care explains informed consent in terms of relational autonomy, hence RAIC. This is contrary to liberal individualistic belief that autonomy is achieved in isolation from others. Furthermore, this Chapter examined ethics of care insistence that emotions play an important part in moral decision-making, also contrary to liberal individualistic belief that emotions are to be avoided in order to make a good moral decision, because, for liberals, emotions have negative influence on moral decision-making. Finally, the Chapter examined ethics of care understanding of rights, including patient rights, in terms of relationships. As a result of RAIC and the concept of rights in terms of relationships, ethics of care does not place too much emphasis on individual patient rights and autonomy in medical decision-making and informed consent. This, too, contrasts with liberal individualism’s emphasis on individual patients’ rights and autonomy in informed consent. Therefore, using ethics of care as a hermeneutic analysis of ATM, the subsequent Chapter will demonstrate that
ATM practices RAIC and places emphasis on relationships and understands autonomy in the context of relationships.
3. E. Endnotes

4 Aristotle, 1984, 1134a1-7, p.1784; and 1094b19-21, p.1730.
6 Held, The Ethics of Care, 22-28.
8 Tronto, Moral Boundaries, ix.
9 Held, The Ethics of Care, 23.
10 Held, The Ethics of Care, 23.
11 Held, The Ethics of Care, 24.
12 Held, The Ethics of Care, 24.
13 Blum, Friendship, Altruism, and Morality, 43.
14 Blum, Friendship, Altruism, and Morality, 43-44.
15 Williams, Ethics, 1-2.
16 MacIntyre, After Virtue, 239ff.
17 MacIntyre, After Virtue; also, Edel and Flower, “Review of After Virtue,” 426.
18 Slote, Goods and Virtues, Chapters 1-3.
19 Slote, Goods and Virtues, Chapter 4. See also comments by Piper, Review of “Goods and Virtues, 469.
20 Held, The Ethics of Care, 172-73, endnote no. 51.
21 Held, The Ethics of Care, 26; Jean Hampton, “Feminist Contractarianism,” 300ff; Baron, Kantian Ethics, 117-226; and Purdy, Reproducing Persons, 1-34.
22 Held, The Ethics of Care, 25-27.
24 Held, The Ethics of Care, 22-27.
29 Held, Feminist Morality, 67ff.
30 Gilligan, In a Different Voice, 165ff.
31 Gilligan, In a Different Voice, 167.
33 Slote, The Ethics of Care and Empathy, 11.
34 Noddings, *Caring*, 69.
35 Noddings, *Caring*, 69.
36 Slote, *The Ethics of Care and Empathy*, 11.
40 Held, “Taking Care,” 60.
41 Bubeck, *Care, Gender and Justice*, 129; also, Held, *The Ethics of Care*, 32.
42 Fisher and Tronto, “Toward a Feminist Theory of Care,” 40; see also Tronto, *Moral Boundaries*, 103.
44 Tronto, *Moral Boundaries*, x.
48 For “Particularity and Irreplaceability” and “Particularity and Relationship” see Po-wah, “Is Just Caring Possible?, 46-47; see also, Sin, Chan, 1993, *An Ethics of Loving: Ethical Particularism …114, Cited by Po-wah, “Is Just Caring Possible?.
49 Held, *The Ethics of Care*, 33.
50 Bubeck, *Care, Gender, and Justice*, 131.
51 Held, *The Ethics of Care*, 33.
52 Bubeck, *Care, Gender, and Justice*, 134ff.
53 Held, *The Ethics of Care*, 32.
54 Held, *The Ethics of Care*, 33.
57 Clement, *Care, Autonomy, and Justice*, 37.
58 Bubeck, *Care, Gender, and Justice*, 132; and Held, *The Ethics of Care*, 32-33.
59 Noddings, *Caring*, 9. She sometimes refers to caring as “caretaking” and sometimes as “caregiving.” Noddings, *Caring*, 9; and Noddings, “A Response,” 120-126; 125, respectively; and Bubeck, *Care, Gender, and Justice*, 152.
60 Bubeck, *Care, Gender, and Justice*, 152-3.
61 Noddings, *Caring*, 69ff.
62 Clement, *Care, Autonomy, and Justice*, 36ff; and Gilligan, *In a Different Voice*, 317ff.
66 Kittay, “The Ethics of Care,” 53.

160
67 Tronto, Moral Boundaries, 126-7.
68 Held, The Ethics of Care, 41-42.
70 Held, The Ethics of Care, 38-39; see also Tronto, as shown above, section 3. B. 2.
71 Held, The Ethics of Care, 40.
72 Held, The Ethics of Care, 38.
73 Held, The Ethics of Care, 38-39.
74 Held, Feminist Morality, 169-170.
75 Gilligan, “Moral Orientation,” 24; Gilligan, “In a Different Voice,” 317; and Clement, Care, Autonomy, and Justice, 36.
76 Held, The Ethics of Care, 42-43.
77 Gilligan, Moral Orientation, 24; see also Held, Feminist Morality, 169-170.
78 Noddings, “A Response,” 124-125. See also Clement, Care, Autonomy, and Justice, 37.
79 Clement, Care, Autonomy, and Justice, 41.
80 Clement, Care, Autonomy, and Justice, 35.
82 Gilligan, “In a Different Voice,” 329; and Clement, Care, Autonomy, and Justice, 38 and 41-3.
83 Held, The Ethics of Care, 36.
84 Slote, The Ethics of Care and Empathy, 94-100.
85 Held, The Ethics of Care, 68.
87 Held, The Ethics of Care, 40.
88 Held, The Ethics of Care, 69.
89 Held, The Ethics of Care, 68.
90 Slote, The Ethics of Care and Empathy, 96-100.
91 Slote, The Ethics of Care and Empathy, 94.
92 Slote, The Ethics of Care and Empathy, 100.
93 Held, The Ethics of Care, 36-41.
94 Held, The Ethics of Care, 41.
95 Sander-Staudt, “Care Ethics.” Online.
96 Sander-Staudt, “Care Ethics.” Online.
97 Held, Feminist Morality, 68.
98 Kittay, “The Ethics of Care,” 54; also Beauchamp and Childress, Principles of Biomedical Ethics 5th ed., 374-75.
99 Kittay, “The Ethics of Care,” 54.
101 Noddings, Caring, 2. See also “Ethics of care,” New World Encyclopedia.


104 Po-wah, “Is Just Caring Possible?” 46-47.

105 Held, *The Ethics of Care*, 45.


110 Oshana, “Personal Autonomy,” 81-102. See also Friedman, “Autonomy, Social Disruption,” 40ff.

111 See Held, *The Ethics of Care*, 47.

112 Meyers, “Narrative,” 292.

113 Held, *Feminist Morality*, 190-1.


128 Locke, *Two Treatises*, Paragraph 74.


137 Kittay, Love’s Labor, xi.
141 Baier, “Pilgrim’s Progress,” 315.
148 Baier, “Hume, the Women’s Moral Theorist?” 56. See also Kroeger-Mappes, “The Ethic of Care vis-à-vis the Ethic of Rights,” 112-3.
150 Po-wah, “Is Just Caring Possible?” 49.
151 Beauchamp and Childress, *Principles of Biomedical Ethics*, 376. Ethics of care with its emphasis on relationships fits this context of relationships better than the liberal rights theory which is poorly equipped for such relationships.
154 Kittay, “The Ethics of Care,” 54.
158 "Ethics of care," New World Encyclopedia, Online.
159 Groenhout, *Connected Lives*, 33-34.
164 Clement, *Care, Autonomy, and Justice*, 22.
165 Clement, *Care, Autonomy, and Justice*, 23.
166 Clement, *Care, Autonomy, and Justice*, 24.
170 Nedelsky, “Reconceptualizing Autonomy,” 10 and endnote no. 10.
175 Held, *Feminist Morality*, 51-52.
180 Kant, *Fundamental Principles*, 69.
189 Slote, *The Ethics of Care and Empathy*, 91, endnote no. 32.
191 Beauchamp and Childress, *Principles of Biomedical Ethics*, 5th ed., 374. This is traceable to Hume.
192 Curtin, “Towards an Ecological Ethic of Care,” 60-74; see also Cockburn, “Children and the Feminist Ethic,” 84.


197 Held, *The Ethics of Care*, 134.


200 Held, *The Ethics of Care*, 134.


204 Held, *The Ethics of Care*, 125.

205 Held, *The Ethics of Care*, 136-137.

206 Held, *The Ethics of Care*, 137.


211 Nedelsky, “Reconceiving Rights,” 12; see also p.12, b.


213 Nedelsky, “Reconceiving Rights,” 8


218 Held, “Rights,” 504

219 West, “Jurisprudence and Gender,” 1-72; and Held, “Rights,” 507.
 CHAPTER FOUR
COMPARATIVE ANALYSIS OF ATM WITH ETHICS OF CARE

This chapter provides a comparative interpretation of ATM with ethics of care. The analysis provides an explanation of ATM as adopting a relational approach to informed consent (RAIC). In this discussion, the ethics of care movement provides the hermeneutic to enlighten the significance of the ATM approach as a legitimate model of RAIC. In order words, ATM exhibits practices similar to those of ethics of care, such as focusing on relationships, maintaining that persons are relational beings who are socially constituted in a community, and exercising autonomy in relationships with others in the community.

As a preamble, it is worth noting that there are limitations in speaking of African culture as if it were one homogeneous culture. There is cultural diversity in Africa ranging from East to West and from North to South. However, there is a valid overall African ethos which characterizes the commonalities of societies within Africa. The areas of such commonalities include value systems, beliefs, and practices. There is a common belief in a Supreme Being, ancestors, emphasis on the values of communal living, on relationships, etc. These areas chiefly reflect the African worldview.¹

4. A. An Overview of ATM

Long before the arrival of modern or allopathic medicine, there existed systems of knowledge and practice of medicine that are indigenous to different continents, countries, societies and ethnic groups of the world. In other words, these medicines and healing practices belong to the traditions of each country or continent or ethnic group, and are, therefore, called the “traditional medicine.” They are also referred to as “indigenous” or
“folk medicine,” although the name “traditional medicine” is used more than the other two. Thus, this dissertation uses the name: “traditional medicine.” There are traditional medicines of Asia, Africa, Europe, Americas North and South. There are also Chinese, Korean, “Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Irani, Islamic medicine, traditional Vietnamese medicine … Muti, Ifá, traditional African medicine, and many other forms of healing practices.”

Traditional medicine developed over many years and was passed on from generation to generation, often without documentations, but with sophisticated systems of knowledge. Although for thousands of years traditional medicine has been attending to the medical needs of large percentage of world’s population, for example, eighty percent (80%) of Asians and Africans utilize it for their medical care. Yet, it has been less studied or researched, especially for documentation. However, more recently, WHO is engineering interests in the study, documentation, and development of national policies for the “evaluation of practices and examination of the safety and efficacy of remedies, to upgrade the knowledge of traditional and modern health practitioners, as well as to educate and inform the general public about proven traditional health practices.”

4. A. 1. Representative Ethnic Groups

As stated above, (Section 4A), traditional medicines are indigenous to both countries and ethnic groups of a continent and the world. Because there are many such ethnic groups in the continent of Africa, and moreover, the scope of this dissertation does not permit the study of each and every one of these ethnic groups, four of them have been chosen. Therefore, this section focuses on the four representative ethnic groups of Africa as delineated in Chapter One: the Akan, the Hausa-Fulani, the Igbo, and the Yoruba.
i. The Akan

The Akan are a broad ethnic group with a number of subgroups: Akuapen, Akyen, Asante, Brong-Ahafo, Fante, Kwahu, Nzema of Ghana and the Baule and Anyi of the Ivory Coast. In Ghana, the Asante and Fante are the two largest subgroups. The Akan possess a common language, Twi, which has coalesced with a large group that is part of the greater Kwa subfamily of West African languages. The Akan also possess a matrilineal system in which the ancestral line is traced through the mother. One’s father’s wealth is inherited by one’s cousin. In other words, one inherits not one’s father’s property but that of one’s mother’s brother. The lineages possess a symbolic stool or chair which is named after the female founder of the line. This stool is a mark of their social autonomy vis-à-vis other groups. Usually, there are two stools: the king’s stool or ohene adwa and the queen mother’s or ohemmaa adwa. Even though there are two stools, the queen mother’s stool is the senior stool and has priority of place over the king’s because the queen mother is believed to be the founder of the Akan community. According to one of the women whom Fiona Araba Gibson interviewed during the course of her doctoral research:

To explain further, in our Akan communities, for that matter, in this Fanti land, we believe that women are the owners of the land, the sole founders of the Akan communities. The old lady, simply is the Queen Mother, who is the founder of the Akan society, literally, this is the meaning of the word the ‘Old Lady.’

The culture of the Akan people of West Africa dates from before the 13th century. Similar to other long-established cultures the world over, the Akan have developed a rich conceptual system complete with metaphysical, moral, and epistemological aspects, and their universe is essentially spiritual. All animate and inanimate things within their universe are blessed with a varying degree of sunsum. They have a belief in a Supreme
Being, *Nyame*, or “Mother Earth,” or *Asase Yaa*, and a host of intermediary deities or *abosom*. The *abosom*, on the other hand, are messengers from the *Nyame*. They reverence the ancestors, *Nzemanfo*. Because of their belief that the universe is endowed with *sunsum*, the Akan consult the ancestors, *Nzemanfo*, prior to making and acting on many daily decisions. The Akan also believe that the ancestors maintain important functions in each person’s life, even though these ancestors no longer occupy physical space on earth. One of the ancestors’ most important roles is being direct messengers to *Nyame*, the Supreme Being. The ancestors are believed to bring good fortunes to the living, especially to members of their lineage. However, if the ancestors are dissatisfied with the lineage, they manifest their displeasure by causing ill fortune and/or sickness. Thus, illness has a spiritual dimension. Even though the Akan share several cultural traits, and the political, social, religious, and customary practices are similar, each clan has its own history and customs.

ii. **The Hausa-Fulani**

Traditionally, the Hausa-Fulani society consists of two different cultures that gradually combined after the Islamic Fulani conquest in the nineteenth century. In 1821, when the Islamic Fulani conquered the Hausa kingdom, there were intermarriages between the two groups and the consequent learning of each other’s language and culture. The Hausa-Fulani are found in West Africa: Northern Nigeria, Southern Niger Republic, Senegambia, Benin Republic, Ivory Coast, Chad, Cameroun, and Guinea. The Fulani population that is semi-sedentary and semi-pastoral are scattered over the West African Savannah belt, namely, Senegal, Gambia, Guinea, Mauritania, Sudan, Ivory Coast, Chad, Cameroun, Ghana, Bissau, Benin, Dahomey, etc. The sedentary communities are found
Hausa-Fulani communities live in family groups in compounds’ or *gida*, in Hausa, with a compound head, a *maigida*, who is usually the oldest man.  

The Hausa were in the process of expansion for many centuries. Much of the expansion was peaceful, because of Hausa skill at statecraft and commerce which was built on family relationships and negotiations. The web of relationships is linked by patrilineal family ties and is organized around male figures. In their political organization, the Hausa-Fulani are ruled by feudal kings called emirs, a title given to Muslim religious and political leaders. The emir has subordinate chiefs, *alhaji* (i.e. one who has done the haji) and local rulers, who are responsible for the administrative supervision of the communities. They also help to maintain social harmony and peace within the communities. While these rulers are predominantly males, the situation appears to be different in the pre-colonial era. Zainab Kabir noted that the status of women was high in early Hausa society because women were not confined and interacted freely with people. They married at a later age than is currently common among the Muslim Hausa. They were important members of the *bori* cult, possessed a significant role in both domestic and community religious rituals, and held titles such as *bori magadiya*, that is, Bori cult leader. Some groups of Hausa had matrilineal inheritance. There were possibilities of women being queens or titleholders. An example is the famous warrior queen Amina. She was one of the many great queens, according to Kabir.  

Furthermore, the Maguzawa or the Hausa that follow traditional religion allowed and still allow greater privileges for women. Their women are freer to go out in public.
The Maguzawa do not practice wife-seclusion at all, while the Muslim Hausa-Fulani do practice it. Wife-seclusion helps to distinguish the Muslim Hausa-Fulani from their neighbors, hence, serving as ethnic boundary marker. Historically, the Hausa-Fulani ruled over local ethnic groups, and these subject ethnic groups were not Muslims, thus, their women were allowed greater freedom. Wife-seclusion and control of women were adopted as essential in the structuring of ethnic relations and in the maintenance of ethnic boundaries.\textsuperscript{12}

Among the Fulani are the Holy men, barka, who act as intercessors. They earn their holiness by genealogy or from their teachers, prophets of Islam. Ultimate holiness comes from Allah, God. These holy men perform a variety of functions including trading, craftsmanship, divining, healing, and providing medicine, which includes amulets. The people use and respond very well to herbal medications such as lekki bale and lekki porto, that is, black and white medicines, respectively. According to Gordon and Sall, the time and choice of treatment, shame and concern for others’ opinions contribute very much to the treatment decision of Fulani patients. In their time of illness and in seeking treatment, patients suffering from bluuri-mmhuuru, the mother of all illnesses, tend to focus on God and on other peoples’ opinions. Shame and fear trigger the desire to be discreet and dignified in order to live up to pulaaku. Pulaaku is the essence of being Fulani, or the foundation of the Fulani self-image, that is, dignity, self-control, patience, self-sufficiency, and religiosity.\textsuperscript{13}

The Fulani feel a close relationship with God, especially in times of sickness when there is no one else to turn to. In Gordon and Sall’s interview with Fulani patients, men recounted how they turned to God, Allah, when ill. According to Gordon and Sall, in
everyday conversations, one hears that the fate of events and healing is in God’s hands, insha Allah (Arabic) or si Allah dyabbi (Fulani-Hausa). Sickness, especially mental illness, is seen as a result of spirit possession, or bori possession.

iii. **The Igbo**

The Igbo people are one of the major ethnic groups of Nigeria. The tropical forest areas of South Eastern Nigeria are their traditional home, but many Igbo people are in diaspora. They are patrilineal, although the filiation of physical life and heredity is bilineal. The Igbo say, ndị igbo na-eri na nna, ma na-ebi, na-erikwa n’ibe nne na n’ibe nna, i.e., the Igbo share a paternal bloodline and also live and derive from both the paternal and maternal lines. They possess a common culture and language, Igbo or asụsụ igbo, which belongs to the Niger-Congo language cognate group with Yoruba, Tiv, and Effik. This is the Kwa language family of forest dwellers. Their society is arranged into families, villages, and lineages. The family is headed by the father assisted by the wife. Beyond the parental authority, the first born male, diọkpara, and the first female child, ada, possess authority over other siblings in the family. Groups of families form a village community, umụnna, that is, members of the same patrilineage, because they are descendants of the same founding ancestor after whom the community is often named. The community is the central social unit of Igbo society. It is the realm of communal conduct of affairs independent of the elders or some distinguished group who convene in order to make decisions by consensus. The community forms the Igbo system of government in which the kinship functions bilaterally, that is, by making for umụnna politics as well as the expression of social democracy.
The Igbo people are deeply religious. This was testified to by a British Divisional Officer responsible for the Southern Nigeria in the 1900s. According to him, the Igbo people are in the strict and natural sense of the word a truly and a deeply religious people, of whom it can be said that they eat religiously, drink religiously, bathe religiously, dress religiously, and sin religiously. In a few words, the religion of these natives as I have all along endeavored to point out is their existence, and their existence is their religion.²¹

Today most Igbo are Christians with few traditional African religious worshipers and few Muslims.

Besides the general Igbo who are patrilineal, there is a section of the Igbo that is matrilineal. Daryll Forde and Gwilym Iwan Jones refer to this group as the “Cross River Igbo.” They are located immediately to the west of the Cross River. The Cross River Igbo include the Ihe, Aro, Abam, Abiriba, Nkporo, Ada, and Ohaffia. They differ from the rest of the Igbo in their system of kinship and marriage, in their rules of inheritance and succession, and in the forms of their men’s associations and cults.²² There are two recognized descent groups or systems: the matrilineage and patrilineage. The matrilineage is an exogamous group as well as the main property-inheriting and land-owning group, especially in the Ohaffia area. The matrilineal Igbo claim common allegiance from the ancestress for whom the group is named. The patrilineage is also an exogamous group, and their residence is patrilocal. The patrilineages are territorial units.²³ Unlike the rest of the Igbo, there are no ritual staves of headship, ofọ, ikenga, and other typical Igbo religious deities, as well as symbols among the Cross River Igbo.

In governance and decision-making, there is dual headship in matrilineage. For example, the Ohaffia have two heads, a male and a female head. The male head performs secular duties, settling disputes, protecting the rights and interests of members in the land
or estate and resources. On the other hand, the female head performs sacred duties. The duties are ritual in character, such as making sacrifices to the sacred pot, ududu, among the Ohaffia. Each of the ududu represents an ancestress. In matrilineage, a male cannot be the ritual head of the ancestress. The women have their traditional law-keeping body, the ikpirikpe. It is responsible for handling of the affairs of the women (i.e., adult women) of the village. It operates independently of the men. Only ikpirikpe can deal with the affairs of women, especially the offences committed by women. For instance, according to Nsugbe, in the case of adultery, the men’s age grade/group, umyaka judges and penalizes the man involved but not the woman. It is the women who deal with the female accomplice to adultery.24

In general decision-making and overseeing the family, the village and community revolve around the men. In Ohaffia, for instance, the most powerful body is the umyaka men’s age grade. They are recruited by the age grade immediately above (ndi ichin, the retiring elders). The members of umyaka are chosen on the basis of their character and achievement. No women are recruited into this group.25 However, the ikpirikpe women group can challenge the decision of the male age group. Though the village head, eze-ogo, is male, he does not run the affairs of the community, at least not openly. He neither attends village meetings nor presides over them. As Nsugbe puts it, the primary function of the village head is “a fearless emissary: heading delegations, sometimes on behalf of the whole of Ohaffia, to government ministers, and high-ranking officials of his region.”26 One can say, therefore, that his function as the community head is external relations. In village and community meetings/assemblies, decisions are made by seeking and reaching consensus as is the case with the Igbo.27
iv. **The Yoruba**

Like the Akan and Igbo, the Yoruba belong to the *Kwa* language group. The Yoruba are one of the largest ethno-linguistic groups in Africa. They are home to Southwestern Nigeria, South Eastern Benin, Togo, Sierra Leone, and Southeastern Ghana. But the main concentration is in Nigeria where they form the majority ethnic group in about a third of the thirty-six (36) states of the Federal Republic of Nigeria. Because of the slave trade and migration, there are many Yoruba in diaspora. Such is the case of Brazil, Cuba, and the Caribbean. Similar to other Africans, the Yoruba are deeply religious people, believing in a Supreme God, *Olorun*, or *Oludumare*. For the Yoruba, everything is imbued with the sacred. Traditionally, right actions are to be achieved through ritual and sacrifice as recommended by the *ifa* oracular and divinatory corpus. The belief is that one should consult *ifa* prior to any of life’s major undertakings. *Ifa* will then prescribe the appropriate rituals and realization of the correct results. *Ifa* makes its prescription through the *babalawo* or the shaman. Like the Hausa-Fulani and the majority of the Igbo, the Yoruba are patrilineal. Today, most Yoruba are either Muslims or Christians. Islam is favored as more compatible with the traditional culture of the people, as, for example, in allowing polygyny. Similarly, Islamic medicine is seen as sharing characteristics with the religio-medical system of the Yoruba. Like the Akan, Hausa-Fulani, Igbo and other ethnic groups in Africa, there are dual medical systems, indigenous or ATM, and the Western medical system. Both systems have been in competition since the introduction of Western medical system by the European colonizers and the missionaries.
4. A. 2. Meaning and History and Interesting Developments in ATM

It was Bob Marley the great reggae musician who said in his song: *Buffalo Soldier:*

If you know your history,  
Then you would know where you coming from,  
Then you wouldn't have to ask me,  
Who the 'eck do I think I am.\(^{31}\)

It makes sense, therefore, to spend some time in this section to trace the history and meaning of ATM. This will help situate and give foundation to the study of informed consent in ATM. This section will also explore some interesting developments that are helping to strengthen and foster ATM practices and better patient care.

i. Meaning and History of ATM

According to J. O. Mume, traditional medicine is the transmission verbally and “by example (of) the knowledge and practice based on customary methods of natural healing or treatment of disease.”\(^{32}\) Abayomi Sofowora understands traditional medicine as “the total combination of knowledge and practice, whether explicable or not, used in diagnosing, preventing, or eliminating a physical, mental, or social disease, and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing.”\(^{33}\) One can say that the term “African Traditional Medicine” (ATM), describes the medical practices and knowledge that existed before the arrival of the allopathic or modern Western style medicine on the African continent. It is transmitted either verbally, through practice, or in writing. The system incorporates the use of plants, animals, and mineral-based medicines, spiritual therapies, manual techniques, as well as exercises, diagnosis, treatment and prevention of illness, as well as
maintenance of health and well-being. ATM concern is for the well-being of both the individual and the community.

For thousands of years a majority of the world’s population had used and continues to use the traditional method of healing and medicine. Similarly, the African people have used methods of healing suited to Africa. These methods evolved over millions of years interchanged with other regions such as the Mediterranean and these predate Western medicine in Africa. It is recorded that the ancient Egyptian medicine reflects African impulses, and has shaped ideas of neighboring civilizations, especially the medicine of classical Greek and Roman antiquity. Before colonization, ATM had come into contact with other medicines such as those of the early Christian faith healing that moved across North Africa and Egypt, the Mediterranean, Persia, Arabia, classical Greek and Roman antiquity, as well as those of Islam. Some of the medical practices associated with such contacts include hot/cold thermal (humeral) treatment, balance exercises, and homeopathy. By the early second millennium CE, these types of traditional medical practice were already known in the African Savannah countries.

By far colonialism brought about the largest contact between Europe and Africa, and between Western or allopathic medicine and ATM. This contact exposed Africa to the Western cultural socioeconomic system and to institutions such as education, health care, and legal systems. Unlike earlier contacts, intercourse with Europe via colonialism was unequal, forced, unbalanced, and protracted. Africans were subjected to Western cultural systems against their will. While colonialism had some positive effects, such as education, it, by and large, belittled, demeaned, and in some cases eroded existing traditional socioeconomic, religious, and medical beliefs and practices. ATM and its
practices were either forbidden or ridiculed by the colonizers as crude, unimportant, and devilish, even as witchcraft and quackery. Under colonial rule, ATM-practitioners in some areas were accused of practicing witchcraft and were, therefore, outlawed. Although modern or Western medicine was introduced to help the people, it was also designed to displace ATM and to eliminate the traditional healing system as a political and medical authority and advisor to the political leadership. For example, it has been noted that in Botswana, Tswana medicine was stamped out by the missionaries because, as a system, it was a major ideological, moral, and political force capable of inducing collective rejection of the missionaries and their ways. Consequently, doubts were raised about the authenticity of African traditional heritage and practices. David Lamb, an American journalist writing on the impact of colonialism on Africans rightly observed that,

The colonialists left behind some schools and roads, some post offices and bureaucrats. But their cruelest legacy on the African continent was a lingering inferiority complex, a confused sense of identity. After all, when people are told for a century that they’re not as clever or capable as their masters, they eventually start to believe it.

After independence, while some African countries continued to look down on or even ban ATM, some African governments promoted and continued to promote ATM. In Mozambique, for example, after its independence in 1975, diviner-healers were sent to re-education camps. In South Africa, at the time of Apartheid, the 1974 Health Act together with “its 1982 amendments restricted traditional healers’ performance of any act related to medical practices.” These laws notwithstanding, ATM in its resilience, survived the Apartheid era. It was utilized at all educational and socio-economic levels. When the African National Congress (ANC) became the ruling government in 1994, it formulated the White Paper for the Transformation of the Health System in South Africa,
which authorized traditional healers to form part of a wider primary health care group.\textsuperscript{42} In 2007, the government promulgated the Traditional Health Practitioners’ Act 22 to inaugurate the Interim Traditional Health Practitioners’ Council of South Africa. The council was charged with the responsibility to regulate the registration, training and practice of practitioners, and to protect people who utilize ATM services.\textsuperscript{43} This 2007 Act was followed by the Traditional Healers Practitioners Code of Ethics of 2010.

In spite of all the colonial hostility, the difficulties and banning, ATM has survived albeit with some struggles. Now it is flourishing and, according to the World Health Organization (WHO), ATM serves about 80\% of the population of Africa.\textsuperscript{44} Reasons have been adduced for the success of ATM. For example, there are few Western medical hospitals and clinics in proportion to the population, and most of these hospitals and clinics are poorly equipped. Also, ATM adopts a holistic approach to health and illness, an approach that is at home in the local culture.\textsuperscript{45}

\textbf{ii. Interesting Developments in ATM}

Lately, WHO is promoting not only the practice of ATM but also the integration of both ATM and Western medical systems to serve the people better. People and governments in Africa are responding to WHO’s call. As a result, there are certainly some very interesting developments which include varying degrees of collaboration and integration of ATM and Western medical systems, political commitments, research institutes, and the formation of local, national and international professional organizations and associations of ATM practitioners. These have also been discussed by the author elsewhere.\textsuperscript{46}
Organizations and Associations

Because of the call and campaign made by WHO, the status of ATM doctors was enhanced. They began to collaborate more and to form support groups and associations. Such organizations and associations now abound and include the Association for Scientific Identification, Conservation and Utilization of Medicinal Plants of Nigeria (ASICUMPON); the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM); Traditional Medicine Healers Associations in Bulamogi County, Uganda, etc. These groups and associations share information regarding their experiences in the practice of both ATM and the materia medica. Such information concerns new herbs, medications, their uses, their therapeutic potency, their side effects, the etiology of diseases, and their treatment. The groups also facilitate the regulation, monitoring, and evaluation of ATM doctors and their practices. In other words, they serve as peer review.

Research Institutes

In addition to the formation of associations of ATM doctors, there are establishments of ATM training and research institutes such as Pax Herbal Clinic and Research Laboratories, St. Benedict's Monastery, Ewu-Ishan, Nigeria; Centre for Scientific Research into Plant Medicine, Ghana; Noguchi Memorial Institute for Medical Research, Ghana; Centre Expérimental de Médecine Traditionnelle (CEMETRA); PROMETRA Traditional Medicine Research and Treatment Centers (Promotion de Médecine Traditionnelle) etc. CEMETRA was founded in 1989 and is located in Founiougne, Senegal, with the permission of the Senegalese government but is sponsored by a Dutch institution, Nederlandse Organisatie voor Internationale Ontwikkelingssamenwerking (NOVIB). The centre has carried out several
multidisciplinary and cross sector-based research studies, both independently and in collaboration with African and American institutions, organizations, and universities. The research studies are intended or designed to promote and develop ATM. PROMETRA Centers, however, abound in various countries of Africa including Benin, Burkina-Faso, Cameroon, Democratic Republic of Congo, Gabon, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Mali, Mozambique, Senegal, South Africa, Togo, and Uganda.

PROMETRA is a non-governmental organization whose mission, like that of CEMETRA, is to promote and protect traditional medicine and indigenous science. It accomplishes this mission through scientific research, provision of traditional medicine services, education, training and advocacy, as well as scientific, cultural, and spiritual exchanges. It serves as an instrument for African integration and international relations.

The education and research centers and institutes bring ATM doctors and intellectuals together via seminars, studies, conferences, and various training sessions. There is a more intentional and controlled use of natural materials as well as laboratory analysis of medicinal plants. This has brought about more intensified use and an analytical understanding of the medicinal materials. There is also the classification (taxonomy), documentation, and publication of the medicinal plants as well as the resulting products. United Nations World Health Organization (UN WHO) is also involved and supports some of these organizations and centers in promoting ATM. WHO in collaboration with African member states has developed programs, policies, regulations, codes of ethics, and has published documents regarding ATM.
Political Commitments

Following the call of the World Health Organization to member countries to foster relationships between Western style medicine and ATM, the African Union (then Organization of African Unity) became involved. Thus, the African Heads of State and Government that met in Abuja, Nigeria, in April 2001 as well as in Maputo, Mozambique, in July 2003 declared that research on ATM used for the treatment of malaria, HIV/AIDS, and other infectious diseases ought to be made a priority in the continent of Africa. Given such declarations, in July 2001 the African Heads of state convened in Lusaka and designated the period 2001-2010 as the decade for ATM. Then, when WHO developed a *Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems*, the document was adopted in 2000 by the fiftieth session of the WHO Regional Committee for Africa in Ouagadougou, Burkina Faso. This strengthened the collaboration of WHO with the African Union and authorized WHO to develop and assist African committees in crafting and publishing model and real policy, regulatory and ethical codes regarding ATM. Consequently, many documents about ATM have been published and issued by WHO African Region. In addition, in response to the request of African member states, in 2002, WHO designated August 31st as the annual ATM Day. The first was commemorated with the theme: *African Traditional Medicine: Our Culture, Our Future*. Thus, there is a high level political interest in and commitment to ATM at both country, regional, (African Union) and WHO levels as noted above.

Federal and/or local governments in some countries of Africa have established some regulatory and monitoring systems for ATM and its practices. Such regulatory and
monitoring systems include the code of ethics and standards of practice. For example, in Ghana there is the “Code of Ethics and Standards of Practice for Traditional Medicine Practitioners.” This was issued by the Ghanaian Ministry of Health in October 2004 and sponsored by the Ghanaian National Drugs Programme. In South Africa, there are the Traditional Health Practitioner’s Act Number 22 of 2007, and the Traditional Healers Practitioners Code of Ethics of 2010. All of these, the Plan of Action for the implementation of the decade for ATM, the declarations and resolutions by political leaders, associations of practitioners, training and research centers etc, and the support of WHO and its partners further boost the development of ATM to the benefit of the immense majority of Africans who use ATM in meeting their health care needs.

However, there are also varying degrees of development in the relationship between ATM and the Western style medicine in Africa. There are countries where ATM doctors are not yet involved in the National System of Care, and there are no regulations for registration or licensing of ATM doctors. By 2001, some of these countries included Cape Verde, Comoros, Ivory Coast, and Seychelles. Then, there are countries that have established a system of registration for ATM doctors but do not officially legislate their practices. Likewise, these countries do not encourage participation by an ATM doctor in primary health care initiatives. As of 2001 the countries in this group were Angola and the Central African Republic. Finally, there are countries like Ghana, which have truly incorporated ATM into its primary health care. According to Mensah, about seventy per cent of Ghana’s population now depends exclusively on health care provided by approximately 45,000 ATM doctors. Most are recognized and licensed by various associations of ATM doctors. At the same time, these associations come under the
umbrella of the Ghana Federation of Traditional Medicine Practitioners’ Association. According to Romero-Daza, Ghana has not only incorporated ATM into its National Health Care System but has also passed decrees to regulate and ensure the safety of other traditional medical practices such as homeopathy, naturopathy, and osteopathy.

Finally, what do these developments mean for informed consent? The developments confirm that ATM is not a quack or illicit practice but an effective health care service recognized locally, nationally, and internationally. Thus, there is the call for its integration into the National Health Care System. These developments also confirm that ATM has a scientific base upon which it can be evaluated in the same way as the Western medicine by using empirical science. Thus, the pharmaceutical products of ATM are tested, regulated, and monitored, accordingly.

4. A. 3. ATM and African Traditional Religion (ATR)

In Africa, it is believed that health and illness are inextricably linked with the supernatural as well as with the biological and the psychosocial spheres. Disease and misfortunes are often understood as religious experiences. They require, therefore, some religious approach in dealing with them.⁵⁴ Among the Yoruba, for instance, people adopt a holistic approach to health, or Alafia meaning “peace.” It is a philosophy of life in which health and death are tied to the ATR.⁵⁵ This section explores the very important intimate connection between ATM and (ATR).

i. African Traditional Religion (ATR)

ATR is more or less a way of life for the community and permeates every aspect of African life: farming, hunting, love and courtship, marriage, birth and death, funeral, life after death, and medicine. Therefore, some knowledge or understanding of African
traditional religion is necessary in order to understand ATM better. First of all, ATR is not a revealed religion, at least not in the sense of Christianity or Islam. It does not have historical persons through whom the revelations come. It deals with the meaning of being human, the correlation between the physical and spiritual world, between suffering and evil, and between human actions in the present life and in their fate in the afterlife. ATR allows a belief in a genderless Supreme Being as a creator, guider, and protector. This Supreme Being is worshiped by prayers, invocation, sacrifices, offerings, as well as by songs and dance. In addition to the Supreme Being, there are divinities, spirits, and ancestors who are also worshiped or venerated, and who are believed to play various active roles in the health and well-being of the African people. Mbiti expressed the relationship as follows,

God is the originator and sustainer of human beings; the spirits explain the destiny of human beings; human beings are the center of the ontology; animals, plants, natural phenomena, and objects constitute the environment in which human beings live, provide a means of existence, and, if need be, human beings establish a mystical relationship with them.57

In ATR, it is said that the vocation and the power to practice medicine come from God, the spirits, or even from the ancestors; that the ATM-doctors are chosen either by the ancestors, or the gods, or the spirits.58 Among the Igbo people, for example, agwu is the patron spirit of doctors, whose persistent possession of an individual is a sign that one is being called to be an ATM doctor. Northcote W. Thomas, an anthropologist who conducted one of the earliest studies on agwu attests to this, saying “It is perhaps a little singular that agu (agwu) is a sort of tutelary deity of the doctors. If he pursues an ordinary individual with misfortune until the limit of his patience is reached and no remedy can be found, it is a sign that the man should become a doctor.”59 Cardinal
Francis Arinze in his work noted that “the clearest and indispensable sign of vocation to be a dibịa, is possession by the spirit of agwu, who is the special spirit of ndị dibịa, the spirit of giddiness, rascality, discomposure, confusion, and forgetfulness (mmụọ mkpasa uche).”

There are instances of apprentices or doctors testifying that they came to the profession led by the spirit that possessed them. In some instances, the spirit continued to disturb its candidates for medical practice till they accepted the vocation. Some practitioners even employ the assistance of the gods and spirits in their medical practice. Some diviners, for example, are able to enter a sort of altered consciousness, a trance which helps them to commune with the ancestors. For others, the spirit continues to use them as mediums to communicate or give messages back and forth from the spirit world to the physical world. This will be discussed in detail below under “types of doctors.” These people are often called the diviner doctors or mediums.

The Babalawo of the ifa tradition (that is, diviners) in Yoruba predict events by focusing not on the problem but on the individuals or the patients. They know themselves and their clients very well. The ifa receive their powers from Orunmila and act as its mouthpiece among the Yoruba. They utilize an opele (divining) chain, to communicate and interpret the 26 odu or sacred stories of ifa. In casting the specific odu for a patient or client, the ifa-priest is able to mesh the universal energy and wisdom of the particular odu with the specific circumstances facing the client. According to Epega and Neimark, it is the “marriage between the truth of the odu and the reality of the client that creates a unique and individual interpretation of current and future events.”
ii. **Community in Understanding ATM & ATR**

The notion of community helps to highlight the relation between ATR and ATM. Community for the Africans includes the living, the (dead) ancestors, as well as the entire invisible supernatural world embracing the spirits and God. Consequently, illness concerns both the living and the dead, ancestors and the spirits. Illness is believed to be caused not only by germs themselves but primarily by interpersonal relationships, such as a breakdown in human relationships. Illness often signifies a malaise in the community of the living and the dead or spirit world. For example, mental and physical illnesses are believed, sometimes, to be the result of conflict between an individual and the ancestors, deity, or spirit. Therefore, the cure is not only achieved by means of herbs and other natural products but also by communicating with the ancestors, who in turn intercede with the Supreme Being. Thus, healing involves reestablishing the right relationships between the sick, and the community, and its ancestors. In such cases, the illness is cured by accepting responsibility to resolve conflicts with the concerned party and to make amends with the community, including its ancestors.\(^65\) According to Dr. Afolabi Epega, a Yoruba *ifa* priest, *babalawo*, and Philip Neimark an American *babalawo*, diviners utilize “the probabilities of future events by restoring harmonious balance” in the patient via ritual sacrifices, and prayer. Epega and Neimark point out further that the diviners foresee what is likely to happen if clients or patients remain in their current state or situation. Diviners understand that “restoring harmonious energy” by using the right divining tools to arrive at the right diagnosis, “enables them to alter unpleasant future events.”\(^66\)

Therefore, the diviners undertake the restoration of harmonious energy and alteration of
unpleasant future events in the life of their patients because they focus primarily on the patients and community and not only on the problems of the patients.\textsuperscript{67}

When the source of the illness is suspected to be of a supernatural cause, it brings out the close ties between the medical and the religious systems, ATM and ATR, Islam or Christianity. Because illness is seen as a religious experience, it therefore requires some religious approach to deal with it. For ATM in such a case, the sick person is drawn to the diviner priest doctor, \textit{babalawo}, for the Yoruba, and \textit{dibịa afa} for the Igbo. Thus, some of the ATM practitioners employ traditional African religious rituals and means in dealing with such illness.

In addition to performing traditional African religious rituals, the ATM doctors spend much time with their patients giving them personal attention, which enables the doctors to penetrate deep into the psychological state of the patients. The importance of this action depends on the frame of mind of the African patients. As Mbiti rightly observed, if an African is told that she is suffering from malaria caused by a mosquito whose bite contains the malaria parasite, she would want to know why she rather than another person, her co-wife or her neighbor, was chosen by the mosquito. The patient often believes that someone by some mysterious means caused the agent of the disease, in this case the mosquito, to attack the sick person. Such line of reasoning brings about the magical connotation of ATM. Healing, therefore, includes finding and countering or uprooting the cause of an ailment as well as a misfortune. Treatment also involves medication, as well as psychological and spiritual interventions.\textsuperscript{68} Many ATM doctors are experts in psychotherapy, using various techniques to “probe deep into the hidden problems of a patient to bring them out to the open, and clear them from the patient’s
mind.” Speaking in reference to the ATM doctors’ expertise in psychotherapy, Professor Dopamu observed that

The Yoruba have discovered with greater exactitude than the Western doctors that psychotherapy has always formed an essential and dynamic basis for effective methods of treatment. It enables us to know the relationship between the patient and the medicine-man (or woman). The medicine-man … must first of all look into the social, cultural and intellectual environment and background of the patient. He can then evaluate and interpret the cause of the disease, and give the necessary help.70

The ATM doctors employ an indigenous psychotherapeutic approach in the management of patient care. It was Plato (420-348 B.C.) who said of the practice of medicine in the West that,

As you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul; and this … is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also; for the part cannot be well unless the whole is well… And therefore, if the head and the body are to be well, you must begin by curing the soul; that is the first thing.71

This highlights the tendency in the Western medical doctors to treat the physical body without regard for the spiritual self, or the soul, and not focusing on the whole person. On the other hand, as noted above, from the beginning ATM focuses directly on the spiritual, or mystical, and psychological causes as well as the physical or organic causes of illness. Thus, ATM doctors speak of such causes of illness as punishment accruing from offended or aggrieved spirits, deities, or ancestors, as results of witchcraft or sorcery, and as pre-ordained destiny.72

The idea of illness and misfortune being sometimes seen as religious experiences is currently rampant and popular within independent African churches. The use of religious rituals in dealing with illness and misfortune resonates with the Christian Sacrament of the Sick. Therefore, from the discussion so far, one sees that the ATM system considers and treats natural, supernatural, and psychological causes of illness and misfortune. It acknowledges the potential of dangerous people including witches and
sorcerers, as well as entities such as evil spirits, deities, and ancestors as ever-present dangers operative in the community.\textsuperscript{73}

4. A 4 ATM Doctors: Types, Vocation, and Training

There are various African traditional healers or doctors. A survey of the literature shows the following: herbalists, diviners, magicians, rainmakers, and priests who offer sacrifices or conduct rituals and prayers.\textsuperscript{74} The ATM doctors are classified into five groups even though they may have various names in accordance with the respective different languages and ethnic groups in Africa. For instance, among the Yoruba there are babalawo ifa (priests and diviners), onisegin or adahunse (herbalists). The Igbo have dibịa afa (diviner), dibịa ọgwụ (herbalist), dibịa aja (priests who perform sacrifices), and ọghonwa (traditional birth attendant), to mention but a few. Some doctors identify themselves principally as one type of healer. Others combine more than one type. For the purpose of this study, the following five categories of ATM doctors will be considered: diviners, herbalists, traditional birth attendants, priest healers, and traditional surgeons.\textsuperscript{75} In the colonial and post-colonial periods, a new group came into being, namely, prophets or faith healers who divine and heal within the context of the African Independent Churches.\textsuperscript{76} These groups include both men and women, young and old. Gender does not constitute a problem in the practice of ATM as there are more women among the traditional birth attendants and in treatment of children than in other categories. In some ethnic groups, for example among the Yoruba, women are not allowed to treat mental illness and other conditions that require the use of powerful supernaturally charged medicines because of the fear that “exposure to such forces by the female ATM doctor causes infertility or birthing of deformed children.”\textsuperscript{77}
The five categories of ATM doctors will now be described individually beginning with the diviners.

i. **Diviners**

Diviners form an essential link between humans and the supernatural. They customarily diagnose illness by throwing cards, bones or stones, and by drawing lines on the floor with chalk while consulting the ancestors. In common phraseology, this act of casting objects is sometimes referred to as a “floor X-ray.” It is so-called because the diviner is able to diagnose the problem from the pattern formed by the fallen bones or stones. Some diviners are believed to be able to enter a trance-like state of altered consciousness which allows them to commune with the ancestors. This form of divination is called the “mediumistic.”

The medium falls into a trance and is able to communicate with both the spirits and the people. The body language and words of the medium must be interpretable. Thus, it is not simply mere spirit possession or madness but intermediary function, linking human beings with ancestors and spirits. Wim Van Binsbergen distinguished four major states of possessions: (1) extremely momentary but intensive; these are usually accompanied by drumming, singing, and sometimes smoking; (2) permanent with diffused, non-intensive manifestations; however, there are possessions at re-activated intervals; (3) others which are similar to the above in being non-intensive manifestations; that is, they are realized after “a short, unique period of more acute and intensive manifestations;” (4) possessions that are permanent throughout life. These have only diffuse, non-intensive manifestations. Mbiti tells a story of a medium activity he witnessed and taped-recorded near Kampala in Uganda.
A young man was dressed up in a backcloth; put on a ring made of a creeping plant, and held another plant half a meter long in his hands. He sat down in the diviner’s room where a crowd of twenty-five to thirty people gathered. One of the men started to sing a highly rhythmical song, and the rest of the crowd joined with singing, clapping and rattling small gourds. The medium-to-be sat quietly on the floor without even turning his head. The singing and rattling went on for about thirteen minutes when suddenly the young man’s hands began to tremble. Three or four minutes later he started talking in an entirely different voice. The singing stopped and the diviner could then talk with the medium for about fifteen minutes in the middle of which the medium (or spirit in him) requested another song to be sung. At the end, the medium jumped about like a frog, banged his head hard on the floor and with his fist hit his own chest very hard twice or thrice. Then he was ‘normal’ once more.  

When Mbiti cross-examined this apprentice afterwards, he assured Mbiti that he was not aware of what transpired during the possession. It is an example of a medium working with an ATM doctor or a diviner.  

ii. Herbalists  

Herbalists are people who have acquired an extensive knowledge and experience of herbal medicine. They are able to prepare various medicines with plants, roots, barks, leaves, flowers, seed, fruits, and parts or whole animals and birds. Besides parts of plants and animals, herbalists utilize inorganic materials for their trade. These inorganic materials include chalks of various colors, salt, sulphur, alum, camphor, shells, pieces of rocks, and steel. The herbalists are masters and solicitors of the forest, collecting and preparing many of their herbal materials in dried, charred, and pulverized forms. In order words they prepare and offer their herbal medicines in various forms which include powder that the patients can mix with other foodstuff or drink, or be prepared as broth which is consumed by the patient. The patients can rub the powder into cuts made with a sharp knife on any part of the body. The powdered preparation can also be mixed with native soap, which is then used for bathing. These sort of medicated soaps are usually used for skin diseases. Likewise, the pulverized herbal medicine can be made into pastes, pomades, or ointments in a medium of palm oil or local butter. Otherwise, the medical
material is chopped and soaked for some time either in water or in local gin, or boiled in water and then left to cool. This can be strained or decanted as required before drinking it.  

Furthermore, because of their in-depth experience of the herbs and their preparations, herbalists are seen as traditional pharmacologists. They take interest in developing the indigenous and cultural endowments of their people. Besides using the herbal medicines for direct treatment and prescriptions, the herbalists display them in the open markets for anyone to buy. Usually herbalists do not possess occult powers. According to Eleanor Ross, not only are they able to diagnose illnesses and prescribe herbal medications and enemas for a range of ailments, they “are expected to provide protection against witchcraft, to prevent misfortune, and to bring prosperity and happiness.” In addition to possessing good knowledge of herbs, their preparation, administration and virtue, true herbalists are familiar with the “workings of the Natural Laws, which are inseparable from the Laws of health.” They (herbalists) respect and cooperate with these laws for the well-being of their patients. Modern herbalists are trained botanic physicians possessing their own botanic gardens. Sometimes, the ATM is wrongly referred to as herbal medicine or herbalism. The reason behind this use of a part (herbal medicine) for a whole (ATM) is because a lot of materials used in ATM derive from plants or herbal materials. Even some of the ATM doctors’ instruments such as the sacred staff, *(ọfo)* in Igbo language, and the doctors’ mystic bags *(akpa agwu)* in Igbo language) woven from a herbal fiber, the raffia palm, all derive from herbal materials.
iii. Traditional birth attendants (TBA)

TBAs assist with delivery of babies. The members are predominantly women, as mentioned above. Although the nature as well as the detailed function of TBAs may vary from one ethnic group or community to another, TBAs exist in most communities or ethnic groups of the world. WHO defines TBA as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs.” TBAs are often older women and are generally illiterate. In a study conducted by A. O. Imogie, E. O. Agwubike, and K. Aluko, in Edo State Nigeria, which is home to the Yoruba among other ethnic groups, the following functions or duties of the TBAs were identified. There is of course their main role as TBAs, assisting women with the delivery of babies. Other roles include family planning, nutritional requirements, recommendations, screening of high-risk mothers, fertility/infertility treatment, determination of ailments or abnormalities relating to reproductive organs and reproduction. They also include care of childbearing mothers during pregnancy, labour, and post-natal periods, care of the infants in health and disease/sickness, recruitment of new acceptors into TBA practice, counseling responsibilities, and preservation and conservation of herbal plants and their derivatives.

The study also found that childbearing mothers have preference for TBAs over mid-wives of Western medicine. The reason is that the TBA services are relatively inexpensive, and easily as well as readily accessible and available. TBAs are near to the grassroots and use familiar language. They are rated and regarded as more efficacious; therefore, people have more confidence in them. They utilize natural herbs, and there is mutual trust as a result of their assumed respect for the peoples’ traditions and customs.

iv. Priests Healers

In addition to prescribing medicine, the priests offer sacrifice and prayers on behalf of the community in times of calamities, such as drought, famine, and wars. They
also intercede for women experiencing difficulties such as being barren. Some are mediums performing the functions of a medium delineated above. Thus, they function as priests, physician, and psychologist.\textsuperscript{89} Stephen N. Ezeanya, writing on the functions of the African traditional healers notes that priests in the traditional medical system are mainly concerned with the performance of sacrifices resulting from “abominable offences committed” against the ancestors, the gods, and human beings. He argues thus,

\begin{quote}
A person who has committed an abominable act detestable to the divinities and men is really a sick person. Such acts like stealing, particularly of commodities like yams, fowls and goats, murder, incest, adultery committed by a wife and such-like offences are abominable acts and call for the healing from ministry of the priest.\textsuperscript{90}
\end{quote}

In general, the priests, who include men and women, are chiefly intermediaries, standing between God, divinities, and human beings. Their duties are mainly religious; however, because Africans do not make much distinction between religion and other aspects of life, priests perform non-religious functions as well. Mbiti calls them “ritual pastors” of their community or nation because they officiate at sacrifices, offerings, and ceremonies according to their knowledge.\textsuperscript{91} Lately, this group has been joined by the prophets or faith healers, a post-colonial syncretism of Christianity and ATR. This post-colonial group divines and heals within the context of the African Independent Churches. They utilize prayer, candlelight, water, enemas, and inhaling the vapor of substances poured over heated stones.\textsuperscript{92}

v. Traditional Surgeons

There is little written about the African traditional surgeons and bonesetters. Among the Igbo the traditional surgeons are called \textit{dibia nka}. Ross and Gessler et al. classify them as belonging to a group of the specialists within traditional healing but say nothing no more about them.\textsuperscript{93} Unlike those authors, Steven H Miles and Henry Ololo
give some account of African traditional surgeons and bonesetters. They distinguished traditional surgery from scarification. Scarification is done to denote maturity, kinship, or tribal identifications, and is often performed by elders, parents or chiefs. These people do not claim to be healers.\textsuperscript{94} Surgeons include the bonesetters. They perform various procedures, including incising and draining abscesses, tonsillar abscesses, uvulectomies to treat or prevent sore throats or to treat chronic coughing, circumcisions, repair of inguinal hernias, intrauterine injections of a fecal fluid from pregnant cows to restore fertility, scarification for snake bite, non-invasive cataract luxation, adult tooth extraction, abortion, and cutting out the primary canine tooth buds of infants and toddlers, to treat diarrhea.\textsuperscript{95} Orthopedic surgery is performed for closed and open fractures and osteomyelitis.\textsuperscript{96} Comminuted fractures are opened and explored. Bony fragments or devitalized bones are excised. Implant grafts of goat bones are sometimes used to replace excised bones. Splints of parallel sticks woven together with grasses or traction may be used after internal or external reduction.\textsuperscript{97} Generally, surgery is performed without anesthesia. Like other ATM doctors, traditional surgeons enter the trade by divine call or passage from family. They receive training in keeping with that of other ATM doctors.

In general, ATM doctors are within the reach of the members of the community and can be visited or consulted by any person at any time. They have the obligation to observe and uphold community values. They are expected to be trustworthy, friendly, morally upright, and able to discern peoples’ needs, willing and ready to serve. They are not to be exorbitant in their rates.\textsuperscript{98} The ATM costs contrast with those of Western medicine where corporate norms of profit-making tend to supersede over other organizational and professional values.\textsuperscript{99}
ATM doctors acquire their skill through one or more of the following: inheritance, spirit possession, apprenticeship, and, more recently, by formal classroom training programs. In traditional societies, ATM doctors undergo a lengthy initiation as part of the process of qualification for practice. The duration of training varies from one ethnic group to another and sometime within an ethnic group. For instance, among the Yoruba, R. Prince and Una Maclean independently note that the training lasts from three to twenty years. The students are expected to acquire knowledge of the medicinal value, quality, and use of all the different parts of plants and trees: roots, leaves, fruits, barks, and grasses. They are also expected to learn the medicinal value and quality of various objects such as minerals, dead insects, feathers, powders, bones, excreta of animals and insects, eggs, shells, and smoke from various objects. Likewise, they learn the causes, prevention, and cure of diseases, illness, and other forms of suffering including “barrenness, failure in undertakings, misfortunes, and poor crop yield in the field, magic, witchcraft and sorcery.” The candidates acquire the skills to handle and combat the spirits, deities, and ancestors (living dead). The candidates learn some other various secrets, some of which they are not at liberty to divulge to the uninitiated. It is believed that the ATM doctors’ knowledge of traditional medicine is given to them as a gift for the common good. Medical knowledge is not an individual’s personal privilege. Rather, it is transmitted by the ancestors to the individual for the well-being of the community.

4. A. 5. Health and Illness: The Need to Seek Healing

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”
However, different cultures and traditions have their own concept of both health and illness. Some of these may be quite different from or a nuanced version of the WHO definition. This section seeks to explore the concept of health and illness and the necessity for healing in ATM.

i. Concept of Health and Illness

In ATM, health is viewed holistically. Good health includes mental, physical, spiritual, and emotional well-being for patients, their immediate and extended family members, as well as for the community. Good health is also a conscious harmony with God, creation, and all beings.\textsuperscript{105} This description of health is close to the definition of health given by the WHO. However, what is meant by a whole person in the African context is to be understood in terms of “I am, because you are,” wherein “I am” is seen as the product of one’s fellow human beings, ancestor spirits, supernatural forces, represented by “you are.”\textsuperscript{106} The Yoruba, for example, believe in a holistic approach to \textit{Alafia} (health) which literally means peace. It embraces physical, social, emotional, psychological, and spiritual well-being in a total environmental setting.\textsuperscript{107} Explaining the holistic approach to health among the Yoruba, Norma H. Wolff articulated the literature on the issue as follows:

Physical health (\textit{ileru}), a prerequisite to achieving life goals, is negatively impacted by \textit{aisan}, minor illnesses, such as fevers, headaches, diarrhoea, and vomiting that interfere with daily activities, and \textit{arun}, which includes serious pathological conditions, communicable diseases such as smallpox and venereal diseases, infirmities, chronic tiredness, debilitating mental illnesses, and unexplained misfortunes.\textsuperscript{108}

The term “disease” is commonly used to denote disorders that result from the presence of pathogenic microbial agents, such as microbes, viruses, bacteria, fungi, protozoa, germs, multicellular organisms, and etc.\textsuperscript{109} Illness, on the other hand, is a phenomenon in which individuals perceive themselves as not feeling well. Illness is a
subjective feeling or experience. It is possible for a person to be diseased without being ill. For instance some human carriers of disease HIV, Sickle cell etc. are diseased but not ill. One can also be ill without being diseased. One perceives a normal experience as a medical condition. The basic difference between disease and illness is that disease is an objective phenomenon which is characterized by altered functioning of the body as a biological organism, while illness is a subjective phenomenon in which individuals perceive themselves as not feeling well. Disease may be objectively evaluated with some degree of certainty.\textsuperscript{110}

In traditional African belief, it is accepted that the gods, spirits, and ancestors do influence human affairs, including health and disease. Therefore, the cause of disease and ill health in ATM is sometimes attributed to mystical forces or spirits. In other words, illness is said to be caused also by the intervention of a supernatural or a human being who possesses special powers. The human beings with special powers include witches or sorcerers. These are accredited with causation of witchcraft. Other evil forces may cause illness as a retaliation or punishment for moral and spiritual failings, such as a religious and cultural taboo.\textsuperscript{111} Among the Igbo, an example of a moral taboo is Ahiajoku, the stealing of yam. The doctors are able to see in a given illness other forces at work in the patient other than germs, microbes, viruses and bacteria. Healing is not reduced to a “body-parts” approach but incorporates the integral person. ATM, on the other hand, is an approach that is contrary to that of Western medicine which does not always consider the wholeness of the person (patient) as integer but limits treatment to a specific body system. At the heart of the difference in the two approaches is their world view.
The Western world view approaches the human person as a material body and a patient merely as a sick body. It tends to overlook the image of the patient as “a complex whole, the psychological, social, spiritual and even moral dimensions of the one to be made whole (healed), due to its inherent materialist and reductionist philosophy.”\textsuperscript{112} Continuing, Theophilus Okere noted that the difference in approach is also the result of the ATM doctors’ “reliance on a cosmology populated with a multitude of micro and macro forces, visible and invisible, natural, preter-natural and super-natural, creating a disease etiology that is more credible and effective because they are more comprehensive than Western medical practice.”\textsuperscript{113} Individual illness is fully explained in the two realms of existence: it is comprehended as a manifestation of broken relationships within the community of the living, and as the sign of an existential situation of dissonance between the communities of the living and their ancestors.\textsuperscript{114}

ii. The Need to Seek Healing

The sick person is expected to seek healing either from the ATM-doctor or from allopathic medicine. If a sick person does not want to seek healing, he is firmly encouraged and even persuaded by relatives and community to seek medical care. This practice is acceptable so long as the treatment meets the Standard of Care - it is clear and certain that it is the proper medication for the illness being treated and something an average ATM doctor would recommend. This type of practice arises from the fact that the patient (the individual), as we saw above, is part and parcel of both a family and a community. The individual’s life is intricately intertwined with the life of other people in the community. The individual exists because the group is and because the group exists the individual is. Therefore, when an individual is sick, the whole community is sick.
What happens to the individual happens to the community and, therefore, an individual’s sickness affects other people. Members of the community urge and accompany the sick person to seek healing.

Another scenario is the traditional African doctor (healer) – patient relationship. Here, the traditional doctor, who sometimes is also the religious leader, divines both the sickness and treatment for it. In other words, the gods working through the traditional healer assists him in diagnosing the illness and in prescribing the treatment required. As a result of the expertise and the assistance of the spirits, the healer is revered not just as a physician who knows best but also as a mediator between humans and gods. Sometime he does know best. For example, in many cases, especially in rural communities, the traditional doctor, being a member of the community, knows not only the customs but also the families and their history. He is in a position to speak for the family. At times, even the patient’s family is part of the divination for the cure. Thus, it is difficult to speak of paternalism, at least not in the sense of the Western individualistic autonomy.  

Some people use both traditional and allopathic medicine. Some switch from one to the other. According to Gordon Chavunduka, a former President of African Traditional Medicine Practitioner in Zimbabwe, the change of therapy is more likely to happen in the following circumstances: when the African traditional medicine fails to cure the illness in question, when the suspicions of the patient and his/her social group about the disease in question are not confirmed by the ATM doctor or when the patient and the relatives and community are unable to accept the ATM doctor’s diagnosis, or when the symptoms that were initially thought to be strange or supernatural disappears. These will cause the possible shift from traditional medicine to allopathic and vice versa.
4. Decision-Making in Traditional African Society

At this juncture, it is necessary to take a look at the ways decisions are made in traditional African societies. For that, this section concentrates on the usual four chosen ethnic groups: the Akan, Hausa-Fulani, Igbo, and the Yoruba. This section will conclude with some comments on the place of women and children in decision-making.

When, in African traditional societies, one has to make serious and important decisions, including those that are medical, it is customary to involve the community -- the family, relatives, and kinsmen -- because one’s wellbeing is intertwined with the wellbeing of the community. Decision-making is by consensus, but only after extensive consultation. Sheila Shaibu’s study in Botswana supports this view. According to her, family- and community-centered decision-making are more common than individual decision-making in Botswana. Decision-making is the prerogative of a group that might include the extended family or even community leaders.117

African elders and statesmen, the one-time President of Zambia, Kenneth Kaunda, the retired President of Tanzania, Julius Nyerere, and Kwesi Wiredu all confirm that decision is by extensive deliberation, consultation, culminating in consensus, and that it is an immanent approach to social interaction. According to Kenneth Kaunda, in the original African societies, people operated by consensus. “An issue was talked out in solemn conclave until such time as agreement could be achieved.”118 Nyerere also asserts that “in African society, the traditional method of conducting affairs is by free discussion.”119 And in approval he quoted Guy Clutton-Brock: “The Elders sit under the big trees, and talk until they agree...”120 My experience among the Igbo, my people, as well as among the Borena, and Guji of Southern Ethiopia where I lived and worked as a
missionary for nine years, confirms these assertions. People will sit under the trees, in community arena, or on family premises for hours or days discussing issues until a consensus is reached. They would consult every pertinent child, woman, or man, if need be. Confirming this assertion, Wiredu writes, “there is considerable evidence that decision by consensus was often the order of the day in African deliberations, and on principle.”

According to Elochukwu E. Uzukwu, among the Manja, the chief is represented as a rabbit with large and broad ears, symbolizing the chief as a great listener. His ears are open to the opinions of all, humans and spirits alike. How well he listens impacts on his authority and power. It is believed that the ruler is “installed” for the good, peace, and prosperity of the community. The ruler has the duty to protect the interest of the community and its members. The respect people have for the authority of the ruler or for the elders are linked to this indispensable service to the community.

The assertions are true also of the Akan, Hausa-Fulani, Igbo, and Yoruba, the four ethnic groups considered in this dissertation.

i. Decision-making among the Akan

For example, among the Akan, Kofi Abrefa Busia, a former Prime Minister of Ghana noted that decisions were also made by consensus and reconciliation of sectional and common interests for the good of both the community and the individuals. He writes

When a council, each member of which was the representative of a lineage, met to discuss matters affecting the whole community, it had always to grapple with the problem of reconciling sectional and common interests. In order to do this, the members had to talk things over: they had to listen to all the different points of view. So strong was the value of solidarity that the chief aim of the councilors was to reach unanimity, and they talked till this was achieved.

It is evident that community and common interests as well as the interests of the individuals are emphasized in decision-making. Painful lengthy discussions are
undertaken to ensure that everyone is heard, and to achieve consensus and unanimity. However, Akan society is a gynocracy, meaning that power, wealth, and independence were allotted to women.\textsuperscript{124} The queen mother is seen as the founder of the community. Besides, the queen mother decides who becomes the chief or the king. The king never chooses the queen; rather the queen is responsible for the selection of the candidate for the filling of the king post when it is vacant. She plays an active role in any decision regarding the running of the community.\textsuperscript{125} This has implications for decision-making among the Akan. It means that women are the leading voice or, at least, very much involved in decision-making in the Akan communities. Certainly, this was true of pre-colonial Akan society.\textsuperscript{126}

ii. Decision-making among the Hausa-Fulani

Decision-making among the Hausa-Fulani appears to be more male centered than in the other ethnic groups under study. Women are very much under the control of men, especially among the Muslim-Fulani who practice wife-seclusion, and observe the cultural ideal of masculine superiority in which the maigida, i.e., household head, is the complete master of his family. However, with skill at statecraft, decision-making can be said to be reached by consensus, considering both community as well as individual interests and well-being.

Among the Jelgobe Hausa-Fulani, the chief or jooro (that is a merger of jom wuro, literally meaning village chief) is usually the most senior genealogically of all those who see themselves as members of the same community. Thus, the chieftaincy is not contested because the genealogy clearly indicates the candidate. The jooro is in power but does not exercise power. He does not compel his subjects to do something.
Rather, he “advises them, he is their arbiter, and he represents them in their relations with the canton chief and with the foreigners.”\(^\text{127}\) One concludes, then, that decision-making is not the unilateral decision of the leader or jooro, but is possibly made by reaching consensus and by weighing the interest and the good of both the community and the individuals concerned.

**iii. Decision-making among the Igbo**

Among the Igbo people of Southern Nigeria, decisions are traditionally made at various levels, depending on the issue at hand. Elders, ofo holders or other title holders, umuada (that is, daughters of the kindred married into other village-groups) may be included in the decision-making process. However, no side or individual possesses an overriding authority in decision-making. Issues are debated, and weighed face-to-face, in order to arrive at a compromise or consensus, no matter how long it takes. This has been described as Igbo democracy. Even though the elders are the leaders of the community, they function more as facilitators/mediators. For example, in a community meeting, nzuko ọha, a general assembly may decide cases for disputants when the elders have retired for private consultation (igba-izu). Charles Meek further notes that the elders “were a body of mediators and referees rather than of prosecutors and judges, and the community was a republic in the true sense of that term, i.e. a corporation in which government was the concern of all.”\(^\text{128}\) If orders are issued by the elders about matters that affect the life of the entire community without having been previously discussed or negotiated, they are ignored. Thus, it buttresses the idea igbo enwe ẹze, meaning the “Igbo do not tolerate autocracy.”\(^\text{129}\) Also found in many communities are associations
such as *ọfo* holders, age grades/groups, and *ụmuada* who are involved in decision-making.

The *ọfo* holders is an aristocratic association that develops as a mark of success with increasing political privilege and responsibility. They are required to be people of integrity and reputable character. For one to qualify as a bearer of *ọfo*, the village or community must acknowledge the person as somebody of probity of character, impeccable, and manifestly honest. The person must be one who prefers and chooses dignity over material profits. It is one who heeds the Igbo proverb -- *aha ọma karịọrị ego* or “a good name is worth more than money.” This level of morality is expected of them because their decision or verdict, especially in cases of disputes, carries a great deal of weight. It is expected to be just and true. Moreover, it is believed that the failure to be just or to speak the truth brings the wrath of the god of *ọfo* on the holder. Likewise, because of their age, elders are seen as symbols of truth and justice; they are expected to seek the good of their family and community and not to lie or speak untruths. Thus, they are viewed as fair and honest in their decisions, and maintainers of peace.

*ụmuada* (also known as *ụmuokpu*) is an institution of daughters of a community who are married into other communities. It is an important decision-making body of a community. It is also a disciplinary body and a guardian of social values. *ụmuada* counterbalances the council of elders that is often made up of men. They not only have power over their fellow women, but over men as well. For example, in my own experience, when my brother died, I was summoned (as the first born and because my father is deceased) to ascertain that my sister-in-law would be well cared for in the absence of her late husband. Therefore, as Iroegbu rightly observed, the *ụmuada* can
question a family or a kindred head if they feel he is not effective enough in his duties or responsibilities. Likewise, they can discipline housewives who misbehave. They mediate in cases, assist a bereaved or troubled family and foster cohesion and solidarity.  \(^{132}\)

Because the \(\textit{ụmụada}\) are born in one community and married into another community, they form a very important link between their birth community and those into which they have married (that is, their husbands’ communities). This gives them an added advantage as mediator.

Thus, for the Igbo, it is a situation where laws or decisions affecting the community at various levels and in various shades and forms are discussed in meetings of the age grade/group (youth), the married women and daughters or \(\textit{ụmụada}\), and titled men and women, \(\textit{ọfo}\) holders and elders. \(^{133}\)

This system of entrusting authority to the hands of people and groups is also found among the Tiv of Nigeria and, the Kikuyu of Kenya. When there is an issue of medical treatment of a member of the community, this will be discussed in a meeting of the family with the elder(s) representing the community or clan. Some other groups, such as the age grade/group of the sick person or the \(\textit{ụmụada}\) may be involved in the decision-making, depending on the nature or seriousness of the medical issue and illness. The head of the family or the assistant where the head is the one who is sick usually initiates the meeting or consultation with the appropriate members of the community. The head or the assistant can be the father, mother, uncle, or the first born child. \(^{134}\)

Among the Cross River Igbo, there is a dual leadership in matrilineage when it comes to governance and decision-making. For example, the Ohaffia have two leaders, a male and a female. The male leader performs secular duties, settling disputes, protecting
the rights and interests of members in matters of land estate, or resources. On the other hand, the female performs sacred duties which are ritual in character, such as making sacrifices to *ududu*, the sacred pot, a deity symbol among the Ohaffia. Each of the *ududu* represent an ancestress. A male cannot be the ritual leader of the ancestress in the matrilineage. The women have their traditional law-keeping body, the *ikpirikpe*. It is responsible for the administering the activities of the adult women of the village. It operates independently of the men. Only *ikpirikpe* can deal with the activities of women, especially offences committed by them. For instance, according to Nsugbe, in the case of adultery, the male age grade/group *ụmụaka* judges and penalizes the man involved but not the woman. It is the women who deal with the female accomplice to the adultery.135

In general decision-making and overseeing the family, the village and community revolve around the men. In Ohaffia, for instance, the most powerful body is the *ụmụaka*, men’s age grade/group. They are recruited by the age grade/group immediately above (*Ndi Ichin*, the retiring elders). The members of *ụmụaka* are chosen on the basis of their character and achievement. No women are recruited into this group.136 However, The *ikpirikpe* women group can challenge the decision of the male age grade/group. Though the village head, *eze-ogo*, is male, he does not supervise the activities of the community, at least not openly. He neither attends village meetings nor presides over them. As Nsugbe says, the primary function of the village leader is that of “a fearless emissary: heading delegations, sometimes on behalf of the whole of Ohaffia, to government ministers, and high-ranking officials of his region.”137 One can say, therefore, that his function as the community head involves external relations. In village and community
meetings/assembles, decisions are made by seeking and reaching consensus, as do the Igbo.\textsuperscript{138}

iv. Decision-making among the Yoruba

Although among the Yoruba the monarch or oba wields authority in decision-making, there is extensive consultation with and listening to representatives. The Yoruba society is organized with the oba as the king ruling over the kingdoms. The oba is assisted by the chiefs whose functions include serving at the oba’s council as well as helping to administer and maintain peace and harmony in the various communities of the kingdom. Backed by the oba, the chiefs also help in settling disputes between lineages, land disputes, and other local altercations.\textsuperscript{139} The oba and chiefs are mainly adult males owing to the Yoruba patrilineal and patriarchal society. Peter C. Lloyd observed that “in each town the lineage was a gerontocratic institution with a large membership, the adult males” with administrative authority over the people.\textsuperscript{140}

Even though only a male adult can be an oba, not every male descendant of a royal family can become an oba. The selection is deliberate in order to insure that a fair person ascends the throne. Anthony Okion Ojigbo notes that, among the Oke Ewi Yoruba of Ekiti in Nigeria, besides belonging to the royal family or lineage, three prerequisite conditions are required in order to qualify to contest the obaship. They are: first, the candidate has to be a prince born while the father was an oba. Even at that, the candidate is disqualified if he happens to be the first born. Second, the candidate’s mother must not be a slave but a free woman. Finally, and the point that interests us here is that the candidate must symbolize all that is good, virtuous and pleasant to behold. Thus, in addition to being free of any physical handicaps or limitations, he must be humble, and
just. For example, a prospective oba was rejected because he was too tall. The reasoning that disqualified him because of his height is that he could look down, literally and symbolically, on his people, something that a Yoruba oba or king and chief should never do.¹⁴¹

Other mechanisms built into the system in order to ensure fair/just leadership are that the chieftaincy title rotates from one segment of the lineage to the other, and a son cannot inherit the title from or of his father. This is a safety measure to stop a family from consistently building “on its position by its occupation of the chieftaincy title and thus, arrogate a further amount of power to itself,” and usurping a title which is believed to be “a common property of the whole lineage.”¹⁴² These stringent rules and the balance of power between the oba and the chiefs ensure that rulers and elders are fair and just in order to earn the trust of the community.¹⁴³ Eventually, the system ensures that community and common interests as well as those of individual subjects are considered in decision-making. Often painful lengthy discussions are undertaken to ensure that everyone is heard and that there is a consensus.

It is worth noting that consensus goes beyond decision by majority opinion, and it is harder to obtain decision by consensus than it is to obtain decision by majority opinion. It is important too that all parties involved agree that proper and adequate attention has been given to their opinion and concern. The African choice for decision by consensus was a “deliberate effort to go beyond decision by majority opinion.”¹⁴⁴

v. Decision-Making and Women

Christopher Agulanna and others have asserted that women had no say and still do not have any say in decision-making in African societies.¹⁴⁵ However, studies show
that this is not exactly the case. Indeed, in pre-colonial African societies, women not only had voices in decision-making, but they also occupied leadership positions and took part in decision-making in the family and society.¹⁴⁶

Some early anthropologists, among them Johann Jakob Bachofen (1815-1887) and Lewis Henry Morgan (1818-1881), argued that many early societies were actually matriarchal.¹⁴⁷ Some contemporary feminist theory has also suggested that a primitive matriarchy did in fact exist in the world, particularly in Africa and Asia. However, although some anthropologists deny such widespread primordial matriarchy, there are the Akan of Ghana, the Boule of the Ivory Coast matriline, and the Cross River Igbo of Nigeria. Moreover, the subsequent absence of women in the corridors of authority and power in some cultures and societies is not solely because of male chauvinism. As has been noted, even in the presence of primitive matriarchy, women gradually relinquished their authority and power to men because of their other responsibilities such as menstruation, pregnancy, breastfeeding, and childbirth.¹⁴⁸ For Haralambos and Holborn, pregnancy and breastfeeding had the most serious social impact on women even in matriarchal societies. Women gradually and eventually, although in varying degree, gave up their leadership position to their male counterparts, that is, their spouses, sons, and fathers.¹⁴⁹

Another school of thought is that the arrival of the colonialists and the missionaries on African soil helped to change the position of women vis-à-vis decision-making. For this school of thought, if women have lost their voice in decision-making, it was largely because of the colonial regime and its system, which initiated and maintained the suppression of women, especially in the public forum. It was a transfer of what was
practiced in Europe to Africa. Ivan van Sertima writing about the women of old or of women in traditional Africa observed that

The myth of female inferiority seems to have been far more developed in Europe and Asia than in Africa. This was due to differences in metaphysic and social structure, even, perhaps, in the very nature of the Indo-European male temperament itself. Whatever it was, the black queens, madonnas, and goddesses dominating the imagination of antiquity have few European or Asiatic counterparts. Yet it would be idyllic to assume that woman did not have to strive to achieve and maintain her equality in Africa, regardless of the countervailing myths…

Colonization was the business of European men. Consequently, the women (their wives) who followed them had nothing to do other than to follow or succumb to the decisions of their men. This dependence and passivity also applied to the wives of administrators and colonial adventurers, as well as to the religious women of the time. According to N’Dri Thérèse Assie-Lumumba, the French women of the colonialists sat around the house most of the time doing little or nothing, dependent on their males. Seeing the African women working hard on their own, with much independence, the French women and men thought the African women were being used, and even made to suffer. That is the origin of myth of the suffering African women.

Therefore, Ifi Amadiume insists that, although women had always struggled to conquer and to maintain equal place of power -- socio-economic, socio-political, and socio-religious -- the real Igbo history as it was and not as the Europeans interpreted it shows that women had a solid political base in this society. They were very visible to the Europeans who decided to relegate them to the home, using education and religion both in the figurative and in the proper sense of these words. According to Assie-Lumumba, the primary aim of colonial schools was to prepare men to be interpreters. Girls were not wanted. Even in France at the time, c.1910, girls were lagging behind in education. Out of a hundred graduates of secondary schools, there were only two girls. African parents
refused to send their female children to the colonial schools because they would be
brainwashed. That would be dangerous because women are the guardians of the customs
and traditions or African civilization. As a result, it was the men who were educated, and
this, later affected women in social-political life. It was when the religious women
founded their own schools to educate girls in the ways of motherhood that the parents
began to send their girls to school.\textsuperscript{154}

Furthermore, the African women played an important role in the fight against
colonialism. For instance, queen Ya Ashantewa of Ashanti of Ghana, who came from a
culture where women are visible in both the political and the social sphere, was the chief
of the army that fought the British. She was later exiled by the British in 1900.\textsuperscript{155} The
Igbo and Ijaw women raised opposition against British taxation in the 1920s in Nigeria.
They exhibited the usual power and status in Africa society.\textsuperscript{156} As a result of these active
roles of women against the colonialists, and in keeping with the custom in the colonialist
home countries, the selection for military service was restricted to men.\textsuperscript{157} Thus, women
were disenfranchised.

The colonial system also disenfranchised and deprived women of decision-
making powers through economic activities and Christianity. Assie-Lumumba argues that
the initial economy of Africa was predominantly agriculture, and women assumed an
active role in the production and processing of a product, as in the case of cotton in
Baoulé. Women also had active part in weaving the cotton into clothes for the family and
for sale. But with the introduction of cloth factories, for example, the economic power of
women dwindled.\textsuperscript{158} Palm oil was another area in which women had an important role in
production and processing. With control of palm oil mills by the colonial administration, however, women lost their economic and bargaining power.\textsuperscript{159}

Furthermore, according to Assie-Lumumba, Christianity is yet another factor that disenfranchised women. Christianity, under the umbrella which most of the colonialists ministered, promoted the image of women as submissive to their men. God as father represented by male priests who lorded it over women; consequently, women were regarded as inferior to men.\textsuperscript{160} Assie-Lumumba noted that African women protested against this male-dominated religion. For instance, Dona Beatrice who was burnt, and Deime Marie Lalou who, following African tradition, founded her own church in opposition to the European male-dominated church.\textsuperscript{161}

Political power and associations were also masculinized during the colonial period as a result, women were also disenfranchised politically. Having lost their economic power, and avenues for education, they were denied membership. Even when women joined political associations, they were not able to aspire to public office. in Ivory Coast, it was not until the 1970s that women could become governmental ministers.\textsuperscript{162} This is in great contrast to the pre-colonial era when women were chiefs, and leaders who were able to champion the opposition against the colonizers.

In all these ways, loss of education, of economic, and political powers, and Christianity’s emphasis on male dominance over women, colonialism disenfranchised women and gradually tilted decision-making powers in favor of men. Therefore, the feeling of an inferiority complex among women was in part, the result of long treatment as inferiors in colonial times.\textsuperscript{163}
On the hand, decisions regarding children considered to be underage and/or those who had not yet reached the age of traditional initiation, i.e., passage to adulthood, were made by their parents or guardians.  

4. B. The Concept of Person and Autonomy: ATM and Ethics of Care Contrasted

The universe, in African ontology, is not considered as some discrete thing. Rather, it is seen in terms of interactions and interrelations. The same understanding applies to the concept of the individual in African thought. While the dominant Western thought views the self as something inside a person, or as a sort of container of mental properties and powers, the self in African thought subsists in relationships to others in the natural and social environments. Anything that exists or is believed to exist must have some connection with the community. The idea of community serves as a conceptual base in which most African concepts, beliefs, values, ontology, cosmology, and ways of life are grounded. It is not that all ethnic groups of Africa share exactly the same normative conception of personhood. Rather, as Ikuenobe rightly remarked, the idea of community is the “logical and epistemic” basis of the “normative conception” of reality and “a person’s own view of self-identity”. This section considers the RAIC approach of ethics of care described in Chapter Three to interpret ATM comparatively in order to enlighten the significance of the ATM approach as a legitimate model of RAIC. In order words, ATM exhibits practices similar to those of ethics of care, such as focusing on relationships, maintaining that persons are relational beings who are socially embedded in a context of social relationships in a community, and exercising autonomy in relationships with others in the community: family members, friends, relatives, age grades/groups, teachers etc.
4. B 1 Relational Being: Individual (Patient) Versus Community

In African culture, persons are defined both individually and communally; that is, they are defined in relation to themselves, to their community and to their personal creative spirit which embodies their destiny. The African ethos presupposes an existing community into which individuals are born. Aristotle asserted that man (the human being) is by nature a socio-political animal and that it is impossible for him to live outside society. Like Aristotle, Africans believe that community is natural to human beings and that community is a necessary condition for human existence. For instance, in the Akan proverb, Onipa firi soro besi a, obesi onipa kurom, “when a man descends from heaven, he descends into a human society,” descending from heaven is a reflection of the belief that human beings are created by a Supernatural Being in heaven (soro) as acclaimed by the Akan and indeed by other African ethnic groups. According to Kwesi Dickson, the sense of community is a “characteristic of African life to which attention has been drawn again and again by both African and non-African writers on Africa. Indeed, to many this characteristic defines Africanness.” Human beings are born into human society, or a cultural community. Community is founded on the belief of an intrinsic and enduring relationship among its members. There is in this community an organic relationship between the individual members. It is not an additive group but what Menkiti calls “collectivities in a truest sense.”

The community is characterized by either a belief in a common origin and/or a sharing of an overall way of life which includes “the existence and acknowledgement of common roles, values, obligations, and meanings or understandings.” The social
settings as well as the networks of a community are of varied forms and shapes. They include the following forms of community: family (both nuclear and extended), clan, village, ethnic group, city, neighborhood, and nation-state. Because individuals take part in various forms of these communities, they participate in a variety of social relationships. Gyekye makes a distinction between an ethno-cultural and a multi-cultural community, where ethno-cultural community is a community of people who see themselves as bound by some intrinsic ties, which can be of common origin or biological ties. An example of such a community includes the four ethnic groups chosen for this study: Akan, Hausa-Fulani, Igbo, and Yoruba. When various ethno-cultural communities merge, as in a city or state, the result is a multi-cultural community. In this dissertation which follows Gyekye, the concept of community as a cultural community is adopted because that culture constitutes the greatest portion of the necessary social context for the development and nurturing of the individual.

The sense of community, whereby the individual is believed to be born into an existing community, indicates a conception of the person as a communitarian by nature. According to Gyekye, this communitarian nature implies the following six points outlined:

1. That the human person does not voluntarily choose to enter into human community; that is, that community life is not optional for any individual person.
2. That the human person is at once a cultural being.
3. That the human person cannot -- perhaps must not -- live in isolation from other person.
4. That the human person is naturally oriented toward other persons and must have relationships with them.
5. That social relationships are not contingent but necessary.
6. That, following from (4) and (5), the person is constituted, but only partly, by social relationships in which he/she necessarily finds him/herself.

Because the African community embraces the living, the dead, the unborn, and ancestors, individuals owe their existence to members of the community, including their
contemporaries and those of past generations. The African understanding of a person values connections with the past or ancestors, the present, that is, through family and community, as well as with other animate beings and even inanimate objects such as Earth, within a “web of relations” that Godfrey Tangwa calls the “eco-bio-communitarian perspective.”

To a great extent, the community produces the individual. For example, a child is taken to be the property of the community, and it is the community members who will see that the child grows to become a significant member of the community, an asset to all. Thus, every one joins in the training of the child as the child begins to walk and talk. The aunts, uncles, cousins, siblings, and neighbors are always available to encourage and instruct the child in matters of tradition. The child is never alone and grows to realize that he or she will always belong to the people of his family and community. The child experiences first-hand the meaning of and the emphasis on relationships. The whole process is achieved through a system of education which involves but is not limited to initiation, socialization, acculturation, experience. The community also provides the individuals with norms, virtues, beliefs, and values. The individuals internalize and apply these norms as guides for conduct. Individuals are evaluated by how much they have internalized, and displayed in their daily decisions and actions the virtues, beliefs, values, and attitudes that the community has taught them. This process of socialization imposes some moral constraint on the actions and behavior of those individuals, even on their personal actions. As the individuals accept the values of the community as their own, they become conscious of their responsibility to the community and of the community’s responsibilities to them.
The affirmation and emphasis on communal life and its values are not necessarily a negation of individuality or a denial of individual values. In order words, it would be wrong to assume or to conclude that, because African culture places emphasis on communal values, relationships, the collective good, and shared ends, it therefore considers the individual person as “wholly constituted by social relationships,” or that it belittles the moral autonomy, freedom of the individual members of the community, making the person totally dependent on the values, practices, activities and aims of the community, thus diminishing individual freedom. Rather, as Kwame Gyekye noted, it is the “recognition of the limited character of the possibilities of the individual which whittles away the individual’s self-sufficiency.”

Moreover, it is not the community alone that defines the individual or personhood. Rather, two other things help to define the individual: the self, i.e. the person him-/herself, and the individual’s personal creative spirit (chi, in Igbo, okra in Assante, ori in Yoruba). As Kwame Gyekye has noted, the individual helps to define him-/herself and the community as well. The individual is both an autonomous and a communal being. It is recognized that besides being a social being by nature, the individual also possesses rationality, a moral sense, the capacity for virtue, emotions, and a capacity for free choice; therefore, the individual possesses the capacity for evaluating and making moral judgments. In order words, a person is capable of making a choice. This has the advantage of allowing the individual’s ability to take an objective view of the practices and the values promoted by one’s community. Sometimes some individuals are critical of values and practices inherited by the community and re-evaluate them. Through such self-assertion by which individuals are able to examine the community, its values, and
practices critically, positive changes in communal goals, values, etc., result. Thus, the
development of communal culture and human culture is a product of the human
community or of its members. The culture of the community is shaped through the
agency of the person in the community, the visionary individual human being.\(^{180}\) It is also
this self-assertion that makes possible some forms of autonomous individual choice, of
goals and plans in relation to the community. The individual remains embedded in
relationship with and in the life of the community because one is not detached from the
communal values and practices. However, because the individual can take an objective
view of the community’s existing values, re-evaluate them, and initiate new ones, it
means that one has the capacity to and does, to some extent, set some of one’s own goals.
By so doing, one partakes in defining one’s identity.\(^{181}\) Therefore, the individual is
shaped both by the community and by him-/herself. Human beings possess these
capacities by nature. The community discovers and helps its members to nurture them,
but these individuals are endowed by nature and not by the community. Consequently,
therefore, Gyekye maintains, and rightly so, that one cannot definitely posit that
personhood is fully defined and constituted by the communal structure or social
relationships.\(^{182}\) The community alone does not define a person but the self as well as the
creative personal spirit helps in defining the individual, or the self.

One must acknowledge that it is not easy to take an objective view of one’s own
cultural and inherited values and practices. Yet, it is not impossible. Alasdair MacIntyre
and Michael J. Sandel attest to this in their works. MacIntyre, for example, observed that:

For the story of my life is always embedded in the story of those communities from
which I derive my identity, I am born with a past; and to try to cut myself off from that
past, in the individualist mode, is to deform my present relationships. The possession of
an historical identity and the possession of a social identity coincide. Notice that rebellion
against my identity is always one possible mode of expressing it.\(^{183}\)
Sandel wrote, “As a self-interpreting being, I am able to reflect on my history and in this sense to distance myself from it, but the distance is always precarious and provisional, the point of reflection never finally secured outside the history itself.”

Establishing that the community alone does not bestow personhood or define the individual seems to place doubt on some of Menkiti’s ideas of community, or communal life and person. Reflecting on Mbiti’s statement or dictum about African communal life, “I am, because we are; and since we are, therefore, I am,” Menkiti inferred that, “…as far as Africans are concerned, the reality of the communal world takes precedence over the reality of individual life histories, whatever these may be. And this primacy is meant to apply not only ontologically but also in regard to epistemic accessibility.” Thus, Menkiti concludes that, in Africa the community takes precedence over the individual, that it is the community that defines the “person as person, not some isolated static quality of rationality, will or memory,” and that it is not only that personhood is acquired but is also “something which has to be achieved, and not given simply because one is born of human seed.” Thus, he concludes that personhood is something at which an individual could fail.

Commenting on Menkiti’s thoughts, Gyekye argues that Menkiti’s assertions on the “metaphysical status of the community vis-à-vis that of the person” as well as his view of personhood in African moral, social, and political philosophy are exaggerated. He claims that the emphasis that Menkiti puts on the idea of community and the normative idea of personhood diminishes the intrinsic value of the individual. However, as Ikuenobe absorbed, Gyekye stresses the metaphysical claims regarding "the free-willing and autonomous nature of isolated persons, which Menkiti’s view does not
make." According to Ikuenobe, Menkiti rather “assumes some elements of such metaphysical claims as the basis for a normative claim about an individual who, though metaphysically free and autonomous, is nonetheless morally structured by the communal normative structures that circumscribe the substantive contents or objects of his autonomy.” The cause of this conflict between Gyekye and Menkiti on the metaphysical and normative understanding of person lies in the fact that “Menkiti does not explicitly account for a moral person as one who is metaphysically isolated, free-willing, and autonomous….” Consequently, he leaves himself open to misconception. That is why scholars, such as Gyekye, misunderstand him as “implying that the community vitiates the autonomy and freewill of the individual;” thus, leading to the assertion that “Menkiti’s accounts of the African views of personhood and community, and the relationship between community and individuals involve radical communitarism.”

Furthermore, Menkiti’s views of African communal life and the individual person are incorrectly echoed by some of the founding fathers of African socialism, Kwame Nkrumah and Leopold Senghor. For example, Senghor observed that “Negro-African society is collectivist or, more exactly, communal, because it is rather a communion of souls than an aggregate of individuals.” And Nkrumah noted that “if one seeks the socio-political ancestor of socialism, one must go to communalism … in socialism, the principles underlying communalism are given expression in modern circumstances.” These men were anxious to find support for their socialist ideology from the traditional African concept of society. They assert, therefore, that socialism is practiced in African traditional communitarianism. They suggested that social order translates into modern
socialism automatically. But, as Gyekye rightly noted, African communal living does not translate into modern socialism, and, as shown earlier in this section, personhood is not conferred by the community alone.

Moreover, Menkiti’s argument is not really true that the pronoun “it” is used in Africa to refer to children and to the newborn because they have yet to become persons, that is, the community has not yet conferred personhood on them. According to Gyekye, the English neuter pronoun “it” for inanimate beings does not exist in the Akan language. In the Ga-Dangme language of Ghana, the “e” is used for all genders -- he/she/it -- animate and inanimate, it is gender neutral. Among the Hausa the “i” is also gender-neutral. For example, ina-zuah, translates “he/she/it is coming.” For the Igbo, the pronoun “ọ” is also used for “he/she/it.” It, too, is gender-neutral. For instance, ọ na-obia, means “he/she/it is coming.” Therefore, Menkiti’s argument that ‘it” used in the English language in reference to the newborn and children implies that they are not yet persons collapses when examined in the context of these African languages. “It” in Akan, Ga-Dangme, Hausa, Igbo, etc., is used to address adults, older people, as well as children and the newborn. They are all persons. Therefore, the community and the self help to define the individual.

However, even Gyekye moderate view of communalism or community does not capture the triad of entities, the community, the self or individual, and the Supreme Being who acts through the personal spirit in African cosmology. While his view recognizes that both the self and the community help to define an individual, and that the individual helps to shape the community, Gyekye does not account for the place of the Supreme
Being or God who acts through the creative person spirit vis-à-vis the individual and the community.

Finally, besides the community and the self, God helps to define an individual through each individual’s personal and creative spirit. In Africa, the belief that human beings are created by God is expressed via a sacred myth which narrates the account of the pre-existence of each human being in the spirit world. Each human person is believed to be “a ‘re-incarnation’ into the human world through the creative act of a … personal spirit that embodies” an individual’s destiny. At creation, God assigns or each person chooses his or her destiny in dialogue with the creative spirit. Writing from the standpoint of Igbo cosmology, Achebe and Christopher S. Nwodo both acknowledge a principle of dualism that is complementary, especially among the Igbo, and not a philosophical dualism implying opposition. They note that a personal spirit may be visualized as the person’s other identity in a spirit land wherein that person’s spirit being complements his or her terrestrial human being. This is evidenced or supported by the aphorism that “… for nothing can stand alone, there must always be another thing standing besides it.” According to Achebe, “The world in which we live has its double and counterpart in the realm of spirits.” This implies that the human being is only one-half of a person. The other half is in the spirit land. One receives or chooses one’s gifts or destiny from that spirit land. The whole idea finds support in the Akan proverb previously cited Onipa firi soro besi a, obesi onipa kurom, (“when a man descends from heaven, he descends into a human society.”) Thus, African mythologies postulate a re-incarnation into the human world of each human person, through the creative function of
a guardian personal spirit. By the creative act of this personal spirit, the individual pre-existent self is assigned a destiny by God or the individual chooses one.

This personal spirit is known by various names according to ethnic groups. *Chi* in Igbo is considered a complex spirit that is dynamically related to individual destiny and to God. Among the Yoruba it is called *Ori* and is highly symbolic, evoking a multiplicity of images. Within the Akan ethnic group, it is known as *Okra*, or *Kra* in Assante, and *Aklama* or *Kla* in Ewe. *Okra* (*Kra*) like *Chi* or *Ori*, is believed to be a personal spark, or spirit from God, which resides in each person. It is the bearer of destiny; thus, only human beings have *Okra*. It is the undying part of a person which returns to God after death.\(^{203}\) Likewise, *Aklama* (*Kla*) determines both a person’s wellbeing and character, or destiny. If one deviates from character/destiny, *Aklama* (*Kla*) can penalize the individual. It also leaves the body after death.\(^{204}\) Last but not least, in *Adja-Fon*, which are major West African ethnic and linguistic groups found in the Republic of Benin and in southwest Nigeria, the personal spirit *Se* “is structurally related to a prenatal ‘democratic’ choice that each existent must follow in life; the choice is made before *Marwu,*” or *Segho*, the Great *Se*.\(^{205}\)

In general, therefore, the personal humanizing spirit from God has some special hold on the individual more than other beings can have on that person. It can dispense with and defeat the physical endowments as well as the terrors of the multiple-headed spirits.\(^{206}\) *Onye chi ya na-ereghi onweghi ihe ga eme ya,* (“if your personal *chi* does not betray you, nothing will happen to you.”) Or, as Achebe states it “*No matter how many divinities sit together to plot a man’s ruin, it will come to nothing unless his chi is there among them.*”\(^{207}\) Therefore, the personal spirit “constitutes the acknowledged and
unacknowledged link with God in the evolving destiny of the individual or in questions asked about fortunes and misfortunes by the individual and community.”

In other words, destiny reveals itself in “patterns of individual lives, in “habitual or persistent traits…,” in “successes and failures, the traumas and enigmas of life; … the observed uniqueness of the individual….”

However, the power of this personal spirit is not absolute because the individual is not a puppet of the personal spirit or destiny. There is a dialogue between the individual and the personal spirit, a democratic choice, in the assignment of destiny. For instance, when somebody’s misfortunes (or sometimes fortunes) are thought to be beyond comprehension; when one tries one’s best but does not succeed, people say: Ọ bụ etu ya na chi ya si kpa, (“it is the agreement the person made with his or her personal spirit.”)

Among other things, it denotes an element of choice on the part of the individual in question. Furthermore, as seen above among the Fon and the Igbo, the exchange between the personal spirit and the pre-existent self in the assignment of destiny is seen as a “prenatal” democratic choice and dialogue. The proto-individual negotiates and chooses the kind of life he or she will live in the world, and the personal spirit fulfills it. Or, according to Achebe, the proto-individual bargains with God, Chukwu, while the personal spirit presides over the transaction. Thus, Achebe declares,

And finally, at the root of it all lies that very belief we have already seen: a belief in the fundamental worth and independence of every man and of his right to speak on matters of concern to him and, flowing from it, a rejection of any form of absolutism which might endanger those values.

Consequently, Achebe noted that “it is not surprising that the Igbo held discussion and consensus as the highest ideals of the political process.” Indeed, it is not just the
Igbo, but most other ethnic groups of Africa hold discussion and consensus as the highest ideals of both decision-making and the political process. While Kofi A. Opoku claims that among the Akan destiny cannot be changed, Bishop Peter Sarpong, an anthropologist thinks otherwise. According to him, destiny can be altered by magic or religious means. Thus, Sarpong agrees with Achebe and Nwodo who also come from West Africa. Agreeing with Opoku, Gyekye argues that the Akan proverbs he examined seem to suggest that destiny is unalterable and unavoidable. He argues that, because destiny is bestowed by a benevolent God, then it must be good; its basic attribute must be good, and, if so, people will not feel any need to change it. Gyekye adds that, because “destiny is determined by the omnipotent Supreme Being, it obviously cannot be changed.” The problem with Gyekye’s argument is that it presumes that people are always content with whatever good thing they receive, even from God, and that they will not seek to change it. The Igbo experience seems to be contrary to his argument. As has been shown, the Igbo concept allows for a negotiation and even an alteration of one’s destiny, thus taking care of those who might not be satisfied with their destiny.

Although Nwodo supports Achebe’s idea that the principle of dualism found in Igbo cosmology is not a philosophical dualism that implies an opposition, he offers more reasons to support the concept of the individuality of the human person. For him, it is a complementary principle of dualism, which is “essentially an antidote to absolutism, and all forms of extremism and obsession.” In its positive form, it is a metaphysical fluidity or resilience that both shapes and defines Igbo perception of being, and makes it both possible and “habitual for the Igbo to reconcile and accommodate contrary ideas and
experiences, as well as multiple demands while vehemently rejecting all forms of imposition even from their gods.”

The proverb which states that even siblings have individuality --*otu nne na-amụ ma otu chi adighi eke,* (“siblings may be born of the same mother but they are not created by the same personal spirit”)-- expresses the following: a strong individuality or uniqueness of a person by the belief that each individual has his or her own uniquely created personal spirit; that the creative spirit which is assigned to each self by God in order to humanize the person varies from individual to individual; and that destinies differ from person to person. Destiny determines the individuality and uniqueness of a person. In view of this, Achebe believes that the form of individuality arising from the Igbo perspective about the creation of the human person is “as far as individualism and uniqueness can possibly go,” and that it goes even further than the Christian understanding of individualism embedded in the principle that God created all people unique and worthy in His sight.

Furthermore, a stronger support of the concept of independence of the individual deriving from the personal spirit is the proverb: *onye kwe chi ya ekwe,* (“if one agrees, one’s personal spirit agrees or follows;”) that is, if one is determined, one’s personal spirit concurs. It implies that the individual not only dialogues with but can also put limits on the exercise of power of his or her personal spirit, thus attesting to the person’s individuality and autonomy. One can renegotiate one’s destiny. Part of the concept of the Igbo complementary principle of dualism is the love of the concept of flow and the hatred for the concept of fixity. The Igbo love movements, travels. Fixity “constrains and limits their movement while flow allows them free movement in a free and yet
undetermined universe.” This free movement of flexibility extends to thoughts and actions. The hatred for fixity includes rejection of extremism and rigidity in the laws of logic.

The boundary between two contradictories can be very fluid indeed such that thoughts, actions, and sentiments tend to flow, float and overlap. The fluidity of thought and action flows and overflows into the realm of logic, temporality and other areas of existence. The rigidity of the sequence of lineal temporality that denies man the possibility of recalling a temporal past is relaxed and made less binding.

One who discovers that one had made an unacceptable choice of destiny can still “by strong effort of will” renegotiate one’s destiny; it is morning yet on creation day.”

Nothing is absolute in the infinitely flexible and fluid universe of Igbo cosmology. In that universe, one is “not totally helpless before” one’s personal spirit. It is a universe “where God consults man in matters that concern him and at crucial stages of creation that is an on-going exercise.” By no means does this mean that the personal spirit is a mere spectator in the drama of life or that God is no longer omnipotent. Rather, the Igbo have a belief and a way of keeping “a delicate balance in a situation of multiple demands.”

In a normal circumstance, destiny is fixed and rigid and, therefore, unacceptable to the Igbo worldview which rejects fixity and rigidity. Thus, the Igbo make it possible for one to be able to renegotiate one’s destiny and, even literally, for one to accomplish anything within one’s capability. Moreover, “even if somebody has a good Chi, if he holds his hands and puts them between his thighs, no Chi can save him from a worthless life: And so the Igbo insist on a second ingredient to a fulfilled life: the thrust which a man makes into his environment.” This is the meaning of onye kwe chi ya ekwe, (“if one says yes, his personal spirit also agrees.”) Thus, the concept of personal creative spirit “unites the three interconnected principles of individuality, destiny, and achievement….”
In conclusion, we see portrayed, in mythical language, the idea of each human person as “a unique creation, a unique concern, and an intimate of God,” a destiny that makes one what one is and influences one, and thus helps to define an individual. But the individual still possesses free will and volition. Therefore, Gyekye rightly affirms that destiny is general, not specific, and that it expresses only the basic attributes of the person. Hence, human actions are neither necessitated nor fated.

This fact gives viability and meaningfulness to the concept of choice. Even if one considered free will not to be absolute in the light of human creatureliness, it must nevertheless be granted that the individual can make his or her own existence meaningful through the exercise of free will within the scope of destiny. Experience bears out Gyekye’s assertion because an individual’s thoughts, volitions, deliberations, decisions, and actions often affect the result of events, and things, even the cause of others’ lives and one’s own. The activities of the personal creative spirit, the bestowal of destiny, help to define the individual. Therefore, in defining an individual, there is a triad of the self, the community, and God (through the personal spirit). That is, the community, the embedded personal creative spirit that embodies the destiny, and the self, all serve in defining the human person. All of this occurs out within the framework of the community to which the individuals (living and dead), ancestors, the spirits, and God are considered to belong. This means that both the self and the personal creative spirit that embody the destiny impact the community or the communal living, because the personal spirit helps to define the individual who is both a communal being as well as an assertive entity capable of evaluation and choice.

4. B 2 Dependency and Interdependency of Person and Human Existence

Closely related to the relational nature of human beings is the affirmation of the dependency and interdependency of persons and human existence. This concept of
dependency and interdependency of persons and human existence is captured and summarized by Mbiti’s dictum “I am, because we are; and since we are, therefore I am” and the resultant implication that the joys, sorrows or concerns of the individual are also those of the community. The community has a responsibility to the individual just as the individual has a responsibility to the group. The members of the community take mutual care of one another because their well-being is connected and somewhat mutually dependent. This interdependency of persons and human existence is also explained by maxims or proverbs from various African ethnic groups. Some proverbs will help to illuminate this discussion.

Proverbs abound in every African language group studied, which is more than a thousand languages. Proverbs, in Africa, are short wise sayings, a repository of values, and moral messages used in the education and socialization of members, in the consolation of their suffering, and into explaining messages. For Africans, proverbs are an important expression of human wisdom, knowledge of nature, psychology, and reality. Although sometimes couched in flowery language, they represent the condensed experience of past generations. Proverbs are a vital part of everyday conversation. For example, the Igbo of Southern Nigeria affirm that proverbs are oil for lubricating conversation. The Yoruba say, “A wise man who knows proverbs can settle disputes.” A few proverbs follow to illustrate the assertion of interdependence of persons and human existence in African thought. *Ukọ kọwa anụmanụ ọ ga n’ukwu osisi ma ọkọwa mmadụ ọ gakwụrụ mmadụ ibe ya,* (“When an animal feels itchy, it goes to a tree to scratch its body; whereas, the human being who feels itchy goes to a fellow human being to be scratched.”) *Onipa yieye firi onipa,* (“The well-being of man depends on his fellow
These are from the Igbo of Nigeria and the Akan of Ghana, respectively. The point of the proverbs is that sometimes one needs the assistance, good will, sympathy, and compassion of others to achieve one’s goals or to fulfill one’s life. Other maxims expressing reciprocity and interdependence are: *Onipa nye abe na ne ho ahya ne ho*, (“Man is not a palm-tree that he should be complete [or self-sufficient]”) -- Akan. This proverb identifies the shortcomings of human beings that make one incapable of fulfilling one’s life whether socio-religiously, emotionally, psychologically, or economically. One, therefore, requires and depends on the assistance of others, that is, on one’s community, in order to be able to fulfill such needs. A Malian proverb also affirms interdependence: “the quiver hangs from the strap and the strap hangs on the shoulder.” It means that human beings depend on one another.  

An Igbo proverb with an Akan counterpart i.e., *Aka nri kwọọ aka ịkpa aka ịkpa akwọọ aka nri*; and the Akan *wo nsa nifa hohorow benkum, na benkum nso hohorow nifa*, literally means “the right arm washes the left arm and the left arm washes the right arm.” The interdependency of the right and the left hands for each other’s cleanliness is a metaphor for reciprocity and interdependence of persons and human existence. The concept of “ubuntu” which signifies communality, interdependence, solidarity, respect for life and its dignity, well expresses solidarity in African societies. According to Mluleki Munyaka and Mokgethi Motlhabi, under *ubuntu* individuals manifesting qualities of individualism such as selfishness and lack of caring are said to lack *ubuntu* or *akanabuntu*, and therefore are *akangomntu, ha se motho*, i.e., they are not person-oriented, not human. The Igbo will call such persons *a楚 oβia*, i.e., beasts. It might sound like a harsh judgment, but nevertheless, “it is a way of expressing displeasure at bad
behaviour.” The individual concerned is said to have gone against human nature by his act. Such acts as self-centeredness, not being compassionate or cooperative, that is, anti-community behavior, are “seen not just as failure to contribute to the well-being of both the person and the community, but as bringing about harm, misery, and pain to others.”

A person may have inherent dignity; however, part of being a person is being in solidarity with others, being compassionate, feeling sympathy for others. Being called akangomntu or any ọhia (a beast) does not necessarily remove one’s personhood, one’s intrinsic worth or dignity, but it depicts that one’s identity, goes pari passu, hand-in-hand with one’s responsibility or sense of duty towards others, the community. Or, as Gyekye says it, “The pursuit or practice of moral virtue is held as intrinsic to the conception of a person.”

Calling the person a beast or non-person is not a descriptive judgment, but a normative one. Similarly, when someone behaves well and the people, the Akan and Igbo, for instance, are fully satisfied with, and appreciate the high degree of the person’s moral conduct, they would refer to the person as a real human person: I ụbụ mmadụ (Igbo), Oye onipa paa (Akan). Furthermore, this sort of normative judgment on the humanness or personhood shows that the Akan, Igbo, and indeed all other African cultures consider human nature essentially good and not depraved by nature. For instance, the Igbo word for a person or a human being, “mmadụ” literally means that “goodness” or “beauty” exists. Finally, the normative judgment also implies that African cultures regard the human person as possessing “an innate capacity for virtue, for performing morally right actions,” and thus ought to be “treated as a morally responsible agent.”

In summary, these proverbs suggest and emphasize values of mutual helpfulness and interdependence, cooperation, collective responsibility, and reciprocal obligations.
African society’s emphasis on such relationships and interdependent existence is similar to the assertions of the ethics of care movement that human beings are relational and that interdependent beings are socially embedded.

Relying on the human experience of caring, ethics of care, like ATM, asserts that persons are relational and interdependent beings. Persons are by nature social beings and are embedded in the community by social ties. They are, therefore, to a large extent constituted and defined by their social or communal ties. This idea differs markedly from the notion of the nature of human being as asserted by social contract philosophers such as Locke, Rawls, and Hobbes (discussed in detail in Chapter 3, Section C.1). Suffice it to say, then, that these social contract philosophers claimed that, in their original nature, human beings were first isolated individuals but later decided to live together by contract. Consequently, in the dominant Western view, the tendency is to move from individuals to society; whereas, in the African view, there is a movement from society or community to individuals. There is an acknowledgment or confirmation of an existing community (“we are”), and the creative personal spirit which are the basis for defining the “identity of the existent and thinking self (‘I am’)”. There is also the a movement tow

The African belief that, by their nature, human beings are embedded in social relationships is not only comparable to the ideas of ethics of care but it also resonates with existential phenomenology which asserts that to be is to be in relationship: I am part of a “we” before I am an independent “I”. We are not only existence, we are co-existence. Thus, social ties are not something added, but something already constitutive of a human being. The African view, however, differs from the existentialist view insofar as the latter, especially the Sartreans, suggest that an individual alone defines the
self that one becomes.\textsuperscript{244} In African thought, however, the individual is also defined by the community and by the relationship entered into by the individual, by the personal spirit embodying the destiny, as well as by the self. Relationships create a web of dependency and interdependent human existence. Every one of us enters into a complex web of relationships and ties that include family, clans, kindred, friends, colleagues, fellow members of the community, and citizens. We are not fundamentally separate and isolated independent individuals of liberal individualists. Or what Polycarp Ikuenobe describes as “rational, autonomous solipsistic atomic and individualistic self as found in Kantian ethics and metaphysics.”\textsuperscript{245}

There is little wonder, then, that African traditional healing treatment or practice, especially for mental or psychological illness, is a community process that involves not only the patient and the healer in individual therapy, but also the family, relatives, or members of the patient’s community and the mythical supernatural world.\textsuperscript{246} This community-oriented process of healing raises patient expectancy of a cure, helps them harmonize their inner conflicts, and reintegrates them with their group and the spirit world. It also stirs them emotionally.\textsuperscript{247} Thus, Adeyemi Idowu insists that in counseling Nigerian students in the United States of America, group counseling and other techniques that emphasize significant client support groups and cultural identity are more appropriate.\textsuperscript{248}

In this relationship of reciprocity and interdependence, the individual exercises vigilance for the good of the group, and the group, in turn, seeks what is good for the individual. Both the future and the present health of individuals are intricately connected with those of other members of the community. Often, the ATM doctor is a member of
that community. The individual cannot but be confident (and trusting) to share and entrust major life decisions (medical decisions, for example) to members of the community. Sick individuals, the patients in this cultural milieu, trust members of the community to be part of their medical decision-making process. It is a decision made by reaching a consensus about what will be beneficial for both the patient and the community. If there is no agreement, the eldest member of the community or family present will resolve matters with the assistance of the sick person keeping in mind the ideas and opinions expressed during the discussion. It is in this context where communal values, relationships, and interdependency are emphasized that final consent in the decision-making process rests on the consensus reached in consultation with the community rather than with/by the individual patient alone that RAIC is realized.

4. B 3 Relational Autonomy in Informed Consent (RAIC)

The discussion in this chapter thus far has established the emphasis on relationships and communal life in African cultures. The chapter has also noted that the human person is a social being; the community alone constitutes the context, the social and cultural space, in which the actualization of the possibilities of the individual person can take place. The context, social or cultural space provides the individual person the opportunity to express his/her individuality, to acquire and develop his/her own personality, and to fully become the kind of person he/she and the community wants him/her to be. The individual is formed and defined by both oneself and the community, or the biological and social relationships. Even one’s capacity for social life, reasoning, moral sense, virtue for free choice and autonomy, though given by nature, is discovered and nurtured with the help of the community through relationships with
others. Just as in ethics of care, Clement argues that a critical examination of both our ordinary desires (first-order desires) and higher-order desires (rational reflection) show that they are not really our desires but are socially constituted. That both our ordinary and higher-order desires are communally or socially constituted would seem to imply that there is no autonomy; or that the individual is a slave of the community or social relationships. However, in African terminology one will say they are constituted by community or communal living.

On the contrary, relationships with family, relatives, friends, members of the community, and others foster the capacity for critical reflection about one’s values, motives and practices, permitting one to be autonomous in relationships. In order words, being socially constituted and embedded in the context of communal living, humans learn to become autonomous from the members of the community through relationships with them. Therefore, autonomy in African context of community offers the social or cultural space for the development, nurturing, and sustaining of autonomy through relationships with others. One speaks then of RAIC. This resonates with accounts of relational autonomy given by ethics of care proponents such as Clement, Nedelsky, and Held as recorded in Chapter Three, Section B3 above.

Consequently, ATM conceives and practices autonomy in relationships hence, relational autonomy and RAIC. Insofar as ATM emphasizes relationships, communal values, and practices autonomy in relationships, therefore, it follows that ATM adopts RAIC just as ethics of care does.251

As noted before, because of the interdependency and interrelatedness in traditional African society, the entire family and community as an extended family are
affected when a person becomes sick. The entire group is sick because the individual’s illness or health is somehow crucial to the well-being of the community, in conformity with sayings such as: “we are because I am,” and “a tree does not make a forest.”

The search for a cure and healing are also a community affair. As noted above, there is convocation or at least a consultation of relatives and elders regarding decisions about the care and treatment of the sick person. Although the initiator of the meeting or consultation, and the details of the procedure may vary among African ethnic groups, there is nevertheless, a consultation of the relevant members of the community, and some may even accompany the sick person to seek medical attention from the ATM practitioner/doctor. Generally, when children become sick, the parents, guardian, or their elder siblings champion the course of treatment and make the necessary decisions on behalf of the children. Children are considered underage if they have not undergone the traditional initiation to adulthood. In that case, their parents or guardians decide for them. Among the Igbo of Nigeria, for example, if the sick person is an adult female or a married woman, then the husband or the eldest child (if an adult) will take the lead and consult or convene a meeting of the relevant members of the community (elders, relatives) to decide the course of action. When the ill person is an adult male, then one’s siblings, spouse, or the eldest adult child takes the lead. That person will confer with or call a meeting of the appropriate members of the community (elders, relatives) to reach a consensus on the course of action.

If the sick person is able to talk about practical matters regarding the situation at hand, the group will discuss them with the patient. Such practical issues may include: which ATM doctor to consult, whether or not the patient will be brought to the ATM
doctor, whether or not the doctor will be invited to the sick person’s house for the
treatment, and how to finance the treatment. In some cases, the diviner doctor is the first
to be consulted in order to determine the cause of the illness and the procedure for
treatment or cure. The consultation includes the ancestors and the personal spirit of the
sick adult if he has a shrine made. If the consensus is that the sick person is to be brought
to the ATM doctor, the group will then decide the following: who will help nurse the
patient if required, who will accompany the patient, who will take care of the house and
children of both the patient and of those accompanying the patient. One or some of the
relatives sit in with the patient as the ATM doctor is consulted. If need be, they help to
describe or explain the history of the patient’s illness and what the sick person has
experienced. In the event that severe illness has weakened the patient, it is also customary
for them to respond to questions. Consent (including final consent) is given within this
context. In other words, final consent to decision-making rests on the consensus reached
in consultation with the group, not by the individual patient alone. Throughout the
treatment period, the family, relatives, and elders also remain available for further
meetings or consultation in order to monitor and evaluate the patient’s progress. They try
to balance the health care needs of the patient and the needs of the family and of the
community. In addition, other members of the community show their solidarity by
visiting and/or bringing food, or fetching water and firewood. They may even offer
financial aid to the patient or to the family. In general, assistance is provided according to
ability and resources. Thus, the community is part and parcel of and essential to the
decision-making and healing processes of a patient. The experience of an allopathic or
Western medical physician working among the Africans in a village explains the
community involvement and concern in medical treatment of a sick member of the community. He observed that this group of people would always come to consult him with the patient. Narrating his observation, he said: “when they are confronted with illness, a group of people invariably comes so that they can listen. They come to listen for this person, or listen with this person. When they come out of the consulting room, what they doctor said is also the concern of those who are waiting. If you want to avoid distortion, you need to continue talking with them, too.” He acknowledged that it was a carryover from ATM practice. It is just as the way the ATM doctors, nyanga, were consulted. “A group of people left the village for the nyanga’s village” to consult the doctor.255 Moreover, for example, Peter Kasenene explains that, within the traditional African context, “one cannot regard even one’s own life as purely personal property or concern. It is the group which is the owner of life, a person being just a link in the chain uniting the present and future generations. For that reason, one’s health is a concern for the community, and a person is expected to preserve this life for the good of the group.”256 Saying that “a person is just a link in the chain uniting the present and future generations” may be too strong. However, it expresses the interdependence.

The form of decision-making described here is not only followed in medical practice but is also used in other areas of life. Studies show widespread decision-making by consensus involving extensive consultation,257 as described earlier in Section 4 A5 of this Chapter.

The African practice described in this dissertation is interpreted as RAIC because autonomy is exercised in relationship with others --family members, kinsmen, friends, and, indeed, the community. In fact, the individual not only exercises autonomy in
relationships, but also develops and nurtures autonomy in relationships with others, namely the community, as ethics of care advocates observed. These relationships enable the individual, the patient, to develop and achieve autonomy as the true socially constituted individual that one is: *Motho ke motho ka batho; umuntu ngumuntu ngabantu,* i.e., a person is a person through other persons. This is a Xhosa (a South African language) *Ubuntu* philosophy asserting that a person is complete only through humane dealing with other people. This whole idea and practice resonates with the notion of RAIC that ethics of care advocates. Thus, one can confidently assert that ATM adopts and practices a similar relational autonomy, namely, the RAIC approach as does ethics of care. This relational approach to informed consent fosters solidarity and an objective concept of the good.

4. B 4 Support for the Objective Concept of the Common Good

As noted above, in the African ethos, the individual or person is embedded in social relationships. Social relationships are an aspect of the cultural community. Community life elicits and fosters shared ways of life, responsibility, reciprocity, mutual sympathies, or mutual assistance and interdependency. These values, especially the shared ways of life, are basic to a community. The implication of this shared way of life is the existence and acknowledgement of common roles, values, obligations, and meanings. It also implies that individuals advance their interests in a way that is constantly respectful and mindful of fostering the good of the community and, therefore, the good of all, reflecting the objective concept of the common good.

The concept of the common good is intrinsically linked to the idea of community and is symbolized in the Akan culture, for example, as a Siamese crocodile. This
crocodile possesses two heads but a single (i.e., common) stomach. The common stomach of this two-headed crocodile depicts that, somehow, the basic interests of all the members of the community are identical. It is, therefore, “interpreted as symbolizing the common good,” that is, the good of all the people within a society or community.  

Western liberal individualism tends to think of the common good as a threat to the good of the individual. Yet, there is no conceptual tension or opposition between the good of the individual members of a community and the common good. Likewise, the common good is not a threat to individual liberty. The contents of the common stomach of the Siamese crocodile cannot conflict with the interests and needs of either of the crocodiles.

The practice of RAIC in ATM supports and projects the notion of the common good and, hence, the objective notion of the good life. (A good life is the good of the community and the good of the individual.) There is more or less a common notion of the good and the goal of medicine in ATM. The goal of medicine is the healing of the patient, the family, and the community, by restoring the balance that has been destroyed by the illness.

Common good is not the aggregate of different individual goods or individuals’ goods. It is that which is essentially good for human beings as such. It embraces the needs or necessities that “are basic to the enjoyment and fulfillment of” each individual’s life. If it were an aggregate of individual goods, then it would not be fulfilled in such a way that would benefit all the individuals in a society. But, as that which is essentially good for human beings as such, its realization is also a realization of individual good.
of a community and the common good. As we saw in Chapter Two, liberal individualism maintains that to pursue the common good in a liberal individualistic society such as the USA, will violate the autonomy and freedom of the individual by jeopardizing one’s ability to choose one’s own good and life plans. They argue that pursuing the common good will mean being intolerant to other conceptions of the good and improper use of political power to achieve this common good. Such arguments arise because the liberal individualism of the USA allows for a plurality of good.\textsuperscript{262}

From the African point of view, communal values require that the good of all determines the good of the individual. That is, the welfare of the individual is dependent on the welfare of all -- of the community. Individuals ought to work for the good of the community -- which also includes the individual’s good. The success and meaning of the life of individuals rest on identifying with the community. Gyekye insists that it is this identification which is the basis of the reciprocal relationship between the individual and the community. The identification with one’s community is also the reason for the overriding power of the group versus that of the individual. The individual’s “personal sense of responsibility is measured in terms of responsiveness and sensitivity to the needs and demands of the” community. All the members of the community “are expected to enhance the welfare” of the community as a whole. Because this sense of responsibility is placed “equally upon each member of the” community, the interests of all the individual members of the community are maximized.\textsuperscript{263}

Finally, the practice of RAIC in ATM does not only support the notion of the common good, but has further implications for health care ethics as can be demonstrated
in applying it (RAIC) to ethics committees. But, first, it is necessary to take a look at the relationship of rights and the communal values in traditional African thought.

4. B 5 Individual Patient Rights

The case has been made above in this section for the self as communal being, who also possesses the capacity to make choices, evaluate and re-evaluate the practices of the community. Every human person possesses also an intrinsic dignity of the human person. This dignity is traceable, in part; to the African belief that God is the creator of all humans and thus human beings possess something of God, the spirit (okra in Akan, mmụọ or Chi in Igbo). These compel the recognition of some form of rights. The communal life cannot and does not overlook or avoid the issue of rights, whether it is individual or communal rights. Gyekye insists that “communitarianism cannot disallow arguments about rights which may in fact form part of the activity of a self-determining autonomous individual possessed of the capacity for evaluating or re-evaluating the entire practice of his/her community.”\textsuperscript{264} The conception of human dignity or rights, no matter how it is derived, whether from theism or from natural considerations, independently of God, obliges the recognition of rights. Thus, it requires the communal cultures just as the liberal individualism to consider rights.

However, communitarianism or communal living does not preoccupy itself with talk about rights. This is evident in traditional African cultures. There is no emphasis on individual rights or even on rights in their entirety because the stress is on communal values. Rather, the emphasis on the common good, the provision of social conditions which should “enable each individual person to function satisfactorily in a human society, does not and should not” subvert individual rights.\textsuperscript{265} Though some form of
individual rights may be recognized by communal cultures, they are not separated as such from the common values of the community and are not given a pre-eminent status. Likewise, individuals are not encouraged to insist constantly on their rights. As Gyekye correctly asserts, the reason is the assumption that rights, whether political, economic, or social, “are built into the ethos and practices of the cultural community.” Consequently, “the economic, political, and social needs of the individual members, which are the concern of most individual rights, would be expected to have been recognized” or even catered for, by the communal structure. There will be less need or urgency for individuals to insist on their rights. This is contrary to the practice of regarding rights in the USA and Western societies, as discussed in Chapter Three above. In this Western practice, as typified by the USA, individual rights and privacy supersedes the corollary to rights, namely, responsibility and duty. In other words, with every right, or privilege, there is a responsibility.

Instead of emphasis on individual rights, traditional African cultures are prone to emphasizing the duties which individual members of the community ought to perform towards others and the community. Because of the African concern with the common good or communal welfare, there is a consideration of duty as “the moral tone,” that is, as the “supreme principle of morality.” In view of this stress on duty and responsibility, “duty” has been designated as one of the principles or characteristics of African morality. Some scholars have even described African morality as duty morality.

Social or community life itself, a robust feature of the African communitarian society, mandates a morality that clearly is weighted on duty to others and to the community, it constitutes the foundation for moral responsibilities and obligations.

Duty or obligation requires each individual to show concern for the interest and well-being of others. Communal existence and relationality denote a responsibility of the
community for the individual and the individual for the community. “Living in relation with others directly involves a person in social and moral roles, duties, obligations, and commitments which the individual person must fulfill.”²⁶⁸ The other characteristics of African communal morality, solidarity, interdependence, cooperation, compassion, reciprocity, and the social and ethical values of social well-being, primarily impose on individual members of the community a duty to the community as well as its members. People carry out their duties to others without necessarily thinking that those others have a right to it. The concept of rights is not commonly thought of, rather one’s responsibility or obligation is considered. In which case, the saying that duty begets right is not exactly true in the traditional African context. Gyekye lends support to this view as follows:

> Our positive duties toward others, then, are not based on their rights: it is not so much a consciousness of the rights of others as our moral responsiveness to their particular situations that impinges on our decision to carry out our duties toward them.²⁶⁹

Menkiti reduces rights to a secondary position by asserting that in the African understanding, “priority is given to the duties which individuals owe to the collectivity, and their rights, whatever these may be, are seen as secondary to their exercise of their duties.”²⁷⁰ Some proponents of communitarian values in the Western societies also attest to the non-prominent and remedial value state of rights in a communal culture. Sandel asserts that rights would not be important, or insisted upon in a communitarian society in which a spirit of generosity exists and is effective. Thus, recourse is made to rights only when there is corruption of satisfactory communal relations.²⁷¹ Charles Taylor rejects the idea of the primacy of rights and wonders why scholars would “find it reasonable to start a political theory with an assertion of individual rights and to give this primacy.” He thinks that it is a misguided effort seeking to find a background for the arguments which commences from rights.²⁷² Alasdair MacIntyre, goes even further than Sandel and Taylor.
He believes that natural or human rights are just fictions, and that it is a plain truth that there are no such rights. Thus, belief in them is the same as belief in witches and unicorns.\textsuperscript{273} While some of these claims are over exaggerated, they point to the fact that, in communal communities, emphases are not laid on rights, especially individual rights. Consequently, because communal values such as solidarity, interdependence, compassion, reciprocity mandate duties and responsibility rather than rights, does not mean that rights do not exist. It does not and should not amount to a denial of the existence of rights and their corollary, namely, responsibility as part and parcel of the structure of moral beliefs and values of a people.\textsuperscript{274} Rather responsibility and duty have an eminent place over rights in Africa communal cultures.

4. C. Summary

With ethics of care as the hermeneutic to interpret ATM, this chapter presents a comparative analysis of ATM with ethics of care. It began with the overview of ATM by tracing the meaning, history, and the important connection between ATM and ATR, observing that a proper understanding of ATM requires some knowledge of ATR. Health and illness are often seen as influenced or caused by supernatural beings and ancestors. Thus, the cure of illness and sickness in ATM is also associated with religious rituals and practices. Thus, it pays particular attention to four ethnic groups in Africa: the Akan, Hausa-Fulani, Igbo, and Yoruba.

Furthermore, through the analysis of the four ethnic groups, this chapter notes that decision-making in Africa is generally by consensus after wide consultation of community or the people concerned; and that, if women have lost their voice in decision-
making, it was largely because of the colonial system and, to some extent, the work of the missionaries that came after the colonialists.

Continuing, the chapter discusses the concept of person and autonomy, observing that, in Africa, persons are defined in relation to their community and to themselves. African thought presupposes an existing community into which individuals are born; consequently, persons are by nature social beings embedded in the context of social relationships, thus, indicating a conception of persons as communitarian beings. There is, therefore, emphasis on communal values, relationships, and recognition of interdependency of persons in human existence. The chapter observes then that autonomy, in such a communal context, is developed, fostered, and practiced in relationships, hence, relational autonomy and, thus, RAIC. This conception of person and autonomy is comparable to that of ethics of care.

Finally, the chapter examines the concept of the common good and rights in African thought, noting that the concept of the common good symbolized by the Siamese crocodile is intrinsically connected to the idea of community. Moreover, there is a common notion of the good and the goal of medicine. Thus, the practice of RAIC in ATM supports and fosters the concept of the common good, and the objective notion of the good life comparable to that of ethics of care. Because of the African emphasis on communal values and the common good, there is no emphasis on rights. Consequently, individual rights of patients are not prominent in ATM and in African cultures.
4. D. Endnotes

3 Painter, “Traditional Medicine,” Online.
6 Gibson, The Akan Queen Mothers, 6.9 and 6.16.
8 Stenning, Savannah Nomads, 1, 6-9; and Hill, Rural Hausa Village and a Setting,1.
9 Solivetti, “Family, Marriage and Divorce, 253.
10 Salamone, “Hausa Concepts of Masculinity,” 47.
13 Gordon and Sall, “Fulani Treatment Decisions,” 68 and 78. Bluuru gives rise to common illnesses such as malaria, colds, arthritis, skin problems, respiratory disorders etc. Fulani believe that this disorder, is peculiar to them because of their vulnerability to the humidity of Sub-Saharan Africa. Gordon and Sall, “Fulani Treatment Decisions,” 68.
14 Gordon and Sall, Fulani Treatment Decisions, 74-5.
16 See also Iroegbu, Healing and Insanity, 117.
17 Forde and Jones, The Ibo and Ibibio-Speaking Peoples of South-Eastern Nigeria, 11; and Greenberg, The Languages of Africa, 8.
18 Iroegbu, Healing and Insanity, 116.
19 Iroegbu, Healing and Insanity, 117-119.
20 Edmund C. Ilogu, Christianity and Igbo Culture: A Study of the Interaction of Christianity and Igbo Culture, 1974, 11; cited by Iroegbu, Healing and Insanity, 118.
22 Forde and Jones, The Ibo and Ibibio-Speaking Peoples, 52; and Nsugbe, Ohaffia, v-vi.
23 Nsugbe, Ohaffia, 92; and Forde and Jones, The Ibo and Ibibio-Speaking Peoples, 52-56.
24 Nsugbe, Ohaffia, 68.
25 Nsugbe, Ohaffia, 59-63.
26 Nsugbe, Ohaffia, 69.
27 Nsugbe, Ohaffia, 67.
28 Ogundayo, “Yoruba” 739.
29 Sofowora, Medicinal Plants and Traditional Medicine. 21. See also Ubrurhe, Urhobo Traditional Medicine, 10.
30 World Health Organization (WHO). “Traditional Medicine Strategy;” Dime, African Traditional Medicine, 45; and Kayne, Traditional Medicine, 2-3.
31 Adekson, The Yoruba Traditional Healers, 25.
33 Owoahene-Acheampong, Inculturation and African religion, 137ff; and Wasunna, “The Discourses of Practitioners,” 319ff.
34 World Health Organization (WHO), “Traditional Medicine Strategy;” Dime, African Traditional Medicine, 45; and Kayne, Traditional Medicine, 2-3.
35 Adekson, The Yoruba Traditional Healers, 25.
45 Wasunna, “The Discourses of Practitioners,” 318-19; and Okere, Philosophy, Culture, and Society, 157ff.
47 Promotion de médicines traditionnelles : PROMETRA Mission. Online.
50 Ebrahim Samba, “Message of the WHO Regional Director for Africa,” 2-3. This is a Magazine of the World Health Organization Regional Office for Africa. See also World Health Organization (WHO) African Region, Tools for Institutionalizing, 7.
51 World Health Organization (WHO), Legal Status, 174.
52 World Health Organization (WHO), Legal Status, 174.
54 Mbiti, African Religions and Philosophy, 165ff; and Dime, African Traditional Medicine, 62-104.

56 Wasunna, “The Discourses of Practitioners,” 56ff.


63 Adekson, *The Yoruba Traditional Healers*, 7; and Epega and Neimark, *The Sacred Ifa Oracle*, viii.

64 Epega and Neimark, *The Sacred Ifa Oracle*, ix; and Adekson, *The Yoruba Traditional Healers*, 8.


75 Ross, “Inaugural Lecture,” 46; and Adekson, *The Yoruba Traditional Healers*, 6-10, and 26ff.


77 Wolff, “Yoruba,” 1032.


82 Adesina, “Traditional Medical Care in Nigeria,” Online; and Iroegbu, Healing and Insanity, 326.
83 Ross, “Inaugural Lecture,” 46.
84 Ihesie, “Who is an African Herbal Practitioner?” Online.
85 Umeh, After God is Dibia, 122-123.
88 Imogie, Agwubike and Aluko, “Assessing the Role of Traditional Birth Attendants,” 98.
89 Adekson, The Yoruba Traditional Healers, 6-10, 26; also, Mbiti, African Religions and Philosophy, 183.
91 Mbiti, African Religions and Philosophy, 183.
97 Miles and Ololo, “Traditional Surgeons in Sub-Saharan Africa,” 506.
99 Turner, “From the Local to the Global” 313.
100 Adekson, The Yoruba Traditional Healers, 6-10, and 26; Ross, “Inaugural Lecture,” 46; and Green, Igbo Village Affairs, 54.
102 Mbiti, African Religions and Philosophy, 163.
103 Mbiti, African Religions and Philosophy, 163-164.
105 Dime, African Traditional Medicine, 71-72; and Helwig, “Traditional African Medicine.” Online.


Leonard, The Lower Niger and Its Tribes, 253-261; Mbiti, African Religions and Philosophy, 165; Dime, African Traditional Medicine, 62-63; Carteret, “Culturally-based Beliefs about Illness Causation,” Online.

Okere, Philosophy, Culture, and Society, 157.

Okere, Philosophy, Culture, and Society, 157-158.


Chavunduka, Traditional African Perception of Illness, 2.

Shaibu, “Ethical and Cultural Considerations in Informed Consent,” 508.


Nyerere, Democracy and the Party System, 1.


Uzukwu, A Listening Church, 18.


Eller, The Myth of Matriarchal Prehistory; and Gibson, The Akan Queen Mothers in Ghana.

Gynocracy/gynecocracy is a “rule by women; a term used by the Swedish scientist J. J. Bachofen to signify a universal stage in the history of society, hypothesized by him to replace the age of hetairism. According to him its basic characteristics were the reckoning of kinship through the mother and the leadership of women in public life. Further study of prehistory has shown that this was the stage of the maternal kinship system, which was based on primitive communist relations and the equality of the sexes. Instead of the term ‘gynecocracy,’ the concept of matriarchy is more frequently used.” “Gynocracy/gynecocracy,” The Great Soviet Encyclopedia. Online.

Rattray, Ashanti, 81-85; Busia, “The Ashanti,” 190-209; and Gibson, The Akan Queen Mothers in Ghana, 6.26ff.

Assié-Lumumba, Les Africaines Dans la Politique, 11-19, 149-156.

Reismen, Freedom in Fulani Social Life, 47ff.

Meek, Law and Authority in a Nigerian Tribe, 130; and Iroegbu, Healing and Insanity, 118.
129 Uzukwu, *A Listening Church*, 15.
132 Iroegbu, *Healing and Insanity*, 123.
134 Uchendu, *The Igbo of South East Nigeria*, 40ff.
141 Lloyd, “The Traditional Political System of the Yoruba,” 382.
144 Ojigbo, “Conflict Resolution in the Traditional Yoruba,” 283. Ojigbo narrates how the colonial government brought about the loss of this trust.
149 Gibson, *The Akan Queen Mothers in Ghana*, 6.21-6.22.
150 Gibson, *The Akan Queen Mothers in Ghana*, 6.23.


166 Ikuenobe, *Philosophical Perspectives on Communalism*, 53.


168 See Chapter Two.


172 Menkiti, “Person and Community,” 166.


175 Gyekye, “Person and Community,” 300.


178 Ikuenobe, *Philosophical Perspectives on Communalism*, 73.


Menkiti, “Person and Community,” 171.

Menkiti, “Person and Community,” 172.

Menkiti, “Person and Community,” 174, 178-179

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CHAPTER FIVE

APPLIED ANALYSIS OF ATM’S RAIC TO HEALTHCARE ETHICS COMMITTEES IN AFRICA

This chapter presents an applied example of the contribution of ATM’s RAIC approach to healthcare ethics committees in Africa by focusing, in particular, on the decision-making process for the informed consent of patients.

5. A. General Description of Healthcare Ethics Committees

A committee can be said to be a group of people officially chosen and delegated to perform a particular function which includes investigating, reviewing, considering, acting, or reporting on a subject or a particular matter. It can also be understood as a group of people appointed to perform a task on behalf of a larger group.1 For instance, a finance committee and a discipline committee for an organization would then be committees charged with the task of finance and discipline, respectively. Similarly, a committee charged with the task of handling the ethical issues of an organization would be an ethics committee. Thus, an ethics committee is not restricted to healthcare; rather, it can be found in non-healthcare organizations or facilities as well. There is, for instance, the ethics committee of the US House of Representatives. In this dissertation, however, the focus is on ethics committees in healthcare organizations or facilities, in other words, on healthcare ethics committees.

5. A. 1. Meaning and Brief History of Healthcare Ethics Committees in the USA

Within healthcare, various labels may also sometimes be applied to ethics committees. Often, a label does not necessarily depict an essential difference, it may instead, represent a variance of facility or institution. For instance, there are hospital ethics committees, institutional ethics committees, healthcare ethics committees, and
clinical ethics committees. They can all have the same meaning within healthcare but possess slight nuances. While the first two designations may refer to facilities, the last two refer to the function. Thus, clinical ethics committees and healthcare ethics committees, and to some extent, institutional ethics committees, embrace hospitals, nursing homes, hospices, etc. Each of these is essentially different from research ethics committees whose primary function is to make decisions regarding the advisability of undertaking a particular research study or not. However, research ethics committees are not within the scope of this dissertation.

i. Meaning of Healthcare Ethics Committees in the USA

A healthcare ethics committee is a group of diverse individuals, professionals, and laypersons appointed by a healthcare facility, such as a hospital, and formally charged with three main functions: education, consultation, and policy review. The committee meets regularly to address ethical problems and issues arising within a specific healthcare institution. The members of such a committee discuss, deliberate, and advise on ethical decisions that arise in clinical care situations. Thus, Ronald E. Cranford and Edward A. Doudera defined an ethics committee as "a multidisciplinary group of health care professionals within a health care institution that has been specifically established to address ethical dilemmas that occur within the institution."4

ii. History of Healthcare Ethics Committees in the USA

The history of ethics committees shows that they arose from the need of hospital and healthcare facilities for expert ethical advice in complex ethical situations. These committees sought to improve decisions in certain cases, for example, deciding whether to withhold or withdraw increasingly complicated life-support systems from patients
whose future quality of life is uncertain. Certain events influenced the emergence of healthcare ethics committees, especially in the USA.

In the 1950s, Japanese and German physicians conducted a series of medical research experiments on captive populations without their consent. In the 1960s, the Americans followed suit. There was also the Tuskegee research in the 1970s by American scientists. During all these experiments, it was abundantly clear that some regulations were needed. In view of this fact, the US Congress established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (Research Commission). The commission, in addition to developing three basic principles to guide research involving human subjects, endorsed a system of peer review of research. However, during the late 1960s, federal agencies, such as the US Public Health Service, the National Institutes of Health, the Department of Health and Human Services (DHHS), as well as the Food and Drug Administration (FDA), the concept of peer review had already been developed. As a result, the Commission suggested that these federal groups or agencies be united into a single system. The resulting system required the establishment of Institutional Review Boards whose approval is needed prior to conduct of any research on human subjects. Later, the concept of such institutional ethics review committees was extended to the clinical setting, albeit with significant modification, leading to the establishment of healthcare ethics committees.

Another avenue of influence on the emergence of healthcare ethics committees was in the area of medical intervention. By their very nature, new medical technologies precipitated new ethical dilemmas. A typical example is that of organ transplantation, especially heart transplantation. Although heart transplantation is life prolonging, the
procedure necessitated a reconsideration of the traditional definition of death, a definition that was based on the irreversible cessation of cardiac function. Another example of new life-prolonging technology is the emergence of kidney dialysis, which, because at the time, was both expensive and in short supply, it raised the disturbing choices of who would live and who would be left to die. Subsequently, there were the new mechanical ventilators. These have the capacity of supporting biological life far beyond the permanent loss of consciousness. These life-prolonging and, thus, death postponing technologies presented ethical dilemmas and, in the public mind, triggered the feeling of loss of control. Chris Hackler and D. Micah Hester nicely expressed these dilemmas:

New technologies continued to emerge that could further postpone the moment of death. The public sensed a loss of control over technology that was expressed not only in religious and philosophical terms, but in drama, fiction, and the visual arts. The moment of death was increasingly seen as a matter of human choice for which we seemed ill prepared.

Responding to this apparent loss of control, the US Congress established the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. In addition to producing reports on such topical issues as definition of death, making healthcare decisions, and foregoing life-sustaining treatment, the Commission recommended that hospitals “establish inter-disciplinary committees to provide guidance in difficult treatment decisions,” particularly around end-of-life decisions, to educate hospital personnel regarding ethical issues, and to formulate hospital policies and guidelines. The Commission also supported the New Jersey Supreme Court approach to decision-making for incompetent or incapacitated patients in the famed Quinlan case. In this case, the Court ruled that the decision regarding whether or not to withdraw life support systems should be made by the guardians of the patient in consultation with the ethics committee. In making this ruling, the Court seemed to take it
for granted that most hospitals had ethics committees. The reality, of course, was that, at that time, most healthcare facilities did not have ethics committees. Furthermore, the Court ascribed a prognostic role to ethics committees by requiring them to ascertain whether there is a reasonable chance of recovery for Quinlan and people in her situation. However, the New Jersey Supreme Court was not the first to propose the idea of ethics committees. The Court was quoting a Baylor Law Review article written by a pediatrician, Dr. Karen Teel. Nevertheless, by this pronouncement the Court fostered the development of ethics committees or healthcare ethics committees. In this way, the Supreme Court of New Jersey ruling on Quinlan and other court rulings helped to influence the development of healthcare ethics committees in healthcare institutions in the USA.

Furthermore, in the 1920s and 1930s, special committees were established in some hospitals to review sterilization decisions. They determined which persons with mental disabilities should be involuntarily sterilized or not. Later, from 1945 to the 1960s, special committees were also formed to review abortion decisions. They were charged with the evaluation of women’s requests to terminate their pregnancies. At the same time, the committee determined whether therapeutic abortions were required to preserve the prospective mother’s life and health. Besides committees on sterilization, medical moral committees were also established. They (medical moral committees) functioned in Catholic hospitals where they dealt with issues related to reproduction, analgesia, and extraordinary medical interventions at the end of life, all from the perspective of Church doctrine. Clinical and administrative staff also started engaging in
interdisciplinary deliberations involving issues of high-tech care. They undertook self-education and exhibited growing professional awareness of ethical implications.\textsuperscript{13}

In response to the New Jersey Supreme Court’s recommendation in the Quinlan case, healthcare ethics committees were founded in some healthcare institutions in the 1970s.\textsuperscript{14} The report produced by the President’s Commission for the Study of Ethical and Biomedical and Behavioral Research in March 1983 intimated that many medical groups favored the experiment whereby some healthcare institutions utilized ethics committees as a means of improving decision-making in certain cases. These groups, which included the American Academy of Pediatrics and the American College of Hospital Administrators, found such an approach preferable to the method used by the Department of Health and Human Services in its first Baby Doe regulations. Therefore, after the federal judge disposed of the Baby Doe regulations, these groups formally encouraged the utilization of healthcare ethics committees. The Department of Health and Human Services partially agreed to the proposal while maintaining the possibility of making use of “Baby Doe Squads” in investigating claims of discriminatory failure to offer treatment to handicapped infants. Some medical institutions formed the “Infant Care Review Committee” and received greater leeway from the Department of Health and Human Services. The Infant Care Review Committees were meant to review care plans for severely disabled newborns, for instance, the Downs syndrome.

A report released in 1992 by the American Hospital Association showed that of five thousand nine hundred and sixteen (5916) hospitals responding to a survey, three thousand and fifteen (3015) or fifty percent (51\%) had a healthcare ethics committee. Some of these committees originated from a specific area of research.\textsuperscript{15} Similarly, other
healthcare ethics committees began in response to the recommendations of both the President’s Commission and the “Baby Doe” guidelines.\(^\text{16}\)

Other factors that later influenced and fostered the development of healthcare ethics committees in healthcare institutions in the USA include the requirement by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that ethics committees or a decision-making body be established and that State Legislations require the establishment of ethics committees as one of the criteria for accreditation.\(^\text{17}\) In 1991, the JCAHO began to require the establishment of a “mechanism” to examine ethical issues in patient care and to educate both healthcare professionals and patients in these issues. In response to JCAHO’s mandate, many hospital ethics committees were established. By the turn of the new century, most hospitals had ethics committees, at least in name.\(^\text{18}\) By 1994, states including Maryland, New Jersey, New York, Arizona, and Hawaii, had passed legislation requiring ethics committees in healthcare institutions, that is, hospitals and nursing homes.\(^\text{19}\)

5. A. 2. Functions of Healthcare Ethics Committees

Generally, ethics committees perform three traditional functions: the education of committee members, the staff of the facility, and the patients; ethics consultation; and the development and review of policies.\(^\text{20}\) The American Society for Bioethics and Humanities (ASBH) states that “Ethics committees and individual ethicists typically offer services that include education, research, policy development, and consultation.”\(^\text{21}\) Susan Derr carried out a study of ten healthcare ethics committees in New Jersey and observed that there were four main recurrent topics in their discussions: case reviews, policies, educational needs, and ethical updates. She relates these four topics to autonomy and
informed consent, advanced directives and values identification, futility and end of life.\textsuperscript{22}

A brief examination of the functions of healthcare ethics committees follows.

i. Education

This is the primary function of ethics committees: to educate its members and the staff of their healthcare institution, and, when necessary, the patients as well. The education function of healthcare ethics committees is imperative because most members of such committees have little or no formal formation in bioethics or healthcare ethics.\textsuperscript{23} Moreover, these committees need to assist others in making complex ethical decisions. In the education of its members, care is to be taken to see that the entire committee has a common and similar knowledge, including an understanding of each member’s function or role as well as the goal and task of the group as a whole.\textsuperscript{24} The benefit of this is that it will reduce confusion and misunderstanding in the group. It will also help members to make meaningful and appropriate contributions to the discussions and at ethics consultations. The education of ethics committee members can be fulfilled in various ways, such as self-education, seminars, conferences, short courses, and workshops. There are also resource books, casebooks, core competency materials such as those issued by the American Society for Bioethics and Humanities (ASBH) which are available for individual self-education or self-structured groups. Healthcare ethics committees can set apart some time in their meetings for an “educational component” in the form of discussion and/or presentation by a member on an important topic. Some healthcare ethics committees do not offer themselves for services until the members acquire some education or until a period of self-education is completed, while most begin services as they educate themselves. Whichever option a group adopts, it should avoid the tendency
to think that its education is ever complete or finished. The healthcare ethics discipline is vast and ever expanding. If the committee has access to funds, it can invite a guest speaker to assist in educating or creating awareness and addressing recurrent issues in healthcare ethics such as surrogate decision-making, allocation of scarce resources, and end-of-life issues. Such a move can prevent problems that emanate from lack of awareness and can foster the visibility and credibility of the committee.\textsuperscript{25} In addition to giving it credibility in the eyes of their colleagues, it will boost their confidence and their ability to help other people.\textsuperscript{26}

Besides being self-formed, healthcare ethics committees have the task of educating the entire hospital community about ethical issues involving clinical care. They begin with making their existence known to the hospital community, explaining their role, as well as how and when to contact them. Then, they facilitate the awareness of topical issues in clinical ethics. Part of the healthcare ethics committee function of educating the healthcare facility community is helping to articulate institutional moral vision where there is none, and, if required. In their encounter with ethical dilemmas in the facility, the healthcare ethics committee may discover the lack of a sufficient moral basis to resolve the moral dilemma at hand. Hence, the committee realizes the need for a morality or a common institutional morality to guide the behavior of the facility. However, where there is an existing institutional moral vision, the healthcare ethics committee assists in directing the application of that common institutional morality to new bioethical challenges.\textsuperscript{27}

The underlying aim of the education function in particular, and that of the other two functions in general, is the promotion of the patient rights and the promotion of
shared decision-making between patients, or their surrogates, and their clinicians. Furthermore, it is the fostering of fair policies and procedures that maximizes the likelihood of achieving good patient-centered outcomes and the enhancement of the ethical tenor of healthcare professionals and healthcare facilities. 

ii. Ethics Consultation

The most visible and often controversial function of healthcare ethics committees is to consult about tough clinical decisions. As medicine becomes more complex, fiscal and bureaucratic pressures mount, and governmental regulations expand, clinicians and administrators increasingly look to healthcare ethics committees for analysis and guidance in resolving healthcare dilemmas with ethical dimensions. Consultations can be done by a single person, that is, “single consultant model,” or by the whole committee, that is the “whole committee model” or by a sub-group of the ethics committee, that is, “a subcommittee model.” In the single consultant model, one person conducts the ethics consultation on behalf of the ethics committee or serves as the healthcare facility’s ethics consultant or ethicist. This model is often used in small healthcare facilities. The single consultant model allows for more flexible scheduling and, perhaps, for faster response to consult requests. It is a good model for bedside consultation. However, it lacks diversity of opinion and experience found in subcommittee and full committee models. 

The problem with the “whole committee model” is that it is difficult to get everyone to attend a consult meeting on short notice and in a timely manner. Furthermore, if everyone were to attend, it would be overwhelming for the petitioner for the consult. It is generally intimidating and frightening for a patient or a family to walk into a room filled with professionals to hold a conversation, answering and asking
questions. It is daunting, no matter how caring and concerned the committee wishes to appear.\textsuperscript{31}

Therefore, a subcommittee approach is favored. The subcommittee is smaller, perhaps two to three members. It is less overwhelming for the patient or the family. It offers diversity of opinion and experience that enriches the consultation. Moreover, it is easier to convene a meeting of two to three people on short notice. The subcommittee model has become popular. For example, a study conducted in the United States in 2007 shows that sixty-eight percent (68\%) of the ethics committees use this model; twenty-three percent (23\%) utilize the full ethics committee approach, whereas only nine percent (9\%) favor the single consultation model.\textsuperscript{32}

There are also different models of facilitating an ethics consult: the authoritarian, the pure facilitation, and the ethics facilitation models.\textsuperscript{33} The authoritarian model emphasizes the consultants as the primary moral decision-maker, by contrast with or by excluding the appropriate moral decision-makers, namely, the patients and relatives concerned.\textsuperscript{34} The authoritarian often fails to maintain a line of communication that is open with all those concerned and that does not seek to reach a consensus.

The pure facilitation model, however, seeks to reach a consensus, but, often at the expense of ethical value. Sometimes a consensus is reached without paying attention to and clarifying the “implications of societal, legal, and institutional values for the case, …”\textsuperscript{35} The ethics facilitation model seeks consensus but does not place emphasis on the consultant as the moral decision-maker at the expense of patients, relatives, and others concerned. This approach is very sensitive to and pays attention to the context in which the ethics consult occurs; it encourages all concerned to speak. It also pays attention to
ethical, legal, and societal values and their implications for the case and for all parties involved. The consultants identify and analyze the nature of the uncertainty of these values while they clarify relevant ethics concepts such as best interest, informed consent or informed refusal, solidarity, futility, etc.\textsuperscript{36} This is a more appropriate model for ethics consultation, especially for integrated ethics committees. An ethics consult requires at least three categories of skill: ethical assessment, process, and interpersonal.\textsuperscript{37} Ethical assessment skills help to identify the nature of the conflict or value uncertainty that underlies the need for consultations. The members of healthcare ethics committees need the following abilities to enable their consultation work: the ability to

- discern and gather relevant data, assess the social and interpersonal dynamics of the case (e.g., power relations, racial, ethnic, cultural, and religious differences), distinguish the ethical dimensions of the case from other, often overlapping, dimensions (e.g., legal, medical, psychiatric), identify various assumptions that involved parties bring to the case (e.g., regarding quality of life, risk taking, unarticulated agendas), identify relevant values of involved parties.\textsuperscript{38}

In order to be able to analyze the value uncertainty or conflict, they need the ability to

- access the relevant knowledge (e.g., bioethics, law institutional policy, professional codes, and religious teachings), clarify relevant concepts (e.g., confidentiality, privacy, informed consent, best interest), critically evaluate and use relevant knowledge of bioethics, law (without giving legal advice), institutional policy (guidelines on withdrawal or withholding life-sustaining treatment), and professional codes in the case.\textsuperscript{39}

For a critical evaluation of and use of relevant knowledge, some members of the healthcare ethics committees need to possess the ability to

- utilize relevant moral considerations in helping to analyze the case, identify and justify a range of morally acceptable options and their consequences, evaluate evidence and arguments for and against different options, recognize and acknowledge personal limitations and possible areas of conflict between personal moral views and one’s role in doing consultation (e.g., this may involve accepting group decisions with which one disagrees, but which are morally acceptable).\textsuperscript{40}
However, although process skills help in ethical assessment, they emphasize efforts to resolve the value conflict as it surfaces in any given healthcare situation.

Process skills comprise the ability to facilitate formal and informal meetings,

identify key decision-makers and involved parties and include them in discussions, set ground rules for formal meetings (e.g., the length, participants, purpose, and structure of such meetings), express and stay within the limits of ethics consultant’s role during the meeting, create an atmosphere of trust that respects privacy and confidentiality and that allows parties to feel free to express their concerns (e.g., skill in addressing anger, suspicion, fear or resentment; skill in addressing intimidation and disruption due to power and/or role differentials).41

Process skills also require the ability to assist people to critically analyze the values underlying their assumptions, their decision, as well as the possible consequences thereof. Likewise, process skills require committee members to be able to engage in creative problem solving, being able to “negotiate between competing moral views,” using the structures and resources of the institution to facilitate the implementation of the selected option.42

Finally, the interpersonal skills, which are very essential to nearly every aspect of ethics consultation in individual patient cases are attained by “doing” or practice. They require members of the ethics committees to be able to

listen well and to communicate interest, respect, support, and empathy to involved parties, educate involved parties regarding the ethical dimensions of the case, elicit the moral views of involved parties, represent the views of involved parties to others, enable involved parties to communicate effectively and be heard by other parties, and recognize and attend to various relational barriers to communication.43

In the consult, the healthcare ethics committee, through its subcommittee, assists the parties concerned “to discern the ethical issues, the options for action,” and the course of action that is better in that given situation, having considered all circumstances.44 In this way, ethics committees assist decision-makers, albeit by advisory recommendations. Through the consult, healthcare ethics committees also serve as forums for airing and
resolving disagreements among staff, patients, and families about clinical care decisions and resolving difficult medical dilemmas.

Healthcare ethics committees can make treatment recommendation. It is known that, when physicians request a consult, they are seeking for some kind of expert opinion, such as whether a given procedure would be ethically justifiable or not. Likewise, patients and families would ask similar questions. Through the ethics consultation, healthcare ethics committees provide ethics education to patients, their relatives, and the community. At the end of the consult, the subcommittee reports to the healthcare ethics committee where the case is reviewed by the entire membership. The case review serves to foster accountability, to provide information to enable the organization and healthcare ethics committees in their policy development and review function, as well as helping in quality improvement and better patient care. Finally, ethics consultations should be documented in an appropriate place such as in the patient record or in some other secure place. Documents of ethics consultations help foster accountability, communication, and improvement of both patient care and organization’s quality.

iii. Policies Development and Review

The third function of healthcare ethics committees is the development and review of ethical policies concerning various aspects of the healthcare activities of the institution or hospital. Healthcare ethics committees are often responsible for creating policies to “effect the bioethical commitments that have been crafted or which are to be applied” to a facility’s healthcare activities. In such instances, the assumption is that “the general morality is clear” and that what is needed is simply an elaboration of particular policies. Such policies include advance directives, orders regarding “do not resuscitate,”
identification of appropriate surrogate, policies pertaining to informed consent, and surrogate decision-making, confidentiality, futility, and framing of triage forms to direct clinical decision-making. Care should be taken to collaborate and involve particular departments or persons that are concerned with a policy under review. However, rather than the healthcare ethics committees, it is the administration or the board of trustees who promulgate the ethical policies developed or reviewed by the ethics committees.48 Healthcare ethics committees make recommendations: “advice from a qualified third party, based on thoughtful examination of the case in the context of the ethical principles of justice, autonomy, beneficence, and nonmaleficence.”49 Although healthcare ethics committee judgments are recommendations, some courts use them as legal evidence in support of physician action.50 The importance of this function, that is, policies development and review, lies in the fact that the ethical climate of any facility is determined, to a large extent, by the policies it adopts and practices. Good policies assist people to make good decisions, thereby preventing ethical problems from arising.51

5. A. 3. Composition and Formation of Healthcare Ethics Committees

The composition and formation of healthcare ethics committees vary according to places and situations. However, it is encouraged that members be drawn from various departments of the facility as well as from the local community which it serves.52 Participation and membership is usually voluntary and non-salaried. The Society for Health and Human Values –Society for Bioethics Consultation Task Force published a position paper in 1998 in which it stated that healthcare ethics committee members “must have institutional support.” Members should be allowed sufficient time and excused from other duties to engage in healthcare ethics committee work such as ethics consultation.

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The institution should also provide members with the necessary access to resources in order to further their ethics education. The committee can include physicians with different specialties, nurses, administrators and trustees, chaplain, social workers, technicians, security personnel, business department staff, representatives of the local community where the healthcare institution is located, and a person trained in bioethics. The interdisciplinary or multidisciplinary nature of healthcare ethics committees cannot be overemphasized. For example, membership on one of the healthcare ethics committees that I belong to, at Forbes Regional Hospital in Pittsburgh, has as members: physicians, nurses, nurse practitioners, a lawyer, ethicists, clergymen, a community representative, social workers, and administrators, etc., The selection of members of healthcare ethics committees should consider the individuals’ concerns for the welfare of the sick and infirm, the candidates’ interest in ethical issues, as well as their reputation in the community and among their colleagues or peers.

There are also some guidelines for the formation and training of healthcare ethics committees. Such guidelines include a two-page document, “Guideline on Hospital Committees on Biomedical Ethics,” published by the American Hospital Association. It is a general document that deals with the composition, function, and deliberations of committees. Another guideline is that of the American Academy of Pediatrics for seriously ill infants. There are also the core competencies for healthcare ethics committee consultation compiled by the American Society for Bioethics and Humanities. This document deals exclusively with ethics consultation. It recommends that every member of healthcare ethics committees acquire some competencies or skills such as those necessary to identify and analyze the nature of conflicts or value uncertainty, as well as
the ability to lead both informal and formal meetings. Likewise, it requires the ability to listen well and to communicate interest, respect, support, and empathy, and to elicit the moral views of those involved in consult.  

5. A. 4. Integrated Healthcare Ethics Committees

There has been a shift in the *modus operandi* of traditional healthcare ethics committees or healthcare ethics committees to what is now known as “Integrated” healthcare ethics committees. The integrated healthcare ethics committee model was occasioned by the idea of an integrated clinical and organizational ethics and consult. The primary reason for the new model was that the existing model in use at the time, and which is still in use in some places is primarily reactive and case-based. It concentrates on acute-care and individual-oriented patient care. In their journal article of 1999, C. R Seeley and S. L. Goldberger reject the distinction or dichotomy between clinical ethics concerns and those of organizational ethics. They posit that making such distinctions is similar to differentiating the concerns between *psyche* and *soma*, which for them is a false dichotomy.  

When the healthcare ethics committee of St. Joseph Health System in California came to the conclusion that their healthcare ethics committees were in trouble or becoming more trouble than they were worth, they decided to attempt to reform the committees. The members concurred on the point that healthcare ethics committees exist for the primary purpose of fostering the care of patients by improving “the ethics of professional caregivers and caregiving organization.” The group reasoned that, given such a purpose, healthcare ethics committees felt the need “to make a demonstrable difference in how patients are actually cared for by making a demonstrable difference in
how the staff and the organization itself actually deal with ethical issues relating to patient care.” To achieve this goal, the group came up with four principles or values that healthcare ethics committees should adopt: 1) healthcare ethics committees should be “proactive and not just reactive, 2) they should be organizationally integrated and not isolated, 3) they should be accountable in accordance with measurable outcomes and not just in accord with the good intentions of their members, 4) finally, they should be “oriented by institutional values and not just patients’ rights.”

In their journal article of 2006, Mary B. Foglia and Robert A Pearlman showed that the traditional case-based approach to ethics consult and framing of ethics issues may result in solutions that attend to the immediate issue but do not resolve “the underlying systems and processes that contribute causally to the problem.” Consequently, the solution does not “prevent a recurrence of the same problem.” They contrasted case-based response to ethics consultation with systems-oriented ethics consultation. Systems-oriented ethics consultation would be the method attuned to the integrated healthcare ethics committees’ method. While a systems-oriented approach might agree with the ethical analysis of that of case-based, its (systems) perspective will, in addition, highlight the facets of a case that might otherwise have been neglected or ignored. In other words, a systems-oriented or integrated approach to consult widens the perspective. It enables “one to view the case through the widest possible lens.” It makes the healthcare ethics committee look constantly for “pre-disposing factors that contribute to the development of ethics concerns.” Thus, a systems-oriented approach places high emphasis on identifying strategies that will assist in preventing future recurrences of the problem. The strategies are supposed to target the organization’s systems and processes frequently.
The systems-oriented approach does not focus on interventions, whether educational or other, their sole purpose is changing individual behavior. The underlying understanding is that the capacity of the employees of the facility to come up with sound ethical judgments and later act on the judgments is powerfully shaped by the organizational environment, a factor which is external to the individual.\textsuperscript{62} Instead, systems-level interventions aim at making the ethical response virtually inevitable. An example would be employing “electronic reminders to update a patient’s advance directive upon admission to acute care.”\textsuperscript{63} The various aspects of the organization, for example, ethics consultants or quality improvement experts, and risk-benefit assessment, are involved and integrated in this approach. While the identified strategies target the systems and processes to prevent recurrences, the systems-savvy consultants are also at work. Applying a healthy skepticism to the proposed corrective strategies, they investigate the possibility that both corrective and preventive strategies generate their own set of unintended negative consequences. Therefore, healthcare ethics committees in their consultation are expected to question constantly whether the case being treated has “systems-level antecedents and implications.”\textsuperscript{64}

In brief, this requires healthcare ethics committees to move from being primarily reactive and case-based, to being primarily proactive and systematic in addressing ethical issues and integrating ethics consultation, preventive ethics, and ethical leadership (organizational ethics). Healthcare ethics committees will address and tackle ethics issues and concerns in advance before conflicts occur. In performing this preventive function, committees need to move beyond the context of individual cases and their management to that of system-oriented patient care. The committees seek and analyze the root cause of
ethical conflicts with a view not only to resolve but also to prevent future occurrence. In this way, the healthcare ethics committees become proactive agents of systemic change leading to improved patient care within the organization. By means of this root cause analysis, they also achieve organizational transformation. However, it requires, first of all, that the management hold the ethics committees accountable for the resources provided to them. Second, it requires some parameters for judging the performance of healthcare ethics committees and the success of the model. No doubt, both the management of the healthcare facility and the ethics committee themselves would be interested in knowing the impact of the venture, that is, of shifting from the old to the new model as well as the resource deployed. Thus, the need for a judgment standard with regards to how management should hold ethics committees accountable arises. Blake suggests that the good intentions of ethics committees are sufficient to judge their performance; that it might be entirely inappropriate to hold the ethics committees to “measurable outcomes” in judging their value to the organization, and ultimately to patient care. Blake’s reason is that ethics committees are staffed by some of the nicest, most sensitive, well-meaning members of the organization, and not the hard core business members of the organization or the physicians who are not very much interested in their healthcare facility. According to Blake, the character and temperament of most of the ethics committees’ members are typically volunteers-driven in nature.

However, the evaluation of how well or how bad the healthcare ethics committees are doing in improving patient care can be done in two ways: healthcare ethics committees can simply continue to advocate for patients’ rights as delineated by law and by the codes of professional organizations. Alternatively, healthcare ethics committees
can widen and deepen their view of their values of their foundation which is associated
with the institutional values of the healthcare organizations. Examples of such
institutional values are those of St Joseph Health System: Dignity, Service, Excellence,
and Justice; or The Pittsburgh Mercy Health System: Help, Hope, and Healing; or the
University of Pittsburgh Medical Center: Live Changing Medicine; or the Cleveland
Clinic: Quality, Innovation, Teamwork, Service, Integrity, and Compassion; or those of
the Sisters of Charity Leavenworth Health Services Corporation: Response to Need,
Respect, Wholeness, Excellence, and Stewardship. These values point towards a
framework which is beyond the individual and the individual’s particular interests and
needs. By orientation and impact, these sets of values are more communitarian than the
individualistic values of the rights of a patient. Hence, Black rightly recommends the
adoption of the second option. In working from the standpoint of the communitarian
traditions of their own organizations, healthcare ethics committees will also deal with the
autonomy and rights of a patient, because it is unlikely that an organization will embrace
values that explicitly deny patient autonomy and/or rights. The healthcare ethics
committees should have a clear mission and vision articulated in line with the above four
principles and in conjunction with the mission and values of their healthcare
organizations. Integrating healthcare ethics committees and ethics into the management
of the organization requires making a “difference for the better in how patients are
actually cared for” and not just having interesting discussions or re-shaping a facility’s
public opinion. It requires the jettisoning of the appearance of healthcare ethics
committees as ‘volunteers’ working as ‘amateurs.’ Members must be serious, and the
training of members must also be taken seriously and must be carried out in a systematic
manner. The selection and support of ethics committee chairs and members have to be a serious administrative responsibility. The advantage of placing healthcare ethics committees in the corridors of an administrative structure is that it will allow direct interaction with the power brokers of the institution and will potentially integrate “ethics activities with the administrative appendages in which core ethical issues arise.” Aligning healthcare ethics committees with the administrative structure would mean that a senior operations officer would be made responsible for the healthcare ethics committee in the facility. The officer will assume the administration’s responsibility for the existence and effectiveness of the healthcare ethics committee. The committee will report its activities to the officer in a manner that is agreeable to both the committee and the officer, who may have only an ex officio role on the committee. Yet, the officer will see to it that the chairs of the healthcare ethics committees are properly supported to fulfill their function on the committee and to the facility.

The integrated healthcare ethics committees are expected to be formally integrated into the organization’s operations and to be internally structured in order to facilitate their own effectiveness. Implementing the transposition from an existing healthcare ethics committee model to the integrated or proactive model requires time, possibly two to three years, depending on the facility. However, based on the above four principles, certain groupings of tasks are required to foster re-formation. These task groups are delineated by Blake in his article. Some scholars, for example, Wenger, Blake and their colleagues, propose a subcommittee ethics resource service as part of the healthcare ethics committees which conduct the valuable function of healthcare ethics committee accountability and evaluation for ethics consultation. If an institute can afford
it fine; instead, rather than being a permanent group, other members of the healthcare ethics committee can alternate in performing that function.

In conclusion, therefore, integrated healthcare ethics committees should be proactive and not just reactive both in their constitution and work habits; they should be organizationally integrated, and not isolated in both their membership and design. They should be held accountable for performance, based on demonstrable outcomes, and not simply on good intentions. Finally, in both their analyses of issues and their activities, healthcare ethics committees should be oriented by organizational core values, as well as external legal, regulatory, accreditation requirements. In the words of Wenger:

The ethical issues of hospitals and hospital systems today require integration of the ethics system into the administrative decision-making mechanism and a level of timing and power that is far different than the HEC of yesterday. Accomplishing these goals will require paradigm shifts such as those proposed in the Next Generation Model. However, in shaping a new institutional ethics structure, many of the troubling issues inherent in HECs (but less obvious in an informal structure) such as independence and quality control become clearly discernible problems to be tackled.

5. B. Situation of Healthcare Ethics Committees in Africa

Now that the meaning, composition, and functions of healthcare ethics committees in the liberal Western societies, especially in the USA, have been established, the need for and how an integrated proactive model of healthcare ethics committee for better patient care can be realized. It now remains to explore the situation in Africa, in ATM, and to demonstrate which type of healthcare ethics committee is suitable for ATM in view of RAIC for better patient care and decision-making process of informed consent of the patient.

5. B. 1. A Brief History of Healthcare Ethics Committees in Africa

In certain African countries, such as Nigeria, some healthcare facilities have what is called “grievance committees.” The members are generally selected by the
administration and are answerable to the administration. Their main function is to mediate disputes between patient and staff or disagreements between staff members. They are not really ethics committees *per se*, because the membership or composition is neither sufficiently diverse nor mixed to reflect facility demographics. There is usually no community representation in the group, and the facility does not receive or provide ethical training for its members or for the hospital community.

In other countries, for example in South Africa where healthcare ethics committees exist, their organization and development were in response to regulations by the Council for Hospital Accreditation for Southern Africa (COHSASA) which requires their formation as a criterion for accreditation of hospitals or healthcare facilities. In 2012, the Mulago Hospital in Uganda formed a healthcare ethics committee. More prominent than the hospital ethics committees in Africa are the many research ethics committees (REC) and, more recently, the national ethics committees. These arose, in part, because of the influence of international collaboration in biomedical research and are sponsored by international agencies such as the WHO and UNESCO. Some of these research ethics committees have a considerable history. For example, the oldest committee of the research ethics was formed in 1967 in South Africa. That of the Medical Research Council of Zimbabwe was established in 1974. Of course, research ethics committees are decision-making bodies which have a rigid protocol geared toward research projects. On the other hand, healthcare ethics committees are not decision-making committees. The national ethics committees (also called national bioethics committees) are very recent and are supported by UNESCO. The plan is for every
country in Africa to establish one of these committees for discussions and consideration of issues in bioethics; they are not necessarily healthcare ethics committees.

5. B. 2. Healthcare Ethics Committees in Hospitals

With regard to the current situation of ethics committees in African countries, the existing data show that, with the exception of South Africa and Uganda, there are hardly any ethics committees in hospitals which consider patient care. As noted above, in South Africa, the Department of Health requires all hospitals to have ethics committees. In January 1998, an ethics committee was formed at Soroka Medical Center I Beer-Sheva. After an exploratory meeting on February 28, 2003, an ethics committee was formed in March 2003, in Grey’s Hospital KwaZulu Natal of South Africa. The first meeting was held on March 14th, 2003. The reason for the lack of healthcare ethics committees in most African countries is that their functions, advantages, and the importance of their need have not been fully appreciated. Consequently, there is a need to create an awareness of the significance of healthcare ethics committees and to develop ways to establish them. In addition, lack of encouragement on the part of individual governments suggests the need to encourage and facilitate the establishment of healthcare ethics committees in their respective countries. In South Africa, where the government and the Hospital Accreditation Board have not only encouraged their establishment but have required them for the accreditation of hospitals, the response is different. Similarly, in most countries, for example, Nigeria, Ghana, and Uganda, where the governments have created the awareness of the importance of and their need, research ethics committees are booming. There are even Centers, such as the West African Center for Bioethics,
charged with the responsibility of assisting in the formation of such committees and in the training of members.

5. B. 3. Healthcare Ethics Committees in ATM

No healthcare ethics committee has been identified for ATM facilities. Even though there are laws and rules in some African countries for guiding, regulating, and monitoring the practices of ATM doctors and practitioners, none seems to require the establishment of healthcare ethics committees. Nevertheless, the need for such committees in ATM and other health care institutions cannot be over-emphasized.

Some biomedical issues that gave rise to healthcare ethics committees in the USA and in Europe exist in Africa. These include issues arising from developing healthcare technologies, commercialization of medicine and healthcare, evolving societal, communal, institutional, professional, and individual values. There is also a rising population of Christian fundamentalists who oppose traditional ways of life as satanic or evil, an expanding array of possible treatments that pose difficult decisions for patients, their relatives, and the community. Some new issues arise from collaborations in healthcare technology and marketing between Africa, the USA, and other continents (Europe, America, Asia, etc.). Moreover, some ATM facilities are utilizing modern medical technology to augment and improve their medical practice. The influence of these technologies and developments has been recognized by the West and Central African leaders as well as by scholars who gathered in Dakar in 2005 for a meeting on ethics and bioethics:

Aware of the advances in life sciences and the impact of their applications in Africa;
Aware of the necessity to engage in appropriate reflection and to promote ethical debates and organized social movements that can help to deal with the issues as well as economic, social, cultural and health challenges which the continent is confronted with;
Aware of the complexity of these questions which require a multidisciplinary and pluralistic approach; ….

The group, therefore, called for the development of frameworks for the practice of ethics in healthcare and beseeched the governments of African countries to make a commitment towards the formation of ethics and bioethics committees, particularly by instituting legal frameworks aimed at specifying conditions for their creation and functioning. Uppermost in the mind of the group were both research ethics committees and national ethics committees. Because the ethical concerns which the group identified were also pertinent to healthcare ethics committees, its call to the governments applies to healthcare ethics committees as well. In addition to recognizing the need, the Dakar declaration also acknowledged the “urgency to put into place a Forum of Reflection, Dialogue, and Action concerning questions of ethics, bioethics, and life sciences for the continent and in particular for West and Central Africa.”

Furthermore, it is not unknown that health professionals themselves experience ethical dilemmas in their work of caring for patients. In their separate surveys in the United Kingdom V. F. Larcher, B. Lask, J. M. McCarthy as well as A. Slowther, C. Bunch, B. Woolnough, and T. Hope demonstrate that many healthcare professionals frequently encounter ethical dilemmas notwithstanding the many guidelines, regulations and recommendations issued by regulators, professional and government bodies. These studies also examined the frequency with which medical personnel experience ethical dilemmas, their nature, the mechanism for dealing with them, and the need for education and training. The surveys identified a need for clinical ethics consultation and support expressed by medical personnel directly involved in patient care.
A number of other studies reveal that healthcare personnel find ethics consultations beneficial and educational. More than eighty-five percent (85%) of physicians surveyed who had previously sought the help of a healthcare ethics committee indicated that they would engage in an ethics consult again in the future. They also recommended ethics consults to their colleagues.\textsuperscript{86} A more recent survey shows that forty-one percent (41%) of physicians polled stated that ethics consultations were “often helpful,” thirty percent (30%) described them as “occasionally helpful,” whereas only fifteen percent (15%) saw them as “rarely helpful.”\textsuperscript{87} Patients and their surrogates likewise found ethics consultations beneficial. However, the level of satisfaction for patients and their surrogates was lower than that of healthcare personnel.\textsuperscript{88} Felicia Cohn and her colleagues analyzed proactive ethics consultations in ICUs and determined that families, patients, and healthcare personnel found ethics consultations to be informative and “helpful for analyzing and resolving ethical conflicts.”\textsuperscript{89} All these surveys and studies based on the testimony of patients, families, and healthcare personnel, found ethics consultations to be beneficial and educational, and help in formulating a compelling rationale for establishing healthcare ethics committees in ATM.

Therefore, the need for healthcare ethics committees in ATM and even in allopathic medical facilities in Africa cannot be over-emphasized. Some of the typical issues that these committees will be addressing include those surrounding the beginning of life, namely, the utilization of reproductive technologies, abortion, infertility, spread of sexually transmitted diseases, misuse of traditional and allopathic medicines, confidentiality, informed consent, medical futility, and relationship between allopathic and ATM. Healthcare ethics committees will assist existing mechanisms in addressing
ethical issues arising in medical practice today. They will further attempt to integrate ethical analysis with medicine, such as an increased emphasis on ethics in medical education, organization of conferences and seminars, publications, and other forums dedicated to ethical issues. That healthcare ethics committees will be helpful in improving the functioning of healthcare institutions as well as the welfare of the patients is shown by the remarks of the administrators of Grey Hospital in Kwazulu-Natal, South Africa regarding their healthcare ethics committee:

The Committee “has formulated ethical guidelines on some topics … posted its Vision and Mission and some documents relating to its activities on the Grey's Hospital website. The Committee has also organized regular Ethics Forum lectures … (usually four per year) … drawing a substantial audience of knowledgeable and enthusiastic participants. Unfortunately the younger members of the medical community (interns and registrars) have not shown a great inclination to participate in these activities. In the last year the Committee has become increasingly involved in considerations of the ethics of health care related research, and has recommended the establishment of an accredited Research Ethics Committee in the Pietermaritzburg Metropole, … it is becoming increasingly sophisticated in its debate on ethical issues and spreading the culture of Ethics in the Hospital Community.”

Some general concerns regarding the need for healthcare ethics committees have been examined by Anne Slowther, Chris Bunch, Brian Woolnough and Tony Hope. They asked if part of the reason for requiring healthcare ethics committees is to introduce discussion of clinical ethics to a wider group in order to allow different perspectives to inform decisions, then could not the same objective be realized by making use of one of the existing committees such as the grievance committee? Likewise, the claim that the term “ethics committee” suggests that a healthcare ethics committee possesses a “particular ethical standing” then “its advice on ethical issues should carry more weight” than that of other groups such as the medical advisory committee or the grievance committee. Consequently, Slowther, Bunch, Woolnough and Hope examined how this can be justified. Addressing these two issues, they pointed out that it is not so much the
question of lack of expertise on the part of medical professionals as a lack of decision-
making support. Therefore, some of the circumstances in which healthcare ethics
committees “can be of most value to professionals is when they are unclear themselves
about an important decision and voicing this in a forum that is designed to aid them in
thinking through this decision.”\(^{93}\) However, on issue of ethical credibility or the authority
of healthcare ethics committees, Slowther and her colleagues argued that it depends in
part on the procedures of healthcare ethics committees. In fact, simply by their
procedures, the healthcare ethics committees will earn some authority should they
(committees) appear “to represent a wide range of points of view, including those of lay
members,” and should these points of view be perceived as being “respectfully, carefully,
and reasonably considered.”\(^{94}\) Slowther and her colleagues supported their argument
with Norman Daniels’ claim that “establishing a fair process is easier than agreeing on
principles.”\(^{95}\) As a result, there remains, at the least, the incentive to, establish a fair
process. For Daniels there are three implications of establishing a fair process:
“Transparency about the grounds of the decisions, appeals to rationales that all can accept
as relevant to meet health needs fairly, and procedures for revising decisions in the light
of challenges to them.”\(^{96}\) Daniels is of the opinion that these elements together guarantee
“accountability for reasonableness.” In light of Daniels’ exposition, Slowther and her
colleagues are confident that healthcare ethics committees are capable of being
reasonable in similar ways, and that becomes surely an important source of the moral
authority of healthcare ethics committees.\(^{97}\)

Furthermore, healthcare ethics committees have a history of working to improve
the quality of healthcare by providing a forum for addressing ethical issues with a
multidisciplinary group of healthcare professionals. Formation of ethics committees in ATM will, no doubt, aid in improving the quality of ATM healthcare. Hence, the need for healthcare ethics committees in both ATM and in allopathic medical facilities is highlighted. In light of this, it is necessary to consider the type of healthcare ethics committee that would be appropriate for ATM, that is, among other things, the type that will improve patient care and work in accord with RAIC.

5. B. 4. The Type of HEC Suitable for ATM

ATM is practiced in both the urban and the rural areas of Africa, albeit predominantly practiced in rural neighborhoods. Most ATM doctors practice from their family premises; therefore, most facilities are small. They attend to patients in their respective homes. It is not uncommon for this group of ATM doctors to travel from village to village treating and caring for their patients. Some practice from compounds other than their own family premises and these are often large facilities. A growing number of practices are following the latter form and some of them utilize both local and foreign medical technology to augment and improve their practices. Good examples would include Blackherbals at the Source of the Nile, Uganda Ltd.; Pax Herbal Clinic and Research Laboratories Ewu, Edo State, Nigeria; Pax Natural Medicine Hospital and Pharmacovigilance Centre in Ikeja, Lagos State Nigeria; Centre for Psychic and Healing Administration Awka, Anambra State, Nigeria; and the Spiran Centre for Self Realization Awka, Anambra State, Nigeria.

Blackherbals at the Source of the Nile (its motto: “We can make you healthy and wise”) is an African Traditional Herbal Research Clinic at Bukoto, Uganda. It is a modern clinic facility established with a three-fold purpose: research, updating ATM doctors, and patient treatment. Some of the therapeutic services it offers include African
herbal medicine, reflexology, acupressure, hot and cold hydrotherapy, body massage, herbal tonics, patient counseling, blood pressure checks, urine analyses (especially for diabetes), nutritional profiles, and spiritual counseling upon request.\textsuperscript{98}

Pax Herbal Clinic and Research Laboratories, was established in 1996 by the Rev. Father Anselm Adodo. According to him, it has grown from a two-room wooden hut to a gigantic edifice the likes of which are yet to be found anywhere in West Africa. It has developed from a staff of two in 1997 to 150 full-time and 50 part-time staff members today. It serves as a research complex comprising diagnostics, quality control, drug formulation, a chemistry laboratory, and a therapeutic clinic. It conducts both in-patient and outpatient services. In 2005, PAX had only two products listed by NAFDAC, but now the facility has 33 pharmaceutical products listed, the highest so far by any single medical organization in Nigeria.\textsuperscript{99}

Finally, the Centre for Psychic and Healing Administration (CPHA) located in Awka, Anambra State of Nigeria, has as its motto “Resolving the conflict between man and nature.” Early in the course of the research for this dissertation, I had an opportunity to visit this center and its founder and owner, Chief Dr. Mrs. Flora I. N. Ilonzo. The facility functions as both a production and treatment center; that is, it produces its own pharmaceutical medicine and offers both in-patient and outpatient services. According to a documentary, the CPHA Awka has offered medical or therapeutic services to about three million (3,000,000) people since its inception in February 1997.\textsuperscript{100}

In light of the situations described above, and considering the necessity for and importance of integrated and proactive healthcare ethics committees, the appropriate model of such committees for ATM would have to take cognizance of the various
situations, sizes, and locations of the ATM facilities. They would also have to be integrated and proactive ethics committees.

Large facilities that have sufficient human and economic resources to afford their own ethics committees can do so. On the other hand, because small facilities lack adequate human and economic resources, they can collaborate and have one healthcare ethics committee, what W. Nelson calls a “multi-facility ethics committee.” When facilities collaborate to form a healthcare ethics committee, it enables them to share the cost of administering and maintaining the committee, to share staff, ethics experts, and educational resources. Each participating facility assumes responsibility for the financial needs of its representative(s) to the committee, in addition to contributing to the general administration of the committee. Furthermore, when multiple healthcare facilities form a joint healthcare ethics committee, they benefit from exposure to problems that the other collaborating facilities are currently experiencing, but which they themselves have not yet experienced at their own facility. Thus, early exposure to such problems can be a precious aid to a healthcare ethics committee’s effort to deal proactively with an ethical dilemma in its own facility. Likewise, a healthcare facility, by virtue of its cooperative association with a multi-facility healthcare ethics committee, can procure valuable information from that committee about how to deal with certain problems its facility is facing by tapping into the experience of other joint member facilities, especially those that had already experienced similar issues. Furthermore, a multi-facility healthcare ethics committee can offer useful educational forum regarding different ethical issues commonly encountered in each member facility.
It is also worth noting that a multi-facility healthcare ethics committee can be time consuming and strenuous for its members. If the facilities involved are geographically separated, even though meetings venues may be rotated among member facilities, the distance that committee members must commute might be a source of concern or pressure. This can be a serious issue in view of the fact that committee members already have obligations where they regularly work. Another issue is that participating members must be careful in their deliberations that they are not perceived as outsiders telling other facilities what to do or how to operate their respective facilities. If some members perceive others in their way, there could be some resentment, which could ruin the relationships and the atmosphere at committee meetings.

Another important point is the need to integrate healthcare ethics committees into the administrative structure of the joint organization. Whether these committees derive from large individual ATM facilities or from multi-facilities ethics committees, they ought to be integrated into the management structure of their particular facility and be proactive in their functions as they seek to improve patient care. Therefore, the following four main characteristics are recommended: i) being organizationally integrated, ii) being proactive and using preventive ethics, iii) ethical leadership, and iv) being accountable.

i. Being Organizationally Integrated

To be organizationally integrated and not isolated will align the committees with the administrative or management structure, and thus, afford them direct interaction with the director/owner of the ATM facility/practice. Integration also means that all facets of the organization will operate in unity or as a community and not in isolation or as isolated factions. Ethics will be integrated into the whole system, thus creating an ethics
environment and culture within the facility/ties. This integrated model of a healthcare ethics committee is very much in harmony with African communal orientation and values: shared decision-making with patients, relatives, and community. It provides an opportunity to examine how well the facility or facilities (i.e., for multi-facility healthcare ethics committees) promote collaborative decision-making between clinicians, patients, and members of the patient’s community.

Furthermore, the integrated approach will enable the healthcare ethics committees to address the following ethical issues:

- To explore the full range of ethical concerns that commonly arise in ATM, such as patient privacy and confidentiality. Therefore, the committees can ask how well the facility protects patient privacy and confidentiality in light of the African tradition whereby members of the patient’s community, out of concern for the wellbeing of the patient, request medical information about their sick community member.

- To examine how well the facility addresses ethical practices and aspects of caring for patients nearing the end of life.

- And, finally, to see how well the facility promotes high ethical standards in business and management practices making sure that patients’ bills are commensurate with the treatment received; and that patients are not secretly used for research without their knowledge.

In fact, the committees have an opportunity to examine ethical practices in the general daily work place, that is, how well the facility supports ethical behavior in everyday interactions in the workplace and in relationships with the local community. In these
ways, healthcare ethics committees can focus on the entirety of their healthcare organization rather than primarily or exclusively on the clinical ethics aspect.

ii. Being Proactive and Using Preventive Ethics

Healthcare ethics committees being proactive and not just reactive involves addressing the underlying systems and processes that influence behavior. Each committee will need to develop a systematic method for proactively identifying, prioritizing, and addressing concerns regarding the quality of ethics at the organizational level, thus targeting systems and processes. The USA Veteran Association National Center for Ethics in Healthcare uses some quality improvement methodologies which ATM healthcare ethics committees and, indeed, all ethics committees can benefit from. The approach is called “ISSUES,” which is a step-by-step method for dealing with ethics quality gaps in healthcare. The acronym “ISSUES” stands for: Identify an issue proactively, Study the issue, Select a strategy, Undertake a plan, Evaluate and adjust, and Sustain and spread. “ISSUES” assists ethics committees to “improve the systems and processes that influence ethics practices in a health care organization.”

Being proactive and using preventive ethics involves engendering and garnering measurable improvements in an organization’s ethics practices and in patient care by implementing systems level improvements. Specific things that can be embarked upon are the adoption of checklists, reminders, and decision support; the undertaking of steady evaluation of organizational performance with regard to ethics practices; the formulation of policies and protocols that foster ethical practices and even offer incentives as well as rewards in order to motivate and boost ethical practices among physicians and staff. Further practical measures that can be adopted include designing education and awareness
campaigns for patients and staff, as the case may be, to deal with specific knowledge that
the healthcare ethics committees wish to address, keeping in mind the high level of
illiteracy among ATM users and the local culture of the place where the ATM facility is
situated.

iii. Ethical Leadership

It is a known fact that leaders and owners of organizations or facilities “play a
critical role in creating, sustaining, and changing the culture of their organizations” or
facilities. They do that through the programs and activities they support and praise, those
they neglect or criticize, as well as by their own behavior. This action of proprietors is
pertinent to ATM because ATM is often a private practice. The facilities are established
and owned by individual ATM doctors or a doctor’s family. It is important and
imperative, therefore, to address ethics quality directly at the level of a facility’s
environment and culture. Through integrated approach, ethics committees will help
leaders of their facilities to adopt behaviors that nurture and promote its ethical
environment and culture.

iv. Being Accountable

Healthcare ethics committees are required to be accountable in accordance with
measurable outcomes and not just in accord with the good intentions of their members. It
is necessary that ATM healthcare ethics committees be subject to this rule in view of the
tendency for modern African societies and people to exploit their companies and
organizations. Moreover, given the time and the resources invested in the facilities, both
the members of the ethics committees and the administration of the facility will want to
know how well or how bad the ethics committees are performing. The good intentions of
the members of the committees can be useful and even good in judging the performance of the healthcare ethics committees in ATM. As David Blake noted, the members of healthcare ethics committees are likely to be the nicest, most sensitive, and well-meaning staff of the facilities rather than selfish, rigid business members.\textsuperscript{106} However, a good intention is not enough. It needs to be augmented with measurable outcomes aimed at making an observable improvement in how patients are actually cared for as well as the making observable and measurable improvements in patient care and in the facility. Therefore, the standard by which the healthcare ethics committees are evaluated is crucial. Rather than following the old familiar autonomy and rights discourse that focuses solely on individual patient or family alone, the healthcare ethics committees will adopt a broader, deeper notion of African values, communitarian values, and RAIC. The committees will take their cue from the communitarian tradition of ATM that advocates the well-being of all involved, namely, the patient, the entire facility and the community.

\textit{Ndụ mmịrị ndụ azụ, mmịrị atala ma azụ anwụla}. Literally this means “The life of the fish and the wellbeing of the water, may the water not dry up and may the fish not die.” This is an Igbo proverb reminding anyone involved in settling disputes, for instance, to be fair and to seek the well-being of all parties to the case; to preserve both the life of the fish and the well-being of the water or river or sea, which eventually will sustain the fish.

An aspect of accountability involves measuring the impact of the activities or the functions of the healthcare ethics committee on professional practices and quality of patient care. Although the old model of healthcare ethics committees has been minimally accountable to its respective facilities, the new model, the integrated model, seeks to devise methods of gauging effectiveness in all aspects of healthcare ethics committee
works, “from meetings through ongoing case consultation and education activities to process improvement initiatives.”107 This means taking practical steps to do something proactively as well as following up on cases and reviews. These steps bring about quality improvement of patient care, which in turn leads to positive change in the facility by concentrating on supporting the facility’s ethics “through measurement, assessment and improvement of practices, systems and processes.”108

5. C. The Implications of Applying RAIC to Healthcare Ethics Committee in Africa on Decision-Making Process for Informed Consent of the Patient

Generally, in clinical ethics, autonomy serves primarily to evaluate decision-making in healthcare and functions to identify actions which are protected by the rules of informed consent, informed refusal, truth telling, and confidentiality.109 It means that the concept of relational autonomy as practiced in ATM will definitely impact on informed consent and informed refusal, truth telling, and confidentiality in healthcare ethics. For instance, while the Western concept and practice of autonomy place responsibility for medical decision-making largely in the patient’s hands, the relational autonomy of ATM, that is, RAIC emphasizes community and relationships giving much more substantive weight to the consensus decision-making process. Because RAIC lays emphasis on relationships and interdependence, the integrated ethics committee model is a suitable model for ATM. The idea of all the aspects of an organization collaborating and working together to nurture ethical practices that foster better patient care resonates with the communal values espoused by RAIC of ATM. When applied to ethics committees, the RAIC approach will have the following implications for ethics committees in Africa, on the decision-making process for the informed consent of the patient.
5. C. 1. Integration of Elements of Traditional Decision-Making Methods into Healthcare Ethics Committees

As noted in Chapter Four, in African societies, decision-making, including medical decision-making, involves reaching a consensus after extensive deliberation and consultation. This is what the RAIC approach of ATM portends for healthcare ethics committees, while at the same time it strengthens the process of decision-making for the informed consent of patients. Therefore, the decision-making process of healthcare ethics committees in Africa, particularly in ATM, should be by consensus, as is the norm in African culture. The extensive deliberation and seeking of consensus offer a suitable procedure and atmosphere for all members to contribute to the discussion. The composition of ethics committees already requires that a representative of the local community where the medical facility or facilities are located be a member of the healthcare ethics committee. This requirement is consonant with the spirit of RAIC of ATM, wherein the community is involved in the medical decision process of a patient. Therefore, some representatives of the community will be co-opted as members of the ethics committees in ATM. The elders (heads of families), titleholders, and experts, being the traditional representatives of the community, are naturally the people to be chosen to be community representatives to the ethics committees. However, other people, especially young adults and more enlightened or suitable persons, can be appointed to represent the community. They will be expected to report to the community because, customarily, the people want to be kept abreast of the proceedings of the meetings, and the health progress of the community members, the patients. This may create some issues of confidentiality and privacy. The issue of confidentiality will be discussed in the next subsection (5.C.2).
However, in line with African communal cultures and with the RAIC of ATM, the community as an extended family is involved in a patient’s decision-making process. It highlights the need to integrate family and relatives in this process. Healthcare ethics committees in Africa should uphold and foster this value. A patient may be well informed to make a better decision with the family’s and, indeed, with the community’s, or with other people’s assistance, and within the communal framework of consultation.\textsuperscript{110}

Moreover, patients are often frail, frightened, and vulnerable; therefore, they need the assistance of others. Thus, Mark Miller argues that in the West, North America, and Europe, bioethics “seems to presume that there is something called an ‘autonomous moral decision-maker’.” However, from Miller’s experience, such persons as patients seldom exist. Patients are frail, frightened, vulnerable, and often lonely. In view of that, they tend to “make decisions within conversations held with family, significant friends, and medical personnel.” Miller, therefore, concludes that the law, which makes the patient the decision-maker, is a helpful legal fiction. He insists that caregivers must always see patients in the context of their family and social world.\textsuperscript{111}

Supporting Miller’s line of thought, Jacquineau Azétosop and Stuart Rennie argue that both infectious and chronic diseases challenge the Western understanding of autonomy. First, the patient being a victim and a vector can no longer be understood as a “rational agent who has the final ethical word on his own decisions.” Second, the risk of getting infected by and transmitting infectious diseases reflects the patient’s interconnectedness with others and the environment. This interconnectedness is always present whether the infectious disease is there or not. Azétosop and Rennie conclude, therefore, that even though a patient’s values and desires need to be taken into
consideration, “the idea of the autonomous agent will remain a fiction unless the social context of the patient’s vulnerability is also considered.” Family and friends stand as important resources for decision-making and long-term daily care for chronic diseases. For that reason, there is a need to recognize that the family and community, both play an important role in patient care and that they too are part of the resources required by a patient to exercise agency.\textsuperscript{112} The exclusion of family and relatives -- community -- from the area of decision-making because of respect for individual autonomy does not necessarily serve a patient’s best interest.\textsuperscript{113}

Furthermore, Azétsop and Rennie posit that an autonomy-based bioethics which lays emphasis on individual autonomy tends to “distort the relationship between individuals and the world,” that it exaggerates the power and range of individual agency. Thus, unlike RAIC, individualistic right based autonomy lacks social rootedness, and underestimates the impact society, culture, and environment have on both individual’s decision-making and on health. Hence, Azétsop and Rennie conclude that atomistic autonomy is divisive, whereas relational autonomy “brings out trust and communality,” and “reveals our true self in society, presents the possibility of placing trust and partnership at the center of the patient-physician relationship.”\textsuperscript{114} The line of thought of Miller, and Azétsop and Rennie, lends credence to the African practice of involving family and community in patient care and informed consent in decision-making. Therefore, the ethical deliberations in healthcare ethics committees should be in line with the communal values of African cultures, taking cognizance of the risks/benefits for the community and not just for the individual patient.\textsuperscript{115} In that way, the members of the healthcare ethics committees will be seen as members of the community, a
communicative network of people caring for the patients along with ATM doctors and nurses.

Members of healthcare ethics committees need to understand that the RAIC of ATM as in ethics of care holds that moral agents are particular, concrete individuals with their own unique life histories, desires, and emotions. ¹¹⁶ “Moral dilemmas are particular, unique situations in which all parties retain their identities, their life histories, emotions, feelings, and relationships.”¹¹⁷ Caring and relationships take place between particular concrete individuals. Like ethics of care, ATM’s RAIC emphasizes relationships, concrete situations, and theory that is contrary to principle-based ethics which maintains the universal and abstract principles wherein moral agents are not particular, concrete individuals with their own unique life histories, desire etc.¹¹⁸ Healthcare ethics committees adopting the above understanding does not mean that they should wholly ignore the theoretical contributions of traditional ethics. Rather, focusing on the situation or context at hand, the healthcare ethics committees struggle to apply the principles cogently and in a meaningful way or to what the principle will mean in that context. In trying to determine how a principle applies to the case at hand, healthcare ethics committees compensate for the narrative aspect of ethics in their deliberations. This is important because it has been said that “an authentic and appropriate ethical deliberation, whatever the task at hand, requires that which only narrative knowledge can give, that is, the coherence, the resonance, and the singular meaning of particular human events.”¹¹⁹

5. C. 2. A Flexible Understanding of Confidentiality

Another impact of RAIC will be on confidentiality. Confidentiality is one of the essential elements in a therapeutic relationship, the relationship between the patient on
the one hand, and the physicians, nurses, the healthcare professional, and, indeed, the medical facility on the other hand. “Confidentiality is present when one person discloses information to another, whether through words or an examination, and the person to whom the information is disclosed pledges not to divulge that information to a third party without the confider’s permission.”\textsuperscript{120} Confidentiality is based on trust and the integrity of the healthcare professionals just as telling the truth is similarly based. Confidentiality is important and necessary because of the inherent respect for the patient’s privacy and autonomy, to prevent possible harm to the patient, and for the good of the society.

The respect for the patient’s privacy in a liberal society is respect for the rights of the patient to control who gains access to his/her information. Moreover, the effectiveness as well as the quality of healthcare that is provided depends, in part, on the disclosure made by patients. Likewise, the quality of the disclosure is in turn dependent on the level of trust and assurance that the healthcare professionals and the facility will safeguard in confidence the information regarding their patients. Hence, the medical facility is duty bound to protect patient information and medical documents from unwarranted disclosure. Because of the gravity of the need for confidentiality of patient information, in the USA, for example, the federal Health Insurance Portability and Accountability Act of 1996 is stringent about confidentiality of patient information.

However, there are some exceptions to the confidentiality issue such as when there is a need to prevent danger to a third party or a specific individual. This is reflected in the Tarasoff v. Regent of University of California, in 1976. Here the Court ruled that a psychotherapist, who had a prior knowledge of the intention of the patient to kill his unsuspecting girlfriend, had a duty to warn her.\textsuperscript{121} Further reason for exception to
confidentiality is when there is need to provide information for the sake of public safety, as in a public health issue. In such a case, the danger is to the general population rather than to a specific individual as in the above example, or in the case of HIV infection wherein the sexual partner(s) of the infected person is in danger.

The ATM RAIC model necessitates a flexible understanding of confidentiality. In Western bioethics, confidentiality is based on atomic individualism where the patient is understood to have an inviolable right to deal with illness and to decide solely regarding one’s own treatment as per one’s choices and interests. What transpires between the patient and the doctor or the medical personnel remains with them and with whomever the patient decides should know. However, in the African context, the patient, as noted above in Chapter Four, is accompanied by family and/or a community representative to consult the doctor and to help make decisions regarding treatment, admissions, feeding, payment, etc. In some cases, these people have to give a situation report to the elders of the family. Thus, members of the community are often privy to the cause of treatment of the patient. After all, the primary aim of the ATM doctor is not only to bring healing to the individual patients but also to make sure that harmonious relationships are restored at all levels of existence: individual and community, ancestors and the environment. The Africans see life as continuous with no division of existence between the living and the dead. The sickness is also a concern to all the members of the community as well as to the environment. Even in allopathic medicine, community members who visit the patient tend to seek information from both the patient and the medical personnel out of concern for the patient. The information is shared back home. This sort of community involvement precipitates issues of confidentiality, and in such a situation, the
understanding of confidentiality assumes an entirely different meaning. Healthcare ethics committees, therefore, have to define confidentiality not just along the line of Western bioethics but also, by taking into consideration African cultural practices, communal values.

Sequel to the issues of confidentiality is truth telling. In Africa, there is a widely shared understanding that healthcare providers should not provide information regarding diagnosis of terminal or serious illness to patients, especially those who are elderly or frail. Diagnosis associated with various forms of cancer, (AIDs) and terminal illness are closely linked to the common cultural norm that patients should not be fully informed of their illnesses. Disclosing such information in a frank, forthright manner is, in some cultural context taken by family members and seriously ill patients to undermine the health of the patient. It undermines the patient’s health by encouraging negative thoughts and condemns the patient to a form of “social death.”

Bad news, in general, is thought to undermine the recovery or the health of the patient. Bad news plays a causal role in hastening the dying process. Against this backdrop, a good compassionate health caregiver is one who protects the patient and supports the family in shielding the sick person from upsetting information. ATM doctors would convey negative or bad news to family or community members. The family or community members will, in turn, conceal the information from their seriously ill or frail relative. Such concepts and practices of confidentiality and telling the truth can be understood from the perspective of relationships. Traditional moral theories, such as liberal rights, concentrate on answering questions regarding whether to lie or to break confidentiality. On the other hand, the ethics of care and ATM (and African bioethics)
emphasize what the physicians do, that is, whether they break or maintain confidentiality; how they carry out those actions; the motives that underlie them; and whether their actions promote or thwart positive relationships. Furthermore, trustworthiness and the quality of care of the doctors and the healthcare personnel as well as their sensitivity in the face of a patient’s or the relatives’ request for (seeming) deception are integral moral factors of concern from the perspective of the ethics of care and the ATM. This sort of cultural model of health and illness in ATM and RAIC that tacitly allows the community members rather than individual patients to receive diagnostic and prognostic information differs from the right-oriented autonomy laws in the Liberal individualism of the West. The healthcare ethics committees have to take all these cultural nuances into consideration in their policy development and definition of confidentiality and truth telling or disclosure of bad news. In fact, these nuances should form the conceptual framework for the operation of the healthcare ethics committees.

5. C. 3. A Nuanced Understanding of Advance Directives

Further conceptual nuance is found in the understanding of advance directives and surrogate decision-making. Advance directives and surrogate decision-making are usually written (or oral) future healthcare instructions, preferences and decisions of a competent person. They include the person’s consent to or refusal of specific medical interventions or treatments. Advance directives become effective when the person is judged to be incompetent or has lost the capacity to make healthcare decisions. In the USA, in particular, advanced directives and surrogate decision-making were crafted to correct the perceived excessive medical paternalism and in medical vitality, that is, the tendency to fight death at all cost to the very end; as well as to protect incompetent
patients from unwanted and futile medical treatments which only serves to prolong a painful dying process. The underpinning ethical framework for advanced directives and surrogate decision-making is the individual right-oriented autonomy of the liberal individualism. The patient’s own choices and interests override every other interest. In a situation where the patient’s choices and interests are not directly known, the appropriate surrogate (s) provides judgment regarding the best interests of the patient, and these hold sway.127 These concepts, legitimized and legalized by the Patient Self-Determination Act, which is a federal statute requiring healthcare facilities to provide written information for each adult patient when admitted, reminding the patient of his/her rights to make decisions concerning medical care, or to refuse medical interventions as well as to formulate advance directives.128 Even in the case of children or minors, and in cases where there are no advance directives, it would seem that the family would automatically take up the decision-making on-behalf of these minors, or adults in the absence of an advance directive. But some state governments have laws or regulations about who the surrogate is and how to choose one. The Pennsylvania Act 169 of 2006, for instance, stipulates that the determination of a healthcare representative of a patient who does not have advance directives follows a statutory list that generally gives priority in the following order:

- spouse and adult child who is not the child of the spouse
- adult child
- parent
- adult sibling
- adult grandchild
- close friend

The sequence of names on the list is followed, whereby the next in the list is sought for in the absence or inability to reach the one on top. If the list is exhausted and none of the people on the list is reachable, or all refused to assume the responsibility, then the case
may go to Court. Except for the healthcare agent whose power can be exercised at any
time, for any other surrogate, the power kicks in when the patient becomes incompetent
or permanently unconscious or has an end-stage medical condition.\textsuperscript{130}

Ho Mun Chan sees a role for the family in the surrogate decision-making in the
liberal model. He supports this with the three reasons outlined by A. E. Buchanan and D.
W. Brock:

1. The family is usually more knowledgeable about the values, preferences and best
interests of the incompetent patient.
2. The family is more concerned about the patient’s best interests.
3. The family needs to be protected from unnecessary intrusion.\textsuperscript{131}

The need to protect the family from unnecessary outside intruders, according to Chan, is
evidenced in the Nancy Beth Cruzan’s case. Her father, after the lengthy legal battle to
get Nancy removed from the life-support system, lamented that his daughter’s life had
been interrupted by too many strangers including the doctors, the press, protesters,
lawyers, and the judges. However, when the dust settles down, only Cruzan’s parents
would be at Nancy’s bedside weeping, and only they would visit her grave long after the
courts, the press, healthcare professionals, and the public had proceeded to another
case.\textsuperscript{132}

Another factor that made the experience tough on the parent of Nancy was that
the Court required clear and convincing evidence of Nancy’s wishes from him. The clear
and convincing evidence is a stringent test for him without advance directive. Moreover,
as John D. Arras correctly noted, the test does not include for consideration those
‘reasons of the heart’ that ‘reason does not know’ and excludes the most persuasive
“testimony of the family members based on years of experience and personal knowledge
of the patient’s values.”\textsuperscript{133}
Continuing, Arras proffers a more appropriate procedure whereby the surrogate
would ordinarily have the final say barring a contrary proof by other people that the
surrogate decision would clearly go against the prior wishes or the best interests of the
incompetent patient. In other words, the burden of proof should rest on those who suspect
or object to the propriety of foregoing treatment rather than on the family members or the
surrogate. However, he adds that this shift of burden of proof, designed to safeguard the
autonomy and the best interests of the incompetent patient should not debar the court,
government protective agent, and the healthcare ethics committee from providing
channels for other parties to challenge the surrogate decision of the patient’s family.\textsuperscript{134}

As has been noted, the two broad types of advance directives are a living will and
a durable power of attorney for healthcare or proxy directives. In contrast to African
understanding, in Western bioethics, durable power of attorney for healthcare is a
document written by a competent individual authorizing or appointing another person of
adult age to make healthcare decisions on behalf of the signer.\textsuperscript{135} Also, in Western
bioethics, the advance directive presupposes the right of the individual to make
independent medical decisions and to deal with illness on one’s own. It also envisages
situations where an individual has no one at all to make healthcare decisions or does not
trust those available. However, in the RAIC model, which presupposes a strong family
and community role in patient care and medical decision-making, there is a substantive
change in the concept of an advance directive. Culturally (and naturally), the family and
relatives, i.e. the community, have the durable power of attorney for health care. They are
the next of kin and therefore, by custom the surrogates- function considered as a fiduciary
duty. Even in the cities within or outside Africa, it is not uncommon to find meetings or
gatherings of people from the same African community, whether it is people of the same ethnic group, e.g. the “Igwe bu ike,” i.e., Igbo association in Pittsburgh and other cities, the Igala peoples’ association of America found in various cities; or from the same village or town, for example, the Ehime group in the USA, or from the same country, the Ghana association of Pittsburgh; or even from the continent, for instance, the union of African students which is found in most colleges and universities in the USA and Europe, and the Pittsburgh Area African Professionals Organization. These are African communities, or their extensions, or vestiges. Even far away from home, they have in some ways carried on the African communal values in the midst of the liberal individualism of the USA and the West. These communities tend to rally around their members in times of celebrations, difficulty, and illness. They in some ways form part of the decision-making of the individual members, depending on how members have become assimilated into American culture.

However, in traditional African societies, the bond of relationship among members of the family and the community is such that one is most of the time rest assured of one’s interests and needs being adequately taken care of, but in relation to the needs and interests of both the family and the community. One can have a list of medical intervention preferences or instructions; however, these preferences and instructions are adhered to within the confines of the needs and means of the family and within the confines of the tradition or cultural beliefs and practices of the people, the community. Chinua Achebe, in his book, tells a story of a man, Obiako from among the Igbos of Nigeria, whose father left a will demanding a cow for the funeral. When the will was communicated to Obiako, he remarked about the poverty of the family. His deceased
father did not leave much livestock behind, not even a goat, how could he ask for a cow for his funeral?\textsuperscript{136}

Also worthy of note is that advanced directives and surrogate decision-making are “largely a phenomenon of the US.” They are hardly found in the statute books of other countries besides Denmark, Germany, the Netherlands, New Zealand, and some Australian Canadian jurisdictions. The United Kingdom and Hong Kong, for instance, are reluctant to give advance directives greater force in law by legislation.\textsuperscript{137} The use of advance directives is very limited in Japan for several reasons. Culturally, patients are not told of their terminal illness by physicians. Therefore, the need to prepare advance directives is remote to patients. Truth telling would create a burden and discomfort among the family undermining the relationship between the patient and the family members because, once the truth is told, they could no longer act as if all were normal. Customarily, it is inappropriate to “articulate one’s wishes or interests in writing because written wishes are interpreted as not trusting one’s family members. In view of their, verbal communication is the norm; moreover, even a written choice or living will can be overridden by a family collective decision.\textsuperscript{138}

In the Catholic moral tradition, which to some extent has been incorporated into the philosophical bioethics, requests that the wishes of the patient be balanced against the needs and capability of the family and community. \textit{The Ethical and Religious Directives for Catholic Health Care Services}, for example, states that one is obligated to use ordinary or proportionate means in preserving one’s life. Proportionate or ordinary means is defined in Catholic moral thought as those means “that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose
excessive expense on the family or the community.”¹³⁹ Thus, one’s autonomy is not permitted to lay an excessive burden on others, whether it is according to a Catholic or an African conceptual framework. Therefore, the RAIC model implies a nuanced understanding of advance directives (living will, durable power of attorney for health care, proxy or surrogate directives, or health care proxy).

Based on the Asian experience, if advanced directives were to be adopted in ATM and in African bioethics in general, their real purpose would not be seen or treated solely as a means for a patient to exercise his or her self-determination. Rather, it should, in addition, be utilized to express the patient’s concern for the family, the community, and the patient’s commitment to their wellbeing when the patient becomes incompetent. That is to say that, the directive becomes a vehicle of helping the family and the community to know the patient’s voice and to facilitate the ongoing dialogue with them when the patient lapses into incompetency. Although advance directives is important, and should help the family or community to arrive at a decision, the final decision does not have to be dictated entirely by the literal meaning of the patient’s advance directives.¹⁴⁰

Moreover, patient autonomy, as conceived by liberal individualism, does not have to be the overriding principle directing the ethical and bioethical decisions in patient care. This is supported by the idea of RAIC which arises from the concept of personhood that includes particularity in human relationships. And as Po-Wah rightly pointed out, the idea of autonomy not being the overriding principle endears bioethicists to move away from the over-emphasis on “higher brain function as the single most important criterion to define human personhood when assessing the mental capacity of brain-injured or demented patients.”¹⁴¹
5. C. 4. Emphasis on Solidarity

The ATM RAIC model requires laying emphasis on solidarity. Community living is about building relationships and fostering solidarity. Most often, what is right or wrong is about what builds and maintains community and solidarity among members. It is not so much about the individual rights of the patient as to the other characteristics of African communal morality: solidarity, justice, cooperation, compassion, and reciprocity. The social and ethical values of communal living, basically, impose on members of the community a duty to the community and to its members. People carry out their duties to others without necessarily thinking that those others have a right to it. Instead, people think of their responsibility to the community and to others, a responsibility of solidarity, which is described by Ubuntu in Southern Africa societies. Being a multidimensional concept, Ubuntu stands, among other things, for humanness in the sense of “a good disposition towards others and a moral nature. It describes group solidarity and interdependence in African culture.” It is a “collective solidarity whereby self is perceived primarily in relation to the perception of others, that is, persons are perceived less as independent of one another and more as interdependent of one another.”

Morphologically, the term “ubuntu” is made up of the augmentative prefix u-, the abstract noun prefix bu-, and the noun stem -ntu, in a Bantu language such as Nguni, meaning “person,” “personhood,” “humanness,” etc. The concept of “Ubuntu” exists also in many other African languages albeit in variant forms. For instance, T. Yanga reports that Alexis Kagame identified the variants of the concept of “ubuntu” in other African languages as follows:

umundu in Kikuyu and umuntu in Kimeru, both languages spoken in Kenya; bumuntu in kiSukuma and kiHaya, both spoken in Tanzania; yumuntu in shiTsonga and shiTswa of Mozambique; bomoto in Bobangi, spoken in the Democratic Republic of Congo; gimuntu
Writing on Ubuntu, Nkonko Kamwangamalu summarized its meaning as a concept that represents the “core values of African ontologies” such as solidarity, interdependence, communalism, caring and hospitality, respect for all human beings, their dignity, and respect for life. It follows then, as already stated above, that the saying that duty begets right is not exactly true in the traditional African context because people’s positive duties towards others are not based on those other peoples’ rights but on the moral responsiveness to their particular situations that impinges on their decision to carry out their duties towards them. This is important for both the members of ethics committees and for the conduct of consults in resolving conflicts.

Thus, the RAIC approach fosters solidarity among family members and the community. The process of decision-making in RAIC allows members of the family and community to exercise their roles and to fulfill what is seen as a fiduciary responsibility toward the sick relative. By fulfilling this fiduciary responsibility, the family and community members have hope that such assistance will be extended to them when they themselves require it. Thus, the process expresses and strengthens the ties and the sense of responsibility to one another as well as respecting and fostering relationships. This solidarity or community participation in the individual’s sickness and treatment is, as Murove noted, “an authentication of the philosophy behind African bioethics that maintains that the individual’s experiences of suffering are also communal. The community is integral to the patient’s decision-making and healing process.” Communal participation is indispensable to the quest for wholeness that is the healing process.
Furthermore, in the context of solidarity and relationships, RAIC requires the stressing of concrete situations, in patient decision-making. Thus, it endears the ethics committees to adopt an approach that emphasizes involvement in and consideration of the concrete situation, and relationality, with attitude of caring, and considering relations between people in their practical reasoning, instead of the often used approach that stresses abstract principles and individual right-oriented autonomy.\textsuperscript{147} Whereas RAIC considers relationships and particular, concrete situations in the patient decision-making process, the liberal individual right-oriented autonomy concentrates on rights, reason autonomy, emphasizing ‘higher-brain functions’ as the single most important criterion to define human personhood when assessing the mental capacity of brain-injuries or demented patients. This focus leads to the danger of equating loss of rationality with loss of personhood and thus, it can result in the conclusion that loss of rationality implies failure to count as a person and, therefore, “less entitlement to care, resources and treatment.”\textsuperscript{148} By implying solidarity, particularity, and relationships, RAIC helps people acknowledge that, “long after the capacity for autonomy has diminished or vanished, relationship ties continue to exert normative force.”\textsuperscript{149} RAIC implies that informed consent does not necessarily or always have to be a decision made by an individual person in isolation from others or from the community.

By contrast, the Western liberal approach to informed consent tends to present autonomy as a decision made by an individual person in isolation from others, that is, as if relatedness is the antithesis of autonomy or as if interdependence is a rare or non-component of autonomy.\textsuperscript{150} Consequently, the emphasis on the individual, individual autonomy, individual interests, and rights in Western liberal medical decision-making
tends to isolate the patient from the family and community. Often, one gets the impression that family members are seen as outsiders without any filial relationship to the patient, as though they are not affected by what is happening to the patient. Likewise, sometimes one gets the impression that family members are treated as intruders interfering with the autonomous decision of the patient. Focusing essentially on individual choices and interests tend to set up a false and deleterious opposition between individuals and the community (or family) to which those individuals belong. It is reasonable, on both a conceptual and an empirical basis, “to suppose that persons acquire their values through engagement with a concrete moral tradition,” instead of “through a private and self-directed process.” This over-emphasis on individual autonomy and interests tends to create what Richard McCormick refers to as a “moral vacuum” that is “the disappearance of the network of shared and established goods and values that make the choices of individuals right or wrong, moral or immoral.”

This moral vacuum arises as a result of making a single value the primary and exclusive criterion for deciding the moral worth. An example given by McCormick is the “absolutization of autonomy” whereby autonomy is taken as the primary and exclusive criterion, thus, excluding from consideration those other goods and values that make choices right or wrong; “they are the factors that support or undermine and promote or harm, the person.” Absolutization of autonomy reduces the rightness or wrongness of choice to a single factor, that is, the individual's choice; consequently, morality is been impoverished, hence creating a moral vacuum. McCormick appropriately pointed out two good examples where this sort of malaise is evident: in abortion and in physician-assisted suicide debates. The pro-choice position on abortion is presented in such a way that the
woman's choice is held out as “the sole right-making characteristic of the choice.” Even though it is known, even by feminists, that there are good and bad choices; and that “absolutizing autonomy represents a failure to wrestle with those dimensions of conduct that make choices right or wrong--in brief, a moral vacuum.”153

In the discussions of physician-assisted suicide, McCormick noted that, in view of Jack Kevorkian, M.D’s belief and utterances, it is no accident that he, Kevorkian, is a cheerleader for absolutized autonomy. For instance, Kevorkian states: "In my view the highest principle in medical ethics -- in any kind of ethics -- is personal autonomy, self-determination. What counts is what the patient wants and judges to be a benefit or a value in his or her own life. That's primary." No doubt, this is "autonomy run amok" as Daniel Callahan correctly affirmed.154 The issue here is that people with this view of autonomy tend to describe themselves in terms of personal characteristics instead of as in connections to other people. As noted above under the section on ethics of care and ATM, human beings are relational and connected. People of this worldview tend to describe themselves in terms of connection with others wherein autonomy is relational, and the caring, empathy, reciprocity, compassion, solidarity, and responsibility of individuals for others are the capacities that define people as moral agents.155

Likewise, as noted in Chapters Three and Four, human beings are not only relational; they are interdependent. They are social beings, and, therefore, relational and dependent on others. And dependence does not necessarily make us less a person or human. Therefore, Daniel Callahan insists:

It is a profound error to think we are somehow lessened as persons because dependency will happen to us, as if that condition itself necessarily robbed us of some crucial part of the self. It does not. There is a valuable and necessary grace in the capacity to be dependent on others, to be open to their solicitude, to be willing to lean upon their strength and compassion. To be a self is to live with the perpetual tension of dependence
and independence. The former is as much a part of us as the latter. The latter may just feel better, and surely flatters us more. It still remains only half the story of our lives, however.\textsuperscript{156}

In their various works, John Hardwig, Augustine Frimpong-Mansoh, and Jacquelyn Ann K. Kegley noted that illness is about the whole person and not just about the biophysical aspect of the person. The biophysical notion of illness and disease leads to thinking that illness -- and, therefore, healing and treatment -- is something that takes place only within the body of the patient. Consequently, it appears that what happens in one’s body, except for a contagious disease, does not affect one’s family members, relatives, friends, and community. On the contrary, illness and disease hardly possess “a solitary causal mechanism.” They have medical, psychological, religio-cultural and economic effects which impact the patients, their families, and the community, as well as the society at large. Medical decision-making should, therefore, include families and close relatives, that is, the community.\textsuperscript{157} The recognition of the need to include families and community in medical decision-making, by African scholars such as Frimpong-Mansoh, as well as scholars from the USA, such as Hardwig and Kegley, gives credence to ATM practice.

Finally, the practice of RAIC in ATM supports and projects the notion of the common good and, hence, the objective concept of the good life. A good life is the good of the community and the good of the individual. There is more or less a common notion of the good and the goal of medicine in ATM. The goal of medicine is the healing of the patient, the family, and the community, including the ancestors, spirits, and the environment by restoring the balance that has been destroyed by the illness. The healthcare ethics committees would have to work with this concept in its deliberations and policy making.
In conclusion, it is hoped that the healthcare ethics committees in Africa will not only be the integrated model, but will also incorporate the implications of the ATM’s RAIC approach to the decision-making process for the informed consent of patients. That African values such as relationships, solidarity, communal living, relational autonomy, etc., should help direct the committees to explore moral pathways that are truly African, and craft institutional morality that is grounded in African values, resulting in appropriate policies. The committees need not uncritically embrace Western, or “American Standard Version” of value or morality and healthcare ethics committees. After all, ethics is about living or “lived lives and moral experience,” even though, often, it appears as an “exercise in the application of moral standards to remote circumstances.” Therefore, sometimes, it is necessary for healthcare ethics committees in the application of ethical principles to consider the content or meaning of the principles, and how to apply them in light of the context and culture. According to Cynthia A. Brincat, these are missing from the principles. In being reflective, critical, and faithful to the African values, healthcare ethics committees will be able to help in the “articulation of important elements of local morality. That is, they may be able to aid in diagnosing and giving expression to understandings of local morality not adequately reflected in the “American Standard Version.”

5. **D. Summary**

By focusing on the decision-making process involving informed consent by patients, this chapter presents an applied example that involves the contribution of the ATM-RAIC approach for healthcare ethics committees in Africa. By way of introduction, the chapter provides a general description of healthcare ethics committees and traces their
history both in the USA and in Africa. The history of healthcare ethics committees in the USA indicates that they arose from needs at healthcare facilities for expert ethical advice in complex ethical situations or dilemmas. In addition to these needs, some other important events influenced and fostered their emergence, namely, the need to regulate research on human subjects which, subsequently led to the formation of the National Commission, Food and Drug Administration (FDA), Institutional Review Board (IRB), and other types of peer review group. These, in turn, precipitated the formation of healthcare ethics committees albeit with some modifications. Other events include the discovery of new medical technologies, which created additional ethical dilemmas, thus necessitating the formation of healthcare ethics committees to help resolve them. Ultimately, the New Jersey Supreme Court ruling in the Quinlan case recommended healthcare ethics committees. The final boost, however, came with JCAHO requiring healthcare ethics committees as one of the criteria for the accreditation of hospitals.

There are no known healthcare ethics committees in ATM. However, in allopathic or modern medicine where few healthcare ethics committees exist in Africa, their origins somehow paralleled those in the USA. On both continents they perform almost the same functions: education, consultation, policy development, and review.

The analysis of healthcare ethics committees in this chapter then progresses to the exploration of the idea of the “integrated” healthcare ethics committee which calls for a shift from being reactive to being proactive and systematic in addressing ethical issues, in integrating ethics consultation, preventive ethics, and ethics leadership. By this integration and proactivity, healthcare ethics committees not only resolve ethical
dilemmas but they also prevent their recurrence and bring about ethical organizational transformation which eventually results in improved patient care.

Furthermore, finding no known healthcare ethics committees in ATM, the chapter analysis addresses the issue of the need for healthcare ethics committees in ATM adducing reasons why they are necessary and required in ATM. The chapter then explores suitable healthcare ethics committees for ATM, and argues that the integrated healthcare ethics committee model reflects African communal values, more than the old model and, therefore, is better suited for ATM. The chapter proffers a multi-facility healthcare ethics committee as a possible alternative for small ATM facilities that cannot afford to form healthcare ethics committees independently.

Finally, the analysis in this chapter concludes with the implications of applying RAIC to healthcare ethics committees while focusing on how the implications influence and foster the patient decision-making process of informed consent, which in turn leads to improvement of patient care. These implications include integration of elements of traditional decision-making methods into healthcare ethics committees, a flexible understanding of confidentiality, advance directive, and emphasis on solidarity.
5. E. Endnotes

3 Levine, “Questions and (Some Very Tentative) Answers about Hospital Ethics Committees,” 9; and Pearlman, “Ethics Committees and Ethics Consultation.” Online.
4 Cranford and Doudera, Institutional Ethics Committee, 6.
5 Youngner, et al., “Hospital Ethics Committees,” 5; Levine, “Questions and (Some Very Tentative) Answers about Hospital Ethics Committees,” 9ff; also, Fletcher and Hoffmann, “Ethics Committees,” 335-336.
12 Ashley, DeBlois, and O’Rourke. Health Care Ethics, 228; and Bernt et al., “Ethics Committees in Catholic Hospitals,” 18-25.
15 Levine, R. J., Ethics and Regulation in Clinical Research. 2nd ed., also, Fletcher and Hoffmann, “Ethics Committees,” 335.
16 President's Commission, Deciding to Forego Life-Sustaining Treatment, 5; and 49 Federal Register 1622-1654 (12 January 1984). See also Fletcher and Hoffmann, “Ethics Committees,” 335.
20 Ashley, DeBlois, and O’Rourke, Health Care Ethics, 228-230; Post, Blustein, and Dubler, Handbook for Health Care Ethics Committees, 1-2 and preface xi; also, Klugman and Dalinis, Ethical Issues in Rural Healthcare, 46ff.
21 ASBH, Core Competencies for Healthcare Ethics Consultation, 1.
22 Derr, Healthcare Ethics Committees, 89.
23 Cf. Ashley, DeBlois, and O’Rourke, Health Care Ethics, 228-29.
28 Pearlman, “Ethics Committees and Ethics Consultation.” Online.
30 Cotter and Vaszar, “Hospital Ethics Case Consultation.” Online; also, ASBH, *Core Competencies for Healthcare Ethics Consultation*, 11.
33 ASBH, *Core Competencies for Healthcare Ethics Consultation*, 5.
34 ASBH, *Core Competencies for Healthcare Ethics Consultation*, 5.
44 Ashley, De Blois, and O’Rourke, *Health Care Ethics*, 228.
49 Cotter and Vaszar, “Hospital Ethics Case Consultation.” Online.
50 Cotter and Vaszar, “Hospital Ethics Case Consultation.” Online.
55 ASBH, *Core Competencies for Healthcare Ethics Consultation*, 15. For comprehensive lists of required skills, see Section 5 A2 above or ASBH, 13-14.


60 Foglia and Pearlman, “Integrating Clinical and Organizational Ethics,” 31.

61 Foglia and Pearlman, “Integrating Clinical and Organizational Ethics,” 33.

62 Foglia and Pearlman, “Integrating Clinical and Organizational Ethics,” 34.

63 Foglia and Pearlman, “Integrating Clinical and Organizational Ethics,” 34.

64 Foglia and Pearlman, “Integrating Clinical and Organizational Ethics,” 35.


68 Blake, “Reinventing the Healthcare Ethics Committees,” 12.

69 Blake, “Reinventing the Healthcare Ethics Committees,” 11.


71 Wenger, “The Healthcare Ethics Committee Model of the Future,” 34.

72 Blake, “Reinventing the Healthcare Ethics Committees,” 22.


74 Blake, “Reinventing the Healthcare Ethics Committees,” and Murphy, “A Next Generation Ethics Committee.”


76 Muller, *Grey's Hospital Ethics Committee*. Online.


78 Frenkel, “The Role of the Ethics Committee,” 627-33.

79 Muller, *Grey's Hospital Ethics Committee*. Online.


Larcher, Lask, and McCarthy, “Paediatrics at the Cutting Edge Do We Need Clinical Ethics Committees?” 245-247; Slowther, et al., “Clinical Ethics Support Services in the UK,” i2-i8. See also Larcher, “The Development and Function of Clinical Ethics Committees,” 47.


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Rueping and Dugan, “A Next-Generation Ethics Program in Progress,” 54.
Azétsop and Rennie, “Principlism, Medical Individualism, and Health Promotion,” 1.


Azétsop and Rennie, “Principlism, Medical Individualism, and Health Promotion,” 4.

Azétsop and Rennie, “Principlism, Medical Individualism, and Health Promotion,” 3 and 4.


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See Chapter Three and Four. See also Sichel, “Ethics of Caring,” 50.

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Jones, “Literature and Medicine,” 1243; and Brincat, “Not Putting All Your Eggs in One Basket,” 221.

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United States Conference of Catholic Bishops, Ethical and Religious Directives, no. 56; and Kelly, Contemporary Catholic Health Care Ethics, 128.


Gyekye, “Person and Community in African Thought,” 311.


Hardwig, “What about the Family?” 5ff;

McCormick, “Bioethics, a Moral Vacuum?” 8-12; also, Azétsop and Rennie, “Principlism, Medical Individualism, and Health Promotion,” 5.


CHAPTER SIX: CONCLUSION

This chapter provides a summary of the analysis of the issues studied in each chapter of this dissertation, and identifies its contribution to bioethics in Africa, and the significance of the dissertation for global bioethics in general.

Traditional African societies are community-oriented and emphasize communal values such as relationships, solidarity, compassion, cooperation, and interdependence. Hence, a widespread practice is to help those who are in need, especially the sick members of the community. This practice has survived despite urbanization and the migration of people to cities. It is common for community members to play an active role in the medical regimen of a sick member, for example, accompanying the patient to consult the African traditional medicine (ATM) doctor or an allopathic medicine physician, and making medical decisions with the patient. Generally, the heads of the family or of relevant community members consult to decide on a common course of action. The decision is reached by consensus. Some of the members of the community sit in with the patient while the ATM doctor is being consulted. If need be, they will help the patient to recount the history of the illness and respond to questions on behalf of the patient. Although consent may be given within this context, the final consent for decision-making rests on group consensus rather than on the individual patient alone.

The ATM practice described herein differs substantively from the Western model of informed consent which characteristically and legally gives full authority and responsibility for decision-making to the individual patient. Although the patient may reach consent by consulting the clinician and, at times, close family members, the individual patient has the final authority to decide and give consent in accordance with
one’s own values and interests. This Western model has so dominated the understanding and practice of autonomy in informed consent that it casts doubt on alternative models from other cultures. The dissertation argues that the ATM practice constitutes a legitimate form of informed consent.

Although some studies have been done on informed consent and autonomy in Africa, to date most of these studies have concentrated on research and clinical trials involving the practice of allopathic medicine. A few scholars, particularly those focusing on the discipline of African philosophy, have studied the place of the individual vis-à-vis the community in African culture, but with little input on the nature of personal autonomy and informed consent in a communal culture. Likewise, these studies have not been correlated with informed consent in the context of ATM and its practices. In effect, the main area of ATM has been neglected in these studies irrespective of the fact that ATM forms a large portion of the health care systems in Africa. For example, World Health Organization (WHO) statistics confirm that as much as 80% of the population in Africa uses traditional medicine for primary health care. With such a large constituency, it is only just that ATM and its practices should receive more attention in bioethics.

This dissertation argues that, based on the concept of relational autonomy referred to as relational autonomy in informed consent (RAIC), the ATM focus on consent via consensus constitutes a legitimate decision of informed consent. To interpret and enlighten the significance of the ATM approach to RAIC, the analysis in this dissertation examines the ethics of care movement in Western bioethics insofar as the latter also advocates a relational approach to informed consent. Interestingly, both the ethics of care movement and the ATM approach have been overshadowed by the dominance of the
autonomy model in Western bioethics. However, by comparing the ethics of care
approach with the ATM approach to RAIC, this dissertation aims to provide a relational
approach to informed consent in order to inform the restrictive emphasis upon individual
autonomy in Western bioethics, with a view towards fostering and enhancing current
discourse on global bioethics.

6. A. Dissertation Summary

The dissertation is divided into four major chapters. The analysis begins with an
historical overview of informed consent in Western bioethics, followed in turn by a
systematic analysis of ethics of care, a comparative analysis of ATM and ethics of care,
and, finally, an applied analysis to ethics committees in Africa. Hence, the analytical
progression moves from a discussion of the historical context to a systematic analysis, a
comparative interpretation, and an applied example (historical, systematic, comparative,
and applied analysis). More specifically, the following points are considered.

Chapter One provides a brief introduction to the dissertation, noting how the
Western concept and practice of informed consent differ and dominate other forms of
informed consent in bioethics. The Western, that is, Euro-North American, tradition
places more emphasis on individual and personal values, and it approaches informed
consent from the perspective of patient self-determination or individual autonomy. The
Asian tradition lays more emphasis on family, and approaches informed consent from the
perspective of family-determination.² Here the family, instead of the individual, has the
final authority to make medical decisions. By contrast, African tradition places more
emphasis on communal values and relationships, hence communal-determination. In
African tradition, informed consent must be understood from the perspective of relational
autonomy or RAIC. This emphasis on relationship and the approach to informed consent from the perspective of relational autonomy can be associated with ethics of care in Western bioethics.

Chapter One addresses the following issues: a) the Western liberal concept of informed consent, especially as it is practiced in the USA; b) the ethics of care which also emanates from Western bioethics; and c) the ATM giving particular attention to four representative ethnic groups on the continent of Africa: the Akan, the Hausa-Fulani, the Igbo, and the Yoruba.

Chapter Two presents the historical context of the analysis by discussing the liberal approach to informed consent in Western bioethics which emphasizes individual and rights-oriented autonomy. Using the historical analysis of informed consent in Western bioethics as a starting point provides a context for the discussion and helps to underscore the contrast in various approaches to informed consent -- liberal, ethics of care, and ATM.

Focusing on the history of informed consent, the study notes that the legal origin of informed consent was marked by various litigations and court decisions over the years, among which is the 1914 landmark opinion of Justice Cordozo in the Schloendorff v Society of N. Y. The legal wrangling in areas of malpractice and negligence in the 1960s was incorporated into the statutory laws of many states in the United States of America. These laws required physicians, as a professional duty, to notify their patients of the following: the nature of the intervention, the condition and its expected course, the benefits and risks of any proposed treatment, and the choice of alternative treatment or non-treatment. In 1973, the American Hospital Association was instrumental in
publishing a patient’s Bill of Rights which was adopted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This Bill of Rights introduced the language of “rights” into the discourse and the practice of patient autonomy. As a result, the language of rights suddenly shifted the focus to a different direction. While the legal formulations were in process, the importance of informed consent was also being critically examined and discussed from a moral perspective in the area of medical experiments and research. There were, for instance, events at Nuremberg, Helsinki, the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) that began to have a cumulative ground-breaking effect on medicine, especially on research ethics. These events, more than anything, drew and directed the attention of scholars in law, theology, history, and biomedical and behavioral sciences to the subject matter of informed consent.

Finally, informed consent emerged, in part, because of a reaction against paternalism: the intentional overriding of an individual's known wishes and choices or actions by another person. Physicians and medical professionals directed the conversation and sanctioned what we today would consider to be ethically suspect, such as the withholding and the distortion of truth. Subsequent medical ethicists and moral philosophers joined to condemn the practice of medical paternalism. Thus emerged the principle of informed concept which is based on respect for autonomy.

Respect for autonomy involves recognizing that individuals have the freedom (or liberty) to make choices based on personal values and beliefs, and to accept or refuse medical treatments that affect their life as well as their well-being. It is embedded in common morality that one ought to respect the autonomous choices of individuals even if
there is little or no agreement about the nature, scope, or strength of this respect for autonomy. This notion of autonomy focuses narrowly on the self as independent and rationally controlling, impartial and devoid of emotion, and has impacted the notion of informed consent operative in the Western thought.

Besides autonomy, informed consent is also defined and affected on by the understanding of the nature of person. There are various notions of human person in Western culture. For instance, the existentialists believe that human beings are relational, that to be is to be in relationship. However, rather than existentialist understanding, it was the Kantian and liberal Protestant concept of the human person that laid the ground that very much impacted the concept of the human person that is at the basis of autonomy in the USA and in Western tradition, in general.

When it comes to the issue of who decides treatment in a liberal society, it really depends on the individual and on the values that shape and give meaning to the life of the individual in question. John Stuart Mill reasons that, even though individuals may sometimes make poor decisions, the individual is in the best position to judge what constitutes one’s own good. Furthermore, not only is the patient as an individual the best judge of these needs, but the patient is also expected to be strong and independent even in illness or vulnerability in order to make sound decisions in healthcare situations. In the clinical setting, the tradition of medical ethics in Western liberal society emphasizes the individual. It focuses on the patient and on the patient’s interests and autonomy as isolated from the patient’s social context. Granted, the need to defend the vulnerability and privacy of patients is a powerful reason; yet, the tendency to treat patients, their
autonomy, and their interests in isolation from their social context needs to be re-examined.

Discussing reason and emotion in morality, René Descartes, Immanuel Kant, and John Stuart Mill ennobled reason over emotion in moral decision-making. Philosophers of history, Plato, and Kantians argue that emotional attitudes towards moral issues themselves interfere with rationality and should be disregarded. They encourage people to discipline themselves against desires, impulse, and inclination in order to ensure a more rational course of moral deliberation and action. For these philosophers, while decision and action based on emotions, that is, impulse, inclination, and passion, might be good, they are not morally good because they are not based on an “appropriate cognitive framework.” On the contrary, it is now known that emotions can direct or alter reasoning, just as reasoning and reasons can inform and modify emotional responses.

Furthermore, regarding individual patient rights, liberty of the individual has dominated the philosophy of Western liberal thought since the eighteenth century. Consequently, there are rights of self-determination, rights to privacy and non-interference, autonomy rights, and rights of informed consent. For example, for a liberal rights theorist, the collective goal is not sufficient justification for denying individuals their rights or denying people what they wish, as individuals, to have or to do.

In exploring individual autonomy, the analysis in Chapter Two notes that, from Descartes to contemporary theorists, many philosophers consider the self as individualistic, isolated, and ahistorical. In health care or within a clinical setting, the Western liberal tradition gives the individual patient the final authority to make decisions according to his/her own values and interests. Self-determination and patient autonomy
were aimed at eliminating the image of patients as passive care receivers, and at curbing paternalistic influences on patients’ decision-making processes, especially from family members who might have divergent values and priorities other than those of the patient. Thus, the Western liberal concept of autonomy is focused narrowly on self as independent and self-sufficient leading to individualistic autonomy, which privileges the independent decision of the individual patient in informed consent.

Finally, the analysis in Chapter Two discusses the subjective conception of the good (Life) in relation to informed consent. Because Western liberal societies promote a social system that delineates value as determined in substance or content by individuals in that society; and because, in the framework of a liberal society, there is a lack of agreement about what constitutes the good life or the common good among individuals and across communities, the basis for individual self-decision-making follows the principle of autonomy in Western liberal society and advocates a subjective conception of the good. One is considered as having made a good decision if that decision satisfies one’s prudent desires, preferences, and expectations. It does not matter whether the individual’s desires and preferences are or are not in conformity with a set of impersonal values objectively defined.11

Chapter Three, however, presents a systematic analysis of ethics of care as a hermeneutic to interpret ATM. The discussion examines the emphasis in ethics of care upon relational autonomy as a foundation for enlightening the meaning of relational autonomy in informed consent (RAIC). The chapter explores the emphasis in the ethics of care movement on relationships that posit a concept of persons as relational beings who are socially embedded, and interprets patient autonomy in relationship with others.
The analysis begins by tracing the history and origin of ethics of care, noting how Howard Curzer, a professor of philosophy at Texas Technical University in Lubbock, tried in his paper to identify some germs of ethics of care in the works of Aristotle. The origin of ethics of care has been rightly traced in part to the revolutionary critique of dominant moral theories: Kantian; utilitarian and deontological; and liberal individualist moral approaches advanced by women and feminist movements. This strand helped to bolster the development of “alternative feminist moral theories” through which contemporary ethics of care emerged. The origin has also been traced in part to “alternative feminist moral theories.” Emanating from the feminist movement and the critique of dominant moral theories, there emerged other moral alternatives such as feminist ethics, feminist contractualism, a feminist form of liberal individualism, Kantian, and utilitarian moral theories. The analysis proceeds to the meaning of ethics of care as a form of ethics that constructs an entire approach to ethics based on our daily activities and universal experience of care or caring. Caring is defined by Diemut Bubeck as the meeting of the needs of one person by another person, where face-to-face interaction between the one caring and the one cared for is a crucial element of the overall activity. As a criterion, emphatic caring works in both the individual or private sphere of life as well in the social, public, political, and international sphere. Held speaks of caring relations, especially when they involve forming a political entity and developing a civil society. Comparing relations of care with those of justice in the formation of a political entity and the development of a civil society, Held believes that it is on the basis of care instead of justice that people can identify with others enough to form a political entity as well as to develop a civil society.
As in the liberal Western tradition, informed consent in ethics of care is defined and shaped by the concept of person and autonomy in ethics of care. Ethics of care characteristically draws from our experience of caring to give a better account of persons as relational, rational, emotional beings, as well as interdependent beings who make moral decisions by taking into consideration both their emotions and their reason.15 Ethics of care emphasizes the notion of personhood as being dependent merely upon connectedness in particularistic relationships, instead of being dependent merely upon the capacity for rationality. Po-wah argues that, because particularity implies irreplaceability and non-substitutability, ethics of care scholars are, in effect, establishing that persons possess value simply because of their irreplaceability. However, Kant proposed that human beings are an end-in-themselves possessing dignity by virtue of their rational will or law-making capacity (i. e., autonomy).16 Critiquing the dominant moral theories or principle-based approaches of Western tradition, ethics of care questions whether rationality is sufficient in defining personhood.

Thus, ethics of care centers on personal relations, family, and social ties, and it rejects the social contract thesis which posits that relations relevant to morality have been entered into voluntarily by free and equal individuals. Rather, ethics of care recognizes the dependency and interdependency of persons and human existence. Caring evokes the element of dependence that is in relationships and which is part of the human condition.17 Human beings exist in interdependent relationships that entail ethical responsibilities.18 This notion of an interdependent being and moral agent in ethics of care contrasts markedly with the Kantian inspired or the dominant moral theories where the moral agent is like an isolated, independent (self-sufficient) individual.
Consequently, ethics of care proposes relational autonomy. Both Nedelsky and Held see relational autonomy as an effort to relate human beings’ experience of relatedness and being socially constituted in relationships to others with “the value of self-determination.” Nedelsky speaks of “becoming autonomous,” in association with other people, wherein relatedness is a literal precondition of autonomy, and interdependence is a constant constituent of autonomy. Therefore, autonomy is developed and fostered through relationships with others. As a result of this analysis of autonomy in the context of relationships, Clement, Nedelsky, Held, and other ethics of care scholars advocate a relational autonomy which, in this dissertation, is referred to as RAIC (relational autonomy in informed consent). One infers that ethics of care adopts an RAIC approach; consequently, ethics of care does not place too much emphasis on the individual patient as the sole authority in medical decision-making or in the informed consent process.

As a result, by contrast with philosophers of history and Kantians who see passion and emotions as impediments to moral judgment, ethics of care regards emotion as an essential part of human nature in moral decision-making. Because in a moral analysis, ethics of care embraces emotions, Held and scholars of ethics of care have a problem with the Kantian Categorical Imperative: the Law of Reason that requires us to act in a manner consistent with reason and logic, devoid of emotions, feelings, wishes, and circumstances in order to act autonomously.

Finally, the analysis in Chapter Three concludes with the concept of individual patient rights. For Kroeger-Mappes, the ethics of care and an ethic of rights are an integral part of one system of ethics. Here the ethics of care is a necessary basis for an
“ethic of rights” emphasizing moral relationships within social reality.20 Critically challenging the concept of rights in liberal and traditional moral theories, Nedelsky asserts that, if rights were to be used in constraining democratic outcomes, then people should employ rights in a way that “is true to the essentially contested and shifting meaning of rights.”21 She insists on the need to confront the history of rights and acknowledge the depth of the changes that have occurred in both legal and popular understandings of rights.

Likewise, Nedelsky admits that rights have been criticized as “undesirably individualistic,” as obfuscating “the real political issues,” and as serving to isolate and distance people from one another. Nedelsky asserts that all rights -- indeed, the very concept of rights -- are best understood in terms of relationship. Hence, she concludes that conceptualizing rights in terms of the relationships that they foster will radically transform the problem of individualism.22

Chapter Four is a comparative interpretation of ATM with ethics of care. The analysis shows ATM exhibits practices similar to those of ethics of care, such as focusing on relationships, maintaining that persons are relational beings who are socially constituted in a community, and exercising autonomy in relationship with others in the community. Therefore, ATM adopts a relational approach to informed consent (RAIC) as does ethics of care. Likewise, in this discussion, the ethics of care movement provides the hermeneutic to enlighten the significance of the ATM approach as a legitimate model of RAIC.

The analysis begins with the meaning and history of ATM. Traditional medicine can be said to be the entire combination of knowledge and practice, whether explainable
or not, used in preventing, diagnosing, healing or eliminating diseases, whether physical, mental, or social, “and which may rely exclusively on past experience and observation” transmitted from generation to generation, verbally or in writing. ATM constitutes medical practices and knowledge that existed before the arrival of allopathic or modern Western style medicine on the African continent. To understand ATM well, one needs some knowledge of African Traditional Religion (ATR) because both ATM and ATR are very much connected. In general, there is a holistic understanding of health wherein good health encompasses physical, mental, emotional, and spiritual wellbeing for the patients, their family members, and for their community; that is, a good relationship with God, creations, and the cosmos. Therefore, the belief in Africa is that the supernatural, biological, and psychosocial spheres are inextricably linked with health. Thus, disease and misfortunes are often explained in terms of religious experience, and, therefore, require a religious approach in resolving them.

Likewise, the practice of ATM is understood as a vocation. ATM doctors are chosen by the special spirit. For instance, the clearest and indispensable sign of a call to be an ATM doctor is possession by the spirit -- of agwu (as it is known among the Igbo people) -- the special spirit of the traditional medicine doctors. Following their call, they go on to receive the required training and initiation for their trade. The training is effected through one or more of the following: inheritance, spirit possession, apprenticeship, and, more recently, by formal classroom training programs.

In African traditional societies, to make a serious decision such as a healthcare decision, customarily the community is involved. The reason is that one’s wellbeing is
intertwined with that of one’s members of the community. Decision is made by reaching consensus after a long and broad consultation and discussion.27

In this approach, patients make medical decisions and give consent in consultation with members of their community and an ATM doctor. Often, but not necessarily, the final consent to decision-making is based on the consensus reached in consultation with the group rather than by the individual patient alone. Thus, the process of consultation in ATM gives much more substantive weight to the consensus decision-making process. The Western model, however, privileges the decision of the individual patient who, typically, reaches consent by consulting the clinician and, at times, close family.

The analysis proceeds to explore the concept of person and autonomy in ATM and contrasts it with the ethics of care movement. Central to this analysis is the idea of relationship community which is the conceptual base in which most African understanding, beliefs, values, ontology, cosmology, and ways of life are grounded.28 The analysis focuses on the following characteristics of human person as related to autonomy and informed consent. The analysis considers the individual patient in relation to the community wherein the human person is seen as a relational being. In African culture, persons are defined both communally and individually where the individual helps to define oneself and the community as well. In African thought, the individual is also defined by the relationship entered into by the individual, as well as by the individual’s creative spirit embodying the destiny of the person.

Furthermore, the analysis presents another characteristic which is closely related to the relational nature of human beings, namely, the affirmation of the dependency and interdependency of persons and human existence. This notion is captured and
summarized by Mbiti’s dictum “I am, because we are; and since we are, therefore I am,” and the resultant implication that the joys, sorrows or concerns of the individual are also those of the community.  

29  *Ukọ kọwa anụmanụ ọ ga n’ukwu osisi ma ọkọwa mmadụ ọ gakwụrụ mmadụ ibe ya,* (“When an animal feels itchy, it goes to a tree to scratch its body; whereas, the human being who feels itchy goes to a fellow human being to be scratched.”) *Onipa yieye firi onipa,* (“The well-being of man depends on his fellow man.”) These are from the Igbo of Nigeria and the Akan of Ghana, respectively. The point of the proverbs is that sometimes one needs the assistance, good will, sympathy, and compassion of others to achieve one’s goals or to fulfill one’s life.  

Because ATM focuses on relationships and understands human beings as social, relational, and interdependent beings, ATM, therefore, sees autonomy in terms of relationships wherein autonomy is developed and fostered in relationship with others in the community. Thus, ATM practices what, in this dissertation, is referred to as RAIC which is similar to the practice in ethics of care. It means that, in medical decision-making, final consent rests on the consensus reached in consultation with the family and representatives of the community, not by the individual patient alone.  

Consequently, the practice of RAIC in ATM supports and projects the notion of the common good and, hence, the objective notion of the good life. This concept of the common good is intrinsically linked to the idea of community and is symbolized in the Akan culture, for example, as a Siamese crocodile. A good life is the good of the community and the good of the individual.  

The practice of RAIC in ATM does not focus primarily upon rights. Communal existence and relationality denote a responsibility of the community for the individual
and the individual for the community. Living in relation with others directly involves a person in social and moral roles, duties, obligations, and commitments which the individual person must fulfill. This emphasis on relation also involves other characteristics of African communal morality, such as solidarity, interdependence, cooperation, compassion, reciprocity, and the social and ethical values of social well-being. These primarily impose on individual members of the community a duty to the community as well as to its members. Rights, therefore, are reduced to a secondary position. Priority is given to the duties which individuals owe to the collectivity, and their rights are seen as secondary to the exercise of their duties.

Chapter Five provides an applied analysis of the RAIC of ATM to healthcare ethics committees in Africa, focusing on the decision-making process for the informed consent of patients in ATM. The analysis is introduced by tracing the meaning, history, composition, and general functions of healthcare ethics committees in the USA and in Africa where healthcare ethics committees arose, in part, because of the need of healthcare facilities for expert ethical advice in complex ethical circumstances. Likewise, among other functions, ethics committees carry out the three traditional broad functions of policy development and review, education, and consultation. There is no known healthcare ethics in ATM practices and facilities in Africa. However, there abound in ATM similar situations, needs, and exigencies that necessitated establishment for healthcare ethics in the facilities of modern medicine in both the USA and in Africa.

However, in consideration of the practice of RAIC and the circumstances in which ATM is practiced, this dissertation proposes the establishment of integrated healthcare ethics committees for better patient care outcomes. There is a need for such
committees to be proactive and not simply reactive. The primary healthcare needs of Africa call for preventive care and avoidance of recurrence of the same problem previously treated. Likewise, following the integrated understanding as well as the relational, communal orientation and values of Africa as well as RAIC, healthcare ethics committees have to be integrated into the organization and function and not isolated from them. Because most ATM facilities are small and private, they will not be able to sustain healthcare ethics committees independently. Multiple facilities can collaborate to form a joint healthcare ethics committee, that is, a multi-facility healthcare ethics committee.

The analysis, then, applies RAIC to healthcare ethics committees in the decision-making process involving the informed consent of patients. RAIC includes elements of traditional decision-making methods in the work of healthcare ethics committees, such as extensive discussions on issues, and reaching consensus after considerable consultation. These provide an opportunity for all members of healthcare ethics committees and everyone involved in the case at hand to contribute to the discussion and to be part and parcel of the decision reached.

Likewise, the practice of the RAIC model in ATM necessitates a flexible understanding of confidentiality. In Western bioethics, confidentiality is based on individualism where the patient is understood to have an inviolable right to deal with illness and to decide solely regarding one’s own treatment. What transpires between the patient and the doctor or the medical personnel remains with them and with whomever the patient decides should be included. However, in the African context, the patient is accompanied by family and/or members of the community to consult the doctor and to help make decisions regarding treatment, admissions, feeding, and payment. In some
cases, when these people get back to the community, they have to give a situation report to the elders of the community. In such a case, the understanding of confidentiality assumes an entirely different meaning. Part of the responsibility of healthcare ethics committees, therefore, is to address confidentiality with regard to this relational situation.

Furthermore, the RAIC model implies a nuanced concept of the advance directive. The advance directive presupposes the right of the individual to make independent medical decisions and to deal with illness independently. Advance directive also envisages situations where an individual has no one at all to make health care decisions or does not trust those available. In the RAIC model, which presupposes a strong family and community role in patient care and medical decision-making, there is a substantive change in the concept of advance directive. The family and members of the community (relatives) are culturally designated to perform the function of durable power of attorney for health care, a function considered as a fiduciary duty.

Hence, the ATM RAIC model emphasizes solidarity. Community living is about building relationships. Most often, what is right or wrong is determined by what fosters community and solidarity among members. It is not so much about the individual rights of the patient. Rather, the interests and rights of the patient are constantly juxtaposed alongside the interests and rights of the community. This is vital for both the members of ethics committees and for the conduct of consults in resolving conflicts.

The RAIC approach fosters solidarity among family members and the community. The process of decision-making in RAIC allows members of the family and the community to exercise their roles and to fulfill what is seen as a fiduciary responsibility toward the sick relative. By contrast, the Western liberal individual
approach to informed consent tends to provoke alienation within the family and among community members because family members are often seen as interfering in patient autonomy.

Finally, healthcare ethics committees should be integrative and proactive, incorporating RAIC in the process of medical decision-making to support informed consent provide better patient care.

6. B. Contribution of the Dissertation

A summary of the dissertation having been given above, this section considers what this dissertation contributes to bioethics in Africa.

First and foremost, this dissertation is the first known study focusing on informed consent in ATM. To date, most of the studies regarding informed consent and autonomy in Africa have concentrated on research and clinical trials involving the practice of Western style medicine in Africa. A few scholars, particularly those concentrating on the discipline of African philosophy, have studied the place of the individual vis-à-vis the community in African culture, but with little input on the nature of personal autonomy in community or in a communal culture. Moreover, these studies have not been correlated with informed consent in the context of ATM and its practices. Effectively, the main area of African traditional medicine has been ignored in these studies.32 Yet, ATM forms a large portion of the healthcare systems in Africa. As noted above, World Health Organization (WHO) statistics show that as much as 80% of the population in Africa uses traditional medicine for primary health care. With such a large constituency, it follows that ATM and its practices should receive more attention in bioethics.
Second, the dissertation is distinctive insofar as it employs the ethics of care as a hermeneutic to interpret ATM. The analysis examines the ethics of care movement in Western bioethics to explore its relational approach to informed consent. The discussion compares ATM and the ethics of care. ATM and ethics of care recognize that human beings are embedded in a context of social relationships or community. Therefore, the understanding of autonomy in both ethics of care and ATM is rooted in this notion of social relationships. Human beings are socially constituted to a large extent. They are dependent on one another because no one individual is self-sufficient. For the African, the self and the community help to define the individual. Individuals are constituted by the relationships of which they are a part. Every one of us enters into a complex web of relationships, and ties that include family, friends, fellow community members, colleagues, and fellow citizens. We are not fundamentally isolated and independent individuals as understood in liberal individualist thought.33

In this context, social relationships or community define individuals. The development and nurturing of one’s autonomy occurs within a communal setting, thereby giving rise to relational autonomy in informed consent (RAIC). The ethics of care and ATM argue that autonomy is fostered and, indeed, can only be nurtured in the context of relationships. The individual can only build and exercise autonomy in relations to family, friends, teachers, and community.34 It is through this prism that the contribution of ATM to healthcare ethics in the area of informed consent can be highlighted. Furthermore, by comparing the ethics of care approach with the ATM approach to RAIC, this dissertation aims to provide a relational approach to informed consent in order to inform the
restrictive emphasis on individual autonomy in Western bioethics, with a view towards nurturing and enhancing current discourse on global bioethics.

Third, the emphasis on relationships and the practice of RAIC in ATM means that patients make medical decisions and give consent in consultation with members of their community and the ATM doctor. Often, but not necessarily, the final consent in their decision-making process rests on the consensus reached in consultation with the group rather than by the individual patient alone.

Hence, the form of informed consent in ATM, (that is, RAIC) constitutes a legitimate form of informed consent even though it differs from the Western model of informed consent which places the authority for decision-making on the individual patient. By contrast, the process of consultation in ATM gives much more substantive weight or authority to the communal or consensus decision-making process. This dissertation argues that the ATM focus on consent based on consensus constitutes a legitimate informed consent based on the concept of relational autonomy which is commonly referred to as relational autonomy in informed consent (RAIC).

Fourth, this dissertation is the first study that discusses healthcare ethics committees in ATM. The analysis explains that integrated ethics committees require ethics committees to move from being primarily reactive and case-based. Instead, they should be primarily proactive and systematic in addressing ethical issues integrating ethics consultation, preventive ethics, and ethical leadership. In this manner, ethics committees combine clinical ethics and organizational ethics.
As a result, healthcare ethics committees can foster the collaboration and integration of ATM and allopathic or modern medicine in Africa. The goal here is to enhance relational decision-making processes of informed consent.

The African healthcare system in the future should fully reflect the African cultural milieu in order to serve the people well. Or, as Murove states, “the African healthcare practice of the future should be the vibrant product of cross-breeding between the mechanistic world-view, as entrenched in Western medical practices and the holistic world-view of African traditional healthcare.” A crucial step will be (the appreciation of) the vital role of ATM and its practitioners in the provision of healthcare in Africa. The focus on RAIC in this dissertation also helps to clarify the significance of the analysis for global bioethics.

6. C. RAIC and Global Bioethics

RAIC makes a substantive contribution to the emerging importance of global bioethics that combines the need for universal rights with cultural diversity. In the practice of RAIC in ATM patients make medical decisions and give consent in consultation with their community. Often, but not necessarily, the final consent to decision-making is based on the consensus reached in consultation with the group rather than by the individual patient alone. Thus, the process of consultation in ATM gives much more substantive weight to the consensus decision-making process. The Western model, however, privileges the decision of the individual patient who typically reaches consent by consulting the clinician and, at times, close family members.

Insofar as the ethics of care movement advocates a relational approach to informed consent (RAIC), it is used as a hermeneutic to interpret ATM. The point of the
analysis is that RAIC, like the ethics of care, emphasizes relationships, presenting a concept of persons as relational beings who are socially embedded, thereby interpreting patient autonomy in relationships with others. This is crucially important for the meaning of global bioethics. By comparing the ethics of care approach to RAIC with that of ATM, the dissertation has proffered a relational approach to informed consent that can inform the restrictive emphasis upon individual autonomy in Western bioethics, thereby fostering and enhancing discourse on global bioethics today.

Human beings live in a pluralistic world, and this should be taken into account. The UNESCO Universal Declaration on Cultural Diversity not only acknowledges our pluralistic world and cultural diversity, it insists that the “defence of cultural diversity is an ethical imperative, inseparable from respect for human dignity.” This “implies a commitment to human rights and fundamental freedoms, in particular the rights of persons belonging to minorities ….” The reason is that culture is understood as a set of distinctive material, intellectual, spiritual, and emotional features of society or of a social group. Culture embraces lifestyles, values systems, ways of living together, beliefs, and traditions. The ethical norms, and moral principles and practices of other socio-cultural groups should be recognized as legitimate unless, of course, they violate fundamental human morality.

As Ruiping Fan noted, people need to stop “taking for granted the moral premises and rules of moral evidence that support social-democratic viewpoints,” especially the viewpoints that emphasize an individualistic, anti-family, and anti-communitarian cultures. This tendency stems from the moral and cultural colonization of Africa, Asia,
and South America by “dominant European and North American secular moral traditions.”

In 1984 when Renée Fox and Judith Swazey returned to the United States of America from their research trip in China, they remarked that “Bioethics as developed in the USA was simply one among many possible incarnations of medical morality.”40 They spoke the truth although their observation wasn’t well received. It has become much more apparent since then that the discipline of bioethics which is grounded in the Euro-North American cultures and moral philosophy does not fit all cultures of the world. The adaptation of Western bioethics to the various cultural settings is not always the best. The issues that come under the umbrella of bioethics -- doing good or beneficence, non-maleficence or avoiding harm, justice, respecting people and autonomy -- may be of concern to all humans and can be said to be universal. However, what people view as benefits or harms, how the human body and illness are to be interpreted as well as the role of religion and belief systems in health and in the alleviation of suffering, vary among cultures.41 Some practices taken for granted in one culture or society may be abhorred in some other culture or society. Such practices include but are not limited to telling the truth about a fatal disease to a patient, removal of life support, use of advance directive, and organ donation.

A proper bioethics should be open to voices from different cultural regions of the globe, such as Africa, America, Asia, and Europe. These cultural regions have their long rich moral traditions, cultural norms and belief systems, as well as healing traditions. A global bioethics (as a global field of inquiry) requires that care be taken not to silence ethical impulses and constrict the moral life of other cultures but to appreciate moral
diversity and take it seriously first, by fostering the conditions under which it can flourish. Second, it is necessary to affirm the importance of exploring regional and cultural bioethics.\textsuperscript{42} Likewise, it is essential that we become conscious of the socio-cultural matrices of our own ideas and principles in dealing with other cultures.\textsuperscript{43} However, to emphasize the significance of culture is not to suggest that bioethics or morality is relative. It is not to say that everything is allowed. It is rather to recognize the “plurality of moral norms, social practices, and patterns of kingship,” insisting at the same time that “particular practices are more humane and justifiable than alternative forms of life.”\textsuperscript{44} Of course, except where a particular norm or a cultural practice impinges on fundamental human dignity. Thus, Article 12 of the UNESCO Declaration warns that “No one may invoke cultural diversity to infringe upon human rights guaranteed by international law, nor limit their scope.”\textsuperscript{45} Its reason is that human rights arise from “erasing cultural differences, from ending the hierarchy of cultures,” because they are not only natural born rights, they “are defined by international law, unlike culture.”\textsuperscript{46}

Often the Western voice is so dominant that it tends to prevent voices from other cultural regions from being heard or recognized. This is the case with the principle of informed consent. The Western liberal approach to informed consent is so dominant that other cultural perspectives to informed consent run the risk of being lost. Therefore, this dissertation highlights the African perspectives of informed consent -- relational autonomy in informed consent (RAIC) -- as a substantive contribution to the emerging awareness and importance of global bioethics.

In 2006, another important international document on global bioethics was published, the \textit{UNESCO Universal Declaration on Bioethics and Human Rights}. This
UNESCO Universal Declaration aimed at setting out “Universal standards in the field of bioethics with due regard for human dignity and human rights and freedoms, in the spirit of cultural pluralism inherent in bioethics.” In effect, UNESCO wanted to make sure that the “standards and regulations concerning bioethical issues reflect a global perspective beyond national and regional interests and concerns.” In doing that the UNESCO Universal Declaration offers ideals to which government organizations, communities, institutions (Public and Private), and individuals should aspire. The UNESCO Universal Declaration makes available a “framework of general principles that is open to various interpretations and applications in the context of human rights and fundamental freedom.” These ideals and standards need practical guidance in different cultures and socioeconomic contexts for their implementation. Without such practical guidance to take care of the cultural, gender, political, and socioeconomic context that might limit the implementation of the standards set out by the UNESCO Universal Declaration. This dissertation offers one such practical guidance and step in the areas of autonomy and informed consent by proposing RAIC which explains, among other things, how the African region understands and practices the concept of autonomy and informed consent.

However, when it comes to the relationship between the individual and the community, it is not always that the interest of the individual trumps that of the community or society. As argued in this dissertation, in African communal cultures the emphasis is on both individual’s and communal interests, and not simply on one of them. The movement is towards harmonization of both interests for the good of both the individual and the community. Both interests are important because both the individual
and the community need each other as is confirmed in the African saying: “I am, because we are; and since we are, therefore, I am.” Thus, autonomy and informed consent of the individual is not disrespected. In this aspect, the analysis in this dissertation agrees in part with the spirit of the *UNESCO Universal Declaration* as expressed in Article 5: that “the autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected;” and to protect the interest of those who are not capable of exercising autonomy.

Nevertheless, the analysis of the dissertation points out that, autonomy and informed consent are fostered and exercised in relationship with others in the community, hence RAIC. Consequently, often, the final consent to decision-making is based on the consensus reached in consultation with the group rather than by the individual patient alone. Therefore, the emphasis is not on individualistic autonomy, isolated from the community wherein an individual’s autonomy always overrides the interests of the community. Thus, the spirit of RAIC does differ from the value Articles 3b and 6c of the *UNESCO Universal Declaration* seem to proffer: that an individual’s autonomy or interest always trumps that of the community. Article 3b of the *UNESCO Universal Declaration* advocates a value that is at variance with the familial and communal values of Asia and Africa respectively. Moreover, Willem Landman and Udo Schuklenk points out correctly that public health policies that are crafted for the purpose of preventing or reducing the spread of infectious diseases, will most likely take precedence over the interests of the individuals concerned. They concluded, therefore, that it is untenable to require that “individual’s interest should always have absolute priority over society” or communities’ interests.
Furthermore, Article 19 of the *UNESCO Universal Declaration* deals with the need for ethics committees. Here there is a call for the establishment of ethics committees to not only provide regulation for research, but to “provide advice on ethical problems in clinical settings;” to “assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this declaration.” Article 19 also advocates for ethics committees to “foster debate, education and public awareness of, and engagement in, bioethics.”

This dissertation not only advocates for the establishment of ethics committees in Africa, but it proposes the kind of ethics committees that will be effective and suitable for the practices of African concept of autonomy and informed consent -RAIC. Therefore, the dissertation can be said to be an aid to the implementation of the *UNESCO Universal Declaration*, thereby contributing to the strife for Global bioethics. The dissertation applies also the ATM’s RAIC approach to ethics committees in Africa, focusing especially upon the decision-making process for patient informed consent. The dissertation presents how ATM’s RAIC approach affects the composition of ethics committees and their policy-making criteria in Africa. It requires a flexible understanding of confidentiality, advance directives, and emphasis on solidarity.

Finally, it is hoped that this dissertation will inspire discourse between the healthcare professionals of both ATM and allopathic medicine, and foster collaboration and eventual integration of both medical systems into one national medical system that is native to Africa. Both forms of medicine have come to stay in Africa, thus, in order to be of better service to Africans and to achieve better patient care, an integration is imperative. It is an integration in which neither side should claim superiority over the
other.\textsuperscript{56} If the integration is achieved, it will be a fulfillment in Africa of the call and the endeavors of WHO for the integration of traditional and allopathic medical systems in WHO member countries.\textsuperscript{57}
6. D. Endnote


4 Faden et al., *History and Theory*, 92-94.


16 Po-wah, “Is Just Caring Possible?” 46-47.


18 New World Encyclopedia. Online.


21 Nedelsky, “Reconceiving Rights,” 3; and Held, *The Ethics of Care*, 125ff.


26 Adekson, *The Yoruba Traditional Healers*, 6-10, and 26; and Ross, Inaugural lecture, 46.


31 Gyekye, “Person and Community,” 307ff.

32 World Health Organization (WHO), *Traditional Medicine*. Online.


41 Helman, *Culture Health and Illness*. See also, Benatar, “Global Health Ethics,” 344.


43 Fox and Swazey, “Medical Morality is not Bioethics,” 338.

44 Turner, “From the Local to the Global,” 317.


47 UNESCO, *Explanatory Memorandum*, no 6. At its 32nd session in October 2003, the General Conference considered that it was opportune and desirable to carry out this vision.


51 Mbiti, *African Religions and Philosophy*, 141.


53 See Fan, “Self-determination vs. Family-determination” for the discussion on this issue.

54 H. Schüklenk, “From The Editors,” v.


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