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African Traditional Medicine: Autonomy and Informed Consent

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

Peter Osuji. *African Traditional Medicine: Autonomy and Informed Consent*

This fascinating study engages a challenging exploration of African traditional medicine interpreted in a manner that astutely coalesces with the western focus on autonomy and informed consent from a relational perspective. By providing an enlightening explanation of the community-focused culture that undergirds the interpersonal practice of African traditional medicine, the analysis constructively compares it with the widely respected discourse on ethics of care in bioethics. In addition to the rich tapestry in the normative analysis, the text presents practical guidance for healthcare ethics committees in African hospitals, integrating their practices with relational autonomy in informed consent that characterizes African traditional medicine. This carefully researched and clearly written book sheds much needed light on the emerging debate on global bioethics whereby traditional cultures can be illuminating and instructive for the development of healthcare in a worldwide context.

Professor Gerard Magill, PhD, Vernon F. Gallagher Chair,
Center for Healthcare Ethics, Duquesne University, Pittsburgh, USA

Preface

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. This book considers another approach to informed consent -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.

I argue 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 book. To interpret and enlighten the significance of the ATM approach to RAIC, the analysis in this book 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 comparing ethics of care approach with that of ATM to RAIC, this book 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. This work 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 book 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, therefore, ATM and its practices should receive more attention in bioethics in the present global era.

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First and foremost, I am also deeply indebted to Gerald Magill, PhD, Henk ten Have PhD, and Fr. E. Uzukwu, C.S.Sp., PhD who offered invaluable advice and helped to bring this work into being. To Margaret Mary Vojtko, R. N., who proofread the entire work right I remain forever thankful.

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Contents

List of Abbreviations

ASBH:	American Society for Bioethics and Humanities
ATM:	African Traditional Medicine.
ATR:	African Traditional Religion
CPHA:	Centre for Psychic and Healing Administration
DFLST:	Deciding Forego Life-Sustaining Treatment
FDA:	Food and Drug Administration
HCE:	Health Care Ethics
HEC:	Hospital Ethics Committee
IRB:	Institutional Review Board
JCAHO:	Joint Commission for Accreditation of Healthcare Organizations
RAIC:	Relational Autonomy in Informed Consent
TBA:	Traditional Birth Attendant
UNESCO:	United Nations Educational, Scientific and Cultural Organization
UNFPA:	United Nations Population Fund (formerly: United Nations Fund for Population Activities)
USA:	United States of America
VHA:	Veterans Health Administration
WHO:	World Health Organization

Chapter 1
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

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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 book 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.

1.1 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 (Fan 1997).

Ruiping Fan observed that although the Western model of patient autonomy has been introduced into East Asian countries, it has hardly been generally accepted (Fan 1997). 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 (Fan 1997). 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 (Fan 1997). 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,” (Fan 1997, p. 317).

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.

1.2 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 (Engelhardt 2000). Consequently, therefore, this study 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 book 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 book 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 study 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 work 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 study 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.

1.3 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 (Gyekye 1997; Ezeome and Marshall 2009), and an unpublished MA thesis by Christopher Agulanna (2008), 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 (Menkiti 1984, 2006). The individual is accompanied by a process of incorporation and assisted transformation into personhood (Menkiti 1984). 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 2006). Menkiti's assertion highlights the contrast between the Western view of person, as represented by Gert (2004), 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* (1997), 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 (Gyekye 1997). 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 (Ikuenobe 2006).

Agulanna's work is the only other research related to the topic under study in this book. 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 book 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 book 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 book 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 book can be said to extend Agulanna's work to the area of ATM.

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 (World Health Organization 2003). With such a large constituency, it follows that ATM and its practices should receive more attention in bioethics. This book 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 study 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 book extends their findings, and proposes a relational autonomy in informed consent (RAIC) model from the perspective of ATM.

1.4 Scope of the Study

In setting the historical context, the book 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 study focuses on four representative ethnic groups in African continent: the Akan, the Hausa-Fulani, the Igbo, and the Yoruba. Because there are many such ethnic groups in the continent of Africa, and moreover, the scope of this study does not permit the study of each and every one of these ethnic groups, four of them have been chosen.

The book acknowledges that both ATM and allopathic or Western-styled medicine exist in Africa. The aim of the book is neither to compare both strands of healing nor to seek which is superior.

1.5 Focusing on Ethics of Care

The book focuses on ethics of care rather than communitarianism proposed by scholars such as Ezekiel Emanuel (1991), Michael Walzer (1990), and Alasdair MacIntyre (Beauchamp and Childress 2009). 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 (Held 1993, 2006; Clement 1996). The above scholars also propose an alternative form of autonomy, namely, relational autonomy, which differs from the liberal individualistic autonomy of the Western model (Held 1993, 2006; Clement 1996).

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 (1993, 2006), Jennifer Nedelsky (1989), and Grace Clement (1996) 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 (Held 2006; Harding 1998). 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 (Gilligan 1993; Beauchamp and Childress 2009).

1.6 Focusing on Ethics Committees

The final chapter of this book focuses on ethics committees rather than on research committees. The rationale is that the author of this book 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 book.

Finally, the book 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 book. 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 book.

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Chapter 2
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 book 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.

2.1 History and Origin of Informed Consent

There is some argument as to when critical discussion of informed consent began (Faden et al. 1986). However, there is a consensus that informed consent became an issue in the American medical practice in the late 1950s and early 1960s (Faden et al. 1986). It was at about this time that the expression "informed consent" became more widely use (Beauchamp 2010b; Faden et al. 1986; Jonsen 1998; Menikoff 2001; Dennis 1999). 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:

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(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 (Faden et al. 1986). 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 (Faden et al. 1986).

The three conditions are reminiscent of Beauchamp and Childress' elements of informed consent: competence, disclosure, understanding, voluntariness, and acceptance (Beauchamp and Childress 2009; Beauchamp 2010a). 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" (Faden et al. 1986, p. 54). 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) …." (Faden et al. 1986, p. 54). 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 (Gert et al. 2006; Faden et al. 1986).

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 (Faden et al. 1986). 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 (Faden et al.

1986). 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 (Lidz et al. 1982; Steinberg 2003). 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 (Berg et al. 2001). 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." (Berg et al. 2001, p. 250). 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." (Jonsen 1998, p. 355). It has both legal and bioethical origins. Its emergence was, in part, a reaction to paternalism.

2.1.1 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 (Faden et al. 1986, p. 116), Mohr v. Williams 95 Minn. 261.104 N.W. 12 (1905), and Pratt v. Davis 1905/1906. 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 (Faden et al. 1986, p. 122). Finally, they are memorable for their strong language about "the nature and importance of self-determination." (Faden et al. 1986, p. 122).

The first legal cases which not only involved informed consent *per se* but which directly impacted and further advanced 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. These three cases will be discussed in detail because of their direct impact on the development and advancement of informed consent.

Schloendorff v. Society of New York In the case of Schloendorff v. Society of New York (1914, and Mary E. Schloendorff, Appellant, v. The Society of the New York Hospital 1914), 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 even if her narrative is improbable, it has to 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 (Schloendorff v. Society of New York 1914).

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 (Faden et al. 1986). 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. However, the opinion of Justice Cardozo is considered as a "classic statement" of the right of self-determination of a patient (Faden et al. 1986). 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 (Faden et al. 1986, p. 123). 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 (Bennett 2000).[1] Most legal cases hinged on this landmark case, Schloendorff v. Society of New York. However,

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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.” (Salgo v. Leland Stanford Jr. 1957). 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, 186 Kan 392, 350 P 2d 1093 (1960), weaved a new concept of informed consent into the legal framework, namely, the negligence theory instead of the battery theory (Jonsen 1998). 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” (Dworkin 1988, p. 101) 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 (Bennett 2000). 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. 464 F 2d 772 (DC Cir 1972) (Cf. Jonsen 1998).

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 (Cf. Jonsen 1998, p. 355).

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 (Cf. Jonsen 1998).

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 (Menikoff 2001).

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 (Menikoff 2001).

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." (Faden et al. 1986, p. 94). 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 (Faden et al. 1986). 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 (Hospital 1973). 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. (American Hospital Association 1973).

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 (Faden et al. 1986). 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 (Faden et al. 1986).

2.1.2 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 (Jonsen 1998). 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 (Faden et al. 1986).

The Nuremberg code of 1947 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." (Beauchamp and Walters 2003, p. 354; Jonsen 1998, p. 356). 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." (Katz 1973, p. 320; Jonsen 1998, p. 356). 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

(Jonsen 1998, p. 357). The Tuskegee Study showed that doctors in USA as well as Nazi war criminals could disregard the Nuremberg code requirement for voluntary consent (Jonsen 1998).

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.” (Jonsen 1998, p. 357). 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 1978; Jonsen 1998). 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 (Faden et al. 1986). 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.” (Jonsen 1998, p. 357). 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 (Faden et al. 1986).

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 (President’s Commission 1982; Faden et al. 1986) 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 President’s Commission 1982, Rept. 36; Jonsen 1998, p. 357). 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." (President's Commission 1983, p. 44; Faden et al. 1986, p. 98).

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," (President's Commission 1983, chs 1–2; Faden et al. 1986, p. 97) 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. (President's Commission 1983, chs 1–2; Faden et al. 1986, p. 97). 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 (Jonsen 1998). 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.

2.1.3 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 (Beauchamp and Childress 2009). 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 (Beauchamp and Childress 2009).

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 (Murray 1990). 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 (Plato, and Cf. Jonsen 1998). 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." (Hippocrates, and Cf. Jonsen 1998, p. 354). 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 (Hippocrates, and Cf. Jonsen 1998). 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 (Veatch 2003).

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." (Murray 1990, p. 104; Faden et al. 1986, p. 63).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 (Faden et al. 1986). 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 (Murray 1990; and Faden et al. 1986). 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 Jonsen 1998). 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.

2.2 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.

2.2.1 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 (Beauchamp and Childress 2009). 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 (Beauchamp and Childress 2009). The understanding of autonomy in Western thought has been greatly influenced by the Kantian and liberal rights moral theories (Beauchamp and Childress 2009; Mappes and DeGrazia 2006). 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 (Schneewind 1998).[2] 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." (Schneewind 1998, p. 6). 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." (Kant 1964b, p. 105 and 108; Mappes and DeGrazia 2006, p. 45).

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." (Mappes and DeGrazia 2006, p. 46). For Mill, to do something because it is the custom is to make no choice (Mill 1962; Mappes and DeGrazia 2006). 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 (Mappes and DeGrazia 2006).

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 (Hill Jr. 1989). 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

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[2] According to Schneewind, Kant's Proposal, Morality as Self-Governance, is a Revolutionary Rethinking of Morality.

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.” (Hill Jr. 1989, p. 93).

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 (Hill Jr. 1989). 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 (Hill Jr. 1989). In other words, they have roots in Kant.

2.2.2 *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 (Beauchamp and Childress 2009; Faden et al. 1986). 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 (Faden et al. 1986). 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 (North Carolina Statute 1975). 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 (Beauchamp and Childress 2009; Faden et al. 1986). 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.” (Miller and Wertheimer 2010, p. 79). 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 (Miller and Wertheimer 2010).

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 (Miller and Wertheimer 2010). 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 (Faden et al. 1986). 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." (Miller and Wertheimer 2010, p. 81). 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 2010). 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 (Miller and Wertheimer 2010).

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 (Beauchamp and Childress 2009; Osuji 2012).

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 (Beauchamp and Childress 2009).

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 (Gert et al. 2006). 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." (Gert et al. 2006, p. 214). 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 (Gert et al. 2006, p. 213; Braddock III et al. 1999, pp. 2313–23 20; Beauchamp and Childress 2009, p. 122; Osuji 2012, pp. 129–161).

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 (Beauchamp and Childress 2009). These include the nature and purposes of the intervention, risks and benefits involved, diagnoses, prognoses, and available alternatives.

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," (Mappes and DeGrazia 2006, p. 65) 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 (Beauchamp and Childress 2009; Gert et al. 2006).

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 (Gert et al. 2006).

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 (Beauchamp and Childress 2009; Gert et al. 2006; Faden et al. 1986). 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." (Beauchamp and Childress 2009, p. 132). 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 (Cf. Beauchamp and Childress 2009). 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 (Gert et al. 2006). 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*." (Beauchamp 2010a, p. 55).

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 (Beauchamp and Childress 2009; Osuji 2012).

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 (Beauchamp and Childress 2009). 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 (Beauchamp and Childress 2009). 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 (Beauchamp and Childress 2009).[3]

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 (Kant 1964a, 2005). For Kant, to contravene a person's

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[3] For the determination of and test for competency, refer to Beauchamp and Childress 2009, pp. 70 ff.

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 (Kant 2005).

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 (Beauchamp and Childress 2009). 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.

2.2.3 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 (O'Neill 2002). 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 (O'Neill 2002).

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 (O'Neill 2002). 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 (O'Neill 2002, p. 12).

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 (O'Neill 2002).

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 (O'Neill 2002).

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." (O'Neill 2002, p. 18). 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." (Wolpe 1998, p. 48; O'Neill 2002, p. 19). 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." (Rothman 1991; O'Neill 2002, p. 20). 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 (Rothman 1991). 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 (O'Neill 2002). 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." (Thomas 2003, Online). 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 (Thomas 2003, Online). 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 (O'Neill 2002).

Finally, the following conclusions can be drawn. O'Neill reinforces the argument of this book, 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 (Cf. Black 2002).

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 book will first explore how Western liberal notions of person influence the concepts and practice of autonomy and informed consent in Western bioethics.

2.3 The Concept of Person and Autonomy

There are various ideas of what constitutes a human person in Western culture. For instance, the existentialists (e.g. Martin Heidegger and John Paul Sartre) believe that human beings are relational, that *to be* is to be in relationship (See Macquarrie 1968). 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 (Luijpen and Koren 1969). "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." (Luijpen and Koren 1969, p. 149). Aristotle too held that human beings are by nature social and political animals. "A social instinct is implanted in all men by nature." (Aristotle 1943, p. 54). 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 (Aristotle 1943).

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 (Genesis 1, pp. 26–27).

Then God ordered them to be fruitful and multiply, filling the earth and subduing it (Genesis 1 p. 28).

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 (Reno et al. 2010, p. 51). 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 (Origen online, and Reno et al. 2010). 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 such as R. R. Reno, Robert Jenson, Robert Wilken, Ephraim Radner, Michael Root, George Sumner, Bruce K. Waltke, and Cathi J. Fredricks (Brown et al. 1990; Reno et al. 2010; Waltke and Fredricks 2001) 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, Chap. 1 belongs to "P," whereas the account in Genesis Chap. 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 (Reno et al. 2010).

Commenting on the image of God, Waltke and Fredicks noted that the expression "image of God" is used in a unique way in reference to human beings (Genesis 1, pp. 21, 24–25). 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 (Waltke and Fredricks 2001).

> 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. (Hart 1995, p. 318).

The passage (Genesis 1, pp. 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, pp. 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 (Macer 1998).

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 (Aristotle 1943; Rachels 1991). The Fathers of the Church saw the divine element in human beings as rationality, hence the "rationality thesis." (Rachels 1991, p. 87). Human beings are special because they are rational. Augustine of Hippo asserts that human reason is the essence of the soul (Augustine 1958; Rachels 1991). 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. (Aquinas 1945, p. 221; Rachels 1991, p. 88).

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 (Rachels 2010, p. 136 ff.). 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 (Kant 2005; Rachels 2010). 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. (Kant 1963, pp. 153–154. Rachels 1991, p. 90).

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 (Kant 1963). 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." (Po-wah 2003, pp. 16–17). 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 (Po-wah 2003). 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." (Christman 2009). 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 (Veatch 2003). 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 (Veatch 2003). 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).

2.3.1 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 (May 2002). 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 (Engelhardt 1996). 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 (May 2002). 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 (May 2002).

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 1991; May 2002).

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 (Mill 1962; Mappes and DeGrazia 2006).

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 (Slote 2007). 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. (May 2002, pp. 4–5).

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 (Nelson 1992). 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 (Nelson 1992).

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 (Hardwig 1990). 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 (Hardwig 1990). 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 (Hardwig 1990). 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 (Sherwin 1988). 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." (Nelson 1992, p. 7). 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." (Sherwin 1988, p. 31).

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 (Hardwig 1990).

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 (Nelson 1992). 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 (Nelson 1992). Following the points made above, this book 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.

2.3.2 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 (Williams 2009). 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 (Kant 2005). 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 (Parks and Wike 2009).

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 (Kant 2005; Paley 2002; Held 1993). 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." (Callahan 1991, p. 98). 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 (2005; Held 1993). 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." (Callahan 1991). 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 (Engelhardt, Jr. 1996, p. 10; Callahan 1991, p. 98). 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." (Pizarro 2000, p. 357). 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 (Pizarro 2000). 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 (Callahan 1991).

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." (Callahan 1991, p. 99; Feinberg 1982, pp. 19–46). 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 (Held 1993). 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 (Held 1993). 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 (Kant 2005; Rachels 1991, 2010). 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 (Fritz and Lauritzen 2001; Callahan 1991). 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 (Callahan 1991, p. 105). Emotions are consciousness, and are interwoven with self-consciousness and moral thinking (Callahan 1991). 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 (1623–1662), remarked that "The heart has reasons that reason knows not of." Moreover, emotional responses reflect internalized past choices and the use of attention (Fritz and Lauritzen 2001). 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," (Pizarro 2000, p. 355) 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 asserts that emotions and desires are objects of our judgments and partly constitutive of them (Christman 2009). 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." (Callahan 1991, p. 113).

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." (Gross 1998, pp. 271–299; Pizarro 2000, p. 355; Callahan 1991, pp. 109–113). 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 (Pizarro 2000, p. 371). 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." (Pizarro 2000, p. 358; Callahan 1991, p. 106). 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." (Pizarro 2000, p. 371). 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." (Pizarro 2000, p. 371). 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 (Callahan 1991, p. 106).

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." (Tomkings 1984, pp. 163–195; Callahan 1991, p. 100). 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 (Callahan 1991, pp. 100–101).

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 (Pizarro 2000). 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 2000; Fritz and Lauritzen 2001).

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 (Pizarro 2000, p. 358). 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 (Bootzin and Acocella 1988, pp. 167–255).

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." (Pizarro 2000, p. 358).

2.3.3 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 (Veatch 2003). 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 (Beauchamp and Childress 2009; May 2002). 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 (Feinberg 1973; Beauchamp and Childress 2009). 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 (Beauchamp and Childress 2009). The concept of rights can be traced back to the ideas of Natural Law seen in the ancient Greek, Roman (Cooney 1998), 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 (May 2002). To balance these rights-claims under which autonomy is protected, the liberals often distinguish between two types of "liberty" namely, positive and negative liberty. Isaiah Berlin offers a widely known popular account of the two forms of liberty in his paper, "Two Concepts of Liberty." (May 2002; Berlin 1969).

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 (May 2002; Veatch 2003). The negative rights theory posits that the overriding moral principle is noninterference (Cooney 1998), 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 (Wellman 1995). 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 (Wellman 1995).[4] 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

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[4] Liberals understand liberty and use its values variously.

legal protections for individuals, in particular, protecting individuals from governmental and societal intrusions (Beauchamp and Childress 2009).

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 (Engelhardt, Jr. 1996). 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 (President's Commission 1983; Fan 1997).

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 (Engelhardt, Jr. 1996). Thus, liberal societies promote a social system that delineates value as determined in substance or content by individuals in that society (May 2002). 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 (Dworkin 1978). 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.

2.3.4 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 (Post et al. 2007; Buchanan and Brock 1990). 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 (Buchanan and Brock 1990). 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 Beauchamp and Childress 2009, and Ho 2008). 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 (Nedelsky 1989). 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." (Sherwin 1988, p. 31; Ho 2008, p. 129).

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 (Schneider 1998; Beauchamp and Childress 2009; Wolpe 1998).[5] 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." (Sherwin 1988, p. 31).

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 (Ho 2008). 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 (Nelson 1992; Ho 2008).

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.

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[5] 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.

2.3.5 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." (Nemetz and Massaro 2003, p. 16).[6] 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." (Nemetz and Massaro 2003, p. 16).

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. (Nemetz and Massaro 2003, p. 17; Mahowald 1995, pp. 1934–1941). 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." (Dupré 1993, p. 687). 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 (Dupré 1993). The question has been raised as to the possibility of identifying the common good or the public interest in contemporary historical and cultural conditions (Hollenbach 1989). 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 (Bellah et al. 1985; Hollenbach 1989). 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." (Dupré 1993, pp. 687–712). 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 (MacIntyre 1984; Emanuel 1991; Callahan 1990; Callahan 1987; Beauchamp and Childress 2009) 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 (Callahan 1991; Beauchamp and Childress 2009).

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

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[6] Hermes is the Greek god of commerce, eloquence, invention, travel, and theft who serves as herald and messenger of the other gods.

of the early Puritan settlers and the classical republican commitments of some of the founders and framers of early American institutions (Hollenbach 1989; Bellah et al. 1985). 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 (Hollenbach 1989; Bellah et al. 1985). 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," (Bellah et al. 1985, p. 277 ff.; Hollenbach 1989, p. 77) or a situation ruled by Hobbes' sovereign Leviathan (Hobbes 1958). 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 (Hollenbach 1989; Bellah et al. 1985). 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 (Elshtain 1988).

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 1991; May 2002). 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 (Engelhardt, Jr. 1996). 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 (May 2002). 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 (Fan 1997; Fox and Swazay 1984).[7] 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 (Buchanan and Brock 1990; Fan 1997). Our basis is hardly a common good or a concept of a good life objectively understood.

2.4 Summary

In order to lay out the historical context of the discourse on autonomy and informed consent, Chap. 2 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 book 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 book progresses from a discussion of the historical context to a systematic analysis of ethics of care.

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[7] 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.

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Chapter 3
Systematic Analysis of Ethics of Care

In Chap. 2, 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.

3.1 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 (Aristotle 1984). *Philein* includes substantial familiarity with the other per-

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son. This familiarity is gained through meaningful personal interactions with the person. The interactions imply compassion and sympathy which are the essential elements of care (Curzer 2007). 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 (Curzer 2007).

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 (Aristotle 1984). He argues that human beings are and should be partial with relationships because individual responsibilities grow from these relationships (Curzer 2007). 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 (Held 2006a). 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.

3.1.1 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 (Flanagan 2004). 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 (Tronto 1993).

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 (Held 2006a). The 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 (Held 2006a). 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 (Held 2006a).

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 (Held 2006a).

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 (Blum 1980). 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 (Blum 1980).

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? (Williams 2006, pp. 1–2)

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 (MacIntyre 1984). 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 (MacIntyre 1984; Edel and

Flower 1983). 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 (Slote 1983). 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 1983; Piper 1986). 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 (Held 2006), 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.

3.1.2 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 (Held 2006; Hampton 2002; Baron 1995; Purdy 1995). 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 (Held 2006).

Held specifically locates the beginnings of ethics of care with the pioneer essay "Maternal Thinking" by the female philosopher, Sara Ruddick, in 1980 (Ruddick

1980). 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 (Held 2006). 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 (Ruddick 1980).

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 (Ruddick 1980). "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." (Ruddick 1980, pp. 347–348) 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 (Ruddick 1980, pp. 350–367). 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 (Held 1993).

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 (Gilligan 1993). 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 (Gilligan 1993).

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 S*cience, Morality and Feminist Theory* (Noddings 2003; Kittay and Meyers 1987; Hanen and Nielsen 1987; Held 2006). 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." (Slote 2007, p. 11). 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." (Noddings 2003, p. 69). 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 (Noddings 2003). 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." (Slote 2007, p. 11).

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 humanity (Hume 1958; Slote 2007). 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 (Paulsen 2011).

3.2 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." (Tronto 1993, p. x) 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 (Held 2004). 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 (Held 2006; Bubeck 1995). 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." (Fisher and Tronto 1991, p. 40; Held 1993, p. 103). 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;" (Groenhout 2004, p. 28) 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." (Tronto 1993, p. x) "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 (Tronto 1993; Maihofer 1988). 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 (Tronto 1993).

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 (Tronto 1993). 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 (Po-wah 2002b).

The face-to-face aspect of caring is also central to care and makes it difficult to imagine caring for more distant others (Held 2006). 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 (Bubeck 1995). 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 (Held 2006). 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 (Bubeck 1995). 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 (Held 2006). 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." (Held 2006, p. 33). 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 (Slote 2007). 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 (Cf. Held 2006). 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 (Clement 1996). 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 (Bubeck 1995; Held 2006). 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 (Noddings 1990, 2003; Bubeck 1995). 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." (Bubeck 1995, pp. 152–153). Like other ethics of care advocates, she rejects universal principles for prescribed action and judgment, and insists that care must always be contextually applied (Noddings 2003).

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 (Clement 1996; Gilligan 1993). Care is, therefore, essentially a relationship, and ethics of care focuses on relationships and communal ties (Held 1993). Furthermore, care can be seen as labor, as relational, as practice, as value, and in relationship to justice.

3.2.1 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 (Held 2004, 2006; Ruddick 1998; Slote 2007; Kittay 2011). For Ruddick, care is work or labor, and inasmuch as care is labor, it is a relationship: "Caring labor is intrinsically relational." (Ruddick 1998, pp. 13–14; Held 2006, p. 33). 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 (Kittay 2011).

3.2.2 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 (Tronto 1993). 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 (Held 2006). 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 (Tronto 1993; Ruddick 1980). 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 (Held 2006, Tronto 1993).

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 (Held 2006). 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 (Held 2006). 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 (Held 2006). It follows, then, that care is seen as both practice and value.

3.2.3 Caring Relations

Besides being purposeful, labor, practice, and value, care is intrinsically a relationship (Held 1993). 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." (Gilligan 1986a, p. 317, 1987, p. 24; Clement 1996, p. 36). 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 (Held 2006). 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 (Gilligan 1987; Held 1993). 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 (Noddings 1990; Clement 1996). 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." (Clement 1996, p. 41). 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." (Clement 1996, p. 35).

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." (Noddings 1990, pp. 124–125).

The comprehension of one's interconnectedness helps one to realize that the apparent conflict between oneself and others comes from a construction of reality which is faulty. 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 (Gilligan 1986b; Clement 1996). 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 (Held 2006). She compares relations of care and of justice as discussed in the next section.

3.2.4 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 (Slote 2007).

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." (Held 2006, p. 68). 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." (Groenhout 2004, p. 29). 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 (Held 2006).

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 (Held 2006). 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 (Held 2006).

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 (Slote 2007). 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 (Slote 2007). 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 (Slote 2007).

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 (Held 2006a, b). 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 (Held 2006).

3.2.5 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." (Sander-Staudt Online). 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." (Sander-Staudt Online).

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. (Held 1993).

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 2011; Beauchamp and Childress 2009). 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 (Kittay 2011).

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." (Nortvedt 2011, p. 148). 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 (Noddings 2003; Ethics of Care 2011).

3.3 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." (Groenhout 2004, p. 24) 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 (Held 1993, 2006a; Slote 2007).

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 (Po-wah 2002b). 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 (Held 2006). 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;" (Po-wah 2002b, p. 48) that long after one's capacity for autonomy has waned or disappeared, "relationship ties continue to exert a normative force." (Pullman 1999, p. 26). 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.

3.3.1 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 (Held 2006; Nedelsky 1989; Clement 1996). 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.
> (Friedman 2000, pp. 40–41)

However, some other scholars criticize Friedman for interpreting social relations as merely causal instead of being constitutive elements (Oshana 1998; Friedman 2000). Of course, social relations are both causal and constitutive. Persons are causally affected and partly and importantly constituted by social relations (Held 2006). 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. (Meyers 2004, p. 292).

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 (Held 2006).

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 (Tronto 1993).

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." (Tronto 1993, p. 162). 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 (Tronto 1993). 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 (Slote 2007).

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." (Tronto 1993, p. 163). 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 (Rousseau 1968; Tronto 1993). 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 (Smith 2002; Tronto 1993). Other liberals say that dependence allows the powerful to have undue influence over other people. 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 *human activity* in terms "either logically or culturally individualistic," *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 (Tronto 1993).

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 (Tronto 1993).

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.

3.3.1.1 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 (Friend 2012). As a modern theory, the social contract theory is very much associated with Thomas Hobbes, John Locke, and Jean-Jacques Rousseau (Rousseau 1987; Locke 2003; Hobbes 1958).

3.3.1.2 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 (Hobbes 1958). 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 (Friend 2012).

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 (Locke 2003). 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) (Locke Online). 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 (Friend 2012).

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 (Rousseau 1997).

3.3.1.3 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 (Baier 1988; Held 1977, 1993). 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 (Baier 1988; Beauchamp and Childress 2001). 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 (Groenhout 2004, pp. 2–26).

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." (Kittay 1999, p. 14; Held 2006, p. 14). 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 (Cockburn 2005). 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." (Kittay 1999, p. xi).

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 whom one interacts with through relations of dependence (Held 1993, p. 194).

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 (Baier 1994).

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." (Gauthier 1986, p. 102). Affective liberty in a free society is the pilgrim's Promised Land (Baier 1988).

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, *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 (Friend 2012).

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." (Held 1993, p. 194 ff., 2006, p. 14). 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." (Held 1993, p. 204 ff.; Friend 2012).

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 1994, p. 28). 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 1994, p. 28). 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. (Baier 1994, p. 28)

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." (Baier 1994, p. 29). 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 (Baier 1987a; Kroeger-Mappes 1994). 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 (Baier 1994, p. 29).

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 Chap. 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 (Po-wah 2002b). 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." (Beauchamp and Childress 2009, p. 376).[1] 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 (Held 1993, p. 187). 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.

3.3.2 The Ethics of Care Concept of 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 (Tronto 1993). 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

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[1] 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.

> 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. (Kittay 2011, p. 54).

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 (Noddings 1986; Clement 1996; Kittay 2011).

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 (Tronto 1993). 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." (Gilligan 1986, p. 247).

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 (Ethics of Care 2011). 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 (Groenhout 2004).

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 (Groenhout 2004; Tronto 1993).

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

(Rousseau 1968; Tronto 1993). 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 Chap. 2 above (Held 2006).

3.3.3 The Ethics of Care Concept of 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 (Tronto 1993). 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 study 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 (Clement 1996). 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 (Clement 1996). 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 (Clement 1996). 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 (Clement 1996). 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 1989, p. 9). 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 (Nedelsky 1989). 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 1989). 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 (Nedelsky 1989). 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 Chap. 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 (Nedelsky 1989, pp. 11–12; Held 1993, p. 62). 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 (Nedelsky 1993). 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 book, is referred to as RAIC (relational autonomy in informed consent). (Clement 1996; Nedelsky 1989).

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." (Nedelsky 1989, p. 12). 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.

3.3.4 Emotion as an Essential Part of Human Nature in Moral Decision-Making

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 (Held 1993). 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. (Beauchamp and Childress 2009, p. 373; Sherman 1989, pp. 13–55). 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 (Baier 1987a, 1994; Held 1993). 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 (Suski 2012). 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 (Beauchamp and Childress 2009, p. 373).

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 (Kant 2005). 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 (Held 1993). 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 (Held 1993).

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 (Held 1993). As was noted in Chap. 2 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 (Callahan 1991; Pizarro 2000; Fritz and Lauritzen 2001; Beauchamp and Childress 2009). Emotions, especially empathy, play an integral role in the process of moral judgment or moral decision-making (Pizarro 2000). Thus, emotions have come to be regarded as "the primary motivating system for all activity." (Tomkings 1984, pp. 163–195; Callahan 1991, p. 100).

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, therefore, encourages people to ask whether their emotions are appropriate. (Nussbaum 1999, p. 74 ff.; Slote 2007, p. 77) 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." (Nussbaum 1999, p. 79; Slote 2007, p. 77) 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 (Slote 2007).

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." (Morgan 1990, p. 2; Held 1993, pp. 51–52) 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 (Beauchamp and Childress 2009).[2] 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 (Held 1993, p. 75). 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." (Curtin 1991, pp. 60–74; Cockburn 2005, p. 84).

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. (Beauchamp and Childress 2009, p. 375).

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

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[2] This is traceable to Hume.

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 (Herman 1983; Baron 1984; Beauchamp and Childress 2009).

3.3.5 The Ethics of Care Concept of Individual Patient Rights

As seen in Chap. 2, 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." (Held 2006, p. 134). 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 (Narayan 1995). 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 (Card 1990; Cockburn 2005). 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 (Held 2006a).

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 (Baier 1987b; MacKinnon 1998). 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 (Held 2006a).

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." (Kroeger-Mappes 1994, pp. 103–131).

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 (Held 2006a). 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 (Held 2006). 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." (Held 2006a, p. 137). Thus, Held concludes that rights presume a background of social connectedness or solidarity based on caring that has value (Held 2006a).

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 (Nedelsky 1993, pp. 1–26). 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." (Nedelsky 1993, pp. 1–26). 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 (Nedelsky 1993).

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. (Nedelsky 1993, pp. 13–14).

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 (Nedelsky 1993). 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." (Nedelsky 1993, p. 12).

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 (Nedelsky 1993). 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. (Nedelsky 1993, p. 8)

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 (Nedelsky 1993, p. 8).

Although some theorists canvass for group rights, rights—legal or moral—are "usually thought to attach to persons as individuals." (Nickal 1994, pp. 84–98; Young 1990; Held 1998, p. 502). 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 (Baier 1994, p. 237). 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. (MacKinnon 1989, pp. 238–248; Held 1998, p. 503).

Rights are seen, especially, by some feminist ethics of care advocates, as "inherently abstract and reflective of a male point of view." (Held 1998, p. 504). 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 (West 1988; Held 1998). 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.

3.4 Summary

In view of the next section, Chap. 4, the systematic analysis of ethics of care as a hermeneutic to interpret ATM was undertaken in the present Chap. 3, 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.

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Chapter 4
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 (Munyaka and Motlhabi 2009; Kasenene 2000).

4.1 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 book 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."

P. Ikechukwu Osuji, *African Traditional Medicine: Autonomy and Informed Consent,*
Advancing Global Bioethics 3, DOI 10.1007/978-3-319-05891-7_4,

(Traditional Medicine, online) 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, 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." (Painter 1996, online)

Mentalities are changing with regard to ATM. While some people are skeptical of ATM and will not use it, others utilize it for want of anything better. However, studies show that more and more people are accessing ATM. About 70 % of Ghanaians rely primarily on ATM (Roberts 2001, p. 1859; Abdullahi 2011, p. 117). In Lagos, Nigeria, there is a significant population of hypertensive patients who are being treated with the western-styled medicine at the tertiary health facilities who at the same time use ATM (Amira and Okubadejo 2007; Abdullahi 2011, p. 117). In Ghana, Mali, Nigeria, and Zambia ATM is the first line of treatment for 60 % of children suffering from malaria high fever (WHO 2003). According to WHO, 90 % of Ethiopians, 70 % of Beninese, 70 % of Rwandans, 60 % of Tanzanians, and 60 % of Ugandans use ATM for primary healthcare (WHO 2002b).

Moreover, as discussed under 4.1.2.2, ATM is becoming popular and being recognized by increasing number of governments and non-governmental organizations. Likewise, the number of countries bringing ATM into the mainstream public utilities is increasing. There are a growing number of countries considering official collaboration or integration of ATM and allopathic or western-styled medicine (Osuji 2012, p. 166).

Those calling for the integration of both systems of healthcare suggest that issues such as efficacy, safety, quality, standardization, regulation of traditional medicines and intellectual property rights, need to be studied and documented. They warn that care should be taken not to transform traditional medicine into a puppet of or inferior to allopathic or western-styled medicine. (Agostinho 2011; Busia and Kasilo 2010; Murove 2009; Hardy 2008). WHO and some African governments are seriously considering these issues and formulating regulations and guidelines accordingly.

4.1.1 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. (Marley online)

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.

4.1.1.1 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." (Mume 1973, p. 27; Ubrurhe 1989, p. 10). 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." (Sofowora 1982, p. 21; Ubrurhe 1989, p. 10). 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 (World Health Organization 2002; Dime 1995; Kayne 2010). ATM concern is for the well-being of both the individual and the community. ATM approach to healing is holistic because it caters for the physical, psychosocial, and spiritual aspects of ill-health. This approach arises from the African understanding of health and illness as will be discussed later.

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 (Adekson 2004). 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 (Janzen 1997; Rasmussen 2008).

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 (Owoahene-Acheampong 1998; Wasunna 2009). 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. In 1953 the South African Medical Association banned the ATM system in South Africa. This law was further strengthened by the Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970. These Acts outlawed the practice of ATM by beleiving ATM to be witchcraft. (Hassin et al.; Abdullahi 2011, p. 116).

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 (Owoahene-Acheampong 1998; Wasunna 2009). 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 (du Toit and Ismail 1985; Wasunna 2009). 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. (Lamb 1983, p. 140; Mbefo 1989, p. 101; Ubrurhe 1989, p. 6).

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." (Felhaber and Mayeng 1997; Ross 2010, p. 46) 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 (South African Government 1997; Ross 2010). 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 (South African Government 2007; Ross 2010; Moagi 2009). 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 (World Health Organization 2002). 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 (Wasunna 2009, and Okere 2005).

4.1.1.2 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 (Osuji 2012).

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 Médicine Traditionnelle* (CEMETRA); PROMETRA Traditional Medicine Research and Treatment Centers (*Promotion de Médicine Traditionnelle)et*c. 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 (Promotion de médicines traditionnelles 2008). 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 (Janzen 1997). 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 (World Health Organization (WHO) African Region. 2004. World Health Organization 2000). 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 (Samba 2003; World Health Organization 2004). 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 (World Health Organization 2002). 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 (World Health Organization 2002). 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 (Mensah 2000; Romero-Daza 2002). 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.

4.1.2 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 (Mbiti 1992; Dime 1995). 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 (Ademuwagun 1978; Wolff 2004). This section explores the very important intimate connection between ATM and (ATR).

4.1.2.1 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 (Wasunna 2009). 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. (Mbiti 1992, pp. 90–91; Wasunna 2009, p. 314).

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 (Singh 1999). Among the Igbo people, for example, *agwụ* 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 *agwụ* attests to this, saying “It is perhaps a little singular that *agụ* (*agwụ*) 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.” (Thomas 1913, p. 28; Aguwa 2002, p. 23) 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 *agwụ*, who is the special spirit of *ndị dibịa*, the spirit of giddiness, rascality, discomposure, confusion, and forgetfulness (*mmụọ mkpasa uche*).” (Arinze 1970, p. 64; Aguwa 2002, p. 23).

There are instances of apprentices or doctors testifying that they came to the profession led by the spirit that possessed them (Ross 2010; Mbiti 1992). 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 (Ross 2010; Mbiti 1992). 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 (Adekson 2004; Epega and Neimark 1995). 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." (Epega and Neimark 1995, p. ix; Adekson 2004, p. 8).

4.1.2.2 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 (Bujo 2003; Murove 2009; Mindset Health 2006; Ross 2010). 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 1995). 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." (Epega and Neimark 1995, p. vii). 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 (Adekson 2004).

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, *babalawo,* for the Yoruba, and *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 (Mbiti 1992). 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." (Dime 1995, p. 80). 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. (Dopamu 1979, pp. 3–20; Dime 1995, pp. 80–81).

The ATM doctors employ an indigenous psychotherapeutic approach in the management of patient care. It was Plato (420−348 BC) 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. (Plato 1937, p. v; Dime 1995, pp. 82–83).

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 (Dime 1995; Mbiti 1992).[1]

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 (Wolff 2004).

4.1.3 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 (Adekson 2004; Mbiti 1992; Ubrurhe 1989; Denga 1983). 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 *ọghọnwa* (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 (Ross 2010; Adekson 2004). 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 (De Andrade and Ross 2005; Ross 2010). 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." (Wolff 2004, p. 1032).

The five categories of ATM doctors will now be described individually beginning with the diviners.

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[1] The diviners and the mediums are relied upon to uncover mystical or spiritual causes of a particular sickness.

4.1.3.1 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 (Fry 1976; Magesa 1997; Mbiti 1992). 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 (van Binsbergen 1981; Magesa 1997). 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 (Mbiti 1992, pp. 167–168).

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 (Mbiti 1992).

4.1.3.2 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 (Adesina 2012; Iroegbu 2010).

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." (Ross 2010, p. 46). 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." (Ihesie 2012, online). 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, (*ọfọ* 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 (Umeh 1999).

4.1.3.3 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 (Leedam 1985, pp. 249–274; United Nations Population Fund 1997, p. 1). 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. (Imogie et al. 2002, p. 96).

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 (Imogie et al. 2002).

4.1.3.4 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 being barren. Some are mediums performing the functions of a medium delineated above. Thus, they function as priests, physician, and psychologist (Adekson 2004; Mbiti 1992). 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,

> 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. (Ezeanya 1978, p. 6; Ubrurhe 1989, p. 16).

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 (Mbiti 1992). 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 (De Andrade and Ross 2005; Ross 2010).

4.1.3.5 Traditional Surgeons

There is little written about the African traditional surgeons and bonesetters. Among the Igbo the traditional surgeons are called *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 (Ross 2010; Gessler et al. 1995; Miles and Ololo 2003). 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 (Miles and Ololo 2003). 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 (Miles and Ololo 2003; Donders et al. 2000; Newman et al. 1997; Olu 1983; Ntim-Amponsah 1995). Orthopedic surgery is performed for closed and open fractures and osteomyelitis (Steinmetz 1982; Miles and Ololo 2003). 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 (Miles and Ololo 2003). 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 (Mbiti 1992; Murove 2009). The ATM costs contrast with those of Western medicine where corporate norms of profit-making tend to supersede over other organizational and professional values (Turner 2005).

ATM doctors acquire their skill through one or more of the following: inheritance, spirit possession, apprenticeship, and, more recently, by formal classroom training programs (Adekson 2004; Ross 2005; Green 1964). 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 (Prince 1961, 1962; Ubrurhe 1989). 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 (Mbiti 1992). 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." (Mbiti 1992, pp. 163–164) 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 (Mbiti 1992). 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 (Mutwa 2000; Murove 2009).

4.1.4 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.

4.1.4.1 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 (Dime 1995; Helwig 2001). 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." (Prinsloo 2001, p. 60; van der Merwer 2008, p. 65). The Yoruba, for example, believe in a holistic approach to *Alafia* (health) which literally means peace. It embraces physical, social, emotional, psychological, and spiritual well-being in a total environmental setting (Ademuwagun 1978; Wolff 2004). Explaining the holistic approach to health among the Yoruba, Norma H. Wolff articulated the literature on the issue as follows:

> Physical health (*ilera*), a prerequisite to achieving life goals, is negatively impacted by *aisan*, minor illnesses, such as fevers, headaches, diarrhoea, and vomiting that interfere with daily activities, and *arun*, which includes serious pathological conditions, communicable diseases such as smallpox and venereal diseases, infirmities, chronic tiredness, debilitating mental illnesses, and unexplained misfortunes. (Wolff 2004, p. 1033)

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 (Emson 1987). 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 (Orubuloye 2012; Disease 2012).

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 (Leonard 1968; Mbiti 1992; Dime 1995; Carteret 2012). 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.” (Okere 2005, p. 157). 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.” (Okere 2005, pp. 157–158). 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 (Murove 2009).

4.1.4.2 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 (van Bogaert 2007).

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 (Chavunduka 2012).

4.1.5 Decision-Making in Traditional African Societies

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 (Shaibu 2007).

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." (Mutiso and Rohio 1975, p. 476; Wiredu 1997, p. 303). Nyerere also asserts that "in African society, the traditional method of conducting affairs is by free discussion." (Nyerere 1963, p. 1). And in approval he quoted Guy Clutton-Brock: "The Elders sit under the big trees, and talk until they agree…" (Nyerere 1963, pp. 1–2; Wiredu 1997, p. 303). 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." (Wiredu 1997, p. 303 ff.). 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 (Uzukwu 1996). The assertions are true also of the Akan, Hausa-Fulani, Igbo, and Yoruba, the four ethnic groups considered in this book.

4.1.5.1 Decision-making among 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 K*wa* 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 (Blay 2009; Johnson Jr. 2010; Dumett 2005; Gibson 2010). 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 (O'Neil 2002; Busia 1954; Rattray 1955; Meyerowitz 1951; Gibson 2010). 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.' (Gibson 2010, p. 6.9 and 6.16).

The culture of the Akan people of West Africa dates from before the thirteenth 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 (Blay 2009). 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.

As regards decision making 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. (Busia 1967, p. 28; Wiredu 1997, p. 311).

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 (Busia 1967; Gibson 2010). 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 (Rattray 1923; Busia 1954; Gibson 2010). 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 (Assié-Lumumba 1996).

4.1.5.2 Decision-making among 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 in Western Sudan, Senegal, Gambia, Nigeria, etc (Stenning 1959; Hill 1972). 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 (Solivetti 1994).

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 (Salamone 2007). 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 Muslin 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 magadjiya*, 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 (1985; Salamone 2007).

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 (Salamone 2007).

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 bhale* 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 *bluurimmhuuru*, 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 (Gordon and Sall 2008).[2]

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 hesars that the fate of events and healing is in God's hands, *insha Allah* (Arabic) or *si Allah dyabbi* (Fulani-Hausa) (Gordon and Sall 2008). Sickness, especially mental illness, is seen as a result of spirit possession, or *bori* possession (Salamone 1970; Greenberg 1946).

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

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[2] 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.

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." (Reismen 1977; 47 ff.). 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.

4.1.5.3 Decision-making among 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 bi-lineal. 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 (Iroegbu 2010). 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 (Forde and Jones 1950; Greenberg 1963). 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 (Iroegbu 2010). Groups of families form a village community, *ụmụnna*, 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 (Iroegbu 2010). The community forms the Igbo system of government in which the kinship functions bilaterally, that is, by making for *ụmụnna* politics as well as the expression of social democracy (Ilogu 1974; Iroegbu 2010).

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. (Leonard 1968, p. 429).

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 (Forde and Jones 1950; Nsugbe 1974). 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 (Nsugbe 1974; Forde and Jones 1950). Unlike the rest of the Igbo, there are no ritual staves of headship, *ọfọ, 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, *ụmụaka* judges and penalizes the man involved but not the woman. It is the women who deal with the female accomplice to adultery (Nsugbe 1974).

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. They are recruited by the age grade 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 (Nsugbe 1974). 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." (Nsugbe 1974, p. 69). 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 (Nsugbe 1974).

Among the Igbo people of Southern Nigeria, decisions are traditionally made at various levels, depending on the issue at hand. Elders, *ọfọ* 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." (Meek 1937, p. 130; Iroegbu 2010, p. 118). 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 eze,* meaning the "Igbo do not tolerate autocracy." (Uzukwu 1996, p. 15). Also found in many communities are associations such as *ọfọ* holders, age grades/groups, and *ụmụada* who are involved in decision-making.

The *ọfọ* 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 *ọfọ,* 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 karịrị 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 *ọfọ* on the holder (Onyema 1999; Ejizu 1986). 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 (Onyema 1999).

ụmụada (also known as *ụmụọkpụ*) 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. *ụmụada* 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 *ụmụada* 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 (Iroegbu 2010). Because the *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 *ụmụada,* and titled men and women, *ọfọ* holders and elders (Uzukwu 1996).

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 *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 (Uchendu 1965).

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 (Nsugbe 1974).

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 (Nsugbe 1974). 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." (Nsugbe 1974, p. 9). 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 (Nsugbe 1974).

4.1.5.4 Decision-making among 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 (Ogundayo 2008). 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 (Ogundayo 2008). 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 (Wolff 2004).

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 (Wolff 2004). 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. (Lloyd 1954, p. 382).

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 (Ojigbo 1973).

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." (Ojigbo 1973, p. 282). 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 (Ojigbo 1973).[3] 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." (Wiredu 1997, pp. 304–307).

4.1.5.5 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 (Agulanna 2008). 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 (Assié-Lumumba 1996; Van Sertima 1988; Amadiume 1998).

Some early anthropologists, among them Johann Jakob Bachofen (1815–1887) and Lewis Henry Morgan (1818–1881), argued that many early societies were actually matriarchal (Eller 2000; Bamberger 1974; Webster 1975). 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 matriliny, 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 (Gibson 2010). 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

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[3] Ojigbo narrates how the colonial government brought about the loss of this trust.

varying degree, gave up their leadership position to their male counterparts, that is, their spouses, sons, and fathers (Gibson 2010).

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 (Assié-Lumumba 1996; Van Sertima 1988). 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… (Van Sertima 1988, p. 11; Assié-Lumumba 1996, p. 18).

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 (Assié-Lumumba 1996). 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 (Amadiume 1987; Assié-Lumumba 1996). 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 (Assié-Lumumba 1996).

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 (Assié-Lumumba 1996). 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 (Gailey 1970; Assié-Lumumba 1996). 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 (Assié-Lumumba 1996). 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 (Assié-Lumumba 1996). 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 (Assié-Lumumba 1996).

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 (Assié-Lumumba 1996). 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 (Assié-Lumumba 1996; Lipschutz and Rasmussen 1986; Boni 2011).

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 (Assié-Lumumba 1996). 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 (Assié-Lumumba 1996).

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 (Spencer 2008; Falola and Ottenberg 2006; Gruenbaum 2008).

4.2 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 (Ikuenobe 2006; Verhoef and Michael 1997). 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" (Ikuenobe 2006, p. 53). 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.

4.2.1 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 (Mbiti 1992; Gyekye 1997, 2003; Munyaka and Motlhabi 2009; Ikuenobe 2006; Uzukwu 2012; Achebe 1998; Nwodo 2004). 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.[4] 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 (Gyekye 1995, p. 155). 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

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[4] See Chapter Two.

and non-African writers on Africa. Indeed, to many this characteristic defines Africanness." (Dickson 1977, p. 4; Gyekye 2003, p. 297). 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 (Gyekye 2003). 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." (Menkiti 1984, p. 166).

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." (Gyekye 1997, p. 43). 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 (Gyekye 1997). In this work 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. (Gyekye 2003, p. 300).

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.” (Tangwa 2000, pp. 39–43; Singer and Viens 2008, p. 344). 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 (Raditlhalo 1996; Teffo and Roux 2003). 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 (Ikuenobe 2006). 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.” (Gyekye 1995, p. 156).

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 (Gyekye 1997, 2003). 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 (Gyekye 1997, 2003). 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 (Gyekye 1997, 2003). 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. (MacIntyre 1984, p. 221; Gyekye 1997, p. 59).

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." (Sandel 1982, p. 179; Gyekye 1997, p. 59).

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," (Mbiti 1992, p. 141) 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." (Menkiti 1984, p. 171). 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," (Menkiti 1984, p. 172) and that it is not only that personhood is acquired (Menkiti 1984) but is also “something which has to be achieved, and not given simply because one is born of human seed.” (Menkiti 1984, pp. 172–173) Thus, he concludes that personhood is something at which an individual could fail (Menkiti 1984; Gyekye 2003).

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 (Gyekye 2003, p. 299; Ikuenobe 2006, p. 76). 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.” (Ikuenobe 2006, p. 76). 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.” (Ikuenobe 2006, pp. 76–77). 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….” (Ikuenobe 2006, p. 77). 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.” (Ikuenobe 2006, p. 77).

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.” (Senghor 1964, p. 49; Gyekye 2003, p. 229). 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.” (Nkrumah 1964, p. 73; Gyekye 2003, p. 299). 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 (Gyekye 2003). 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-abia*, 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 (Gyekye 2003). 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 (Uzukwu 2012, p. 152). At creation, God assigns or each person chooses his or her destiny in dialogue with the creative spirit (Uzukwu 2012; Achebe 1998; Nwodo 2004). 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.” (Achebe 1998, p. 130; Nwodo 2004, p. 254). According to Achebe, “The world in which we live has its double and counterpart in the realm of spirits.” (Achebe 1998, p. 133). 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 (Sarpong 1993). 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 (Uzukwu 2012).[5] 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* (Uzukwu 2012, p. 152).

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 (Achebe 1998). *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*." (Achebe 1998, p. 135). 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." (Uzukwu 2012, p. 153). 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…." (Gyekye 1995, p. 106; Sarpong 1993, p. 38).

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 (Achebe 1998; Uzukwu 2012). 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 (Uzukwu 2012; Achebe 1998). 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 (Nwodo 2004). Thus, Achebe declares,

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[5] Both Assante and Ewe are subgroups of Akan.

> 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 (Achebe 1998, p. 144).

Consequently, Achebe noted that "it is not surprising that the Igbo held discussion and consensus as the highest ideals of the political process." (Achebe 1998, p. 144). 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 (Opoku 1975; Gyekye 1995; Sarpong 1974). 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." (Gyekye 1995, pp. 115–116). 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 (Nwodo 2004; Achebe 1998).

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." (Nwodo 2004, p. 254).

The proverb which states that even siblings have individuality –o*tu nne na-amụ ma otu chi adịghị 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 (Uzukwu 2012; Gyekye 1995). 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 (Achebe 1998, p. 138–139).

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 (Achebe 1998). 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." (Nwodo 2004, p. 266) 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 area 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. (Nwodo 2004, p. 266).

One who discovers that one had made an unacceptable cfhuman actions are neither necessitated nor fated hoice of destiny can still "by strong effort of will" renegotiate one's destiny; it is morning yet on creation day." (Nwodo 2004, p. 266). 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." (Nwodo 2004, p. 266). 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." (Nwodo 2004, p. 266). 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." (Nwoga 1984; Nwodo 2004, p. 269). 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…." (Nwodo 2004, pp. 268–269).

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. (Gyekye 1995, p. 121).

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.

4.2.2 The African Concept of 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 (Mbiti 1992; Kaphagawani 2006). 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 (Knappert 1989). 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 (Knappert 1989). 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." (Ajibola 1955, p. 42; Knappert

1989, p. 8). 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 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. Other maxims expressing reciprocity and interdependence are: *Onipa nye abe na ne ho ahyia 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 (Knappert 1989, p. 36).

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 (Gyekye 2011). 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 *anụ ọhia*, i.e., beasts. It might sound like a harsh judgment, but nevertheless, "it is a way of expressing displeasure at bad behaviour." (Munyaka and Motlhabi 2009, p. 64 ff.). 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." (Munyaka and Motlhabi 2009, p. 71). 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 *anụ 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 (Munyaka and Motlhabi 2009). 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 bụ mmadụ* (Igbo), *Oye onipa paa* (Akan). (Gyekye 2003). 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*" literarily 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." (Gyekye 2003, pp. 303–304).

In summary, these proverbs suggest and emphasize values of mutual helpfulness and interdependence, cooperation, collective responsibility, and reciprocal obligations (Gyekye 2011). 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 (Held 2006; Nedelsky 1989; Clement 1996; Tronto 1993). 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 Chap. 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')" (Menkiti 1984, p. 167, Ikuenobe 2006; Uzukwu 2012; Achebe 1998; Nwodo 1984). 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 (Luijpen and Koren 1969; Macquarrie 1968). 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 (Menkiti 1984; Gyekye 1997). 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.” (Ikuenobe 2006, p. 54).

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 (Adekson 2004). 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 (Frank 1978; Adekson 2004). 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 (Idowu 1985).

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.

4.2.3 The African Concept of 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 (Gyekye 2003).[6] The individual is formed and defined by both oneself

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[6] See Sect. 4 B2 above.

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 (Clement 1996). 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.[7]

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 (Murove 2009). 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. (Spencer 2008; Falola and Ottenberg 2006; Gruenbaum 2008). Among the Igbo of Nigeria, for example,

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[7] See Chapter Three above.

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 (Murove 2009). 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." (Mbombo 1996, pp. 114–115) 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 (Mbombo 1996, p. 114–115). 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.” (Kasenene 2000, p. 349; Murove 2009, p. 168–171). 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, (Wiredu 1997; Uzukwu 2012) as described earlier in Sect. 4 A5 of this Chapter.

The African practice described in this work 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 (Nedelsky 1989; Held 1993; Clement 1996). 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.

4.2.4 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 (Gyekye 1997, p. 45–47).

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 (Gyekye 1995).

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, that is, collective good. Rather, common good 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 (Gyekye 2011). 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. There is no conceptual tension or opposition between the good of the individual members 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 (May 2002).

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 (Gyekye 1995, p. 156). The good being sought after remains the common good rather than the collective good.

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.

4.2.5 The African Concept of 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." (Gyekye 2003, p. 307). 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 (Gyekye 2003, p. 308). 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 (Gyekye 2003, pp. 308–309). 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. (Gyekye 2011).

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." (Gyekye 2003, p. 310). 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. (Gyekye 2003, p. 311).

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." (Gyekye 2003, p. 180). 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 (Sandel 1982; Gyekye 1997). 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 (Taylor 1985, pp. 189–190; Gyekye 1997, p. 62). 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 (MacIntyre 1984; Gyekye 1997). 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 (Gyekye 1997). Rather responsibility and duty have an eminent place over rights in Africa communal cultures.

4.3 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.

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Chapter 5
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.

5.1 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 (Committee 2009). 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 book, however, the focus is on ethics committees in healthcare organizations or facilities, in other words, on healthcare ethics committees.

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 (Hackler and Hester 2008). However, research ethics committees are not within the scope of this book.

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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 (Levine 1986; Pearlman 2008). 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." (Cranford and Doudera 1984, p. 6).

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 (Ashley et al. 2006; Post et al. 2007; Klugman and Dalinis 2008). 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." (ASBH 2010, p. 1).

5.2 Situation of Healthcare Ethics Committees in Africa

This section explores the situation of healthcare ethics committees in Africa, in ATM, and investigates the type of healthcare ethics committee that is suitable for ATM in view of RAIC for better patient care and decision-making process of informed consent of the patient.

5.2.1 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 (Muller 2003). 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) for instance the West African bioethics

Center in Nigerian is training physicians for research ethics committees. Recently, there is a formation of 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 (Kass et al. 2007). 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.

5.2.2 Healthcare Ethics Committees in Hospitals

With regard to the current situation of healthcare ethics committees[1] in African countries, the existing data show that, with the exception of South Africa and Uganda, there are hardly any healthcare 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 (Kass et al. 2007, pp. 627–633). 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 (Muller 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 (Kass et al. 2007; Moodley and Myer 2007). 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.

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[1] Research ethics committees are not the concern of this work. Thus, the current discourse is not about them but healthcare or clinical ethics committees. As earlier stated, there is no known literature on healthcare ethics committees in Africa, even in relation to ATM.

5.2.3 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 (Ministry of Health Ghana 2004a, b; South African Department of Health 2008; African Union 2007). Nevertheless, the need for such committees in ATM and other health care institutions cannot be overemphasized.

As has been discussed above, traditionally, decisions are commonly made in a group involving all the parties to the issue. If there is a misunderstanding, the case is discussed and teased out in a gathering of all the people concerned. This is the model of decision making that ethics committees encourage. Therefore, healthcare ethics committees are suitable for ATM facilities.

While the Pentecostals may not frequent ATM, their non-Pentecostal relatives might. The Pentecostals tend to consider ATM practices as idolatry and backward. The Christian fundamentalists have a tendency to follow the footsteps of some colonialists and early missionaries in condemning ATM as witchcraft. The concept of disease and illness in Africa used to be misunderstood as embedded in witchcraft. Witchcraft was then seen as reinforcing superstition and backwardness, thus Africa was labelled the "Dark Continent." This misconception tends to lead to friction between ATM providers and some patients' relatives. The Healthcare ethics committee can be a suitable forum to settle such misunderstandings. Because the healthcare ethics committee's membership will be wider and more varied than a village community, it will be seen to be more neutral than the village community. Thus the healthcare ethics committee is a proper place to settle such issues.

There is increasing call for the integration of ATM and the practitioners into the healthcare system of each African country (Murove 2009; Busia and Kasilo 2010; WHO 2013a, b). Integration will offer patients wider choice in using the services and may contribute to the treatment of acute diseases (WHO 2013a, p. 37). Certain criteria have been put forward by WHO to help facilitate the process of integration. The criteria include: to survey ATM use, the benefits, "and risks in the context of local history and culture"; to promote "a keener appreciation of the role and potential" of ATM; analysis of national health resources: "finance and human resources for health"; to evaluate existing relevant policies and regulations for ATM products, practices, and practitioners with a view to strengthening good ones and establishing new ones if required; to promote equitable access to health, and integration of ATM "into the national health system including … potential referral and collaborative pathways." (WHO 2013a, p. 37) The steps taken in the process will definitely not be the same for each country. They will vary from one country to another. However, the healthcare ethics committees will be suitable working groups with rich variety of members, grass root groups to brainstorm, and carry out the basic or fundamental deliberations regarding the integration and the process. The healthcare ethics committees are better positioned to flesh out the criteria proposed by WHO. Being at the grass root the committees have firsthand knowledge and experience of the ATM facilities and practices.

It is important to note that some ATM doctors are embracing modern means of marketing products, advertising and speaking on local radios and TV broadcasts in vernacular. There are associations of ATM doctors for the purpose of marketing and improving their knowledge of diseases as well as their knowledge of medicinal raw materials and their uses. In view of this, ATM is becoming lucrative and charlatans are infiltrating the profession. The charlatans put up billboards with bogus claims about the efficacy of their medicinal products. Again, healthcare ethics committees can represent the ATM practitioners and liaise with the ministry of health to identify the charlatans and protect the true ATM providers, their practices, and the consumers. In addition, it will be the function of healthcare ethics committees to maintain and promote ethical practices and behavior in the ATM facilities; to device guidelines and regulations to maintain the holistic approach of ATM to health and illness (Mumo 2012, pp. 118–119); and to promote better understanding and better attitude towards the healthcare providers—ATM and the facilities.

There are many policy guidelines, regulations, and literatures regarding ATM and its practices coming from health ministries, regional and international organizations such as WHO (WHO African Region), and UNESCO. Some of the policies and guidelines need to be brought to the level of the ATM doctors. It will be the duty of healthcare ethics committees to help member facilities and ATM doctors to understand and apply guidelines and policies issued by the ministry of health and non-governmental organizations such as WHO (i.e. WHO Africa Region) and UNESCO. They can carry out these functions through workshops, seminars and talks.

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; …. (Dakar Declaration 2007, p. 11)

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." (Dakar Declaration 2007, p. 12).[2]

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 (Larcher et al. 1997; Slowther et al. 2002; Larcher 2009). The surveys identified a need for clinical ethics consultation and support expressed by medical personnel directly involved in patient care (Larcher 2009; Slowther et al. 2002).

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 (DuVal et al. 2004; Cotter and Vaszar 2008). 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." (Chwang et al. 2007, pp. 320–324; Cotter and Vaszar 2008). 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 (McClung et al. 1996; Orr et al. 1996; Cotter and Vaszar 2008). 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." (Cohn et al. 2007, pp. 140–147; Cotter and Vaszar 2008: online). 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 further typical issues that these committees will be addressing include those surrounding

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[2] The emphasis is mine.

the beginning of life, namely, 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 (Levine 1986). 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…. (Muller 2003: online)

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 (Slowther et al. 2002, p. 5). 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." (Slowther et al. 2002, p. 5). 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." (Slowther et al. 2002, p. 5). Slowther and her colleagues supported their argument with Norman Daniels' claim that "establishing a fair process is easier than agreeing on principles." (Daniels 2000, pp. 1300–1301; Slowther et al. 2002, p. 6). 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." (Daniels 2000, pp. 1300–1301; Slowther et al. 2002, p. 6). 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 (Slowther et al. 2002).

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. The studies of Slowther and his colleagues were carried out in the context of Western Cultures and therefore, may not directly apply to African cultures. However, their findings can serve as a working tool, and a starting point in formulating field studies on healthcare ethics committees in Africa and in ATM.

5.2.4 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 Spiritan 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 (Traditional African Clinic 2007; What Is the African 2012).

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 (Gbenga-Mustapha 2011).

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 book, 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 3 million (3,000,000) people since its inception in February 1997 (Ilonzo 2008).

However, one of the reasons behind the lack of healthcare ethics committees in ATM is that ATM is often practiced individually. The ATM doctor is often the sole staff and the proprietor. There are also facilities where the proprietor has other healthcare workers other than him or herself. Some of the workers might be apprentices. The small sizes of most of these ATM facilities tend to preclude a typical healthcare ethics committee structure. But it does not necessarily mean that such ATM facilities cannot benefit from the formation and use of healthcare ethics committee. A possible structure is for a group of individual ATM doctors and the small facilities to form a healthcare ethics committee together. For instance, individual doctors from one autonomous community in Nigeria or one *Mahebre* in Ethiopia can form a healthcare ethics committee.

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.” (Nelson 2006, pp. 193–195; Klugman et al. 2008, p. 49). 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 (Loeben 1999). 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 (Loeben 1999).

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.

5.2.4.1 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.

5.2.4.2 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: **I**dentify an issue proactively, **S**tudy the issue, **S**elect a strategy, **U**ndertake a plan, **E**valuate and adjust, and **S**ustain and spread. "ISSUES" assists ethics committees to "improve the systems and processes that influence ethics practices in a health care organization." (Fox et al. 2010, pp. 19–20). 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.

5.2.4.3 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 (Fox et al. 2010, p. 7). They do that through the programs and activities they support and praise, those they neglect or criticize, as well as by their own behavior (Fox et al. 2010). 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.

5.2.4.4 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 (Blake 2000). 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. 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.” (Rueping and Dugan 2000, p. 54). 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.” (Rueping and Dugan 2000, p. 54).

5.3 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 (Azétsop and Rennie 2010). 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.

5.3.1 Integration of Elements of Traditional Decision-Making Methods into Healthcare Ethics Committees

As noted in Chap. 4, 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 (Frimpong-Mansoh 2008). 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 2011, pp. 9–14). 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 (Miller 2011, pp. 9–14).

Supporting Miller's line of thought, Jacquineau Azétsop 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. Azétsop 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. (Azétsop and Rennie 2010; Francis et al. 2005; Barth-Rogers and Jotkowitz 2009). 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 (Azétsop and Rennie 2010).

Furthermore, Azétsop and Rennie posit that an autonomy-based bioethics which lays emphasis on individual autonomy tends to misrepresent the relationship between the world individuals, 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." (Azétsop and Rennie 2010, p. 3, 4). 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 (Promoting Bioethics 2007). 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 (Cf. Sichel 1989).[3] "Moral dilemmas are particular, unique situations in which all parties retain their identities, their life histories, emotions, feelings, and relationships." (Sichel 1989, p. 50). 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

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[3] See Chaps. 3 and 4.

with their own unique life histories, desire etc (Sichel 1989). 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." (Jones 1997, p. 1243; Brincat 1999, p. 221).

5.3.2 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 professionals, 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." (Beauchamp and Childress 2009, pp. 305–306). 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 (Post et al. 2007). 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 Chap. 4, 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 (Murove 2009). 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.

Although RAIC challenges the concept of confidentiality as it is understood in the West, the need for confidentiality persists even in African communal society. This work does not advocate an approach to confidentiality that will expose, without reservations, a patient's entire personal intimate information to everyone, including members of his family. For instance, in some pathology such as sexual impotence, the patients sometimes would be reluctant to accept that his intimacy be divulged, and shared all over the village. Traditionally, sexual issues such as the virility, is guided secretly. So the healthcare professionals would have to be discreet. 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." (Cf. Gordon 1990, pp. 273–295; Turner 2005, p. 309).

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 back drop, 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 (Turner 2005; Beyene 1992). 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 (Beauchamp and Childress 2001). 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.

5.3.3 A Nuanced Understanding of Advance Directives[4]

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 (Post et al. 2007). 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

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[4] This work is not advocating the adoption of advance directives in ATM.

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 (Veatch 1998; Chan 2004). 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 (Chan 2004). 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. (Facts 2010)

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 (Facts 2010).

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. (Chan 2004, p. 92; Buchanan and Brock 1990, p. 136).

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 (Chan 2004).

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." (Arras 1994, p. 407; Chan 2004, p. 92).

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 (Arras 1994; Chan 2004).

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 (Post et al. 2007). 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? (Achebe 1994).

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 (Capron 1998; Chan 2004). 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 this, verbal communication is the norm; moreover, even a written choice or living will can be overridden by a family collective decision (Chan 2004).

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. *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." (United States Conference of Catholic Bishops 2009: no. 56; Kelly 2004, p. 128). 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 (Chan 2004).

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 (Po-Wah 2002b). 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." (Po-Wah 2002b, p. 48).

5.3.4 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." (Laden 1997, p. 134; Kamwangamalu 1999, p. 24).

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; vumuntu in shiTsonga and shiTswa of Mozambique; bomoto in Bobangi, spoken in the Democratic Republic of Congo; gimuntu in kiKongo and giKwese, spoken in the Democratic Republic of Congo and Angola, respectively. (Yanga 1997; Kamwangamalu 1999)

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 (Kamwangamalu 1999). 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 (Gyekye 2003). 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." (Murove 2009, p. 170). 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 (Allmark 2002; Dickenson 2006). 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." (Derrick 2000, pp. 209–218; Po-wah 2002, p. 48). 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." (Pullman 1999, p. 26; Po-wah 2002, p. 49). 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 (Nedelsky 1989; Held 1993). 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 (Hardwig 1990). 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." (McCormick 1999, pp. 8–12; Azétsop and Rennie 2010, p. 5). 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." (McCormick 1999, pp. 8–12; Azétsop and Rennie 2010, p. 5).

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." (McCormick 1999, pp. 8–12) 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." (McCormick 1999, p. 9; Kevorkian 1991).

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 (McCormick 1999, p. 9). 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 Chan 2004).

Likewise, as noted in Chaps. 3 and 4, 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. (Callahan 1993; McCormick 1999)

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." (Hardwig 1990, pp. 5–6; Kegley 2004, p. 91 ff.). 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 (Hardwig 1990, pp. 5–6; Frimpong-Mansoh 2008, p. 113; Kegley 2004, p. 91 ff.). 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." (Brincat 1999, pp. 220–221). 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 (Brincat 1999, pp. 220–221). 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." (Engelhardt 1999, p. 97).

5.4 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.

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Chapter 6
Conclusion

This chapter provides a summary of the analysis of the issues studied in each chapter of this book, and identifies its contribution to bioethics in Africa, and the significance of the work 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 book 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

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nature of personal autonomy and informed consent in a communal culture (Gyekye 1997, 2003; Menkiti 1984). 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 book 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 book 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 work 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.

6.1 Grand Summary

The book 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 1 provides a brief introduction to the book, 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 (Fan 1997). 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 1 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 2 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 (Jonsen 1998). 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 (Faden et al. 1986). 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 (Jonsen 1998). 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 (Faden et al. 1986).

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 (Beauchamp and Childress 2009). 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 (May 2002; Mill 1962). 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 (Nelson 1992). 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." (Beauchamp and Childress 2009, p. 373; Kant 2005, p. 69). 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 Chap. 2 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 Chap. 2 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 (Fan 1997; May 2002; Mill 1962).

Chapter 3, 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 (Curzer 2007). 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 (Held 2006a, pp. 22–28). 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 (Held 2006a).

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 (Held 2006a, 1993; Slote 2007). 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). (Po-wah 2002b). 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 (Tronto 1993). Human beings exist in interdependent relationships that entail ethical responsibilities (Ethics of Care 2011). 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 (Nedelsky 1989, pp. 11–12). 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 book, 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 Chap. 3 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 (Kroeger-Mappes 1994). 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." (Nedelsky 1993, p. 3; Held 2006a, p. 125 ff.). 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 (Nedelsky 1993, pp. 13–14).

Chapter 4 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 (Sofowora 1982; Ubrurhe 1989; World Health Organization 2003; Dime 1995; Kayne 2010). 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 (Mbiti 1992). 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 (Arinze 1970; Thomas 1913; Aguwa 2002). 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 (Adekson 2004; Ross 2010).

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 (Van Bogaert 2007; Chavunduka 2012; Shaibu 2007).

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 (Ikuenobe 2006; Verhoef and Michel 1997). 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 (Mbiti 1992, p. 106, 141). *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 (Gyekye 2011; Knappert 1989).

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 book, 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 (Gyekye 2003). 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 5 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 book 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.

6.2 Contribution of the Book

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

First and foremost, this work 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 (World Health Organization 2003). 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 study 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 (Nedelsky 1989; Held 2006a; Clement 1996; Gyekye 1997; Po-wah 2002b).

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 (Nedelsky 1989; Held 2006a; Clement 1996; Gyekye 1997). 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 work 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 book 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 work 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." (Murove 2009, p. 174). 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 book also helps to clarify the significance of the analysis for global bioethics.

6.3 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 book 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." (UNESCO 2001, p. 4; Revel 2009, p. 200). This "implies a commitment to human rights and fundamental freedoms, in particular the rights of persons belonging to minorities …." (UNESCO 2001, p. 4; Revel 2009, p. 200). 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 (Revel 2009, p. 200). 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." (Engelhardt 2006, p. 6).[1]

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

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[1] By recognizing moral pluralism, this book is not necessarily encouraging moral relativism.

USA was simply one among many possible incarnations of medical morality." (Gorovitz 1986, pp. 356–374; Chattopadhyay and De Vries 2009, p. 106). 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 (Helman 1990; Benatar 2008). 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 (Engelhardt 2000; Po-wah 2002a). Likewise, it is essential that we become conscious of the socio-cultural matrices of our own ideas and principles in dealing with other cultures (Fox and Swazey 1984). 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." (Turner 2005, p. 317). 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." (UNESCO 2001, p. 4; Revel 2009, p. 200). 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." (Revel 2009, p. 200).

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 book 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 *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." (UNESCO 2005, p. 6).[2] 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." (ten Have and Jean 2009, p. 43). In doing that the *UNESCO Universal Declaration* offers ideals to which government organizations, communities, institutions (Public and Private), and individuals should aspire (ten Have and Jean 2009; Macpherson 2007). 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." (ten Have and Jean 2009, p. 43). 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 book 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 book, 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." (Mbiti 1992, p. 141). Thus, autonomy and informed consent of the individual is not disrespected. In this aspect, the analysis in this work 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 (UNESCO 2009, p. 361).

Nevertheless, the analysis of the book 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

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[2] At its 32nd session in October 2003, the General Conference considered that it was opportune and desirable to carry out this vision.

of the *UNESCO Universal Declaration* advocates a value that is at variance with the familial and communal values of Asia and Africa respectively.[3] 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 (Landman and Schüklenk 2005, p. v).

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." (Huriet 2009, p. 266; UNESCO 2009, p. 364).

This work 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 book can be said to be an aid to the implementation of the *UNESCO Universal Declaration*, thereby contributing to the strife for Global bioethics. The book applies also the ATM's RAIC approach to ethics committees in Africa, focusing especially upon the decision-making process for patient informed consent. The book 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 work 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 (Murove 2009). 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.

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[3] See Fan, "Self-determination vs. Family-determination" for the discussion on this issue.

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