Topic: Deontology, Ubuntu and Doctor-Patient Relationship

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DECLARATION

I declare that this thesis is my own, unaided work. It is submitted for the Degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

18 February 2020

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Signature **Date**

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Through ubuntu, a person is always regarded as a person through others. This thesis would not have been completed if it was not through the harmonious relations and assistance from other people.

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General Introduction

In this thesis, I critically explore the prominent Western moral theory (of deontology) as well as the African moral theory (of ubuntu) in context of bioethics with the purpose of defending a plausible and inclusive perspective of doctor-patient relationship. Deontology underpins current medical practice in respect of doctor-patient relationship.[1] This study argues that (a) a deontology underpinned doctor-patient relationship is deficient and problematic; and (b) an ubuntu underpinned doctor-patient relationship is a better account than a deontology underpinned doctor-patient relationship. Although the dominant approach in bioethics, generally, remains the four principles approach, I think Principlism does inform a lot of Kantian deontology in the field, by means of its formulation on the principle of respect for autonomy. Furthermore, Beauchamp and Childress ground their framework in the "common morality", which is, arguably deontological.

The doctor-patient relationship is vital in the health care sector and is essential for the delivery of meaningful and beneficial health care. Patients are now given an opportunity to autonomously express their own medical preferences. And as Narayan notes, "a person's choice should be considered autonomous as long as the person was a 'normal adult' with no serious cognitive or emotional impairments and was not subject to literal outright coercion by others" (Narayan, 2002: 429). In addition, Buss states that "the key to self-governing agency is the distinction between a healthy human being and a human being who suffers from some psychological or physiological 'affliction' (e.g., intense pain, fear, anxiety, fatigue, depression, and obsession)" (Buss, 2005: 215). Currently the doctor-patient relationships and the obligations and biomedical principles that are involved in medical practice are driven by deontology. The problem is that we have an account or picture of the doctor-patient relationship that is not rich enough; namely, it is unjust and unfair in virtue of not properly taking into account the interests, considerations and other factors in the doctor-patient relationship due to its emphasis on individual autonomy. Additionally, it is argued that deontology presents a mistaken view and picture of the self and persons as atomistic especially because in the doctor-patient relationship the patient's illness can affect his/her mental competence, renders him/her unable to make autonomous choices and raise questions about his or

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[1] I am using the notion of doctor patient relationship as proxy for any dual relationship that mimics the sort of relationship and power relations that one typically find in the doctor patient relationship.

overall interests. Deontology is about individual’s duty to follow the rules (and in Kantian ethics the categorical imperatives) where essentially the principle of autonomy ensues; whereas ubuntu is more inclusive in a sense that it takes into account all the interests, considerations and other factors in the doctor-patient relationship, and it also does not perceive the self or persons as atomists.

This thesis answers the following principal research questions: Can there be a plausible and acceptable moral theory which recognizes the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self? Particularly**,** in what ways is an Ubuntu underpinned doctor-patient relationship a better account than a deontology underpinned doctor-patient relationship?

Deontology perpetuates a view of the improvised self or persons that see the self without being socially integrated within the web of social relationships. I discuss the Kantian moral theory of deontology and ubuntu with the purpose of defending an account of moral theory that takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self. It is argued that ubuntu underpinned doctor-patient relationship is a better account than a deontology underpinned doctor-patient relationship because ubuntu takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self.[2]

The thesis that I defend in this research is that an ubuntu underpinned doctor-patient relationship is a better account than a deontology underpinned doctor-patient relationship because ubuntu takes into account all the interests (meaning it considers family interests), considerations (it considers persons as relational) and other factors (mental capacity is not global, but relative in the doctor-

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[2] The above phrase which says; the interests, considerations and other factors in the doctor-patient relationship has been used to refer to the notion of the self that is different from the self-perpetuated by Kant’s formulation of autonomy. The interests refer to (an account that includes family interests), considerations (an account that considers persons as relational) and other factors referring to an account that views (mental capacity as not global, but relative in the doctor-patient relationship).

Kant’s account allows patients to make choices in exclusion of the interests of the family members. This moral approach focuses only on one factor in the doctor-patient relationship which is the mental capacity of the patients; those who can exercise their autonomy, while leaving behind those who are mentally incompetent to express their medical choices. Kantian concept of the autonomous self is not inter-relational, but rather individualistic.

patient relationship) and consistent with a rich view of the self. This connotes altruistic relations between the members of the community. Advocacy for this theory in doctor-patient relationship regards patients within the web of relationships whereby all the interests of the involved parties in the healing procedures are recognized.

The significance and novelty of this study are based on the sub-Saharan African moral theory because ubuntu properly recognizes the interests, considerations and other factors in the doctor-patient relationship) and does not perpetuates a view of the improvised self or persons that sees the self as atomistic like deontology does. African philosophy in bioethics has not been explored as an inclusive account to enhance doctor-patient relationship this view has also been noted by other scholars like Karori Mbugua (2009); Kevin Behrens (2013: 33); Cletus Andoh (2011: 69). If the results of this research becomes successful, by providing an inclusive moral account which takes the interests of all the stakeholders in the doctor-patient relationship, then it would add a new contribution to the field.

The potential global contribution of the Afro-communitarian theory of ubuntu has also been noted by Barbara Nussbaum (2003: 21) when she pointed out that "we should imagine how the world would look like if the potential of ubuntu's sunlight were to be embraced as a vital part of the African renaissance or even as Africa's contribution to help a divided, fragmented world." As well, Behrens (2013: 33) has talked about what African moral perspectives can significantly contribute to bioethics.

The thesis is divided into seven chapters. In chapter one, I give a brief overview of deontology and ubuntu in the literature. Here, I first discuss deontology and its factors constituting doctor-patient relationship as well as indicating that Kant's deontology among other forms of deontology is the one that has been used in bioethics. I also show how Kant's philosophy and the principle of respect for autonomy have been criticized in bioethics for being too individualistic. Lastly, I briefly discuss the moral theory of ubuntu.

Chapter two focuses critically on Kant's deontology as a moral theory. In this chapter, I basically discuss the formulation of Kantian deontology and autonomy in a detailed manner. In addition, I also discuss the arguments of the neo-Kantians on the principle of respect for autonomy.

Chapter three deals with ubuntu. In this chapter, I first discuss the etymological definition of ubuntu and its formation which was grounded by Mogobe Ramose. I also discuss what ubuntu is according to some other scholars. I then discuss Metz's account of ubuntu together with objections on his account. Lastly, the summary of some core ideas of ubuntu in the chapter are expounded.

In Chapter four, the discussion is mainly on obligations and biomedical ethics principles that constitute doctor-patient relationship. Here, I discuss informed consent, the notion of patients' competence, surrogate decision making, limitations of patients' autonomous preferences, paternalism, weak paternalism, principles of biomedical ethics namely; respect for autonomy, beneficence, non-maleficence and justice, voluntariness as well as the principle of confidentiality.

Chapter five will focus on deontology underpinned doctor-patient relationship and its shortfalls. In this chapter, I critique Kantian deontology and the principle of respect for autonomy as being individualistic. I further argue that there is a relative relevance of categorical imperative in doctor-patient relationship. The critique of the feminist view on individual's autonomy is discussed as well as their proposed relational autonomy. I then summarize the key shortfalls of Kant's deontology in bioethics.

In chapter six, ubuntu underpinned doctor-patient relationship is discussed. Here, I defend the thesis that an ubuntu underpinned doctor-patient relationship is a better account than a deontology underpinned doctor-patient relationship because ubuntu takes into account all the interests, social relations and other factors entailed in doctor-patient relationship. I also discuss the difference between extreme communitarianism and moderate communitarianism as well as indicating that the preferred Afro-communitarian theory is in the form of moderate communitarianism.

Chapter seven discusses and responds to some of the objections to ubuntu. For instance, ubuntu has been objected for being paternalistic, violating individuals' privacy as well as not being different from utilitarianism. I provide responses towards these objections.

The thesis concludes by summarizing the key points that make ubuntu to be a preferable theory in doctor-patient relationship than Kant's deontology.

Chapter One: Brief Overview of Deontology and Ubuntu in the Literature

1.1. Deontology and Factors Constituting Doctor-Patient Relationship

The current medical practice under the notion of doctor-patient relationship is underpinned by Kantian deontology. It must be pointed out that Kantian deontology is one form of deontology and that there are other forms of deontology. Ross has developed a pluralist deontology which regards all moral principles' obligations to be *prima facie.* According to him, there are seven *prima facie* duties which need to be taken into consideration when deciding which duty should be acted upon:

- Duty of **beneficence** (to help other people to increase their pleasure, improve their character, etc).
- Duty of **non-maleficence** (to avoid harming other people).
- Duty of **justice** (to ensure people get what they deserve).
- Duty of **self-improvement** (to improve ourselves).
- Duty of **reparation** (to recompense someone if you have acted wrongly towards them).
- Duty of **gratitude** (to benefit people who have benefited us).
- Duty of **promise-keeping** (to act according to explicit and implicit promises, including the implicit promise to tell the truth) (Ross quoted in Beauchamp & Childress, 2001: 402)

According to Ross, "there may be discordance between these duties and a choice must be made. Although there are no objective set rules determining which duty is of higher importance. Ross's major innovation is that these principles state *prima facie* rather than absolute obligations" (Beauchamp & Childress, 2001: 203). For Ross, "Kant is wrong to think that the rightness or wrongness of an individual act can be inferred with certainty from its falling or not falling under a rule capable of being universalized. Kant is also wrong to think that moral rules have absolute authority admitting of no exception" (Beauchamp and Childress, 2001: 203). I think lack of absolute authority within this theory of Ross can create a room for the breaching of patients' rights if ever it can be applied in medical ethics. For instance, if all moral principles are *prima facie*, the implication is that frank disclosure of medical information will sometimes be ignored if ever it is in conflict with another moral principle.

In addition, “divine Command Theory is also a form of deontological theory which states that an action is right if God has decreed that it is right, and that an act is obligatory if and only if (and because) it is commanded by God” (Koons, 2012: 180-181). According to this theory, acts are considered to be good because God determined them to be good and, in this case, human beings simply ought to follow what God has commanded. On the other hand, “the moral theory of contractarianism claims that moral norms derive their normative force from the idea of contract or mutual agreement. Morally wrong acts are, on such accounts, those acts that would be forbidden by principles that people in a suitably described social contract would accept” (Rawls: 1971).

My focal point will be on the Kantian formulation of deontology because it is the one currently being used in medical ethics as a moral theory promoting doctor-patient relationship. Mandal has noted that “the doctor-patient relationship is by nature, deontological since medical teaching practices inculcate this tradition, and when this deontological practice is breached, the context of medical negligence arises. This tradition drives clinicians to do good to patients and strengthening the doctor-patient bond” (2016: 5).

I will say more about paternalism and informed consent later on. For Kant, “the intrinsic worth of human beings has no equivalent that can be substituted in value. As such, human beings are ends in themselves and we have a moral duty to respect both ourselves and others as rational beings who have the capacity to decide on their own” (Veitch, 2007: 58). According to this moral theory, human beings possess human dignity because they possess rationality and autonomy. As a matter of fact, it would be unethical, for instance, to apply therapeutic privilege to mentally competent patients because in that way they will be used as the means to an end and it is against the duty of truth-telling. [3]

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[3] “Therapeutic privilege refers to the withholding by doctor of certain information from patients regarding the diagnosis or treatment of a condition, because the disclosure of such information may prejudice the patient’s recovery from that condition” (McQuoid-Mason & Dada. 2011: 417).

Obligations of truth telling in medical ethics has been motivated and supported by Kantian deontology as a fundamental element that enhances doctor-patient relationship. “Telling a lie is always evil because it harms human discourse and the dignity of every human being” (Campbell, 2013: 22). In addition, “the categorical imperative requires unconditional obedience and overrides our preferences and desires. For Kant, it does not depend on your having certain desires at all, but solely on knowing your duty and following it, whatever the consequences” (Kant, 1997a: 46). Frank disclosure of medical information does not depend on the desires of the health care professionals; but they have moral and legal obligation to do so because it shows respect to the patients. “To have a moral worth, a person’s motive for acting must come from a recognition that he or she intends what is morally required” (Beauchamp & Childress, 2001: 350).

1.2. Kantian deontology

Kantian deontology in bioethics has also been used as a moral tool to urge health care professionals to reveal even medical errors they have performed on their patients. As Bernstein & Brown notes:

> It is morally right and morally obligatory under deontological perspective for health care professionals to openly disclose medical errors and to recognize their fallibility and to attempt to develop strategies and tools for minimizing the occurrence of medical errors. To not disclose this type of error would require the surgeon to practice an act of obvious deception, the commission of a lie, the only purpose of which would be to serve only his own interests (2004: 169-170).

Kant’s argument on the duty not to lie conforms to a rule of categorical imperative which disallows lying because it cannot be universalized, for by such a law there could properly be no respect to patients’ rights that ought to be treated as ends and not as mere means. According to Kant, “respect for another human being entails the element of allowing that person to choose what s/he wants without any coercion. Someone who makes a false promise in order to get some money treats others’ reason and capacity for making decisions merely as an instrument for his own use” (Kant, 1997a: xxii). In addition, Kant considers all rational agents to be respected unconditionally because he argues that “humanity itself is a dignity because human beings cannot be used as the means by any human being" (Kant, 1997a: xxii). The perception of Kant towards the notion of humanity is priceless because he argues that "in the whole of creation everything one wants and over which one has any power can also be used merely as a means; a human being alone, and with him every rational creature, is an end in itself and by virtue of the autonomy of his freedom he is the subject of the moral law" (Kant, 1997b: 74).

1.3. Critiquing Kantian notion of autonomy

Several criticisms have been leveled against Kantian notion of autonomy. One of such is the feminist criticism of traditional autonomy theories including that of Kantian deontology. The criticism is that these theories seem to require substantive independence and other masculine norms. In contrast, feminists have formulated the theory of autonomy that is relational autonomy (Charles, 2010: 412). The other criticism has been illustrated by the African theorists whereby Kant's autonomy is considered to be individualistic hence, excluding the communitarian way of living (for representative statements see; Metz: 2010; Etieyibo: 2014; Kevin, 2013).

1.4. Deontology, paternalism and informed consent in medical practice

In this section, I want to discuss part of what one could say has made a deontological ethical view attractive in medical practice, namely, the need to avoid paternalism and to enhance the patient's informed consent. The notion of doctor-patient relationship is a cardinal element that promotes the rights and welfare of the patients. Medical practice has shifted from hard paternalistic approach to a patient autonomy promotion approach. In Kantian deontology, hard paternalism is viewed as a violation to the dignity of rational and autonomous beings because it does not allow patients to express their medical preferences.

1.5. Informed consent and competency

Kant's deontology has also been coined with the application of Informed consent because it enables rational agents to be the self-legislators. Informed consent has been considered as a necessary guiding principle that helps the patients to express their medical preferences. The process of informed consent obliges the health professionals to disclose all the relevant information to patients who are mentally competent. Kantian perspective in bioethics encourages full disclosure of medical information so that patients can make their own independent choices. Mental competence enables patients to understand their diagnosis and prognosis so that they can express their preferences. Hence, Kant's autonomy can well be exercised by patients who have the mental capacity to decide.

1.6. Deficiency in deontology

There is no objective standard of testing the mental competence of the patients. As a matter of fact, considerations of patients as atomistic may pose harm to the patients due to the assumption that their autonomous medical decisions always depict their interests. Under the guidelines of Health Professions Council of South Africa (HPCSA) on withholding and withdrawing of treatment on booklet 12 (guideline 7.1.2) it is stipulated that "health care practitioners should bear in mind that the decisions of competent adult patients to refuse a particular medical intervention must be respected, even where this would result in serious harm to them or in their death." This guideline entails a Kantian view which is based on the absolutism of autonomous patients who are regarded as atomistic. This atomistic view has a history and context. It is consistent with the view of substance one finds in scholastic philosophy. Boethius takes a person as an individual substance. Iroegbu has noted that in scholastic metaphysics, substance is that which exists in itself and not inhering in another. Substance is contrasted to accident, which is a reality that exists not independently, but rather depends on another reality" (2005: 67). The atomistic view is also seen in Descartes and the idea of the *cogito*. In the *Second Meditation*, Descartes (1901: 48) argues that he is a "thing that doubts, understands, affirms, denies, is willing, is unwilling, and also imagines and has sensory perceptions. He reaches this conclusion by arguing that the nature of the mind (that is, a thinking, non-extended thing) is completely different from that of the body (that is, an extended, non-thinking thing), and therefore it is possible for one to exist without the other." Descartes' dichotomy between the body and the mind is absolute and renders them mutually exclusive. It can be deduced from Descartes' approach that he exists independently as a substance/atomistic.

Given the deficiency in the Kantian moral standpoint in respect of doctor-patient relationship there is the need to find an inclusive account that takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self. This research attempts to seek this alternative and inclusive moral standpoint in ubuntu.

1.7. The moral theory of Ubuntu

The sub-Saharan moral theory of ubuntu under this study avoids the problematic issue entailed in deontology because it properly recognises the interests, considerations and other factors in the doctor-patient relationship and does not perpetuates a view of the improvised self or persons that sees the self as atomistic. Ubuntu as a moral theory entails that; "*umuntu ngumuntu ngabantu/motho ke motho ka batho*. These are, respectively, Zulu and Sotho versions of a traditional African aphorism, often translated as: a person is a person through other persons" (Shutte, 1993: 46; Ramose, 1999: 42; Metz & Gaie, 2010: 274).

Given the nature of ubuntu, I argue that its incorporation in bioethics can enhance the communal harmonious character of the healthcare professionals which in turn can enhance the notion of doctor-patient relationship. This is because ubuntu as a moral theory does not only focus on the interests of the patient and it also does not perpetuate a view of the improvised self or persons that sees the self as atomistic, rather it focuses on the communal context that makes the person a person. According to ubuntu, an injury to one person is regarded as an injury to all or everyone. That is, patients' sufferings are also regarded as integrally connected with family members and the community. The implication of this is that decision-making in respect of the patient's illness is not left solely to the patient. That is patients are not left alone to make their own individualist medical decisions and what constitute interest is interpreted broadly to include and encompass the interest of the patient as well as those of his or her family.

According to Bessler (2008:43) "ubuntu is the capacity to express compassion, justice, reciprocity, dignity, harmony and humanity in the interests of building, maintaining and strengthening the community. Ubuntu articulates our inter-connectedness, our common humanity and the responsibility to each that flows from our connection. It is a worldview that emphasizes the communality and interdependence of the members of the community.” For to take human beings as dependent on one another is a way to recognize their worth and to recognize the worth of others is to help them achieve their goals.

In this chapter, I have briefly highlighted both deontology and ubuntu. The next chapter will discuss in detail the moral theory of Kant’s deontology; while chapter three will comprehensively discuss ubuntu.

Chapter Two: Deontology as a Moral Theory

2.1. Introduction

This chapter discusses in detail Kantian deontology. I first examine Kantian deontology together with the categorical imperative. I examine the kingdom of ends formulation of the categorical imperative as well as that of autonomy of the will and how they have influenced respect for patients' preferences in bioethics. I then discuss the connection of rationality and autonomy within the Kantian perspective of human dignity. I further discuss the arguments of the Neo-Kantians with a view of finding whether deontology takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self.

2.2. Kantian Deontology and Autonomy

Kantian deontology specifies constraints on what we can or cannot do to other human beings. A formulation of the categorical imperative is this: "act only according to that maxim by which you can at the same time will that it should become a universal law" (Kant, 1997a: xviii). Another is: "act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only" (Kant, 1997a: xviii). The second rule or formulation of categorical imperative which is generally called the Humanity Formula or respect for Person Formulation is more practical in bioethics especially in the practice of informed consent. This rule specifies constraints on what the health care professions can do to their patients. For example, medical treatments and operations should not be given to patients without their informed consent and/or participants should not be recruited into the clinical trials without their consent. The implication is that one's action ought to conform to the rules of categorical imperative because they guide moral decision making so that we can do our duties. Expressing the categorical imperative in terms of the laws of the kingdom of ends and the laws of freedom Kant says:

> The laws of the kingdom of ends are the laws of freedom, both because it is the mark of free citizens to make their own laws, and because the content of those laws directs us to respect each citizen's free use of his or her own

> reason. The conception of ourselves as legislative citizens is the source of the dignity we accord to human beings (Kant, 1997a: xxv).

Kant considers the categorical imperative as a fundamental principle of morality. He further argues that "a rational being must always regard himself as lawgiving in a kingdom of ends possible through freedom of the will" (Kant, 1997a; 41). According to him "this principle is based on reason alone, specifically on the idea that humans are defined essentially in terms of the capacity for reason" (Glannon, 2005: 10). As I indicated in chapter one, Kantian deontology plays a major role in doctor-patient relationship because it rejects hard paternalism which denies patients the chance to express their medical preferences.

According to Kant (1997a: xxii), "human beings should not sacrifice themselves or one another for merely relatively valuable ends. Since it is insofar as we are rational beings that we accord ourselves this absolute value, the formula enjoins us to respect ourselves and each other as rational beings." Kant considers rationality as the element that gives human beings an absolute value because he argues that "as rational beings, we make the law and we legislate it to ourselves" (Kant, 1996: 30). Kant considers freedom as the only one innate right. For Kant, "freedom (independence from being constrained by another's choice), insofar as it can coexist with the freedom of every other in accordance with a universal law, is the only original right belonging to every man by virtue of his humanity" (Kant, 1996: 30). Being free is part of the essence of human beings and that attribute is substantially inherent not accidental. This substantial attribute of the will in human nature can be seen clearly from Kant where he argues that "the will is thought as a capacity to determine itself to act in conformity with the representation of certain laws: and such a capacity can be found only in rational beings" (Kant, 1997a: 36). It is out of this will that human beings are able to adhere to the existing moral laws not merely because they are determined. According to Kant (1997a: 48), "the will is not merely subject to the law but subject to it in such a way that it must be viewed as also giving the law to itself." Furthermore, Kant (1997a: 88), says "the will is a capacity to choose only that which reason gives it and independently of inclination which reason cognizes as practically necessary. It is opposed to heteronomous principles. Such principles are from inclination rather than from reason and yield only hypothetical imperatives such as I ought to do something because I will something else."

Autonomy is very central and influential in Kant’s deontology and Kantian formulation of autonomy has widely been used in bioethics. This should be expected since Kantian deontology, as I have highlighted, is central in bioethical and medical practices. “The word autonomy derived from the Greek autos (self) and nomos (rule, governance or law), originally referred to the self-rule or self-governance of independent city-states” (Beauchamp & Childress, 2001: 57). Kant takes “the principle of autonomy to be very well suited to be the categorical imperative, because it suggests that the reason we are bound to obey the laws of morality is that we legislate these laws ourselves, that they are our own laws” (Kant, 1997a: xxiv). Such laws are formulated autonomously by the rational agents without any interference.

In addition to the point that illustrates that autonomy exists inherently within the nature of rational beings, Kant further says:

> Autonomy must be conceived of as a condition of mastery over our inclinations in our choice of ends and actions, and for that reason as a condition of cooperation with, but not domination by, others as well, a condition which we can freely choose to maintain, but which we can just as well freely choose to subvert. Autonomy is not identical with a noumenal “act” of freedom. Autonomy is a condition, dependent upon an a priori principle but realized in the empirical world, which we can freely choose to realize and maintain, or to subvert or destroy (Kant, 1997b: 79).

Kant’s autonomy of the will is transcendental because it exists first in the *a-priori* but its application can be realized in the *a-posteriori* or in the empirical world. For Kant, “when you act rationally, you take yourself to choose your actions not be impelled into them, and you think you could have chosen otherwise. Rationality requires that we act under the idea of freedom, and freedom is government by the moral law” (1997a: xxvii). For instance, in Kant’s view, “each individual person’s ability to legislate for himself and make autonomous choices confers a unique value and dignity on that individual. Failure to respect the individual’s autonomous choices is morally wrong because it involves treating the individual as something which has value only for others instead of something which has value in itself” (Plomer, 2005: 96).

In the context of bioethics under the light of Kantian deontology, it would be unacceptable for the medical researchers to coerce the research participants to take part in the clinical trials. In support of this claim, Kant argues that "autonomy is a property of the wills of all adult human beings insofar as they are viewed as ideal moral legislators, prescribing general principles to themselves rationally, free from causal determinism, and not motivated by sensuous desires" (Hill, 1991: 44). In Kantian perspective, what makes coercive acts wrong is due to the denial of rational agents to be moral legislators. Kant has also elaborated that "autonomy of the will is the property of the will by which it is a law to itself (independently of any property of the objects of volition). He further indicated that the principle of autonomy is, therefore: to choose only in such a way that the maxims of your choice are also included as universal law in the same volition" (Kant, 1997a: 47). Kantian autonomy does not will any maxim other than the ones that can become the universal law. Kant considers rationality and autonomy as valuable in a human nature. He further elaborates that:

> Nothing can have a worth other than which the law determines for it. But the law-giving itself, which determines all worth, must for that reason have a dignity, that is, an unconditional, incomparable worth; and the word respect alone provides a becoming expression for the estimate of it that a rational being must give. Autonomy is therefore the ground of the dignity of human nature and of every rational nature (Kant, 1997a: 43).

Autonomy of the will for Kant is regarded as the ground for human dignity because rational agents autonomously give themselves the universal laws. He argues that "rational agents should obey only those laws which he himself gives and in accordance with which his maxims can belong to a giving of universal law to which at the same time he subjects to himself" (Kant, 1997a: 43). This way of analyzing autonomy indicates that rational individuals are at liberty to make their own individualistic laws in as far as they can will that their maxim should become the universal laws that are obligatory.

In addition, Kantian deontology is against placebo effect because his second principle of the categorical imperative sees placebos as using human beings as the means rather than using them as ends in themselves. According to Currie & Waal (2005: 135), "to act in the morally right way, people act according to duty and it is not consequences of actions that make them right or wrong but the motives of the person who carries out the action." Tannsjo has also elaborated that:

> Treating people as ends requires seeing them as autonomous beings who are entitled to control their own fate and not to be deceived or manipulated; actions which are consistent with the dignity and autonomy of moral agents are intrinsically good, because treating people simply as means, however, is to regard them as something that we use for our own purpose without their full and free consent and such actions are inherently wrong (Tannsjo, 1999: 105).

However, if we can look at what is happening when a patient enters in a clinical trial, we will find out that the doctor in charge is not acting against the preferences of the patient because patients must be adequately given the information regarding the nature and risks of clinical trials and give full voluntary consent to participate in the trials. In this case, "respect for autonomy includes respecting an individual's right to self-determination as well as creating the conditions necessary for autonomous choices, since autonomous patients act intentionally, with understanding, and without controlling influences" (Tannsjo, 1999: 78). Kantian autonomy has also been used as a remedy towards unethical medical practices that were performed on human subjects such as the Tuskegee Syphilis Study. Moodley illustrated that:

> The Tuskegee Study of Untreated Syphilis in the African American Male was the longest nontherapeutic experiment on human beings in medical history. The subjects were recruited with misleading promises of "special free treatment," which were actually spinal taps done without anesthesia to study the neurological effects of syphilis, and they were enrolled without their informed consent. The subjects received heavy metals therapy, standard treatment in 1932, but were denied antibiotic therapy when it became clear in the 1940s that penicillin was a safe and effective treatment for the disease (Moodley, 2010: 318).

The application of Kantian autonomy in the doctor-patient relationship completely rejects such practices like the Tuskegee Study because such acts have treated human beings as the means as well as violating their dignity. Autonomy and informed consent in bioethics promote self-regulation. Autonomy remains a fundamental principle in health research ethics especially during clinical trials whereby it is used to restrict the medical researchers from using human beings as research participants in the clinical trials without their informed consent. “By entering research participants in a randomized controlled clinical trial, a doctor is treating them as mere means for the sake of generating scientific knowledge. But the doctor is also treating the research participants as ends in themselves by obtaining informed consent to participate in the clinical trials” (Glannon, 2005: 53).

2.3. Neo-Kantians on the Principle of Respect for Autonomy

The neo-Kantians on the principle of respect for autonomy have continued to appreciate the value of Kantian autonomy in bioethics. However, it is worth noting to highlight that Beauchamp and Childress have acknowledged that their concept of autonomy is different from the Kantian autonomy of the will; while theirs is basically on the autonomy of the person. They argue that their “usage of autonomy typically refers to what makes judgments and actions one’s own (heteronomy). According to them, this conception of autonomy is emphatically not Kant’s notion. Persons have autonomy of the will for Kant if and only if they knowingly act in accordance with the universally valid moral principles that pass the requirements of the categorical imperative” (Beauchamp and Childress, 2001: 351). On the same point, O’Neill argues that “claims by bioethicists to find their notion of individual autonomy on the moral philosophy of Kant are misplaced. Kant never refers to the autonomous self, autonomous persons or autonomous individuals. Rather, of the autonomy of the will because for Kant autonomy is a matter of acting on certain sorts of principles and specifically on principles of obligations” (O’Neill, 2002: 83-4).

In response, Kantian principle of autonomy of the will can still be used in bioethics especially in the case where patients may express their autonomous medical preferences with the view that they will that their maxim should become the universal law. For example, if the research participants who are mentally capacitated can consent autonomously to participate in the clinical trials, then their intent to participate can be willed to become the universal law. Their will in this context is universalizable because they will be self-legislating that any rational agent who is mentally competent should not be coerced to participate in the clinical trials, but their participation should derive from the autonomous volition. In this manner, the research participants will be applying the Kantian autonomy of the will because autonomy in Kantian perspective "is, therefore: to choose only in such a way that the maxims of your choice are also included as universal law in the same volition" (Kant, 1997a: 47).

The rejection of coercion and deception in bioethics can also be willed to become the universal law because this approach treats the patients as ends into themselves rather than as the means. This approach is in line with Kantian argument that says "a will whose maxims necessarily harmonize with the laws of autonomy is a holy, absolutely good will. The dignity of humanity consists just in this capacity to give universal law" (Kant, 1997a: 46-7). However, Allen Wood has questioned the value of Kantian autonomy of the will especially because it allows people to legislate laws for themselves which are expected to be obligatory. He argues that:

> Autonomy of the will as the ground of moral obligation is arguably Kant's most original ethical discovery (or invention). But it is also easy to regard Kant's conception of autonomy as either incoherent or fraudulent. To make my own will the author of my obligations seems to leave both their content and their bindingness at my discretion, which contradicts the idea that I am obligated by them. If we reply to this objection by emphasizing the rationality of these laws as what binds me, then we seem to be transferring the source of obligation from my will to the canons of rationality. The notion of self-legislation becomes a deception or at best a euphemism (Wood, 1999: 156).

The above argument by Wood is sound because if rational agents make laws for themselves with the view of willing them to become the universal laws, it is not clear as to how they can be obligatory. Instead, these self-created laws appear to be subjective rather than being universal because they allow one to choose which laws he or she wills to be obligatory. Some medical decisions patients face have some moral issues while others are not such as whether to perform abortion or choose active euthanasia. In these situations, patients can choose to follow the concept of Kant's autonomy of the will and choose not to perform abortion because killing cannot be willed to become the universal law. On the other hand, patients' medical decisions are completely based “on personal preferences rather than a matter of morality. For instance, whether a patient chooses to perform a surgery of lumpectomy or mastectomy is just a matter of personal preference and it has nothing to do with the Kantian autonomy of the will. For most patients, the primary goal in interacting with the health practitioners is not to revise their moral values, but to receive health care that they prefer” (Secker, 1999: 54).

Besides these prevailing criticisms on the autonomy of the will, the contemporary bioethics practices have allowed the patients and the research participants to make their voluntary decisions without any coercion. For example, “a doctor would be obligated to respect a competent adult Jehovah’s Witness’ refusal of a blood transfusion for severe anemia resulting from chemotherapy to treat leukemia” (Lockwood, 1985: 111). This means that, the doctor cannot administer blood transfusion even if failure to do so would be detrimental to the patient. According to Beauchamp & Childress “personal autonomy is a self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choices. The autonomous individual in this regard acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and sets its policies” (Beauchamp & Childress, 2001: 58).

Kantian autonomy plays a fundamental role in the notion of doctor-patient relationship because in the current medical practice, patients are engaged in medical decision making. According to Glannon:

> An example of the engagement of autonomy in medical practice is when a patient refuses chemotherapy for a form of cancer that can be treated and controlled. The oncologist is obligated to try to persuade the patient to accept the treatment. But if the patient is competent enough to understand his diagnosis and prognosis, and consequences of refusing the treatment, then the oncologist is obligated to uphold the patient’s autonomous decision (2005: 12).

Under Kantian autonomy, patients are completely regarded as atomistic. Patients’ autonomous medical decisions are absolute in as far as their decisions do not pose any harm to other people’s welfare. This view of atomistic approach in Kantian account of autonomy becomes clear where

Kant argues that “every rational being must act as if he were by his maxims at all times a law-giving member of the universal kingdom of ends. The formal principle of these maxims is, act as if your maxims were to serve at the same time as a universal law” (Kant, 1997a: 45). This rule of categorical imperative allows patients in bioethics to express their independent medical preferences anyhow they prefer in as far as they may will that their maxims should be universalizable. For example, a mentally competent patient who refuses to be amputated on his leg as part of the lifesaving treatment of cancer even after a frank disclosure of the diagnosis and prognosis, may also will that his maxim of refusing the treatment in such conditions should become the universal law. In this case, his autonomy of the will has been exercised in such a way that is in accordance with the universal law because as a self-legislating rational being, there were no external causes to motivate his medical decision.

Kant argues that “the principle of autonomy is the sole principle of morals and autonomy alone gives people respect, value and proper motivation. A person’s dignity comes from being morally autonomous” (Beauchamp & Childress, 2001: 351). Failure to respect one’s autonomy automatically violates the dignity of that person because human beings have the capacity to choose what they prefer in as far as it is in line with rules of categorical imperative.

According to Hassoun (2011: 96), “autonomy is often equated with individuality, freedom of the will, integrity, independence, self-knowledge, responsibility, freedom from obligation; self-assertion, critical reflection, and absence of external causation”. Autonomous agents should take charge about their life making decisions because they are independent, free from bondage. Raz is also of the view that people are at liberty with regard to decisions that shape their lives. Raz says:

> If a person is to be maker or author of his own life then he must have the mental abilities to form intentions of a sufficiently complex kind and plan their execution. These include minimum rationality, the ability to comprehend the means required to realize his goals, the mental faculties necessary to plan actions, etc. For a person to enjoy an autonomous life he must actually use these faculties to choose what life to have. There must in other words be adequate options available for him to choose from. Finally,

> his choice must be free from coercion and manipulation by others, he must be independent (Raz 1986: 373).

Consequently, Raz further acknowledges that people should autonomously express their preferences as long as they have the mental capacities to formulate their intentions. However, the noticed difference from his conception of autonomy and the one of Kant is that Raz does not limit his formulation of autonomy; whereas Kant modeled his autonomy along the lines of the categorical imperative rules. Lockwood (1985: 114), however argues that "the principle of respect for autonomy is the principle that shows the worth of human dignity, because this principle emphasizes strong respect for self-determination." Respect for ones' autonomy gives power to the person to express his/her interests and values.

Beauchamp & Childress (2001: 63) argue that "respect, on this account, involves acknowledging decision-making rights and enabling persons to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult or demean others' rights of autonomy." Currently this principle is used to enable the patients and the research participants to be free from the coercion or paternalistic model. For Plomer:

> The dignity of the person commands us to respect individual persons, and since autonomy generically is the credo of the contemporary human in medical ethics, especially in Western countries, it however, implies that the patient has the capacity to act intentionally with understanding and without controlling influences that would militate against free and voluntary actions (Plomer, 2005: 58).

On autonomy and competency, Veitch (2007: 82) notes that "an adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. This right is not limited to decisions which others might regard as sensible or whether the reasons for making the choice are rational or irrational." On a similar point, Buchanan & Brock (1989: 92) assert that "the competent individual's right of self-determination with respect to medical decisions is a right to refuse all forms of medical treatment and care, including nutritional support by ordinary or artificial means, except when refusal imposes significant health risks on others. It is not a right to demand whatever services one desires, nor right to active euthanasia." These views of Veitch, Buchanan and Brock regard patients who are mentally competent as the sole decision makers. In this case, the surrogate decision makers cannot intervene during the proposed medical interventions.

Informed consent and autonomy are amalgamated together because the provided frank information to the patients is intended to help the patients to make an informed medical decision. "In the area of medical practice in particular, the principle of respect for autonomy requires the physician to obtain informed consent from the competent patient before he medically acts, to maintain confidentiality and to avoid deception" (Beauchamp & Childress, 2001: 78). Patients' medical confidentiality can also be breached if and only if the patient has consented autonomously. However, this right is not absolute but *prima facie* because where confidentiality is likely to cause harm to the other party, such confidentiality can be breached in order to avoid causing harm. "Respect for autonomy obligates professionals in healthcare and medical research that involves human subjects to disclose information, to probe for and ensure understanding and voluntariness, and encourage adequate decision-making" (Beauchamp & Childress, 2001: 63).

Patients and research participants ought not to be forced to accept medical treatments or to participate in a research study. Such motives are considered to be unethical and unprofessional because they fail to accord respect to human beings. In health research, manipulation and deception are viewed as violation to the principles and values of research integrity. In other words, coercion and undue influence are completely not acceptable. For Buchanan & Brock (1989: 26) "if the decision is not voluntary, but instead coerced or manipulated, it will likely serve another's ends or another's view of the patient's good, not the patient's own view, and will in a significant sense originate with another and not with the patient."

O'Neill also argues that "what is mistakenly spoken of as patient autonomy masks the fact that the patient's role is to say 'yes' or to go without treatment" (2002: 206). She does not consider autonomy as the capacity to choose any treatment that is not available in the health centre. However, I do not think that O'Neill's argument downgrades the autonomy of the patients at all because even in our normal day to day life situations we cannot choose anything beyond what is available to us. So, when medical options are few, logically it follows that patients' right for autonomous decisions will also be limited. But at the end of the day, mentally competent patients will choose their medical preferences. As a way of assisting the patients to make informed decisions, healthcare professionals have an obligation to furnish all the relevant information. For Buchanan & Brock (1989: 92) the "competent individual's right of self-determination with respect to medical decisions is a right to refuse all forms of medical treatment and care, including nutritional support by ordinary or artificial means, except when refusal imposes significant health risks on others. It is not a right to demand whatever services one desires, nor right to active euthanasia." This point simply highlights that autonomy can be limited in bioethics especially in cases where patients cannot demand any type of treatments that is not legally acceptable within the specific country (e.g. voluntary euthanasia).

The application of autonomy in contemporary bioethics has always been linked with the mental capacity of the patients. Glannon (2005: 24) defines a competent patient as "one who understands the nature of his or her condition and the consequences of accepting or refusing an intervention for it." On the same point, Quante (2011: 598) says "mentally competent patients are able to make their own independent medical decisions during the process of informed consent. Personal autonomy in this regard is also understood as a capacity of persons to reflect critically upon their first order preferences, desires and wishes." Similarly, MacDonald (2002: 195) argues that "autonomy is understood as the ability to direct one's own life and to make one's own decisions."

The motive behind the above points is that competent patients are generally considered to have the moral and legal capacity to control their own healthcare. However, since personal autonomy goes together with mental competence, it means that some patients cannot be able to exercise their autonomy due to severe mental diseases such as Alzheimer's disease, Parkinson and schizophrenia. The point I am making has also been considered by Sjöstrand *et al* when they argue that:

> Autonomy may concern competence (or decision-making capacity), that is, the ability to make adequate decisions based on one's particular plans, aims, and desires. Competence is a matter of degrees and may vary depending on the situation; a person can be able to make decisions in some cases, but not

> in others. Generally, persons are to be considered competent if they are able to assess the relevant information in a situation and use it (Sjöstrand *et al.* 2013: 711).

According to Barbara Secker (1999: 50), the "highly rationalistic, individualistic Kantian account in bioethics appears to assume that all patients qualify to be autonomous rational agents. However, patients frequently are in vulnerable positions, are unable to act on their decisions, and require that positive measures be taken on their behalf." She further argues that:

> If we appeal to the Kantian view (based on an ideal of the self as independent and exclusively rational), very few, if any, patients will be regarded as autonomous. There are a variety of constraints common in health settings which may undermine Kantian autonomy. For example, some patients may lack or have reduced cognitive and volitional capacities which, on the Kantian view, render them imperfectly autonomous or non-autonomous. Other common internal constraints include pain, anxiety, fear, and depression, effects of treatment, lack of information, inadequate understanding, and false beliefs. In addition, patients generally are subject to a variety of external controlling influences (Secker, 1999: 50).

The above point indicates that the autonomy of the mentally competent patients in bioethics is relational rather being global because there are many factors that can render one incapable or fail to exercise his or her autonomous decisions such as pain or depression. Kantian deontology does not provide the inter-relationality and connectedness of the patients and their relatives during medical decisions. Rather, it perpetuates a view of the improvised self or persons that see the self as atomistic. In this regard, patients are allowed in bioethics to make their own individualistic medical decisions (they can even deny lifesaving treatments) in as far as they do not pose harm to other human beings. This Kantian moral theory with its principle of autonomy does not say anything about patients who may be mentally incompetent to express their medical preferences and/or mentally competent but unable to express their medical preferences. Secker (1999) has indicated that "a more applicable account of moral theory is needed for health care contexts, one which accommodates the realities of patients' situations; respects dependence and independence;

while at the same time promotes inter-relatedness and does not justify hard paternalism.” Relationality amongst the human beings forms part of their substantial nature, and as a way of discovering and articulating a better way of promoting doctor-patient relationship, I now focus on the moral theory of Ubuntu.

2.4. Summary of Kantian deontology

In this chapter, I have discussed the formulations of categorical imperative that specify that human beings should never be used as mere means, but always treated as ends in themselves. In addition, under the kingdom of ends, human beings are regarded as self-legislators, that is they give laws to themselves. It has also been discussed that in Kant’s deontology, rationality and autonomy are valuable in human nature to an extent that Kant considers autonomy as the source of intrinsic human dignity. Autonomy of the will can only be exercised by the rational beings because it helps them to legislate laws to themselves that conform with the rules of categorical imperative. Therefore, failure to respect an individual’s autonomous decisions is considered as a violation of his/her dignity because it treats them as mere means to an end. The Neo-Kantians have also grounded autonomy as a principle that shows respect to humanity as well as enhancing doctor-patient relationship. Having said all these, the next chapter will discuss ubuntu, which in contrast considers human beings as embedded within the web of social relationships.

Chapter Three: Ubuntu as a Moral Theory

3.1. Introduction

This chapter analyzes the sub-Saharan moral theory of ubuntu with the aim of attaining a plausible and attractive moral theory which does not presents a mistaken view and picture of the self and persons as atomistic. I discuss the fundamental components of ubuntu, which is viewed as "*motho ke motho ka batho* (in Sotho language) and *umuntu ngumuntu ngabantu* (in Nguni languages)." Both are translated as "a human being is a human being because of other human beings". I further argue that ubuntu perceives people as relational to other persons. It is argued that ubuntu's articulation on the interconnectedness, interdependence and inter-relational in harmonious relationships among human beings considers human beings under the web of the integral relationships whereby people take care of others and help them to overcome the life difficulties they are going through. Hence, in this chapter ubuntu is considered to be a promising moral theory that takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self.

3.2. Etymological Definition of Ubuntu

Ubuntu generally has been used to refer to humaneness and to indicate that by nature people are interdependent and inter-relational to one another. Christian Gade (2011: 308) asserts that "in a number of texts from before 1980, the term 'quality' appears in descriptions of ubuntu, and in many texts ubuntu is evidently considered to be a very positive quality. Ubuntu has, for example, been described as goodness of nature, good moral disposition." Following the same view by Gade, ubuntu does not only focus only on the interdependence of human beings within their societies, but it also focuses on how the individuals' character can be improved morally. This moral theory considers that a person can improve and realize his or her potentials through communal relationships. For Mogobe Ramose ubuntu consists of prefix and stem. Ramose further says:

> Ubu- evokes the idea of be-ing in general. It is enfolded be-ing before it manifests itself in the concrete form or mode of existence of a particular entity. At the ontological level, there is no strict and literal separation and division between ubu-and-ntu. On the contrary, they are mutually founding in the sense that they are two aspects of be-ing as a one-ness and an indivisible whole-ness. Ubuntu is the fundamental ontological and epistemological category in the African thought of the Bantu-speaking people. It is the indivisible one-ness and whole-ness of ontology and epistemology (Ramose, 1999: 41).

From the above analysis by Ramose, it becomes clear that just like the prefix ubu- and the stem-ntu- which are considered to be indivisible, it can be inferred that individuals are also considered to be integrally interconnected and inter-relational with other persons in the community. This moral theory is, on both *motho* and *botho* concern with "the value of being human on the one hand and the corresponding necessity for mutual respect and compassion on the other" (Ramose, 1999: 77). In addition to Ramose's analysis ubuntu has been employed along expressions like '*umuntu ngumuntu ngabantu*'. On this issue, Gade (2011: 318) says "ubuntu was identified for the first time as something connected with the proverb '*umuntu ngumuntu ngabantu*' during the period of 1993 to 1995. Since 1995, this proverb has developed as a very important reference for describing what ubuntu is." For Ramose, the maxim of '*umuntu ngumuntu ngabantu*' cannot be exhausted clearly by the English language, "but it may nonetheless be construed to mean that "to be a human being is to affirm one's humanity by recognizing the humanity of others and, on that basis, establish humane relations with them. Ubuntu understood as being human (human-ness); a humane, respectful and polite attitude towards others constitutes the core meaning of this aphorism" (Ramose, 1999: 42).

In relation to the foundational level on ubuntu that was formulated by Ramose, Justice Mokgoro (1998) posits that "ubuntu has been described as a worldview of African societies and a determining factor in the formation of perceptions which influence social conduct." In addition, Mokgoro (1998) "further argues that ubuntu is a humanistic orientation towards fellow beings. She has also illustrated that ubuntu pursues key values of group solidarity, compassion, respect and human dignity. For Mokgoro, the fact that the spirit of ubuntu emphasises respect for human dignity implies a radical turn against ill treatments and violation of human rights." Furthermore, Mokgoro (1998: 3) says that "harmony is important for ubuntu and it is achieved through close and sympathetic social relations within the group. This however implies that the common good of caring and loving one another can be attained through communal relationships." In this context, people feel the sense of belonging and need to care for others' welfare.

On the other hand, ubuntu should not be tangled with *simunye* which refers to oneness. According to Jason Van Niekerk (2011: 62), "some accounts of ubuntu conflate ubuntu with *simunye* (oneness). In this context, if we take *simunye* to mean acting out of solidarity with and for the sake of one's particular community, then "ubuntu is not *simunye*". On the same point, Van Niekerk (2011: 62) further elaborated that "one reason to reject the association of ubuntu with *simuny*e is that the patriot – even the jingoistic patriot – seems to meet the requirements of solidarity with and action for the sake of his community, but jingoistic patriotism is not what is normally meant by ubuntu." Van Niekerk (2011: 62) has also rejected the assimilation of ubuntu with *simunye* by referring to the argument raised by Tutu which says; "the person with ubuntu is generous, hospitable, friendly, caring and compassionate."

I do also agree with the above-mentioned argument that ubuntu is not *simunye*. Firstly, if the "affirmation of ubuntu (botho) is a metaphor for ethical, social and legal judgment of human worth and human conduct" (Ramose, 1999: 43) then, the affirmation of *simunye* would mean that we are simply in solidarity without referring to the human worth and any human conduct that shows humanness towards one another. For example, people can remain as *simunye* in terms of fighting for the proper roads and access to clean water, and after their grievances have been solved, they go their separate ways. And they will remain in *simunye* again when there is a crisis. *Simunye* simply refers to solidarity without necessarily focusing on the development of one's moral character and without necessarily being in harmonious relationships. Whereas ubuntu is understood as humanness and that state of being requires humane acts and polite attitude towards others in mutual respect. Humanness goes together with the moral character of acting benevolently towards other persons who need our care, help and support; hence ubuntu does not imply *simunye* because the latter simply implies that we are in the same struggle without necessarily being interdependent and inter-relational to one another. As Ramose (2002: 75) says, “to be a human being, for Ubuntu, is to affirm one’s humanity by recognising the humanity of others and, on that basis, establish humane relations with them.” To affirm one’s humanity simply means to perceive the self as interdependent and intertwined with others in a mutual respect.

3.3. Communitarianism and Relational Approaches in Bioethics

This section specifically discusses the difference between moderate and extreme communitarianism, as well as the relational approach in bioethics. The moderate one “refers to the reconciliation of rights and social responsibilities, which is the balancing of social forces and individual autonomy” (Gyekye, 1997: 52). The moderate communitarian thought recognises the individual’s human worth, while at the same time considering on the importance of social relationships. In support with this view of recognizing the autonomy of individuals within ubuntu as a relational theory, Metz (2017: 115) says “the cooperative behaviours through ubuntu include being transparent about the terms of interaction, allowing others to make voluntary choices, acting on the basis of trust, adopting common goals.”

In addition, social responsibilities towards other persons are enabled by the fact that human nature is bestowed with rationality and autonomy; these attributes enable them to understand that the social relationships are substantially embedded. According to Gyekye (1997: 72, 76), “a harmonious cooperative social life requires that individuals demonstrate sensitivity to the needs and interests of others. . . . Communitarian moral theory. . . . advocates a life lived in harmony and cooperation with others, a life of mutual consideration and aid and of interdependence, a life in which one shares in the fate of the other.” I concur with Gyekye’s view that moderate or restricted communitarianism recognizes the self that is in relation with other societal members. In support to Gyekye’s account on moderate communitarianism, Andoh (2011: 70) also says “the individual is both autonomous and a communal being. It is recognized that besides being a social being by nature, the individual also possesses rationality, moral sense, capacity for virtue, and capacity for free choice.” Moreover, Gyekye (1997: 36-37) asserts that “strong communitarianism is whereby the individual is wholly molded by his/her immediate community. This implies that just as a parent natures a child the individual’s worldview is defined by the community that natures him/her right from birth." In contrast to strong communitarianism, Masolo perceives an individual's worth as inherently rooted in the community. He says that:

> Individuals and community regulate and depend on each other for whom and what they become. Human worth is constituted by interplay between the culturally objectified perceptions of persons and the subjectively apprehended aspects of social life through which individuals express their subjective subjectivity in opposition to or conformity to the conventionally defined roles, rules, and regulations (Masolo, 2010: 218).

In addition, Masolo (2010: 219) argues that "we become persons through acquiring and participating in the socially generated knowledge of norms and actions that we learn to live by in order to impose humaneness upon our humanness." Ubuntu recognizes both the worth of the individuals and their interdependency to other communal members. "Feminist and communitarian scholars argue that autonomy treats persons in an atomistic manner because it ignores values such as mutual responsibility, cooperation and care towards others which are seen as playing a crucial role in important areas of decision-making such as healthcare and research" (Dove *at el,* 2017: 153).

According to Stoljar (2011: 376) "relational conceptions emphasize that agents are situated in historical, social, class, race and gender contexts. The agent's social situation has an impact not only on her identity and self-conception but also on the nature of important capacities like autonomy." The relational approach in bioethics does not connote paternalism because the aim of the family members is to assist the patient to make medical decisions that will serve their best interests.

In addition, Amitai Etzioni (2011: 17) argues that "communitarianism seeks to balance autonomy with concern for the common good, without a priori privileging either of these two core values." Ubuntu on the same point does not swallow the autonomy of the individuals, rather it recognizes that due to relationality factor, human beings within their communities and families have a common good to attain as integrally interdependent to one another. In this view, individuals are not viewed as atoms, but as relational beings. Furthermore, Ogunbanjo & Bogaert (2005: 51) argue that “at the heart of communitarianism is the view that the individual is embedded in a context of social relationships and interdependence, but never an insulated person. Peace, harmony, stability, solidarity, mutual reciprocity and sympathy are the social values upheld by communitarianism.” Moreover, Daniel Callahan (2003a: 288) considers communitarianism “as a way of thinking about ethical problems, not to provide any formulas or rigid criteria for dealing with them. It entails that human beings are social animals, not under any circumstances isolated individuals, and whose lives are lived out within deeply penetrating social, political, and cultural institutions and practices.” The analysis of Callahan on communitarianism depicts that social harmony and relationality are not accidental among human beings, but they are substantially rooted within their nature. According to Gyekye (1997: 63-66), “the dignity or worth of the individual cannot be diminished by his natural membership in the community but both the individual and community ought to be equally morally acknowledged.” In this case, the community does not take away the human worth of the individuals. Charles Taylor (1985: 189) argues that “atomism affirms the self-sufficiency of the individual, whereas communitarians adopt a social thesis about human beings. The social nature of man is not just that men cannot physically survive alone, but much more that they can only develop their characteristically human capacities in society.”

To sum up the discussion in this section, there is consensus among moderate communitarian theorists and feminists that patients’ autonomy is valuable, but it should not be considered as a factor that separates them from the social relationships. Individuals should make medical decisions within a social setting and hence, must consider the welfare of others into account because medical decisions affect the entire family. This relational approach is considered to be vital in terms of supporting the patients when making their medical decisions as we have seen previously that mental capacity is not global but relative; meaning that it can deteriorate in some cases. From this juncture, I discuss ubuntu in the next section as a preferred theory in doctor-patient relationship than Kant’s deontology.

3.4. Ubuntu as a Moral Theory

3.4.1. Some Scholars' Views of Ubuntu as a Moral Theory

In this section, I will primarily present Ubuntu by discussing what a number of scholars have said about it as a moral theory. As a moral theory, ubuntu considers human beings as integrally related to one another and on this idea they ought to show respect and mutual care to others. While it is true that John Mbiti does not directly discuss ubuntu, but his popular statement which says "I am because we are and since we are, therefore I am" (1969:108) signifies that in an African context, to be is to belong because by nature human beings are interconnected and relational. This point by Mbiti is also affirming the fact that an individual existence is within the communal relations. Unlike the individualistic argument that was once raised by the French philosopher Rene Descartes who first proved his own existence as a substance that is not in relation with any other beings. From this conjecture, Menkiti asserts that "in the African view it is the community which defines the person as person, not some isolated static quality of rationality, will, or memory. The African view supports the notion of dignity as acquired through communal relations not merely granted as a consequence of birth" (Menkiti, 1984: 173). For Mokgoro (1990: 3) "harmony is achieved through close and sympathetic social relations within the group. This however implies that the common good of caring and loving one another can be attained through communal relationships." Harmonious relationships have also been supported by Setiloane. According to him, persons cannot exist apart from their social relations with other persons (Setiloane, 1986: 14). In addition, Setiloane puts this well when he says: "this manner of understanding human personality explains the interplay which takes place when people come into contact or live together. The essence of being is participation in which humans are always interlocked with one another. This human being is not only vital force, but more vital forces in participation" (1986: 14). This argument by Setiloane illustrates the difference between Leibnitz's theory of monadology whereby monads exist without any relationality to each other. The thoughts of Ramose, Setiloane and Mbiti promote the harmonious belongingness of human beings. In addition, Gyekye (1998: 364) argues that:

> The success that must accrue to communal or corporative living depends very much on each member of the community demonstrating a high degree of moral responsiveness and sensitivity in relation to the needs and well-being

> of other members. This should manifest itself in each member's pursuit of his/her duties.

Shutte (2001: 30) argues that "our deepest moral obligation is to become more fully human, and this means entering more and more deeply into community with others. So, although the goal is personal fulfillment, selfishness is excluded." This means that ubuntu encourages only virtuous characters given that these virtuous characters enhance harmonious relationships with other people. Shutte (2001) says, "selfish behavior in this regard will not help individuals to become more fully human in terms of developing positive attitude towards other human. On this understanding, the proper way to relate to others, is to seek out community or to live in harmony with other humans" (for representative statements, see Biko, 1971/2004, p. 21; Kasenene, 1998, p 21; Tutu, 1999, p 35; Mkhize, 2008, pp. 38-41).

Ubuntu also speaks to a person's character. On ubuntu and character, Shutte (2001) stipulates that "a person is able to develop his or her character very well when s/he is in relation with other human beings unlike if he or she is isolated." In other words, through inter-relationships a person is able to develop positive attitude towards other human beings. Furthermore, Desmond Tutu makes the point that:

> A person with ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good; for he or she has a proper self-assurance that comes with knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed, or treated as if they were less than who they are. As a human being through other human beings it follows that what we do to others affects us through the interwoven fabric of social relationships (Tutu, 1988: 2).

This point about seeing oneself as a communal being and portraying good moral character has been described by Tutu in terms of the individual acting in certain ways: "when we want to give high praise to someone in sub-Saharan morality we say; Hey, so-and-so has ubuntu. Then you are generous, you are hospitable, you are friendly and caring and compassionate. Anger, resentment, lust for revenge, even success through aggressive competitiveness, are corrosive of this good" (1999: 31-35). Tutu further points out that "a person with ubuntu has a certain character disposition which leads to the expression of certain virtues, namely those of hospitality, friendliness, caring and sharing or compassion and generosity, openness or accessibility to others, sympathy and empathy. As a human being through other human beings it follows that what we do to others affects us through the interwoven fabric of social relationships" (Tutu, 1988: 2). These virtues can be seen and improved well when a person is in relation with others.

The systematic social relations manifested by ubuntu is made possible by the fact that people with ubuntu do not consider themselves as atoms that exist independently from the other, but humanity for this moral theory is relational by nature. "Ubuntu is the capacity in African culture to express compassion, reciprocity, dignity, harmony, and humanity in the interests of building and maintaining community. Ubuntu calls on us to believe and feel that: your pain is my pain; my wealth is your wealth and your salvation is my salvation" (Nussbaum, 2003: 21). "The interdependence of human beings is viewed as an approach that helps people to develop good moral characters within their communal loving relationships. That means ubuntu sees community rather than self-determination as the essential aspect of personhood" (Nussbaum, 2003: 22).

Ubuntu requires people to engage in humane relations hence, it is in the community where people can encounter humane relations. Letseka (2014: 548) argues that "the essence of ubuntu as humanness is thus a requirement to act humanely towards others. As an ethno-philosophical component of African philosophy ubuntu animates the indivisible oneness and wholeness of ontology and epistemology of African thought and conduct." On the related analysis of ubuntu, Ewuoso and Hall (97: 2019) notes that "in ubuntu, personhood/humanness is in a symbiotic relationship, or is inextricably bound up, with the dynamic (bio) physical and spiritual worlds. This means that an individual is involved in a web of interconnectedness and relatedness." They further argue that "the view of the individual and the community as coterminous is a mutually constitutive one, in which the good of the individual and that of the community are interwoven such that the individual's subjectivity is not solely determined by the community but co-substantively constituted with that of the community" (Ibid).

Khoza further says (2006: 6) says; ubuntu is about harmonious relationships and focuses on mutual respect and care that people should display to one another. Mike Boon also recognizes the interrelatedness encouraged by ubuntu. He argues that:

> One's humanity can, therefore only be defined through interaction with others…..the group is as important as the individual and a person’s most effective behaviour is in the group. All efforts working towards this common good are lauded and encouraged, as are all acts of kindness, compassion and care, and the great need for human dignity, self-respect and integrity (Boon, 1999: 32).

Communal relationality is unavoidable in the African context because it is considered that by nature human beings are interconnected. This worldview forms the fundamental basis of considering human beings as beings that are interdependent and in relations with other persons in their communities. Good characters such as respecting one’s dignity can also be realized and developed when people are living in harmony with one another. As Letseka argues:

> In traditional African life a person depends on others just as others depend on him/her. The task of African philosophy is therefore to speculate about the communality of the individual in the African setting. It should provide conceptual frameworks for interpreting and analysing the humanness that Botho and Ubuntu capture. It should provide rational tools for critical reflections on personal wellbeing or human flourishing, on communal ethics and how these ought to impact on human conduct. Ubuntu has normative implications in that it encapsulates moral norms and values such as altruism, kindness, generosity, compassion, benevolence, courtesy, and respect and concern for others (Letseka, 2000: 182).

Ubuntu emphasizes the fundamental importance of being in communal relationships as well as caring for others. This moral theory also advocates for the interdependence because our human potentialities can be realized through interactions and relating with others. Letseka (2014: 548) has also raised a fundamental point regarding the community and the individual. According to him “while ubuntu often passes as communal and interdependent, these features do not imply that ubuntu is anti-individualistic." On the contrary, as Louw (2006:168) points out, "ubuntu's respect for the particularity of the other links up closely to its respect for individuality. This is because ubuntu defines the individual in terms of his/her relationship with others." A similar point was also raised by Murove where he says that

> The individual's relatedness to the community finds its expression in the African concept of ubuntu, a concept that literally means humanness. What it means to be human is something that the individual derives from the community; there is simply no dichotomy between the individual and the community because the individual and the community exist in a symbiotic relationship (Murove, 2009: 30).

Broodryk (2002) perceives ubuntu/botho "as a comprehensive ancient African worldview based on the values of humanness, caring, sharing, respect, compassion and associated values, ensuring a happy and qualitative human community life in a spirit of family." For Masolo (2004: 27) "African morality is a relational category because the moral potentialities we bear enable us to imaginatively project ourselves into the situation of others, making it possible for us to make judgments about others' cases as if they were our own." Ubuntu is basically focusing on the social harmonious relationships where people love and assist each other to achieve their set goals. This moral theory is said to "articulate our communal inter-connectedness, our common humanity, our interdependence and our common membership to a community" (Letseka, 2013: 339). On the similar issue, Masolo relates the inter-connectedness in this way:

> Through ubuntu, the sense of belonging or the realization and acceptance that the self is located in the midst of others becomes the basis of his or her moral outlook within the context of a common set of values. Within this mode of thought, no person is considered to be a self-sufficient entity in and for him or herself. Rather, the existence of others is an essential part of the very structure of the self, from which emanates the communitarian exigency (2010: 249).

Individuals within the moral theory of ubuntu are not considered as loners, but they are considered to be integrally related to other members of the community. It is through this relationality that helps individuals to develop their moral characters (such as loyalty, compassion and benevolence) with the aim of helping others to live a meaningful life. Letseka (2000: 180) further argues that “ubuntu has normative implications in that it encapsulates moral norms and values such as altruism, kindness, generosity, compassion, benevolence, courtesy, and respect and concern for others.” Another similar point to the one above was raised by Munyaka and Motlhabi. According to them, “a humane person is understood as a person who possesses good moral qualities and who puts them to good use. The values of ubuntu are concerned with both the character and behaviour of persons within the context of community” (Munyaka & Motlhabi, 2009: 82). For instance, in bioethics health care workers, patients and family members are in a relationship, so if health care workers may choose not to inform the patients about his sufferings they will be failing to act humanely towards the patients and family members, such actions are not recommended by ubuntu. Ubuntu expects “people to be in solidarity with one another especially during times of duress when the need for ubuntu becomes more acute. Persons in need should be able to count on the support of those around them. Individualistic acts are seen as bringing about harm, misery and pain to others” (Munyaka & Motlhabi, 2009: 71). In addition to this point, Munyaka & Motlhabi further indicated that:

> Ubuntu is inclusive because it is manifested in living in community; it is best realized in deeds of kindness, compassion, caring, sharing, solidarity and sacrifice. Ubuntu is the source or basis of feelings of compassion responsible for making life more humane for others, in particular the disadvantaged, the sick, bereaved and poor as well as strangers. There is commitment to advance their interests and concerted effort is made to do so (2009: 74-5).

People with ubuntu respect and portray kindness, compassions as well as caring for others. In ubuntu, the aim is not based on the individual capacity to choose what s/he wants (self-determinant), rather the individuals’ preferences should incorporate and have a sense of feeling for others ‘situation. David Lutz shares the same view when saying that:

> In a true community, the individual does not pursue the common good instead of his or her own good, but rather pursues his or her own good through pursuing the common good. The ethics of a true community does not ask persons to sacrifice their own good in order to promote the good of others,

> but instead invites them to recognize that they can attain their own true good only by promoting the good of others (Lutz, 2009: 314).

Under the moral theory of ubuntu, people consider themselves as integral parts of the whole entity which is indivisible. Even if they can develop their interests as individuals, they consider themselves to be morally obliged to pursue the interests of others. In this African perspective, existence precedes belonging; that is one has to belong to a certain community where people act benevolently towards each other. Kwame Gyekye has also echoed that communal relations in the African context do not neglect the existence of the individuals. He further argues that:

> The clan is like a cluster of trees which, when seen from afar, appear huddled together, but which would be seen to stand individually when closely approached.... The proverb stresses the social reality of the individual; it expresses the idea that the individual has a separate identity and that, like the tree, some of whose branches may touch other trees, the individual is separately rooted and is not completely absorbed by the cluster. That is, communality does not obliterate or squeeze out individuality (Gyekye, 1996: 32).

There are no communal relations without individuals relating and interacting with one another. In relation to the above argument by Gyekye, while it is true those individuals live their own lives, but it should be considered that their life values depend on others. According to Etieyibo (2014: 78), the African moral theory of ubuntu "requires that individuals or moral persons ought to or need cultivate good character, to have certain virtues, to be just, honest, compassionate, to care and share and to act within the broader common good of human flourishing." His argument reflects the need to relate with other human beings in order to cultivate good characters and taking care of other fellow human beings. Etieyibo's point seem to be that ubuntu is "a philosophy or a worldview that defines the individual in terms of the idea of humanity, in general, and about human interdependence and relationship with other humans, in particular" (Etieyibo, 2017a: 312). That is to say, "ubuntu takes the essence of humans to be relational; that is, humans have a shared humanity or are embedded in the community of humanity" (Etieyibo, 2017a: 312).

The above point by Etieyibo signifies that the self in ubuntu is regarded as integral and relational to the community in a sense that it harmoniously recognizes the welfare of others. Etieyibo (2017a: 317; Etieyibo, 2017b: 141) further argues that "at the core of ubuntu is the concept humanity or humanness. That is, in ubuntu an individual is a human or person or exists as a human through other persons and his/herself is embedded with others. Ubuntu is more underpinned by African ontology which emphasises holistic and communitarian relations." Etieyibo considers the notion of embeddedness as a force behind engaging in harmonious communal relationships. In addition, Etieyibo (2017a: 317) argues that the "African ontology sees humans as one kind of being that exists with other beings that informs ubuntu's values, the idea of humanity being bound together or of your humanity being intertwined with my humanity, and ubuntu's ethical prescription of forming humane relations with others." One's humanness is achieved and improved within the web of relations with other persons within the family or community. One displays this relational spirit by embedding oneself in community, forming humane relations, being compassionate to others as well as taking care of others. The role of the family and community can be seen clearly on the argument raised by Wiredu when he says:

> In African context, the classic role of the family and the community is the transmission of values and virtues and, therefore, these institutions play a pivotal role in transferring values to its members. The family and community are identified as the domain for the dissemination of morals and ethical principles, simply because it is recognized that traditional African morality and its ethical system does not evolve in a vacuum. Rather, they develop and function within a specific context (Wiredu, 2002: 288).

The above point simply illustrates that it is through other persons whereby the individual becomes cognizant of his/her own being, his/her own moral values and responsibilities towards others. Mbiti (1969: 141) says "when the individual within the family suffers, he does not suffer alone but with his corporate group: when he rejoices, he rejoices not alone but with his kinsmen, his neighbours and his relatives whether dead or living....Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual". In addition, Gyekye (1998: 349) "observes that a person is inherently (intrinsically) a communal being, embedded in a context of social relationships and interdependence, and never as an isolated, atomic individual." On the same issue of relationality and interconnectedness, Etieyibo argues that:

> The idea of a communal bind or of being communally bound explains why ubuntu is not seen as an individualistic philosophy, but as a communalistic philosophy. The idea of community for ubuntu is not just the collection of individuals in some social space. Neither is it the idea of an aggregate of people that live lives that impact on one another. Rather, the idea of ubuntu's community is deeper. Ubuntu's community is one that takes individuals to be deeply connected or inextricably linked. It is a community of deeply shared life in virtue of the bounded humanity of individuals (Etieyibo, 2017a: 319).

Ubuntu considers the self as integrated within the social relationships. The sense of belonging and relatedness is substantial in ubuntu and not accidental. Pitsoe & Letseka (2012: 24) argue that "ubuntu articulates a view of oneself in the realm of social interdependence. That realm manifests in belonging to and being grounded in one's community." Turaki (2006: 36) says; "people are not individuals, living in a state of independence, but part of a community living in relationships and interdependence." Turaki's point simply illustrates that social relationships are unavoidable.

The interrelatedness among human beings in their communities has also been recognized by Jean Paul Sartre when he was discussing concrete relations with other (*being with and the "we")* in his book *Being and Nothingness: An Essay on Phenomenological Ontology*. According to Sartre, "we discover ourselves not in conflict with the other but in community with him." For Sartre (1943: 413) "the 'we' includes a plurality of subjectives which recognise one another as subjectivities. The 'we' is a particular experience which is produced in special cases on the foundation of *being-for-others* in general. The *being-for others* precedes and founds the *being-with-others*" (Sartre, 1943: 414). The self through ubuntu is perceived as the self that seeks for others and engage in mutual respect; it's a self that is in relation with others.

The essence of ubuntu constitutes the fundamental relations of the self, which is interconnected and relational with other persons in the community. This moral theory is totally different from Leibniz's monads which "have no relations with one another and cannot act upon one another"

(Mourant & Freund, 1964: 271). In contrast, “ubuntu implies an interactive ethic in which our humanity is shaped by our interaction with others as co-dependent beings” (McCluskey & Lephalala 2010). In addition, Musopole says that:

> In order to recapture our human dignity, integrity, and wisdom, we do not need an education; rather we need reconciliation to our essential humanity. To be human in Africa is to be a reconciled person-in-community-and-communion responsibly living out the integrity of one’s humanness in all spheres of life and thus contributing to the development and realization of what we have called the good village or community and harmony in the cosmos (1994: 178-179).

The above argument of Musopole illustrates clearly that people need to value communal relations because it is through this harmonious communal life that an individual can develop his/her moral character as well as attaining his/her dignity. For Gbadegesin (1993: 258) “being a person means that one has certain rights and responsibilities more of the latter than the former including the responsibility to be useful to the community and to be of good behaviour. In this perspective, the community shapes the moral character of the individuals and help them to act humane towards others.” Gyekye assert that:

> African communal approach immediately sees the human person as an inherently (intrinsically) communal beings, embedded in a context of social relationships and interdependence, never as an isolated, atomic individual. Consequently, it sees the community not as a mere association of individual persons whose interests and ends are contingently congruent, but as a group of persons linked by interpersonal bonds, biological and/or non-biological, who consider themselves primarily as members of the group and who have common interests, goals, and values (Gyekye, 2002: 351).

In this context, individual autonomy does not swallow the essence of social relations amongst the human beings. In addition, Jabu (1995: 8) asserts that “ubuntu is humanistic experience of treating all people with respect, granting them their human dignity. For example, a person who does not relate harmoniously with other people in a community diminishes his or her personhood, and s/he is said to lack *botho*/humanity. In cases whereby, the individual is not behaving in a virtuous manner, he is described not as a person because of the unethical actions he has chosen or performed."

In the African perspective, individuals are considered as beings that live in a human society and which are not perceived as self-contained atomic individuals who do not need others for survival. Gyekye further argues that "it is the necessary relationships which complete the being of the individual person who, prior to entering into those relationships, would not be self-complete for, as we are reminded by an Akan maxim, a person is not a palm tree that he should be self-complete or self-sufficient" (Gyekye, 1998: 352). The philosophy of ubuntu encourages us to promote the welfare of others as well as treating them with respect which is an attribute of humanness. Solidarity, interdependence, compassion and reciprocity are viewed to characterize the moral theory of ubuntu. It is also through communal relations that can help individuals to develop their moral characters because a loner promotes only his/her beliefs without necessarily striving to attain the common good with others in the community. The relationality element within the African communities has also been articulated by Gyekye when he says:

> The sociality of the person immediately makes him/her naturally oriented to other persons with whom he/she must live in relation. Living in relation with others directly involves a person in social and moral roles, duties, obligations, and commitments which the individual person must fulfil. The natural relationality of the person thus immediately plunges him/her into a moral universe, making morality an essentially social and trans-individual phenomenon focused on the well-being of others. Our natural sociality then prescribes or mandates a morality that, clearly, should be weighted on duty, i.e. on that which one has to do for others (1998: 364).

The moral theory of ubuntu accentuates the fundamental significance of harmonious relationships and mutual respect complemented by mutual care and sharing. For Wiredu, "no human society or community is possible without communication, for a community is not just an aggregation of individuals existing as windowless monads but of individuals interacting as persons, and an interaction of persons can only be on the basis of shared meanings" (1996: 13).

Another scholar who has written prolifically on ubuntu is Thaddeus Metz and he has refined this theory by including identity and solidarity as the key factors towards harmonious communal relationships. Metz (2007a: 240) argues that "ubuntu is a theory of right action." He writes that "the most justified normative theory of right action that has an African pedigree is the requirement to produce harmony and to reduce discord, where harmony is a matter of identity and solidarity" (Metz, 2007a: 240). Metz considers these two elements as vital in constituting harmonious communal relations. It is through these loving relationships that develop our moral conduct so that we treat other humans in a humane manner. Metz (2007a: 328) has indicated that there are six competing theoretical interpretations of ubuntu to be found in the literature namely:

> **U1:** An action is right just insofar as it respects a person's dignity; an act is wrong to the extent that it degrades humanity.
>
> **U2:** An action is right just insofar as it promotes the well-being of others; an act is wrong to the extent that it fails to enhance the welfare of one's fellows.
>
> **U3:** An action is right just insofar as it promotes the well-being of others without violating their rights; an act is wrong to the extent that it either violates rights or fails to enhance the welfare of one's fellows without violating rights.
>
> **U4:** An action is right just insofar as it positively relates to others and thereby realizes oneself; an act is wrong to the extent that it does not perfect one's valuable nature as a social being.
>
> **U5:** An action is right just insofar as it is in solidarity with groups whose survival is threatened; an act is wrong to the extent that it fails to support a vulnerable community.
>
> **U6:** An action is right just insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community (Metz, 2007a: 328-334).

Metz has rejected Ul, U2, U3, and U5 as unsatisfactory; and he suggests that "we need to consider only the remaining two interpretations of ubuntu"(Metz, 2007a: 331). However, Metz rejects U4, which he calls "probably the dominant interpretation of African ethics in the literature and accepts

U6 as the most promising theoretical formulation of an African ethic to be found in the literature" (2007a: 331-334). U6 is better, he argues, because U4 roots ethics in the good of the agent, while U6 roots it in the good of other persons. He argues that U6 has the capacity to promote harmonious relationships and to prevent discordant ones.

Metz submits that "the fundamental emphasis of U4 on self-realization has counter-intuitive implications. Suppose that you need a new kidney to survive and that no one will give one to you. Then, to maximize your self-realization, you would need to kill another innocent person so as to acquire his organs" (2007a: 332). However, I do differ with Metz on this point because an emphasis on self-realization does not negate the fact that people should relate positively with others. Killing others in order to get the kidney is inhumane and therefore anti-ubuntu because that act fundamentally fails to attain harmonious relationships and mutual respect. U4 entails the substantial element of relationality where individuals are expected to relate positively with others. Consequently, I share the same views with David Lutz (2009: 315) when he says; "it is possible to interpret "umuntu ngumuntu ngabantu/ "a person is a person through other persons", in such a way that both U4 and U6 are true. The actions that produce harmony, reduce discord and develop the moral conduct of the community members are simultaneously the actions that perfect one's humanness."

According to Metz, "ubuntu maintains that harmonious or communal relationships are to be valued for their own sake not merely as a means to some other basic value such as pleasure" (2010: 51). Along this line, Metz (2010: 51) formulation of the principle of ubuntu is that "an action is right just insofar as it is a way of living harmoniously or prizing communal relationships, ones in which people identify with each other and exhibit solidarity with one another; otherwise, an action is wrong." This however, means that people should consider themselves as integrally part of the existing social relationships.As Metz and Gaie puts it: "there is the idea that one has a moral obligation to be concerned for the good of others, in terms of both one's systematic emotional reactions toward other people and one's helpful behavior toward them. One has a duty to exhibit solidarity with others. There is also the idea that one has a moral obligation to think of oneself as bound up with others, that is, to define oneself as a member of a common group and to participate in its practices" (2010: 276). The attainment of common good should always be aimed at when one is acting along the lines of ubuntu.

For one to be under the web of 'we' one has to consider himself or herself as part and parcel of the existing community relationships whereby one feels bad when they see other people suffering. social relationships pursuit by ubuntu depicts that "sub-Saharan morality is essentially relational in a way that other western approaches usually are not. That is, in a typical African ethic, the only way to develop one's humanness is to relate to others in a positive way. One becomes a person solely through other persons, which means that one cannot realize one's true self in opposition to others or even in isolation from them" (Metz & Gaie, 2010: 275). Metz has also described the interconnectedness relationship pursued by ubuntu through two elements namely identity and solidarity. Metz argues that:

> To identify with each other is largely for people to think of themselves as members of the same group, that is, to conceive of themselves as a 'we', as well as for them to engage in joint projects, coordinating their behaviour to realize shared ends. To exhibit solidarity with one another is for people to care about each other's quality of life, in two senses. First, it means that they engage in mutual aid, acting in ways that are expected to benefit each other. Second, caring is a matter of people's attitudes such as emotions and motives being positively oriented towards others, say by sympathizing with them and helping them for their sake (Metz, 2010a: 51).

In relation to Metz's two elements namely identity and solidarity, ubuntu is of the view that we have to consider ourselves through the web of 'we' as well as exhibiting solidarity by taking care of other human beings and help them to overcome the life difficulties they are going through. Metz (2010a: 52) also argues that "what is special about us requiring respect is our capacity for communal or friendly relationships, understood as the combination of sharing a way with others and of caring about their quality of life. Actions that promote the welfare of other human beings and those that demonstrate respect to human dignity are encouraged by ubuntu." For Metz (2010a: 52; Metz, 2010b: 84) "acts such as breaking promises, stealing, deceiving, cheating, raping and the like are well characterized as being unfriendly, or more are carefully as seriously failing to respect the value of friendship. They involve discord in the following senses: the actor distancing himself from the person acted upon and subordinating others, instead of enjoying a sense of togetherness."

The element of living within communal relationships with other persons should always reflect the element of respect to ones' dignity. "Ubuntu/Botho does accord all human beings a moral status and considers everyone in principle to be potential members of an ideal family based on loving or friendly relationships" (Metz & Gaie, 2010: 281). In addition to this point Metz (2011a: 540) also argues that "according to the moral theory of ubuntu, grounded in a salient Southern African valuation of community, actions are wrong not merely insofar as they harm people (utilitarianism) or degrade an individual's autonomy (Kantianism), but rather just to the extent that they are unfriendly or, more carefully, fail to respect friendship or the capacity for it." Metz says "a loving relationship is plausibly nothing other than thinking of oneself as a 'we' with another person, participating in joint activities with her, going out of one's way to help her, and doing so on the basis of compassion and for her sake" (Metz, 2011b: 236). The emphasis to respect and engage in supportive social relationships is not paternalistic, but it comes from the good moral character of the individuals. "Harmony is achieved through close and systematic social relations within the group. Individuals consider themselves as integral parts of the whole community, and a person is socialized to think of himself, or herself, as inextricably bound to others. Ubuntu ethics can be termed anti-egoistic as it discourages people from seeking their own good without regard for, or to the detriment of others and the community" (Metz, 2011a: 539).

For Metz, we have a dignity in virtue of our capacity for loving relationships (2012: 27). In addition, Metz (2013a: 79) argues that the relationality approach in ubuntu entails "a caring relationship which is widely taken to include a certain kind of awareness of the other, one is that is attentive to details about him, not only considering his outward appearance and listening to what he says, but also thinking about what he might be holding back. A large part of the knowledge of the other will involve empathy, which means taking up the other's standpoint and thinking about what it is like to be him."

According to Metz and Miller (2016: 5), in ubuntu, “there is a relationship of sharing a way of life, a matter of considering oneself as part of the whole, experiencing life as bound up with others, and feeling integrated. On the other hand, there is reference to a relationship of caring for one another’s quality of life that is, achieving the good of all, being committed to the good of others, and being concerned for others’ welfare.” In addition to that point, they further argue that “an individual through ubuntu is reconceived as the self-in-relation, a concept that highlights both the fundamentally relational nature of human social ontology, as well as the constitutive importance of relationships for establishing moral agency in the first place” (Metz and Miller, 2016: 7).

3.5. Objections on Metz’s Account of Ubuntu

Metz’s account has encountered some criticism both from the African and Western theorists. In this section, I will not discuss the objection made by Macpherson and Macklin where they are arguing that “the application of African theory by Metz in medical treatment does not raise any moral dilemma because African and two Western moral principles point to the same outcome of an ethical issue.” I have discussed their objection in detail in chapter seven where I show the difference between ubuntu and utilitarianism.

The crucial objection on Metz’s account of ubuntu was illustrated by Ramose. He starts first by acknowledging that it is true that he discusses the etymology of the term ubuntu, but the fundamental problem then is that “Metz fails to discern the philosophic character of ubuntu as –ness as incomparable with the many Western –isms to which he has referred. Methodologically, it is as though Metz is holding in his right hand a green pumpkin that he insists should be compared with the green apple in his left hand. This, he submits as the fundamental flaw of Metz's entire project” (Ramose, 2007: 353).

In reply, Metz says since Ramose notes in his contribution of ubuntu that he grounds his interpretation of ubuntu as an ethic on the etymology of the term, Metz says such a reference does not suggest, or at the very least was not meant to suggest, that this is all he has done. However, Metz does not do this, but simply employing a strictly analytic methodology. Metz therefore, finds his methodological analysis on ubuntu plausible. Metz further argues that for the mere fact that he does not discuss the etymology of the term ubuntu, would not follow from this that the moral theory he defends is “Western” or “non-African.” The argumentative defence of the theory appeals to moral judgments that are more common in Africa than in the West (Metz, 2007b: 376). I think Metz has contributed prolifically on ubuntu as an African theory by adding some values entailed within ubuntu such as identity, solidarity as well as emphasising more on the importance of harmony. Metz seeks to develop a theory of rightness that rationally reconstructs primarily those values associated with talk of ubuntu and cognate terms that are prevalent among sub-Saharan Africans. I think he respectively managed to identify such values. His clarification has made it clearer that in African context an action is wrong if it fails to promote the harmonious relationships where people identify and solidify with others under the maxim of ‘we’. Therefore, his account still suffices even after such an objection from Ramose.

The other objection to ubuntu was perpetuated by Bernard Matolino and Wenceslaus Kwindingwi. They consider “ubuntu an elitist project so conceived by the new black elite. It is conceived both as a restorative move that is aimed at securing the dignity of the black masses as well as an attempt at forging a so-called black identity” (Matolino & Kwindingwi, 2013: 197). They argue that “political elites who invoke ubuntu do so in ways that serve nefarious functions, such as unreasonably narrowing discourse about how best to live, ubuntu is advanced to serve a certain Africanist agenda when it best suites the elite” (Ibid). Besides questions of interpretation on whether ubuntu in itself represents an authentic mode of Afrocentricity, they ask whether “this form of Afrocentricity or any other form for that nature is desirable or appropriate. They question the desirability of ubuntu as a mark/guide of the spirit of the nation, hence, concluding that ubuntu has reached its end and it should be jettisoned.”

In relation to this objection, Metz has replied by saying that “ubuntu is far from at an end; it is rather just getting started. One major part of ubuntu is sharing a way of life, but another is caring for others’ quality of life. Since the state must be concerned for its people and do what it takes to meet their needs, it must produce much more ubuntu when it comes to improving the quality of their lives” (Metz, 2014: 69). Furthermore, ubuntu, when interpreted as an ethical theory, is well understood to prescribe honouring relationships of sharing a way of life and caring for others’ quality of life. Sharing a way of life is roughly a matter of enjoying a sense of togetherness and engaging in joint projects, while caring for others' quality of life consists of doing what is likely to make others better off for their sake and typically consequent to sympathy with them (Metz, 2014: 71).

Basing himself on above points, Metz maintain that "the considerations they have proffered are insufficient to draw their conclusion because ubuntu as an ethical theory has a lot going for it as an account of how individuals and institutions should be moral in the twenty-first century." Another similar view raised by Metz can also be found in Wiredu where he says "ubuntu considers morality as the observance of rules for the harmonious adjustment of the interests of the individual to those of others in society" (Wiredu, 2000: 338). The meaning of ubuntu is clearly articulated as well as the rules pertaining to the practices of ubuntu as an African theory hence, the claim that ubuntu is dead would also attack the advocacy of Afrocentrism.

I also think that ubuntu and its inherent values have not failed because for the fact that some individuals within their societies have failed to adhere to the practices of ubuntu and have preferred to use ubuntu inappropriately to attain their individual goals should not be presumed as a failure of the theory. In this case, Matolino and Kwindingwi's objection on ubuntu does not compromise the ethical efficacy of ubuntu because they specifically object ubuntu through the wrongdoings that are done by politicians not that the theory itself misleads people. As a matter of fact, they have just committed straw man fallacy because they argue "that ubuntu is only advanced to serve a certain Africanist agenda when it best suites the elite" (Matolino & Kwindingwi, 2013: 197. This is not the mandate of ubuntu at all and for the fact that in politics ubuntu is used inappropriately should not be regarded as the dead end of ubuntu.

3.6. Summary of Some Core Ideas of Ubuntu

In this chapter, ubuntu has been discussed as a relational moral theory that considers human beings within the web of social relationships. Ubuntu's ontological being is a being that is in relation with other beings. The prefix ubu- and the stem -ntu are substantially indivisible just like matter and form in hylomorphism. So, since the ontological being of ubuntu is a being that is in relation, then this implies that human beings are integrally interconnected with others. This interconnectedness and interrelationality permeated by ubuntu is not accidental, but it is integrally connected to the substantial essence of human beings. The approach of considering oneself as part of the whole and feeling integrated promotes harmonious relationships of caring for one another's quality of life, being committed and being concerned for others' welfare. The moral theory of ubuntu simply connotes that the self is embedded with others. Consequently, the pragmatic notion of self in relation is considered as a social responsibility to formulate humane relations with others. Ubuntu considers persons as social beings in relationships and interdependence, never as an isolated, atomic individual. This Afro-communitarian theory is best realized in deeds of kindness, compassion, caring and sharing within the web of 'we' where people solidify and identify themselves with others. Ubuntu regards communal relations as a fundamental approach that helps persons to develop their characters.

As a way forward, I will not use the formulation of ubuntu by Ramose in chapter six because he has not clearly clarified the reason why individuals are considered to be indivisible, of which it can be inferred that individuals are also considered to be integrally interconnected and inter-relational with other persons in the community. He only managed to attain the indivisibility of the individuals by showing that the prefix ubu- and the stem- ntu- are indivisible. Hence, reaching the conclusion that ubuntu must be referring to communal connectedness where good moral disposition can be shared by individuals within the society. I therefore, consider the formulation of Metz's account of ubuntu as promising whereby he considers identity, solidarity and harmony as major factors that make ubuntu to be relational. The slide gap within Metz's account is that he did not provide the aspect that makes possible the above three factors within ubuntu. As a matter of fact, in chapter six, I incorporate Etieyibo's analysis of ubuntu because he regards the self as embedded with others. Etieyibo further considers the notion of embeddedness as a force behind engaging in harmonious communal relationships as well as identifying and solidifying with others.

Chapter Four: Obligations and Biomedical Ethics Principles that Constitute Doctor-Patient Relationship

4.1. Introduction

This chapter discusses the obligations and biomedical ethics principles that constitute doctor-patient relation as they have been used as a way of showing respect to the patients by including them in the medical decision making; as well as solving the prevailing moral dilemmas in bioethics. It is argued that while these obligations and bioethics principles are fundamental in bioethics, however, there are some exceptional cases whereby they can be breached. Thus, this denotes that they are not sacrosanct but rather *prima-facie* especially when the principles conflict with each other. The exceptional cases that may lead to the breaching conduct have been identified and discussed. In addition, the obligations and principles of bioethics that protect the welfare of the mentally incapacitated patients have also been discussed and among the other practices, soft paternalism has been supported; while hard or strong paternalism has been rejected in doctor-patient relationship. Furthermore, this chapter generally depicts that autonomy of the patients as one of the fundamental elements constituting doctor-patient relationship is not sufficient because it can be affected by some medical factors, which will then require assistance for the agent or subject from surrogate decision makers. Hence, inter-social relationships as we have seen from the previous chapter on ubuntu can make a significant contribution in doctor-patient relationship.

4.2. Analysis of Informed Consent

The current practice in bioethics requires health care practitioners to disclose all the relevant information to their patients in a manner that would be understandable and does not cause confusion to the patients. Coercion is considered to be unacceptable to patients who have the ability to express their medical preferences because it makes patients to make hurried choices with inadequate information, and thus violate their basic principle of respect for autonomy. It is encouraged that patients should be given an opportunity to make their well-informed refusals in cases where they do not agree with the prescribed treatments. Beauchamp & Childress (2001:78) define informed consent as an "individual's autonomous authorization of a medical intervention or of participation in research. Under the practice of informed consent, patients determine what should happen to their bodies in as far as their autonomous choices do not pose harm to the lives of other people." On the very same point, Glannon has identified two components that constitute the doctrine of informed consent. He says:

- The first component is the doctor's disclosure of medical information to the patient. This includes diagnosis, prognosis, available and alternative treatments, and the risks, benefits, and consequences of having or refusing treatment.
- The second component is the competent patient, who decides whether to accept or forego treatment on the basis of this information. A competent patient is one who understands the nature of his or her condition and the consequences of accepting or refusing an intervention for it (Glannon, 2005: 24).

The first component shows that health care practitioners ought to reveal to the patients all the relevant medical facts regarding the health issues of the patient. All these steps are meant to enable the patients to understand their conditions and the possible solutions to be taken. The second component is more on the decision making by the patient on the provided information by the health care practitioners. Having been informed about the existing health conditions, the patient is now in a good position to reflect upon what he thinks will be in his best interests. "In this regard informed consent serves as an ethical basis for a patient-doctor relationship characterized by mutual respect and shared decision-making. Informed consent shows respect for one's life as a human nature that has cognitive capacities to reflect upon his own preferences which are supposed to be respected without any manipulation" (Glannon, 2005: 24).

The practice of informed consent also helps the patients to take responsibility about their lives by choosing the treatment that will serve their best interest. I support the point raised by (Beauchamp & Childress, 2001: 78) when saying that "informed consent occurs if and only if a patient with substantial understanding and in the absence of substantial control by others intentionally authorizes a health care professional to do something on his body." According to Meisel *et al* (1977: 286) patients must be provided with some quantum of information about treatment before their decision can be considered valid. They must be informed of the risks of the proposed treatments, the anticipated benefits of such treatments, and the likely consequences of a failure to be treated at all. In this case it shows that disclosure of information to the patients does not only depict a step away from paternalism, but it is also a step to incorporate patients in the medical decision making according to their own preferences. This kind of practice rejects the lop-sided power sharing in doctor-patient relationship. “Informed consent is ethically important because it adds a tough safeguard by which individuals can protect themselves against coercion and deception” (O’Neill, 2002: 160). It is vital that patients should be given the information in the language that they can understand before they can participate in the clinical trials. This approach shows respect to their dignity. According to Council for International Organizations of Medical Sciences (CIOMS) in collaboration with the World Health Organization (WHO) (2016: 33) “researchers have a duty to provide potential research participants with the information and the opportunity to give their free and informed consent to participate in research, or to decline to do so, unless a research ethics committee has approved a waiver or modification of informed consent.” Informed consent should be understood as a process, and participants have a right to withdraw at any point in the study without retribution. In addition, CIOMS and WHO provides that researchers have a duty to:

1. Seek and obtain consent, but only after providing relevant information about the research and ascertaining that the potential participant has adequate understanding of the material facts;
2. Refrain from unjustified deception or withholding of relevant information, undue influence, or coercion;
3. Ensure that the potential participant has been given sufficient opportunity and time to consider whether to participate (CIOMS and WHO, 2016: 33).

In addition to the above points on informed consent, the International Covenant on Civil and Political Rights (1966: 175) Article 7 of the Covenant states "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation*". Informed consent is considered to be the essential tool to help the research participants to make well informed decisions before they can participate in the clinical trials. Thorough information should be provided to the participants including their rights to withdraw from the trials. Deception and persuasion at this stage is considered to be unacceptable because such acts do not show respect to persons and they compromise the voluntary participation of the research participants. “Informed consent implies that the researcher and participant have entered into a voluntary agreement without any element of coercion and that the participant is fully knowledgeable of the implications of participation” (Karim *et al*, 1998: 637). On the same point, Ames Dhai (2008: 29) argues that “informed consent is not merely a legalistic exercise but must be seen as a process that empowers our patients to exercise their capacity to plan and execute their decisions regarding their health, taking into consideration their own values and beliefs.”

In South Africa, the practice of informed consent is protected under the Bill of Rights in Chapter twelve (12), section 12 (s2) which stipulates that “everyone has the right to bodily and psychological integrity, which includes the right: to make decisions concerning reproduction; to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent” (Currie and Wall, 2005: 269). Buchanan & Brock (1989: 26) argue that “informed consent in medicine requires free and informed consent of a competent patient to medical procedures that are to be performed.” On the same point, Etieyibo (2013: 2) sees “informed consent as the process by which a fully competent (rational, mentally mature) patient or subject participates in choices about his or her healthcare and, on the other, as placing a legal and ethical duty on healthcare professionals regarding the care of patients.” This entails a kind of relationality where medical alternatives and prescriptions are made in collaboration with the healthcare practitioners and family members in ways that will satisfy the patient’s best interests.

While patients may decide in collaboration of the above-mentioned parties, it is worth noting that at the end of the day what matters are the preferences of the patient. From these stipulated arguments it follows logically that “respect for the person requires a patients’ autonomous consent be obtained before any treatment or procedure involving the patient can be carried out, and that no consent will be autonomous unless it is fully informed” (Harris, 1985: 205). This means that consent serves as an authorization that the patient has understood the given information and as a matter of fact s/he allows the healthcare practitioner to go ahead with the treatment. In order for consent to be valid, patients should have the necessary mental capacity to understand the issues entailed in the prescribed treatments. The notion of mental capacity has been defined by Doyal & Tobias as:

> An adult patient who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another treatment being offered. This right of choice is not limited to decisions which others might regard as sensible; it exists notwithstanding that the reasons for making the choice are rational or irrational (Doyal & Tobias, 2001: 186).

An acceptable process of informed consent requires voluntariness. "When competent patients consent to a procedure or treatment, it means then that they agree both with the goal and with the means towards its achievement because at the end of the day, the health care professionals will be implementing what was in the best interest of that particular patient." (Beauchamp & Childress, 2001: 78). The provided medical information ought to be in a form that the patient can understand otherwise patients will not be able to determine how available alternatives will serve their best interests. Bowling and Rowe (2005:914) argue that "a preference can only be true if based on full, clear, and unbiased information about the treatment options."

Kravitz & Melnikow elaborated further on the preferences of the patients by indicating that "respect for patient preferences is the moral attitude that disposes one to refrain from interference with the autonomous beliefs and actions of others in the pursuit of their goals. The recognition of patient preferences respects the value of personal autonomy in medical care." (Kravitz & Melnikow, 2003: 584). On the other hand, Currie & Waal (2005: 275) argue that "patient preferences are legally significant because all persons have a fundamental right to control their own body and the right to be protected from unwanted intrusions or unconsented touching. Bodily intrusions without consent constitute an illegal battery." Their argument is valid because failure to obtain sufficient informed consent can result into malpractice.

According to Harris (1985: 206) "disclosure will not be complete unless it includes a description of the proposed treatment, an indication of the alternatives, an outline of the inherent risks of death or serious bodily injury and of any problems of recuperation that may be anticipated, a clear description of any likely side-effects and a statement of the long-term prognosis.”. However, various approaches of disclosure of information have been suggested by Beauchamp & Childress, including the “professional practice standard, the reasonable person standard, and the subjective standard.” Beauchamp & Childress indicate that:

> The professional practice standard views adequate disclosure as determined by a professional community’s customary practices. Disclosure of possible treatment is a task that belongs to physicians because of their professional expertise and commitment to the patient’s welfare. The reasonable person standard uses the guideline of a hypothetical reasonable person. The authority is therefore shifted towards the patient. While the subjective standard of disclosure, the adequacy of information is judged by reference to the specific informational needs of the individual person, rather than the hypothesized reasonable person (Beauchamp & Childress, 2001: 81-83).

For Beauchamp & Childress, “the subjective standard is a preferable moral standard of disclosure, because it alone acknowledges persons’ specific informational needs. They suggest that disclosure should be achieved by means of active participation by patient and physician through the mutual exchange of information to facilitate the decision-making process.” (Beauchamp Childress, 2001: 81). The process of disclosing the information should conform with the principle of beneficence because disclosure of information has the possibility of causing harm to the patients. Social support on this point plays a very fundamental role especially when the patient is about to receive the bad news or after receiving the bad news about his/her life saving treatment.

While it is true that informed consent is viewed to be the fundamental principle that shows respect for autonomy of the human beings, however, there have been some other exceptional cases whereby the information can be withheld. Coetzee (2003: 268) stipulates that “withholding distressing information from patients is a very old practice among doctors who believe in the ethical principle of nonmaleficence. This practice enjoys a measure of legal endorsement in the form of a so-called 'therapeutic privilege' which restricts the doctor's duty to inform where the disclosure of information could harm the patient.” The intention behind the practice of therapeutic privilege is to avoid causing more harm to the patient who is deemed vulnerable due to illness.

Among other documents, the Constitution of South African under section 32(1) “makes public-sector information available on a right to know unless there are good reasons for withholding it. Information in public hands is, after all, the public’s information and should be accessible to the public, unless disclosure will cause harm to legitimate government interests of the rights of others” (Currie and Waal, 2005: 701). This shows that the principle of respect for autonomy and informed consent of the public are not absolute, hence, therapeutic privilege can be considered.

Therapeutic privilege refers to an idea that “a doctor can withhold medical information when it is potentially harmful to a patient” (among others see: Glannon, 2005: 32; Beauchamp and Childress, 2001: 84; McQuoid-Mason and Dada, 2011: 417; Coetzee, 2003: 268). The legal support of paternalism in a form of therapeutic privilege in South Africa is entailed in the Mental Health Care Act 17 of 2002 section 13(3) provides that a mental health care provider may temporarily deny mental health care users access to information contained in their health records, if disclosure of that information is likely to: (a) seriously prejudice the user; or (b) cause the user to conduct himself or herself in a manner that may seriously prejudice him or her or the health of other people. On the same point of withholding the information, the National Health Act 61 of 2003 (s6(1)(a)) also provides that “when obtaining informed consent, health care providers must inform patients of their health status except in circumstances where there is substantial evidence that such disclosure would be contrary to the patients’ best interests.

Therapeutic privilege is grounded on the principle of nonmaleficence which clearly stipulates that harm should be avoided. Following this principle, health care practitioners feel obliged that their patients should not be harmed either physically or through the provided information. For example, if a patient has a medical history of kidney failure and s/he visits the hospital every month to be dialysed and suppose on one visit review of body systems revealed heart failure; then the physician in charge may feel inclined to withhold the diagnosis to the patient because the disclosure of information will pose harm to the patient. The most fundamental “objection to the therapeutic privilege is that it is paternalistic and undermines the patient's right to self-determination, which is the cornerstone of the informed consent doctrine" (Coetzee, 2003: 269). On the point, Coetzee further says:

> Withholding information from patients (or lying to them) has the potential to undermine the trust placed in doctors. Patients who discover the truth having been deceived whether through getting a second (or further) opinion, or by discovering it through the materialization of an undisclosed risk, the experiencing of an undisclosed discomfort, the lack of experiencing a promised benefit, or (in the case of a terminal disease) the instinctive knowledge of death's approach-are likely to lose faith in the doctor who deceived them, and perhaps even in the medical profession. Once a patient has been deceived by disclosure, it becomes ever more difficult to break the bad news, precisely because the patient may, upon disclosure, in addition to the anxiety expected upon a disclosure at the outset, lose trust and feel betrayed (Coetzee, 2003: 276-7).

Therapeutic privilege is a clear approach of consequentialism which focuses more on the good end results regardless of the means being used. This practice is also along the practice of the principle of double effect because it produces good results while on the other side it distorts the trust in doctor-patient relationship. "This principle is invoked to justify claims that a single act having two foreseen effects, one good and one harmful, is not always morally prohibited. This principle incorporates a pivotal distinction between intended effects and merely foreseen effects" (Beauchamp and Childress, 2001: 129). In addition, this principle says "the agent must intend only the good effect. The bad effect can be foreseen, tolerated and permitted, but it must not be intended" (Ibid. p. 129).

In relation to therapeutic privilege, the doctor who decides to withhold the information that is potentially harmful to the patient will be intending only the good effects, while the probable distortion of trust in doctor-patient relationship will be considered as the foreseen effects. "The 'right to the truth' involves disclosing all the pertinent facts to a patient so that an informed decision can be made. Furthermore, in some situations, the doctor is confronted with a moral dilemma, caught between the necessity to inform the patient (principle of autonomy) and the desire to ensure the patient's well-being by minimising suffering (principle of beneficence and nonmaleficence)" (Richard *et al.* 2010: 353). The practice of minimising the suffering of the patients by withholding some certain information may be viewed as a slide way of falling back into medical paternalism. Therapeutic privilege rests on the fallacy of assumption that the patient can benefit from the act of withholding information. Coetzee has also picked this point when he says "therapeutic privilege has been criticized on the basis that the medical profession lacks the expertise to predict (or at least is susceptible to a high error rate in assessing) whether disclosure of certain information to a particular patient will have a positive or negative therapeutic effect, or no therapeutic effect at all" (Coetzee, 2003: 285). In addition, Kant also argues that:

> We are tempted to make exceptions to the rule against lying because in some cases we think the consequences of truthfulness will be bad and the consequences of lying will be good. However, we can never be certain about what the consequences of our actions will be- we cannot know that good results will follow. Lying in any circumstances is the obliteration of one's dignity as a human (Kant, 1997a: xxiii).

The act of assuming the good results by lying or deceiving the patients is questionable through Kantian rules of categorical imperative especially because lying cannot be willed to become the universal law. According to Kant (1997a: xxii) "respecting someone as a rational being also means respecting her right to make her own decisions about her own life and actions. This leads to particularly strong injunctions against coercion and deception, since these involve attempts to take other people's decisions out of their own hands, to manipulate their wills for one's own ends."

In Kantian perspective, therapeutic privilege entails an element of deception and hence, it undermines the rational decision making that is possessed by human beings. Kant remains strong on the point that "we must tell the truth so that others may exercise their own reason freely- and that means that, in telling the truth, we are inviting them to reason together with us, to share in our deliberations. We need the cooperation of others; we must also be prepared to give them a voice in the decision about what is to be done" (Kant, 1997a: xxiii). The only challenge regarding Kantian argument is its absolutism for telling the truth to every human being regardless of their health conditions. In the medical practice such an approach is likely to pose harm to the patients because sometimes they may be terminally ill whereby truth telling may not be in their best interests. While it is true that the notion of doctor-patient relationship demands an element of trust between the two parties, there are also other circumstances that can justify the practice of therapeutic privilege. Disclosure of medical information is also prima facie and not absolute in bioethics like confidentiality and autonomy because it can raise a moral dilemma that entails the double effects of respecting the autonomy or abiding by the principle of beneficence and nonmaleficence. According to Patrick Van den Heever, the following occasions should be recognised as exceptions to the medical practitioner's general duty to disclose in respect of treatment, namely if:

> (i) Full disclosure could be life-threatening to the patient or could detrimentally affect his physical or psychological welfare; (ii) full disclosure might influence the patient's decision-making to such a degree that it may prevent him from coming to a rational decision; (iii) full disclosure would possibly cause such anxiety and distress that it may jeopardise the final outcome of the proposed medical intervention; (iv) the patient is moribund and full disclosure would be insensitive or inhuman; (v) disclosure could seriously prejudice third parties (Van den Heever, 2005: 420).

The guidelines that regulate therapeutic privilege need to be clearly stipulated so that it cannot be abused and distort the notion of doctor-patient relationship. Therapeutic privilege cannot be totally rejected in medical ethics because disclosure of information is also prima facie because it cannot be concluded that autonomy always takes precedence over beneficence. Each and every medical case has its merits and demerits, hence, exceptional cases within the health practitioners’ duties and the rights of the patients will always be faced with the moral dilemmas. I therefore support the suggestion made by Pucci *et al.* (2003: 53) that “when a physician claims therapeutic privilege and conceals relevant information about the diagnosis he/she must have available accurate and expert clinical assessment. This assessment must reveal a psychopathological condition which may worsen, due to the communication of the diagnosis, to the point of compromising the patient's self-determination.”

4.3. The Notion of Patients' Competence

The notion of competence for the patients is regarded as an essential element in bioethics. Mental competence enables patients to authorize the treatment that they prefer. It is through this element of competency that makes it possible for patients to act autonomously and fulfill the requirements of informed consent. The link between the notion of competency and autonomy has also been discussed by Etieyibo. He argues that "competency is conceptually linked to informed consent and autonomy. It concerns the capacity of a person to act on his/her own behalf; consequently, the evaluation of patient competence is an essential element of every doctor-patient relationship" (Etieyibo, 2013: 1). He further says:

> Competency is a legal term which refers to the capacity of a person to act on his/her own behalf. Within the medical profession and as it relates to a patient it is broadly construed as the ability of a patient to understand the information that he/she is presented, to appreciate the consequences of acting or not acting on that information, and to make a choice on the basis of such information. Simply put, competency is about understanding and choice; understanding the medical condition, the natural course of the medical condition, the proposed treatment intervention, the risks and potential benefits, the consequences of treatment or intervention refusal, viable alternatives and choosing according to one's understanding (Etieyibo, 2013: 2).

The expression of the medical preferences required the patients to be mentally capacitated in order to understand the information regarding their prescribed treatments together with the risks and benefits that are likely to follow. The above point made by Etieyibo clarifies that the notion of mental competence enables patients to make well informed medical decisions or to make informed refusals regarding the suggested treatments without being coerced by anybody. The other explanation similar to the one given by Etieyibo is the one given by McQuoid-Mason and Dada (2011:99). They analyse a person with mental capacity as a person who "understands the nature and effect of what he or she is doing. While a person without mental capacity is unable to understand the nature, effects and consequences of the proposed health services" McQuoid-Mason and Dada, 2011: 99). For James Drane (1984: 925) competency assessments focus on the patients' mental capacity, specifically the mental capacities to make an informed medical decision. On the same point Beauchamp & Childress (2001: 72) explain that "a person is usually considered competent if s/he is able to understand a therapeutic or research procedure, to deliberate regarding its major risks and benefits, and to make a decision in light of this deliberation." Mental competence is also viewed by Edwards (2010: 275) as referring to the "set of mental capacities that are required for a particular task. The term has gained a legal and medical significance associating it with decision-making and paternalism; while mental incompetence disrupts our self-determination and undermines our ability to form and pursue our goals."

According to Gareth Owen *et al*. (2008: 1) significance of competence "is linked to the principle of autonomy, which demands that an individual's autonomous decisions relating to the acceptance and refusal of medical treatment be respected." The common factor about the arguments on competence is that patients should be in a stable mind in order to understand the provided information. Then after he has grasped the facts, he can make his autonomous decisions. The assessment of competence "has become increasingly important with the move away from the paternalistic role of healthcare professionals towards a greater emphasis on an individual's own treatment decisions" (Okai *et al*, 2007: 291).

According to Buchanan & Brock (1989: 18) "competence is to be understood as decision-making capacity, but the notion of decision-making capacity is itself incomplete until the nature of the choice as well as the conditions under which it is to be made are specified." Buchanan & Brock argue that:

> Competence is decision-relative, not global, because a patient may be competent to make a particular decision at a particular time, under certain circumstances, but incompetent to make another decision or even the same decision, under different conditions (Buchanan & Brock, 1989: 18).

They have noticed that competence cannot be universal, but it is decision-relative in a sense that there are some other incidences where patients can be deemed to be mentally competent to make their decisions while at the same time within the same incident, they can be incompetent. For instance, the patient who is suffering from a leg cancer can be competent to decide that he wants the physicians to cure the cancer but if the cure will be the amputation, the same patient can be incompetent to consent to amputation. Another scenario can be for the woman whose uterus has cancer while at the same time being pregnant. She can agree with the physician to clean the cancer in her uterus but may be incompetent to give consent if the physician can inform her that the procedure of cleaning her uterus will also affect her pregnancy/fetus. In this case, it is clear that competence is relative to case to case. On the same point, Anita Damle argues that:

> Where treatment choices have different and well understood outcomes, what matters most when deciding which treatment is best is the patient's preferences. However, even the preferences of patients who have capacity may be based on misinterpretation or perceived benefit of less effective drug or treatment. While patients' preferences are important but again, they are not always in their best interest. For example, hypomanic patients may prefer to continue with less effective drugs so as to remain in an aroused grandiose and elated state, and psychotic patients may have a delusional explanation for their preference (Damle, 2009: 309).

While it is true that the notion of competence can be associated with one's autonomous decision-making that is basically based on that person's self-interests; but the above point clearly depicts that competence does not imply that patients will always make best decisions. That is, their personal preferences may fail to promote their welfare even though they have been deemed to have the capacity to decide. This notion gives the patients an authority to weigh the pros and cons of the prescribed medical procedures by their health care practitioners, but they may still fail to choose the best treatment for themselves. On the other hand, it should be noted that the notion of competence does not give patients an absolute autonomous right to choose and refuse every prescribed treatment that may be harmful to other people's welfare. There are legal documents that stipulate that "every human being has an inherent right to life. No one shall be arbitrarily deprived of his life" (for representative statements see, South African Constitution, Chapter Two, Section 11; Constitution of Lesotho, Section 5 (s5)). However, for adult patients who are mentally competent, "there is now a rather broad agreement in public opinion, in the writings of bioethicists, and in the law that a competent patient has the right to refuse medical care even life-sustaining medical care" (Buchanan & Brock, 1989: 90).

In order for the mentally competent patients to make well informed medical decisions they need to be provided with frank disclosure of the medical facts, otherwise they are likely to make uninformed decisions if ever the provided information was inadequate. Unethical conduct by health care practitioners such as being rude to patients or using too technical language intentionally can distort the notion of doctor-patient relationship and this conduct can cause confusion to the patients. Such confusion will also lead to incompetency of the patients. "The central purpose for assessing competence is to determine whether a patient retains the right to accept or refuse a particular medical procedure, or whether that right shall be transferred to a surrogate" (Buchanan & Brock, 1989: 23). Patients whose competencies keep on fluctuating should not be allowed to make the medical decisions alone without the concurrence of the family. It is not that much easy for one to make sound decisions while going through a vulnerable state due to illness. According to Anderson & Mukherjee (2007: 648) "symptoms of schizophrenia may threaten the decisional capacity element of the informed consent process. Avolition is a common feature of the diagnosis and is characterized by an inability to make decisions. There is also evidence that the decreased neuropsychological functioning and negative symptoms (such as apathy, anhedonia, flattened affect) experienced by many patients with schizophrenia are associated with impairments in decisional capacity."

Patients who have shown the symptoms of schizophrenia will not be able to make sound medical decision because they render people to think rationally about the decision at hand. For Anderson & Mukherjee (2007: 648) the capacity for voluntarism refers to an individual's ability to act freely and without coercion and is crucial for obtaining meaningful informed consent. Then this assertion clarifies that meaningful informed consent can be obtained from patients that are not influenced when making their decisions or at least those that do not have mental disabilities. Hence, this is why Beauchamp & Childress (2001: 70) argue that "a person can be viewed as competent to make decisions on certain things, whereas incompetent to make others because competence in one person also varies over time." Having said all these, I will now turn to discuss the need for the concurrence of the surrogate decision makers for the patients who are deemed to be mentally incapacitated. However, it should be noted that emergency treatment should always be offered to the patients without delaying to get the consent from their medical proxies. According to McQuoid-Mason and Dada (2011: 94) "consent in an emergency refers to situations where patients are unable to give consent and will be faced with death or reversible damage to their health if treatment is delayed and they have not refused consent for such treatment.” In other words, the state of emergency requires that patients must be treated urgently unless the patient has a written advance directive standard where s/he has expressed the preferences stating the unwanted treatments. Otherwise many countries have issued the ethical guidelines on good practice stating that “no patients should be denied treatment during emergency” (HPCSA guidelines, 2014).

4.4. Surrogate Decision Making

The concurrence of the surrogate decision makers in medical practice is very fundamental for patients who are mentally incapacitated. For McQuoid-Mason and Dada (2011: 99) “consent on behalf of mentally incompetent patients refers to situations where somebody else who has legal capacity gives consent on behalf of such patient. Surrogate decision makers play an important role in bioethics issues because they are expected to promote the welfare of the patients.” In this case, the surrogate decision makers are expected to act in such a manner that the patient would have acted while mentally competent. This approach reflects the importance of the element of trust in bioethics because medical proxies are expected to make decisions that would be in the best interest of the incapacitated patient. There are various situations that can lead a person to be mentally incompetent, among others; one can be a minor, very aged people and/or severe mental disability. “If a patient is not competent to choose or to refuse treatment, a hospital, a physician, or family members may justifiably exercise a decision-making role or go before a court or other authority to resolve the issue before implementing a decision” (Beauchamp & Childress, 2001: 98).

Health care professionals have an obligation to guide the surrogate decision makers when choosing the best decisions on behalf of their relatives especially in circumstance whereby the incompetent patient did not express his medical preferences. “The advance directive standard is the process whereby someone who has been autonomous and competent before, made his/her wishes regarding treatment known or appointed someone specifically to act as a surrogate to make these decisions on his or her behalf” (Beauchamp & Childress, 2001: 152). Advance directive standard also depicts the fact that patients are currently considered as self-regulating beings because they can voluntarily express their future life plans.

Advance directive standard enables mentally competent patients to express their preferences while still competent. This practice also helps to avoid conflicts of medical preferences during the time of incapacitation. Adequate medical information ought to be provided to the surrogate decision makers in order to help them to make sound decisions on behalf of their patient. Health care workers are not expected to neglect the medical proxies if they are of the view that their choices could have adverse effects on the patients' welfare. In cases whereby, the family members are adamant to continue with their preferences even after they have been informed by the health care practitioners that their medical choices are not in the best interest of the patient, then it is allowed to overrule their decisions. In support of this clam I would like to refer to the point made by Beauchamp & Childress (2001: 157) when they say "the courts should be invoked when there are good reasons to seek to disqualify the family or health care professionals in order to protect an incompetent patient's interests or to adjudicate conflicts over those interests."

Buchanan & Brock have put forward three guiding standards to be considered in surrogate decision making which are: the advance directive, the substituted judgment, and the best interest standard. They consider "advance directive standard as the process whereby someone who has been autonomous and competent before, made his wishes regarding treatment known or appointed someone specifically to act as a surrogate to make these decisions on his or her behalf" (1989: 88). Regarding the practice of advance directive standard, it is acceptable to fulfil the best wishes of the patient and allow the nominated medical proxy to decide on behalf of the patient during his/her mental incapacitation. Therefore, patients' preferences can be upheld and exercised by the medical proxy. "The substituted judgment standard instructs a medical proxy to choose as the incompetent individual would choose in the circumstances whereby he or she would be competent" (Buchanan & Brock, 1989: 112).

Substituted judgment standard entails some shortcomings because it is not easy to predict how the incompetent patient would have chosen had they still had the mental capacity and it is even worse incases whereby the patient has always been mentally incapacitated due to mental disability for instance. On this point, I concur with Buchanan & Brock (1989:121) when arguing that "under substituted judgment there is always a fear that the family, whether intentional or not, may misrepresent what the individual would want if competent. This worry is exacerbated by the fact that the physician may have no independent evidence, apart from the family's statements of what the individual would want." In instances where there are not written advance directive standards, it is possible that family members may not reach consensus about the best treatment for the patient as was in the case of Terri Schiavo. The medical case below depicts the conflict of medical preferences between family members especially in the case whereby the patient did not express his or her medical preferences through advance directive standard. Quill reports that:

> Terry Schiavo from U.S.A suffered a brain damage in 1990. She was living at the mercy of a tube that supplied a nutrient solution to her body. Doctors ruled that she was in a persistent vegetative state (PVS), with no real consciousness or chance of recovery. Terry Schiavo had been sustained by artificial hydration and nutrition through a feeding tube for 15 years. Terry's preferences or wishes and values were unknown since she unfortunately left no written advance directive; the next step would be to meet with her closest family members and try to understand what she would have wanted under these medical circumstances if she could have spoken for herself. Her husband, Michael Schiavo, was locked in a very public legal struggle with her parents and siblings about whether such treatment should be continued or stopped.
>
> On this case, Michael Schiavo (the husband) of Terry was made to be her legal guardian under Florida law which designates the spouse as the decision maker above other family members if a patient becomes irreversibly incapacitated and has not designated a health care proxy. Her husband won the legal battles by arguing that his wife would not have wanted to live in her condition, thereby calling for the disconnection of the tube. This was against the views of Terri's parents and family; they argued that their daughter wouldn't have opted for the disconnection of the tube because she is a Christian and she beliefs in sanctity of life (Quill, 2005; 352: 1630-1633).

In Terry Schiavo’s case where substituted judgment standard had to be applied; indicates a clear scenario of conflict of medical preferences between family members. This difficult case could easily have been avoided had there been a clear articulation of Terry’s preferences. Her medical situation was irreversible making it impossible to ever attain her preferences to resolve the dispute between her spouse and her parents.

In cases where the incapacitated patient did not leave a testament and it is impossible to apply the substituted judgment standard, then this would call for the application of best interest standard. “The best interest principle states that a surrogate is to choose what will best serve the patient’s interests, in other words, that which will maximally promote the patient’s good” (Buchanan & Brock, 1989: 94). Sometimes in life we are faced with circumstances where we need to exercise the best medical preferences not only for ourselves, but also for our beloveds who may be in incapacitated states without expressing their preferred medical choices. Hence, “the best interest principle instructs us to determine the net benefit for the patient of each option, assigning different weights to the options to reflect the relative importance of the various interests they further or thwart, then subtracting costs or disbenefits from the benefits for each option” (Buchanan & Brock, 1989: 123). The reality of it is, the lives of patients that have lost their cognitive ability to indicate their preferred medical choices hang at the mercy of choices expressed by others. Literally, the difference between life and death for them depends on what the next person views to be best for them. Thus, this huge responsibility requires one to act benevolently.

What is most challenging about the best interest standard is that the medical proxy has to make decisions which in most cases may be about circumstances they themselves have never been exposed to; making it undeniably the case that the decisions may not necessarily be in the best interest of the incapacitated patient. As a way of supporting this position, I refer to the argument raised by Buchanan & Brock (1989:126) when they say “a patient in a persistent vegetative state (permanently lacking all consciousness) will experience no pain or discomfort from life-sustaining efforts. So, it cannot be said that it is in the patient’s best interest to withhold such systems because the pain and discomfort would outweigh any benefit to the individual.” What will remain intriguing about pulling the plug on patients in a vegetative state is how can we ever justify something that leads to the death of a patient to be in their best interest. In a way, it is an undeniable fact that medical proxies have a moral duty to decide in such a way that they promote the best interests of patients. It goes without saying that even the decisions made by the mentally competent patients can also be limited. In the next discussion, I will review the elements that can limit the competent patients' rights to refuse the prescribed treatments.

4.5. Limitations of Patients' Autonomous Preferences

The right to autonomy does not connote absolute decision making even whereby ones' medical decisions will pose harm to others. On the other hand, in medical ethics it is said that "competent patients have got the right to accept or refuse any kind of medical procedure that they do not like, even if other people may be convinced that, accepting it would be into their benefit" (Glannon, 2005: 24). However, there are some limitations of the competent patients' rights to refuse care or treatment. For instance, a patient who is infected with airborne infections such as tuberculosis (TB) and at the same time refuses to take the treatment can justifiably be forced to take the treatment because s/he poses a threat to life of people living around. This limitation of the (TB) patient can be related to harm principle expressed by John Stuart Mill. According to him "the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others" (Mill, 1962: 165). Mill's point is also similar to the Penal Code of 2010 in Lesotho under Section 36 on suicide which provides that "No offence is committed by a person who attempts to take his or her own life." The restriction of one's liberty for Mill and the demands of the Penal Code of 2010 in Lesotho will be exercised only when the actor's action poses harm on other persons. Otherwise the person in these two observations is allowed to kill himself.

O'Neill (2002: 26) has also identified the limitations on the autonomous decisions on the patients. According to her the "autonomous patient is not actually going to be allowed to determine his or her own treatment. He or she is only to be allowed to accept or refuse treatment proposed by professionals." She further illustrated that anyone who doubts this has only to consider what happens to a patient who demands treatment not available in a particular context. "On this view what is misleadingly spoken of as 'patient autonomy' masks the fact that the patient's role is to say yes or to do without treatment" (O'Neill, 2002: 26). In this case, the patients' autonomous preferences can be limited by the available alternatives proposed by the health care professionals. Autonomy on its own does not imply that patients will be granted whatever the treatment they have initiated even if it is against the standard of medical practice.

Another limitation is that "the right to refuse treatment or care is not a right to receive whatever services the patient demands. Whether or not there is a general moral right to health care is a much-disputed question" (Buchanan & Brock, 1989: 92). Informed consent and autonomy are restricted by the legal framework. For instance, if abortion, euthanasia or physician assisted suicide are prohibited in a particular country, a competent patient cannot demand such. This shows that self-regulation cannot be fulfilled without some limits. For example, in South Africa "euthanasia is governed by the common law which provides that active euthanasia is unlawful and constitutes murder" (McQuoid-Mason and Dada, 2011: 186). In Lesotho abortion is regarded as a violation of the law. However, there are some exceptional clauses related to abortion. According to the Lesotho Penal Code Act it is stated that:

> It shall be a defense to a charge under this section that the act intended to terminate pregnancy was performed by a registered medical practitioner:
>
> (a) In order to prevent significant harm to the health of the pregnant female person, and the person performing the act has obtained a written opinion from another registered medical practitioner to the effect that the termination of pregnancy is necessary to avoid significant harm to the health of the pregnant female person.
>
> (b) In order to prevent the birth of a child who will be seriously physically or mentally handicapped and the person performing the act has obtained in advance from another registered medical practitioner a certificate to the effect that the termination of the pregnancy is necessary to avoid the birth of a seriously physically or mentally handicapped child (Lesotho, Penal Code Act, 2010: s45 (2)).

The above legal framework constitutes restrictions to one's autonomy except on the circumstances stipulated in the Penal Code. In addition, "the right of the competent patient to determine future treatment and care decisions by an advance directive is not a right to refuse treatment when doing so would impose significant health risk to others" (Buchanan & Brock, 1989: 110). Following the same line of argument, Beauchamp & Childress (2001:65) assert that "respect for autonomy has only prima facie standing and can sometimes be overridden by competing moral considerations. Examples include the following: If our choices endanger the public health, potentially harm others, or require a scarce resource for which no funds are available, others can justifiably restrict our exercise of autonomy." This means that an individual's autonomy does not take precedence over the public's welfare especially whereby expressed preferences can disadvantage others. "Competent patients who choose to forgo life-sustaining medical treatment are protected by common law and by statutory and constitutional rights, even though their rights are not absolute, and must act along state interests of preserving human life; preventing suicide; safeguarding the integrity of the medical profession; and protecting innocent third parties" (Majjete, 1998: 5). The principle of autonomy is not beyond the existing laws within the different countries, but it is limited by the very same laws.

4.6. Paternalism

Generally, paternalism can be justified when dealing with mentally incapacitated patients, while on the other hand some exceptional cases have been identified that autonomous choices of a mentally competent patient can be overruled if his refusal poses harm to other people's welfare; such as Tuberculosis (TB) patients who refuse to take the treatment. It is also accepted that they can be forced to take the (TB) treatment. According to Jayne Breeze (1998: 260) "paternalism can be defined as an action which restricts a person's liberty justified exclusively by consideration for that person's own good or welfare and carried out either against his present will or his prior commitment." A similar definition was discussed by Etieyibo (2013:3) whereby he defines paternalism as referring "to a class of actions by a person, organization or state that limit some person or group's liberty or autonomy. Such interference or limitation of autonomy is generally motivated by the welfare of those whose autonomy is interfered with that is, the claim that such interference makes them better off or protected from harm."

There are different forms of paternalism. There is soft and hard paternalism. Beauchamp & Childress (2001: 178) takes hard paternalism to refer to "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences are overridden." According to Etieyibo, soft "paternalism is justified if the person being interfered with is not acting voluntarily or knowledgeably" and hard paternalism "is sometimes justified even in cases where the person being interfered with is acting voluntarily or knowledgeably" (Etieyibo, 2013: 3). As Thomas Percival quoted in Beauchamp & Childress (2001: 12) argued that "during paternalistic era non-maleficence and beneficence fix the physician's primary obligations and triumph over patient's preferences and decision-making rights in circumstances of serious conflict."

Currently, the doctor-patient relationship in biomedical ethics operates under the guidance of four ethical principles as seminally initiated by Belmont Report and elaborately developed by Beauchamp and Childress. These ethical principles provide a comprehensive framework for ethical decision-making in medical practice. The principle of beneficence and non-maleficence can be conceived in a consequentialist way because they require us to do good and avoid causing harm to others. However, focusing only on the end results without also considering the justifiable means may take us back to the practice of hard paternalism which is currently not encouraged in the contemporary bioethics.

The practice of paternalism intentionally violates the principle of autonomy with the hope of attaining the best consequences for the person whom the decision is made for. "During the practice of paternalistic approach, physicians were patient's decision makers; they made decisions about the best thing to do and about what and how to tell patients about their circumstances" (Cassel, 2000: 16). From the Kantian perspective, paternalism for mentally competent patients will not be justifiable because it does not show respect to their autonomous decisions and it treats them as means to an end due to the fact that their known preferences are intentionally violated. In support with Kantian view Joel Feinberg (1988: 260) says that "interference with a person's acting as he wishes within the self-regarding sphere is never justified in order to promote his good; instead, it is justified only if the person's conduct is substantially non-voluntary or to establish whether the conduct is voluntary." However, the current medical practices in bioethics accept that the principle of autonomy is prima facie and as a matter of fact autonomous decisions from mentally competent patients can justifiably be restricted if they pose harm on other people.

Hard Paternalism is considered unfavourable primarily for its distraction of the doctor-patient relationship and its violation of the patients' autonomy and right to informed consent. Patients feel respected when they are involved and given an opportunity to express their medical choices. Hard Paternalism is viewed as an unjustified interference with the free will of patients who are mentally competent to express their autonomous medical preferences because it undercuts what they want. Hard paternalism is viewed as a practice that violates doctor-patient relationship and which leads to medical malpractice.

On the other hand, there may be a case to be made for hard paternalism. So, for example, if we look at the South African context, the law has recognized paternalism under the name of "therapeutic privilege," which refers to "an idea that a doctor can withhold medical information when it is potentially harmful to a patient" (see Glannon, 2005: 32; Coetzee, 2003: 268). The legal support of paternalism in a form of therapeutic privilege in South Africa is entailed in the Mental Health Care Act 17 of 2002 section 13(3) as well as in the National Health Act 61 of 2003. The demands of respect for autonomy and informed consent in the situation of therapeutic privilege are viewed to be *prima facie* because disclosure of horrendous medical news will pose harm to the patient. In addition, autonomous decisions can be restricted in some certain cases such as the one mentioned above for the patient infected with TB. Beauchamp and Childress have stipulated conditions that can justify hard paternalism as follows:

- A patient is at risk of a significant, preventable harm.
- The paternalistic action will probably prevent the harm.
- The projected benefits to the patient of the paternalistic action outweigh its risks to the patient.
- The least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted (Beauchamp and Childress, 2001: 186).

These four conditions according to them justify hard paternalism and these conditions depict that it is not always the case that hard paternalism can be viewed as violating the autonomy of the patients, but it is sometimes needed as a way of promoting the welfare of the patients as it is required by both the principle of beneficence and nonmaleficence. In contrast with the above-mentioned elements stipulated by Beauchamp and Childress, O'Neill says;

> Even if medical paternalism can benefit some patients, it is ethically unacceptable for two reasons. First, it unnecessarily gives professionals powers that can also be used to harm patients. Secondly, even the proper uses of those powers, paternalists assume that they will only be properly used, requires and condones an unnecessary degree of concision or deception. Failure to restrict professional powers to act paternalistically assumes falsely that these powers are needed for the proper practice of medicine, that there will be no conflicts of interests between patients and professionals and that there will be no misuse of paternalistic structures and powers (O'Neill, 2002: 151).

The practice of medical paternalism seems not to consider the fact that power relations can be abused by the health care professionals. It also fails to address the existing conflict of interests between the patients and their health care professionals. As a matter of fact, weak paternalism has been considered to be ethically acceptable in doctor-patient relationship because it does not transgress the informed consent and autonomy of the mentally capacitated patients.

4.7. Weak Paternalism

Weak paternalism is viewed to be acceptable in medical practice because it is applied only to individuals who are deemed to be mentally incompetent to express their choices as well as understanding the information regarding their health conditions. However, it is not clear as to how the other person can paternalise the individual who has no control over his situation. This gap has also been discussed by Feinberg (1986: 14) when he says, "it may be severely misleading to think of weak paternalism as any kind of real paternalism." In principle, weak paternalism does not intervene with one's autonomy or consent because it is only applied when patients are incapable to decide on their own. Thus, in such cases we cannot say the autonomy of the patient was violated when the patient actually lacked the capacity to decide or even to grasp any shared information regarding their situation. Instead of leaving them alone and continue to suffer, healthcare practitioners are required to involve the medical proxy to consent on behalf of the patient.

Weak paternalism seems to be relevant for patients who may not be able to understand as well as balance the benefits and risks entailed in the prescribed treatment options. “Hard paternalism is generally considered as an unwarranted interference with the liberties of people who can act autonomously because it undercuts what they want for themselves and their liberty to live out their lives as they wish as long as they do not interfere with the lives of others” (Kravitz, 2001:584). Looking at the case of Terri Schiavo who was declared to be in the persistent vegetative state for fifteen years, even if the medical practitioners were to compile all information regarding her condition for her, she would still have been unable to express her preferences because she was brain dead. So divulging the information to her family members for them to decide on her behalf was a reasonable measure hence in this case application of weak paternalism was warranted. It can therefore not be argued that Schiavo’s autonomy and consent were violated as she did not have any capacity to make such decisions known. This however should not be confused with hard paternalism whereby a competent patient can be treated without their consent if the healthcare professional believes it is in the best interest of that patient.

Weak paternalism can also be warranted even in cases of temporary incapacitation of patients such as being in a coma or emergency situations where further delay in treating the patient may be detrimental to them. For this timely intervention, it can be argued that the patients’ autonomy was not violated. Even the Constitution of the Republic of South Africa, Act 108 of 1996: Section 27 (3) states that “no one may be refused emergency medical treatment.” These illustrate the broader spectrum for instances in which application of weak paternalism is indeed justifiable. As a way of supporting weak paternalism, O’Neill says:

> Medical paternalism can be acceptable in the treatment of those who are temporarily or permanently unable to consent of refuse, but not beyond. Its justification in these contexts is not, however, that professionals have a general right or a duty to act paternalistically, but that patients without mature capacities to consent and dissent can best be protected by allowing

> professionals, relatives to act with a carefully regulated and limited degree of paternalism (O’Neill, 2002: 152).

The above point indicates that asymmetrical powers in medical decision making does not always supersede the preferences of the mentally competent patients except in such mentioned conditions where patients lack the mental capacities to express their medical preferences. However, O’Neill’s argument seems not to consider the exceptional cases whereby the preferences of mentally competent patients can be justifiably overridden intentionally, such as in the case whereby their refusal to treatment can cause harm to other human beings. So far, weak paternalism seems not to raise controversial issues because it is applied where patients cannot do anything for themselves.

4.8. Principles of Biomedical Ethics

4.8.1. Autonomy

Originally bioethics principles were established in the Belmont report and later on developed by Beauchamp and Childress. They have substituted the principle of respect for persons with the principle of respect for autonomy and also added the principle of nonmaleficence. They propose that the four principles namely; autonomy, beneficence, nonmaleficence and justice indicate a common morality and can form the foundation for all moral decision making. According to (Cassel, 2000) there were only “three principles in the Belmont report which were; respect for persons, beneficence and justice.” He further argues that:

> The meaning of benevolence has shifted from acting for the good of the sick person to act- ing for the good of a body part or physiological system. Respect for per- sons has been redefined from overriding concern for the sick person (almost solely) to the right of the patient to choose independently from among all options. Justice was originally not seen to apply to clinical medicine; now it is apposite because we no longer understand the medical act as that of an individual clinician caring for an individual patient within a relationship, but as a commodity or a resource within a marketplace. Their relationship

> devalued, the actors in the medical drama have become atomistic individuals (Cassel, 2000: 21).

The above argument by Cassel indicates that the shift from the Belmont report has changed the moral aspect of the relations of the health care practitioner and the patient. For instance, beneficence was not only considered as a way of doing good to the patients, but also as a way of developing a moral character of acting benevolently towards the patients and respecting them as persons. The substitution of the principle of respect for persons has devalued the relationship between the doctor and the patient because patients are being treated in an atomistic approach.

For Beauchamp and Childress (2001: 59) “an autonomous person is one who has the capacity to rationally accept, identify with, or repudiate a lower-order desire independently of others’ manipulation of that desire.” They have also associated the autonomous action with intentions and understanding without controlling influences. It becomes clear that persuasion and manipulating patients to accept some certain treatments will be considered as a violation to their autonomy. Beauchamp and Childress have also acknowledged the limitations of personal autonomy under a negative obligation. They argue that “we must respect individuals’ views and rights so long as their thoughts and actions do not seriously harm other persons” (2001: 64). It should also be notified that for Beauchamp and Childress (200: 14) there is no principle that takes precedence over the other when people are faced with the conflict of obligations; rather people should be able to weigh and demonstrate the balance of right and wrong.

4.8.2. Principles of Beneficence, Nonmaleficence and Justice

According to Watt (2000: 310), “the principle of beneficence in its simplest form is that we ought to do good or if, expressed as an obligation, that there is an obligation to help others; narrowing it down to health care, the principle of beneficence implies that healthcare providers are ethically and morally bound to act in the best interest of the patient” Beneficence as a principle does not simply require us to do good to others, but also to respect their human dignity as well as promoting humane relations. This is not limited to just avoiding causing harm to others but making strides to assist others. “Human beings ought to be taught to be strongly benevolent and beneficent; where benevolence signifies a wish or disposition to help others where beneficence signifies actually producing good" (Childress & MaCquarrie, 1986: 87). In addition, they maintained that "beneficence refers to an action done for the benefit of others; benevolence refers to the character trait or virtue of being disposed to act for the benefit of others." Furthermore, Beauchamp & Childress (2001: 167) made the distinction between ideal and obligation beneficence. They are of the view that "the Good Samaritan's act is more an ideal beneficent than an obligatory beneficence. This is because his act seems to exceed more than ordinary morality. Both the actions and motive of the Samaritan are beneficent, and the parable suggests that positive beneficence is more ideal than obligation. But for the healthcare professionals, it is their obligation to provide good for the patient, they are duty bound to help the patients." The Good Samaritan story therefore connotes the fact that doing good to others may sometimes be impelled by a moral character other than merely following the set guidelines that oblige others to do good. "The principle of nonmaleficence asserts an obligation not to inflict harm on others. In medical ethics, it has been closely associated with the maxim 'primum non nocere': Above all or first, do not harm. This principle entails some moral rules such as; do not kill, do not cause pain and suffering, do not incapacitate and do not deprive others of the goods of life. While the principle of justice requires that equals must be treated equally and unequals must be treated unequally" (Beauchamp & Childress, 2001:114). For example, if it is required that all mentally competent patients should be given an opportunity to choose their medical treatments without any coercion; then they should all be given the same opportunity equally.

4.9. Voluntariness

Voluntariness has been explained by Pojman (1998: 229) as a "responsibility of one's autonomous actions to determine his or her own style of living without any forces of determination. Determinism means that all events are without exception totally determined/caused". In our day-to-day life experiences, we give praise and blame to others because they are responsible for their deeds. "The concept of voluntariness as an element of informed consent refers to a person's independence from manipulative and coercive influences" (Tannsjo, 1999: 56). Following the similar definition, Etchells *et al.* (1996: 1084) "voluntariness refers to a patient's right to make treatment decisions free of any undue influence. A patient's freedom to decide can be impinged upon by internal factors arising from the patient or the patient's condition or by external factors." Voluntariness is ethically required for consent to be acceptable because patients would be acting without any coercion or paternalistic measures. In regard to the above point, it is clear that anxiety or pain as well as coercion from the health care professionals can affect the voluntary consent of the patients.

Manipulation or misrepresentation of information swallows the voluntary self-determination that is expected to be exercised by the patients. In support of giving patients the freedom to participate in the decision making, Meisel *et al* (1977: 286) argue that "patients must be free from coercion and from unfair persuasions and inducements. There must be social support for their belief in their own freedom, at least to the extent that those responsible for providing medical care have an obligation to make patients aware that they possess the right to make their own decisions regarding treatment."

A conducive environment which includes adequate space and timeframe is necessary to enable patients to thoroughly assess their medical circumstances so that they can comprehend the likely outcomes for proceeding or denying the prescribed interventions. Human beings should be considered as capable to contemplate and rationally choose between various medical options. Just like the notion of competence, voluntariness can also be relative and be affected by forces of severe depression. In addition, Beauchamp & Childress (2001: 93) assert that "the voluntariness with which someone makes decisions can therefore be diminished by conditions such as a debilitating disease, psychiatric disorders or drug addictions." Besides these debilitating conditions of the patients, influential forces used by health care practitioners can also affect the voluntary actions of the patients. For example, "if a physician orders a reluctant patient to undergo cardiac catheterization and coerced the patient into compliance through a threat of abandonment, then the physician's influence controls the patient" (Beauchamp & Childress, 2001: 94). They have further formulated three types of factors that are violating the principle of autonomy and assert that:

- Coercion occurs only if one person intentionally uses a credible and severe threat of harm or force to control another. Both parties must believe that the person making the threat can follow through on it, or the person making the threat must successfully convince the other person that it can be done. No room for autonomous decision-making is allowed on this point.

- Persuasion occurs if a person is convinced to believe in something through the merit of reasons put forward by another person. Non-rational and forceful persuasions are forms of manipulation and not persuasion.
- Manipulation involves the swaying of someone to do what the manipulator wants them to do by means, other than coercion or persuasion. Informational manipulation is often used as lying, withholding information, providing misleading information and exaggeration of information. All of these are incompatible with autonomous decision-making (Beauchamp & Childress, 2001: 94-95).

All these three forms of influences do not give the patients any chance to make their own voluntary decision making. Coercion nullifies the autonomous decision making of the patients completely because they will end choosing treatments that they did not prefer, but out of fear and pressure from the family members or the health workers, they end up accepting the treatment. Persuasion and manipulation brain-washes the mind-set of the patients in the sense that they are made to believe what was not in the first their own preferences. These acts undermine the mental capacities that humanity is endowed with especially when the patients are competent to choose what they want. On the other hand, voluntariness as a requirement can also be a challenge for the people with intellectual disabilities because their condition renders them to critically analyze and understand the possible outcomes of the prescribed treatment. As a matter of fact, their mental disability makes them vulnerable and lacking power to voluntarily make their own decisions. In this case therefore they cannot exercise either informed consent or autonomy.

4.10. The Principle of Confidentiality

Although health care practitioners are obliged to divulge all the relevant information to the patients regarding their illness and prognosis, they also have an obligation to keep the information provided to them by the patients. Failure to respect the information concerning the patients would result into the violation of confidentiality. According to Glannon (2005: 35) “confidentiality is present in medicine when a doctor discloses medical information about a particular patient to that patient alone. The doctor pledges not to disclose the information to a third party without the patient's permission."

On the same point, McQuoid-Mason and Dada (2011: 88) assert that "confidentiality is the duty imposed on health care professionals to ensure that all information concerning a patient is not disclosed without the consent of the patient or under the conditions prescribed by law." In addition, they further stipulated that patients' confidential information can only be breached through their consent; in cases whereby, the court of law orders require the health care practitioners to do so or when failure to disclose the information poses harm to society. For Beauchamp and Childress (2001: 305) "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 without the confider's permission." On the other hand, the principle of confidentiality is seen by Glannon as a duty entailing two moral theories. He says:

> There are two arguments supporting physicians' obligation to uphold confidentiality with their patients. The first argument is deontological and involves respect for the patients' autonomy and privacy. Confidentiality is an extension of a patients' right to privacy and disclosing information about the patient without consent is a violation of this right and fails to respect the patients' right to self-determination. The second argument is consequentialist. If physicians violate confidentiality by divulging information about their patients to third parties, then patients might lose trust in their physicians. They might become reluctant to seek medical care and they might not be forthcoming in providing an honest, accurate medical history (Glannon, 2005: 35).

Breaching of medical information fails to consider patients as beings who are capable for self-determination in a sense that their consent for the disclosure was overruled. On the other hand, the violation of confidential information might force patients to disclose inaccurate medical information to the health practitioners. However, without accurate medical information, health care practitioners are likely to make inaccurate diagnosis and the patients' wellbeing will be worsened. For Raanan Gillion (1985: 1634) “the principle of medical confidentiality that doctors must keep their patients' secrets is one of the most venerable moral obligations of medical ethics. The Hippocratic Oath enjoins: Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.” He also considers confidential information as an act of showing respect for other people’s privacy.

The challenging question regarding the practice of confidentiality is whether confidential information can be breached in cases whereby failure to disclose such information may pose harm to the family members. So far the principles of biomedical ethics do not offer any solution because it was stipulated clearly by Beauchamp and Childress (2001: 14) that there is no principle that takes precedence over the other when people are faced with the conflict of obligations; instead rational agents should be able to use their discretion by weighing the balance of right and wrong. In this line of argument, it can be argued that the principle of confidentiality is prima facie because there are many situations whereby breaching of medical confidentiality can be justifiable.

According to Roy Gilbar (2004: 195) “disclosure of sensitive information for the benefit of family members in certain circumstances can be justified. This would arise where a patient refuses to consent to such disclosure and the benefit of disclosure substantially outweighs the patient’s claim to confidentiality.” This argument depicts the limitation to patients’ autonomy regarding the principle of confidentiality especially in situations where confidentiality poses harm on others. The point I am raising has also been discussed by Richard Tur (1998: 17) when he says, “the duty of confidentiality is relative, not absolute; and that it is primarily a matter for the professional judgment of the reflective health practitioner to determine in the particular case whether competing public interests or other compelling reasons override that duty.” In addition, Gillon says:

> The principle of confidentiality can be breached when (a) the patient "or his legal adviser" gives written and valid consent; (b) when other doctors or other health care professionals are participating in the patient's care; (c) when the doctor believes that a close relative or friend should know about the patient's health but it is medically undesirable to seek the patient's consent; (d) exceptionally when the doctor believes that disclosure to a third party other

> than a relative would be in the "best interests of the patient" and when the patient has rejected "every reasonable effort to persuade"; (e) when a judge or equivalent legal authority directs a doctor to disclose confidential medical information (Gillon. 1985: 1635).

The above argument by Gillion illustrates a situation that while it is true that health care practitioners have a duty to respect the confidential information of the patients, but clearly this principle is not absolute because it can be breached where the stipulated conditions are encountered. Sissela Bok (1983: 28) says the "autonomy we grant individuals over personal secrets, first of all, cannot reasonably be thought to extend to plans of violence against innocent persons; at such times, on the contrary, someone who knows of plans that endanger others owes it to them to counteract those plans, and, if he is not sure he can forestall them, to warn the potential victims." In other words, Bok's argument indicates that respect for one's autonomy for self-determination regarding confidential information does not imply that confidential information should always be respected even in cases where it can pose threats to other people's welfare. For instance, Glannon (2005: 36) made a very relevant example when he says "informing a third party that a patient is HIV positive without consent can be justified only when there is a significant risk of harm to an identified individual who could become infected and exposed to the health risks it entails." The motive behind this act is mainly to avoid causing harm to the other party. On the same argument Beauchamp and Childress (2001: 308) also indicate that obligations to divulge confidential information most commonly emerge when third parties face serious dangers. "When rules of confidentiality are used as absolute shields, they can eventuate in outrageous and preventable injuries and losses. The best approach is to treat rules of confidentiality as prima facie in ethics as in law" (Masiye and Ssegubuku, 208: 246).

In this way of arguing, it is clear that paternalizing the patient by overriding his or her autonomy to breach the medical confidential information can be justified even if the initial patient does not want to consent. In this case the application of the principle of beneficence (doing good to the third parties) that may be in danger if the information is not breached takes precedence over autonomy. In the African context, Murove has indicated that the principle of confidentiality does not only apply to the individual patient alone, but it also includes the whole family. In support of his argument he says:

> African bioethics brings into focus the whole question of doctor to patient confidentiality which has for so long been part of the discourse of western bioethics. Confidentiality is based primarily on atomic individualism and the incorrigibility of the individual who is assumed to be endowed with intrinsic properties that cannot be subsumed from the generality of human existence. Confidentiality thus implies that individual patients have an inviolable right to deal with sickness and all matters of health as they choose. If the patient is the whole community or family, as in African bioethics, it is at such a level that confidentiality is upheld (Murove, 2009: 171).

Confidentiality in the African context is not viewed as a principle that allows patients to deal with their health matters individualistically without the concurrence of the family members. Individual’s illness is viewed as crucial to the well-being of the entire family. Therefore, confidentiality is maintained by the entire family, not individualistically. This African world-view of considering individuals through the web of interrelationality does not however encourage paternalism; but it is the very idea that considers individuals as relationally constituted within the family and community to an extent that one’s ailments affect the entire family.

4.11. Eight (8) Principles of Patient-Centered Care

The principles that constitute patient-centered care have been perceived as a vital approach in the promotion of wellbeing of patients in doctor-patient relationship. As indicated by Davis, Schoenbaum and Audet (2005: 954), “research by the Picker Institute has delineated 8 dimensions of patient centered care, including: 1) respect for the patient's values, preferences, and expressed needs; 2) information and education; 3) access to care; 4) emotional support to relieve fear and anxiety; 5) involvement of family and friends; 6) continuity and secure transition between health care settings; 7) physical comfort; and 8) coordination of care. Although these dimensions were originally applied to hospital-based care, they could apply equally to care in the ambulatory setting.” The patient-centered care signifies a model modification in how patients, providers, and other stakeholders deliberate about diagnoses and prognoses. This model has been defined as the act of:

> Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions, patient-centered care prizes transparency, compassion, and empowerment. The rise of patient-centered care makes way for a healthcare system designed to optimize the agency and comfort of the most important and vulnerable people in the equation: patients, their families, and their communities" (Davis, Schoenbaum and Audet, 2005: 954).

This model focuses on the holistic approach when dealing with treatments and healing processes by engaging other parties whose role in the patient's life is important. The model is not basically focusing only on the expressions of autonomous medical preferences by the patients. In contrast, it includes other factors that are entailed in the treatment or recovery of the patient. These principles serve to achieve the best healthcare delivery for all and also by not seeing patients as clients that can simply just exercise their autonomy to choose medications, but an approach that is meant to treat the dignity of patients as socially relational beings.

4.12. Summary of key elements constituting doctor-patient relationship

This chapter focused more on the traditional understanding of the elements that constitute doctor-patient relationship. It examined the obligations and biomedical ethics principles that bind the doctor-patient relationship as a way of facilitating the showing of respect for the patient in the making of medical decisions by medical practitioners. The argument developed here is that there are also exceptional cases where such obligations and biomedical ethical principles such as autonomy, beneficence, non-maleficence and justice can be violated. A consequentialist justification for the violation of such obligations and biomedical ethical principles have also been provided by appealing to therapeutic privilege as a non-maleficence principle that seeks to avoid harm by all means. The argument/s developed in this particular chapter will then guide me in the discussion of the shortfalls of Kantian deontology in doctor-patient relationship, which focuses only on patients’ autonomy without taking into consideration the role played by social relationships during health care delivery services.

Chapter Five: Deontology Underpinned Doctor-Patient Relationship and its Shortfalls

5.1. Introduction

This chapter discusses the Kantian notion of deontology and its shortfalls as it is applied in bioethics under the notion of doctor-patient relationship. The acknowledgement of the importance and influence of Kantian deontology and autonomy in bioethics has been accepted as a shift from the paternalistic approach which was regarded as using human beings as mere means to an end as well as violating their autonomy to express their individual's preferences. On the other hand, Kantian deontology is criticized for promoting individualism. Firstly, it is argued that deontology perpetuates a view of the improvised self or persons that see the "self as atomistic, as ideally self-sufficient, as operating in a vacuum unaffected by social relationships" (Stoljar: 2013). Secondly, it is argued that Kantian deontology focuses only on the patients who are mentally competent because he views them as the bearers of human dignity due to the fact that they are autonomous lawgivers to themselves and they have the capacity to understand the rules of categorical imperative.

This individualistic approach by Kantian deontology in bioethics inevitably excludes the welfare and value of the patients who are mentally incompetent because dignity is accorded only to rational agents who are at liberty to make their own individualistic laws in as far as they can will that their maxim should become the universal laws that are obligatory. Lastly, it is argued that the relevance of Kant's categorical imperative in doctor-patient relationship is very narrow regarding the medical decisions patients are faced with in medical fraternity because it is not always the case that when the patients make their medical decisions, they also will that their maxim should become the universal laws; and patients also do not make their decisions in exclusion of their inclination as Kant (1959) has argued that "an action done from duty must wholly exclude the influence of inclination."

5.2. Critique of Kantian Deontology and Autonomy as Individualistic

The notion of doctor-patient relationship has changed from hard paternalistic approach to a patient autonomy promotion approach, which advocates involving patients in the medical decision-making. Kantian deontology has also been used in bioethics as a guiding moral theory to show respect to the patients. Deontology is about individual's duty to follow the rules of categorical imperatives where essentially the principle of autonomy ensues. Kantian deontology regards rational beings always as lawgivers in a kingdom of ends possible through autonomy of the will. No rules should be imposed on the rational agents because they are their own lawgivers and they should obey only self-legislated laws which can be willed to become the universal law.

Rational agents are regarded by Kant as beings that are capable to formulate their own laws independently in as far as they can will them to become the universal laws. Kantian perspective does not consider these laws to be done collectively, but they are formulated individually. In support of this claim Kant says, "a rational being obeys no law other than that which he himself at the same time gives" (Kant, 1997a: 42). In bioethics, this Kantian account gives the individual patients an absolute right to decide autonomously what they want with their bodies without considering the welfare and concerns of the family members. Kantian autonomy is individualistic in the sense that it focuses on the self that is also considered to be autonomously self-regulating.

The atomistic view that circumscribes autonomy and autonomous patients is an individualist moral philosophy and it can be contrasted with a communitarian moral philosophy. Etieyibo has made a compelling distinction between individualistic moral philosophy and communitarian moral philosophy. He says that:

> The view of an embedded notion of the self which is the view of the self from communitarian moral philosophy standpoint holds that the self or individual is constituted by the community that it belongs to. This is a holistic, social, thickly-constituted conception of the self. By contrast, an unembedded self, the view of the self from an individualistic moral philosophy standpoint holds that the self or individual is constituted by nothing other than itself. Or what Charles Taylor call an atomistic view of the self, the view that individuals are

> self-sufficient and may develop and exercise their capacities qua human beings independently of any society (Etieyibo, 2011: 5).

Deontology underpinned doctor-patient relationship in medical practice is deficient and problematic because it is based on individualistic moral philosophy whereby individuals are regarded as atomistic and capable of making their own exclusively independent medical choices. Deontology also does not recognize the interests, considerations and other factors in the doctor-patient relationship. For instance, "if a patient who has had a heart attack consents to donate a kidney for a transplant, then allowing the patient to donate could harm him, because given his condition; undergoing surgery could entail a significant risk of morbidity or even mortality" (Tannsjo, 1999:5). Healthcare professionals who follow this Kantian perspective feel compelled to respect the autonomous preferences of the patient because failure to respect patients' autonomous decisions will be viewed as undermining their intrinsic dignity.

As a form of individualistic moral philosophy, Kantian deontology gives the patients in medical practice an absolute right to express their medical preferences autonomously without anyone limiting their interests. Hence, the approach of treating human beings as atoms or like mere monads in Leibnitz terminology does not resemble the actual web of social relationships and interactions that human beings have and that we find in the world. Patients may be ambivalent or even express contradictory preferences, which doesn't seem to be recognised by Kantian deontology

Owing to its emphasis to autonomy, Kantian deontology fails to appreciate the social interaction and interdependency that is embedded within the human nature. Interrelationality within our different communities is unavoidable. On the same view of the interrelationality among the human beings, Susan Sherwin says:

> Relational autonomy requires a focus on the importance of supportive social conditions for fostering autonomous action. In such a view, individual autonomy is socially constructed; that is, the capacity and opportunity for autonomous action is dependent upon our particular social relationships and the power structures in which we are embedded. Autonomy requires more than mere freedom from interference; it requires that one's relationships with

> particular individuals and institutions be constituted in such a way as to give one genuine opportunities for choice (Sherwin, 1998: 16).

The above point signifies that supportive social relations do not annihilate the interdependency and interactions among the human beings. In doctor-patient relationship, patients' preferences play a fundamental role especially where there are different prescribed treatments, but at the same time treating patients as loners may subject them to harm. For example, "the preferences of patients who have the required mental capacity may be based on misinterpretation or perceived benefit of less effective drug or treatment" McPherson: 2008). On the other hand, Damle (2009: 309) argues that "while patients' preferences are important but again, they are not always in their best interest. For instance, hypomanic patients may prefer to continue with less effective drugs so as to remain in an aroused grandiose and elated state, and psychotic patients may have a delusional explanation for their preference." Given that the mental competence of the individuals can deteriorate when making decisions, particularly when they are ill, deontology seems to get it wrong by focusing only on the patients' interest and capacities. This arises partly because it presents a mistaken view and picture of the self and persons as atomistic and accordingly treats individuals as if they are in isolation from existing social relationships. In addition, MacDonald also argues that:

> The notion of 'relational' autonomy has recently gained prominence as a reaction against the failings of the more traditional, liberal, understanding of the concept. The liberal understanding of autonomy is accused by critics of assuming an atomistic model of human agency and interaction. Such a model involves a 'false conceptualization of individuals as capable of existing apart from any social relationships, as linked together only by voluntaristic social ties'. In this liberal atomistic model, moral agents are seen as limited only by their own values and capacities, and all that other agents need to do by way of respecting their autonomy is to refrain from interfering with the courses of action that agents choose. Thus, to focus on autonomy in the individualistic sense is misguided; this criticism seems even more apt within the domain of health care, suffused as it is with relationships of care and dependency (MacDonald, 2002: 197).

Being a patient on its own is a situation that makes one to be vulnerable and it needs social support. So, if Kantian deontology considers humans as autonomous self-legislators then patients may make medical choices that do not promote their welfare. In addition, having mental capacity does not precede making right or good medical decision if ever such ailing member of the family is left alone to carry the burden of illness on his or her own. The Kantian deontology of the self is not relational; in fact, it is a self that is independent because it makes laws for its sake. Furthermore, his deontology perceives the self or individual as capable of making his or her choices without the assistance of others who may help to shape his or her values or beliefs and interests.

Kant's account in bioethics has also ignored the empathy bond that is between the patient and the family members. In support of this claim, when the patient has been discharged from the hospital, family members continue with the home-based care because it is their wish to see him or her recover. This act depicts two effects namely that; family members care and share the burden the patient is going through and that the relationality aspect is unavoidable among persons, particularly those related. But unfortunately, Kant's account does not consider the interrelationality that human beings have; rather it treats them as atoms. Firstly, this approach especially makes it very difficult for patients who lack the mental capacities to make their own laws because Kant did not include them in his account of dignity. For instance, in Kantian account human beings have dignity because they are endowed with rationality and autonomy. So those who do not have these attributes fall below the borderline of those who have dignity. Secondly, it is also mistaken for Kant to assume that mentally competent patients can express their preferences autonomously. "There are a number of instances where a person is deemed to be able to understand the medical information that is relevant to their decision, but their decision is driven by overriding affective attitudes such as fear or anxiety. Despite being able to use and weigh the relevant information, their ability for autonomous decision making is impaired" (Herring and Wall, 2015: 706). The state of being ill can lead patients to make frivolous decisions and/or being unable to make a decision. Furthermore, Herring and Wall (2015: 698) argue that "it is a terrible thing to be said to have capacity when you do not; to be left to cause yourself and those you love great harm on the basis that you know what you are doing and you are making your own choices, when in fact your decisions are not really yours." The argument based on capacity can erroneously end up declaring patients to be mentally competent while they are actually not.

Kant’s moral theory has influenced the western medical ethics practice because medical proxies are only involved when the patient has lost his/her mental capacity. This becomes a serious problem for patients who may lose their mental capacity before writing the advance directive standard/living wills because family members normally experience a conflict of medical preferences due to the fact that all along the patient was left alone to exercise his/her autonomy. Hassoun (2011: 96) has also indicated that Kantian deontology and autonomy are often “equated with individuality, freedom of the will, integrity, independence, self-knowledge, and responsibility, freedom from obligation, self-assertion, critical reflection, and absence of external causation.” In addition, this way of analyzing autonomy indicates that rational individuals are at liberty to make their own individualistic laws insofar as they can will that their maxims become universal laws that are obligatory.

While it is true that the Kantian deontology in bioethics “endeavours to promote and protect patients’ autonomous decision-making to entrench their rights to ultimate decisional authority” (Secker,1999: 49), it somehow fails to consider the other vital factor in doctor-patient relationship which is mental competence of the patients. Kantian deontology assumes that all the patients can be competent and express their autonomous medical choices under the guidance of the supreme principle of categorical imperative. Fluctuation of mental competence of the patients due to pain, anxiety and fear can render competent patients to make decisions that will serve their best interest.

The concurrence of the surrogate decision makers (family members) in medical practice is very fundamental for both mentally competent and incapacitated patients. This is premised from the facts that (1) persons by nature are socially interrelated, (2) the notion of mental competence is not global but relative from case to case. In addition, patients are in most cases vulnerable which impairs them from deciding for themselves, and need helpful means to support them. The Kantian moral theory and autonomy which is grounded on the model of the self that is independent, self-legislators and exclusively rational leads to the view that very few patients will be considered as autonomous because in medical practice, treatments and operations attract factors that can affect the mental competence of the patients. It is also very difficult for human beings to act only on rationality and discard their inclinations as Kant has claimed. For Kant (1997a: 42) “the practical necessity of acting in accordance with this principle, that is, duty, does not rest at all on feelings, impulses, and inclinations, but on rationality alone." Caring for someone who is suffering from chronic illness affects the emotions; it demands some signs of compassion. Rationality alone which is exercised in conformity with the rules of categorical imperative will not help us to care, show our interdependency and harmonious relationships towards others. Kant further argues that "maxims based on sensuous inclinations are called empirical or *a posteriori maxims*: they depend on our experience of desire. While maxims not based on sensuous inclinations are called a priori maxims, that is, they do not depend on experience of desire" (Paton, 1967: 61). Under this point, only mentally capacitated patients who are capable to act from duty which will be guided by a priori maxims and which does not emanate from the inclinations.

Human nature is not constituted with rationality alone, hence why they are called sentient beings. They are endowed with rationality and the senses. The act of feeling compassionate for our fellow patients who are going through debilitating situation in life forms part of our social relationships. Hence, Kant focused only on the individuals who have the capacity for rationality and who can act from the duty of the categorical imperative rules. In addition, Kant further argues that "beings without reason have only a relative worth, as means, and therefore called things. Whereas rational beings are called persons because their nature already marks them out as an end in itself" (1997a: 37). This Kantian argument depicts that he is mainly focusing on the patients who are mentally competent because they are able to give laws to themselves autonomously as rational beings who possess dignity. According to Mappes and DeGrazia (1996: 28), "a Kantian position central in biomedical ethics describes autonomy in terms of self-control, self-direction, or self-governance. The individual capable of acting on the basis of effective deliberation, guided by reason, and neither driven by emotions or compulsions nor manipulated or coerced by others is, on the Kantian position, the model of autonomy."

5.3. Shortfall of Deontology Underpinned Doctor-Patient Relationship: The Relative Relevance of Categorical Imperative

Kant's deontological categorical imperative plays a very narrow role for the patients in doctor-patient relationship because the medical preferences of the patients are different. Hence, it is very difficult for the patients to always will that their maxim should become universal laws. Kant's formulation of categorical imperative requires us to be able to say, “I am never to act otherwise than so that I could also will that my maxim should become a universal law” (for representative statements see Kant, 1997a: xviii; Kant, 1949: 19; Rachels, 2007: 131). Kant further says “a man is morally good, not as seeking to satisfy his own desires or to attain his own happiness, but as seeking to obey a law valid for all men and to follow an objective standard not determined by his own desires. A man shows moral worth if he does good, not from inclination, but from duty” (Paton, 1965: 22). The different health conditions that patients are faced with lead them to make different medical choices. It is not easy for the patients to will that their maxims should become the universal law. These medical decisions are sometimes affected by different religions and cultural practices. Illness affects both the patients and medical proxies emotionally and psychologically, so it is not practical for these two groups to detach their inclinations when making medical decisions and rely only on rationality which is likely to be affected by the current critical health conditions. According to Kant:

> An action done from duty must wholly exclude the influence of inclination, and with it every object of the will, so that nothing remains which can determine the will except objectively the law, and subjectively pure reason for this practical law, and consequently the maxim that I should follow this law even to the thwarting of all my inclinations. Thus, the moral worth of an action does not lie in the effect expected from it, nor in any principle of action which requires to borrow its motive from this expected effect (Kant, 1949: 18).

When patients make their decisions, they do not intend their decisions to become the universal laws for other humans. Hence, Kantian deontology which is guided by categorical imperative is relatively relevant in bioethics. For example, its relevance is vivid whereby patients are dealing with moral problems such as patients who want to do abortion, requesting euthanasia or physician assisted suicide because such request raises some moral issues. But generally, patients and health care professionals do not make medical decisions through the lens of universalizable laws; patients simply make their personal preferences while healthcare professionals follow the existing legal and ethical guidelines without necessarily saying that they will that their maxim should become the universal laws.

In addition, Kant's categorical imperative cannot provide solutions when confronted with moral predicaments in doctor-patient relationship because of its absolutist approach which does not have some grey areas. Kant's deontology is transcendental, and it excludes the human experiences. For instance, he considers the maxim that are morally worthy as those that are a priori (not emanating from an experience). This transcendental approach makes it very difficult for us to know whether the maxims of the individual patients were intended to become the universal law especially because Kant says, "if the maxim passes the categorical imperative test, the action is permissible; if it fails, the action is forbidden" (Kant, 1997a: xxi). The detection of such maxims is also out of the scope of the health care workers to detect. In doctor-patient relationship, health care workers rely on what their patients tell them without knowing the nature and moral status of their maxims. Patients make decisions basing themselves on the positive consequences that are likely to follow, not because they follow the moral duty of the categorical imperative.

5.4. Shortfall of Deontology Underpinned Doctor-Patient Relationship: The Feminist View of Relational Autonomy

One feminist criticism of traditional autonomy theories including that of Kantian deontology is that "these theories seem to require substantive independence and other masculine norms. In contrast, feminists want a theory of autonomy that can accommodate a wide range of preferences. Most recent theories of autonomy admit that we are all products of our socialization (hence the name relational autonomy)" (Charles, 2010: 412). The difference between Kantian formulation of autonomy and the feminist is that Kant's autonomy emphasizes particularly on the patient's autonomy to choose treatments administered on him/her. This principle completely regards patients as atomistic beings that ought to make their medical preferences without any interference, whereas feminist's autonomy refers:

> To conceptions of autonomy grounded on the social nature of people's lives. On these views, people are integrally connected with a social environment marked by economics, politics, ethnicity, gender and culture. Their identity is formed and shaped by their social environment, as well as their experience of embodiment, interactions with others, and possibilities for a good life.

> Along with interconnection, the fact of interdependence pervades this relational understanding of the self, as people are only dependent and independent relative to the circumstances in which they find themselves (Ells, Hunt and Chambers-Evans, 2011: 85-86).

The above points to relational autonomy which encapsulates social relationships among human beings. “Adopting a relational understanding of autonomy would contribute to the understanding of patient choice and agency within patient-centered care without minimizing the complex nature of people and the value of collaborative decision making and collaborative approaches to care” (Ells, Hunt and Chambers-Evans, 2011:88). Feminist’s relational autonomy considers a need to recognize the involvement of the interests of the family members in patients’ decision making. As many feminists have pointed out, “our self is constituted to an important degree by relations with and responsibilities towards our intimates, and these relations and the welfare of our loved ones may be more significant than the interests of any individual self in isolation” (Anita, 2008: 131). In contrast, Kantian autonomy considers the self as exclusively individualistic. Anita also notes that “the focus of Kantian autonomy in contemporary western bioethics has been on that of patient to the exclusion of the interests of anyone else” (2008:129). Instead of rejecting the principle of respect for autonomy, feminist scholars re-conceptualized and applied it to the spheres of social dimensions where persons are viewed to be within the web of social relationships with other humans in their different communities.

5.5. Summary

Kantian deontology is in the form of individualistic moral philosophy, because it gives the patients in medical practice an absolute right to express their medical preferences autonomously in exclusion of the existing social relationships that the patients have with their families. His moral theory also commits a fallacy of assumption that all patients are mentally competent to act from duty as required by the categorical imperative without noticing that competence is not global but relative. This assumption misses a crucial point that in bioethics patients may be deemed to be capacitated to perform some certain tasks, while at the same time the very same patients can show signs of mental incompetence. So, if ever patients are given such an authority to decide on their own without the involvement of the family members or taking their interests into account, then they are left with the possibility of making harmful decisions about their lives.

Kant’s deontology says nothing about mentally incompetent patients that are unable to express their medical preferences. His deontology segregates the other group of human beings because it considers autonomy as the source of dignity. This implies that those who lack mental capacity simultaneously lack the notion of human worth. Given the deficiency in the Kantian moral standpoint in respect of doctor-patient relationship there is the need to find an inclusive account that takes into account all the interests, considerations and other factors in the doctor-patient relationship and consistent with a rich view of the self.

Chapter Six: Ubuntu Underpinned Doctor-Patient Relationship

6.1. Introduction

In this chapter, I defend the thesis that an ubuntu underpinned doctor-patient relationship is a better account than a deontology underpinned doctor-patient relationship because ubuntu takes into account all the interests, social relations and other factors entailed in doctor-patient relationship. I also discuss medical case studies based on different mental conditions of the patients and argue that the relational approach which takes into account the vital value of social relationships in doctor-patient relationship is a plausible approach.

Ubuntu in this chapter is discussed as a better moral theory to Kant's deontology in doctor-patient relationship because the former does not assume that all patients are mentally competent to make their decisions due to the fact that competence is not global but relative hence why, it encourages the involvement of the family members in medical treatments; whereas Kant's deontology assumes that all human beings are competent to be self-legislators under the light of categorical imperative hence, they should be self-legislators. Kantian deontology also assumes that what matters are the interests, preferences, self-giving laws of the individuals in separation with the relationships that these people have with other human beings. In contrast, ubuntu is consistent with a rich view of the self because it does not perpetuate a view of the improvised self or person that sees the self as atomistic like deontology does.

6.2. Ubuntu as a Promising Theory with a Rich View of Self in Doctor-Patient Relationship

As has been shown from the discussion so far, the doctor-patient relationship has been dominated by autonomy as pioneered by Kant's moral theory, which is individualistic, and which stipulates that individuals are self-legislative beings. Here, I want to show that ubuntu is the plausible approach that can enhance doctor-patient relationship. The observation that Kant's approach to ethics is individualistic because of its core crux on autonomy which is regarded to be in contrast to ubuntu as a sub-Saharan moral theory has been discussed among others by (see Andoh, 2011: 69; Behrens, 2013: 33-34; Behrens, 2017: 2; Etieyibo, 2014: 75; Etieyibo, 2017: 321; Fagan, 2004: 18; Metz, 2010a: 52; Metz 2016: 9; Metz, 2017: 119; Murove, 2012: 37). In this part, I provide some reasons to favour ubuntu as a sub-Saharan moral theory in doctor-patient relationship prior to Kant's deontology. It is argued that Kant's individualist deontology which is grounded on autonomy does not depict the actual relationships that are taking place in doctor-patient relationship; instead it treats patients as atoms.

The basis of the view that an ubuntu underpinned doctor-patient relationship takes into account all the interests (this includes family interests), considerations (it considers persons as relational) and other factors (mental capacity is not global, but relative in the doctor-patient relationship) and consistent with a rich view of the self; is supported by the argument found in Etieyibo where he makes reference to ubuntu by arguing that:

> Because of the natural sociality of humans, the individual is implicated in some social and moral roles in the form of obligations, commitments to other members of his or her community which the individual must fulfill. Thus, it could be said that African ethics takes our primary moral obligation to involve concern for the interests of others (Etieyibo, 2014: 78).

The emphasis of ubuntu on the mutual respect, interconnectedness and dependency of human beings to each other can enhance the notion of doctor-patient relationship because ubuntu regards patients within the web of relationships whereby all the interests of the involved parties in the healing process are recognized. Those who are sick are not left alone to find solutions by themselves, but family members are involved to give social support. For example, under a deontological approach, the focus is only on the promotion of the interest of the patient alone and this approach does not provide us with any guidance towards patients who are making medical decisions that are not in their best interests. It simply stipulates that individuals should respect only the laws that they have given to themselves. According to Edwin (2011: 5) "ubuntu does not hold that the self or individual is constituted by nothing other than itself; rather it considers the self as embedded within the web of social relations." It is through this approach that makes ubuntu to consider the interests and welfare of others. In doctor-patient relationship, ubuntu encourages the social support from the family members as a way of sharing the difficulties the patient is going through, as well as caring for the patient. It is not a possible task for the patient to make medical decisions while going through critical health conditions; ubuntu therefore, entails the value of caring for others. Caring in this manner refers to “being fond of someone, feeling sympathy or empathy for them, being concerned for their well-being” (van Hooft, 1996: 83).

Ubuntu’s approach on harmonious relations and mutual concern for others can be seen in such cases whereby ailing patients are given the support in order to make decisions that will serve their best interests. As Metz (2017: 114) illustrates that ubuntu considers an act to be “right insofar as it honours (people’s natural capacity for) communal relationships, one’s identity and brings one in solidarity with others. This point simply shows that under ubuntu, people consider themselves as sharing a way of life, belonging, being close, and feeling integrated.” Metz further indicates that, with Ubuntu “one finds reference to promoting the common good, engaging in service, being sympathetic, and living a life of mutual concern for others’ welfare, which he regards as solidarity” (2017: 114). This account of communal relationships has also been discussed by Pantaleon Iroegbu. He says that “the purpose of our life is community-service and community-belongingness” (2005: 442). Consequently, Masolo has advocated for the “communitarian values of living a life of mutual concern for the welfare of others, such as in a cooperative creation and distribution of wealth and feeling integrated, as well as willing to integrate others into a web of relations free of friction and conflict” (2010: 240). These arguments simply mean that ubuntu recognises humanity as a notion that binds us together as social beings, and it is substantially endowed upon our essence as human beings. The component of oneness that is preceded by ubuntu extends to all people within our communities who may need our help during their life difficulties. Masolo talks more about the idea of helping one another within our communities when he says:

> Strictly speaking, the ethic of communalism that is encouraged by ubuntu is not a moral value like attending to a sick mother or going to war to protect one’s own country would be. Failing to extend one’s helping hand to a stranger in need is not a moral failure of similar degree to that of failing to help one’s sick mother or refusing to enlist to fight for one’s country at war. But consciously choosing not to help someone in need when we are in fact able to do so brings the realization that if we had acted differently, we could have improved the condition of life for one more person (2010: 248).

The recognition of considering oneself under the web of ‘we’ connotes the common belonging that requires that we ought to help others just like we would also wish them to do the same if we need help. Failing to help others while in need is considered to be in contrast with the character of benevolence and such acts fail categorically to promote harmonious relationships among the community members, instead it promotes individualism. When it comes to health of the individuals, the family is the first communal unit to know about the illness of one of the family members and they consider his/her sufferings as their suffering as well. According to Metz (2010: 279) “in an Afro-communitarian ethic, individuals are understood to have weighty duties to aid others, particularly family members, it is not merely up to the individual what she does with her body and mind because family members have a stake in the individual’s health. It does not obviously follow that coercive or unqualified paternalism is justified by ubuntu; but it does seem to follow form this ethic that an individual’s illness is a collective affair to some degree.” On the same issue of helping other people, Metz says:

> Another thing that “harmony” might mean is a certain caring or supportive relationship. One has a relationship of good-will insofar as one: wishes another person well (conation); believes that another person is worthy of help (cognition); aims to help another person (intention); acts so as to help another person (volition); acts for the other’s sake (motivation); and, finally, feels good upon the knowledge that another person has benefited and feels bad upon learning she has been harmed (affection) (Metz, 2007: 336).

These acts symbolize that through the moral theory of ubuntu, relationality and inter-connectedness do not only take place when family members are well, but each is given support and care during the tough times of illness. Ubuntu encourages mutual concern and mutual care and support for one another during the weal and woe. The moral theory of ubuntu is inclusive in the sense that it recognizes illness as the major factor that affects the mental competency of the individuals during medical decision making. When people are sick, it is normal for them to feel a sense of anxiety which may lead them to make wrong individualistic medical decisions if ever they are treated in an atomistic perspective. In addition to the issue of interrelatedness in health procedures, Makhaye has eloquently indicated that:

> Instead of one person coming in for treatment, the patient would be accompanied by a sort of entourage. It is the right of the company to sit in during consultation because your health is the concern of everybody. That's why nobody goes to the doctor unaccompanied… The whole family travels with the patient as part of the healing process (1973: 158).

It is in relation to the above point that Murove (2009: 168) says "the individual's ailment is understood in terms of relatedness and interrelatedness between the individual and all those realities that constitute existence." This relationality becomes vivid through ubuntu because people are not considered as substances that exist independently, but people are considered as integrally related and engaged in harmonious relationships.

6.3. Ubuntu as Better than Kant's Deontology in Doctor-Patient Relationship

There are many relatives who see themselves as playing a vital role in the treatment of their family members, whether in following them to the hospital or in caring for them at home. However, ubuntu is not about what people say about themselves in connection with the treatment of sick relatives but how conceptually they ought to see themselves and why seeing themselves in the way ubuntu has prescribed, namely as relational, embedded selves and as those aiming towards harmonious relationships is a better approach to doctor-patient relationship than the approach where they see themselves as atomistic individuals in Kantian dialogical terms. Ubuntu is a better account because it does not only perceive the condition of mental incapacitation as a call for family participation during the ailing moments of the family member. Through ubuntu, the self is viewed to be in relation with others regardless of being mentally competent or incompetent. Families through ubuntu remain together during the weal and woe and bear the burdens of illness until the patient has recovered and they do not let the sick individual to battle with his/her sickness alone and stepping aside during decision making. They share the pain together because individuals are inextricably tied up with their families.

According to Behrens (2017), “if we respect persons, we must surely recognize that obtaining informed consent entails more than just the free informed choice of the individual; every individual is also a relational being, and it may be very important to the individual that those with whom she has important relationships share in her decisions.” Ubuntu advocates for interrelationality when making medical decisions because such decisions can also affect the family as a whole. So, the family is striving to attain the best decision for all by giving the patient the social support because “social harmony is regarded as the greatest good” (Tutu, 1999: 34). The importance of social harmony through ubuntu has been endorsed by Behrens (2017) when he argues that “human flourishing is dependent upon being in relationships and sharing a way of life with others. Whether described as ubuntu or not, these fundamental values are shared by many sub-Saharan communities.” Ubuntu in doctor-patient relationship encourages harmonious relations and interdependency among human beings because familial communities give us an identity. Ubuntu does not perpetuate the notion of doctor-patient relationship that is only between the health care providers and the patients, but generally it’s ontological being is in relation with others and interdependent. Furthermore, Behrens (2017) says “social harmony entails a necessity for individuals to recognize that their choices do not only affect themselves, but also have an impact on the lives of their family and others in their community.” Simply put, interrelationality is a key factor behind this point illustrated by Behrens because the family automatically becomes affected by the illness of the family member.

The African moral theory does not consider healthcare providers as loners, but it considers them as integrally connected with the patients and their families. This African moral theory encourages the healthcare professionals to administer medical treatments in such a manner that considers the best interests of the patients, rather than just prognosing because the patient has expressed his medical preferences. The reason behind this approach is basically because persons through ubuntu are considered to be indivisible to one another; they are bound up in social relationships.

The importance of the solidarity within the existing social relationships such as that between family members and the patients can be seen clearly after the patient has been discharged from the hospital whereby family members continue to take care of their patients. According to Behrens, “the emphasis on community, identifying with others and solidity and caring make ubuntu a relational ethic that prizes harmonious relationships. This approach challenges western bioethics, which focuses on individual autonomy and the rational application of abstract theories and moral principles to ethical issues" (Behrens, 2013: 34). Kant's deontology is too speculative in a sense that it does not address the reality of the essence of human beings whom are interconnected in social relationships. The application of self-legislating beings who obey only those self-given laws that are considered to be binding to themselves classifies human beings as atoms instead of social beings. This individualistic moral philosophy allows individuals to pursue interests that are self-centered rather than caring for other people's welfare. In contrast, Etieyibo says:

> African ethics emphasizes the interests and welfare of the community with regards to the individual and subscribes to duties as a way to satisfy them. The individual qua human being is in a relational existence with others by virtue of his social nature, that is he or she is implicated in his or her community as a social being. (Etieyibo, 2014: 78).

The above point by Etieyibo conveys out the communal dimension of ubuntu whereby patients' illness is seen as part and parcel of the concern of the entire family. Healing does not only consider the patients' interests, but it is done in a holistic manner because patients are not considered as atomistic beings, but as relational beings where all stakeholders are involved in the healing process of the patients. For one to be under the web of 'we' one has to consider himself as integrally existing within the community which automatically binds him to be a relational being. Interdependent beings have common goals and they feel bad when they see other people suffering. For example, ubuntu does not perceive the principle of beneficence in bioethics as an individual's choice to do good to others, but it considers it to be a humane act that reflects the character of humanness within the harmonious relations with others in their communities.

6.4. Involvement of Family in Doctor-patient Relationship

Among the eight (8) principles of patient centred care that I have discussed in chapter 4, ubuntu attests to be a better approach in doctor-patient relationship because its worldview incorporates patient centred care principles especially the involvement of family, emotional support and coordination integration of care. The involvement of family members in healthcare services is encouraged by ubuntu because this Afro-communitarian theory perceives a human life as integrally embedded in communal relationships and never existing in a vacuum. Ubuntu also entails in itself the African proverb which says, “it takes a village to care for a patient.” Thus, “patient-centred care encourages keeping patients involved and integrated with their families and their communities in their everyday lives. Practitioners should get to know the whole picture of a patient's life, including the people involved who can provide the sort of support professionals sometimes cannot” (Davis, Schoenbaum and Audet, 2005: 955).

In addition, John Hardwig also supports the involvement of the family members during the medical treatment of the patient as a sign of showing support to the patient during the hardships. He says:

> Justice and fairness require the patient to take into account the relatives’ concerns. He adds that the relatives should have a role in the decision-making process when decisions affect them; when decisions dramatically affect relatives’ lives, their interests might prevail. This is because to be a family member is to be morally required to make decisions on the basis of thinking about what is best for all concerned, not simply what is best for yourself (Hardwig, 1990: 6).

The involvement of the family members during the medical-decision making serves as a significant indication that the life of the ailing family members is intimately intertwined and interrelated with the lives of the family members. Through ubuntu, “harmony is achieved through close and systematic social relations within the group. Individuals consider themselves as integral parts of the whole community, and a person is socialized to think of himself, or herself, as inextricably bound to others. Ubuntu ethics can be termed anti-egoistic as it discourages people from seeking their own good without regard for, or to the detriment of others and the community” (Metz, 2011a: 539).

The sub-Saharan moral theory of ubuntu regards “the individual’s health or sickness as indispensable to the well-being of the community, a sickness that afflicts the individual becomes a communal sickness” (Murove, 2013: 170). For example, ubuntu does not perceive the principle of beneficence in bioethics as an individual choice to do good to others, but it considers it to be a humane act that reflects the character of humanness within the harmonious relations of human beings in their communities. In addition, and speaking about ubuntu as representative of African ethics, Edwin Etieyibo argues that:

> African ethics emphasizes the interests and welfare of the community with regards to the individual and subscribes to duties as a way to satisfy them. The individual qua human being is in a relational existence with others by virtue of his social nature, that is he or she is implicated in his or her community as a social being. (Etieyibo, 2014: 78).

The above point by Etieyibo on African ethics and community clarifies that treating a patient's illness does not only consider the patient's interests separately, but they are considered holistically within the family. The reason behind this approach is because patients are not considered as atomistic beings, but as interdependent and relational beings. The healing process of the patients is considered along with the interests of other beings/family members and the factor that capacity is relative.

In this regard, patients are not left alone to make their own individualistic decisions and bear the burden of their health situations, but the family members share the burden with the patient because they consider each other's interests. The concern about others' interests through the lens of ubuntu starts from the moment when a member of the family is sick and continues even after that member of the family has been discharged from the hospital. According to Ho (2008: 129) "illnesses and injuries are physically challenging and emotionally exhausting for many patients, especially when the diagnoses are unexpected or grim. Patients are often in different power positions with others surrounding them, particularly healthcare professionals who provide them with needed health services. There is therefore a concern that vulnerable patients may be prone to manipulation and coercion." Furthermore, another argument that depicts the factors that can affect the competency of the patients was raised by Wim Dekkers when he says:

> Contemporary patients are faced with increasingly complex data and choices, some of which are expensive and/or existentially tragic, such that patients who are already burdened by illnesses and the unfamiliar medical culture may feel even more overwhelmed when they have to analyse complex medical

> information and make decisions on their own. Ironically, the decision-making process that sees contemporary patients as the only legitimate decision-makers has led some to feel more helpless and isolated than ever (Dekkers, 2001: 187).

The approach of giving an absolute power to the individuals as self-legislative beings can be dangerous to the lives of the patients because mental competency is not global but relative. That is, it can be affected by other factors during the time of illness. For example, patients cannot cope alone with the illness and stressing medical information that is given to them without the involvement of the relatives. According to O'Neil (2000: 82) "even in cases where patients are competent and able to participate in decision making, such deliberation is often physically and emotionally exhausting rather than empowering. Patients' priority may thus not be the exercise of an autonomous experiment in taking charge of their desires when they weave through the medical maze." Hence, there is a dire need for the consideration of moral theory that is more inclusive; that entails interconnectedness, interdependency and relationality. On this view, Jeffrey Berger argues that:

> Even as patients enter the professional care setting, families remain an important part of the care and recovery processes. Intimates often accompany patients to consultation and diagnostic sessions, visit and bring food to them at the hospital, and care for them at home after discharge. Healthcare decisions are not simply individual affairs; they affect others and are thus interpersonal or family events. Reciprocal concern and sympathy that people feel for their loved ones can help to explain why intimates' involvement and consideration of their well-being do not necessarily constitute undue pressure (Berger, 2005: 4).

Ubuntu points out that our self is constituted within the web of relationships and responsibilities towards other people. Ho (2008: 131) asserts that "these relations and the welfare of our loved ones may be more significant than the interests of any individual self in isolation." A relational account was also discussed by Metz (2010: 279) where he argues that "in an Afro-communitarian ethic, individuals are understood to have weighty duties to aid others, particularly family members, it is not merely up to the individual what she does with her body and mind because family members have a stake in the individual's health. It does not obviously follow that coercive or paternalism is justified by ubuntu; but it does seem to follow form this ethic that an individual's illness is a collective affair to some degree." The similar account to ubuntu can also be found in East Asia. Ruiping Fan stipulates that:

> People in East Asian account are not accustomed to making medical decisions regarding their own diseases by themselves without consulting the family. Decision-making for medical procedures and care for the patient may be done with the mutual consent of both himself and the remaining members of the family. This is because of their deep regard and respect for the opinions and feelings of the family. When one member of the family becomes sick, it is the responsibility of the entire family to look after the sick person. The family knows that the care of the sick member is a family matter not an individual matter (Fan, 1997: 316).

In relation to the above point, Tsai (2008: 173) indicates that under Confucianism, "individuals are never recognized as separate entities; they are always regarded as part of a network, each with a specific role in relation to others." Moazam (2000: 30) argues that "in Pakistan, there is a saying that 'you are your family and your family is you'. Religion has an influence on people's decision-making and that in Islam the family is perceived as a source of strength and protection." Furthermore, Moazam says:

> Members of the extended family with whom the patient resides generally undertake decisions regarding terminal care for both competent and incompetent patients. Nursing homes for those who are aged, terminally ill, or incompetent are unknown in Pakistan; such individuals are cared for at home by the family (Moazam, 2000: 30).

The health approaches of both East Asian families and in Pakistan reflect an element of relationality and interconnectedness that is also found in ubuntu. However, there is a difference between the ways families in Pakistan and in sub-Saharan Africa handle the illness of their patients. For instance, while it is true that ubuntu allows interdependency and interconnectedness, it does not allow family members to make medical decisions on behalf of the mentally competent patients. Rather it allows the concurrence of the family members in medical decision making in a mutual consent which reflects a way of giving the support to the ailing family member and help the fellow member of the family to make a decision that will be in his/her best interests.

The fundamental relevance of interdependency and relationality in clinical settings has also been supported by Ho (2008: 129) when she argues that "when family members are invited or allowed (by health care professionals) to be involved, their role is generally limited to helping the patient to endure the healthcare experience, relaying patient information to clinicians, or providing long term care once the patient returns home. In other words, family members are seen mostly as a means to the patient's clinical ends." In relation to the above point, Hilde and James Lindemann-Nelson (1995: 114) argue that "the love of the family members express to one another leads them to be considerate of each other's needs and preferences when making decisions. They further argue that the intimacy produces a sense of responsibility. Thus, just as the relative provides support to the patient when she is ill, the patient should choose the treatment which considers the relatives' concerns." These scholars have also considered the role that ought to be played by the patient during the decision-making because they argue that "the patient has a greater stake in the decision-making than anyone else so the relatives' interests cannot supersede the patient's wishes" (Hilde and James Lindemann-Nelson (1995: 114).

In doctor-patient relationship, ubuntu complements the existing relationship between the patients and health care workers in a sense that it does not instill individualistic approach. For example, incases whereby patients make medical decisions that cannot be in their best interests, health care workers should advise them accordingly, unlike letting them to make decisions that will harm them in the name of respect for autonomy. For Kant, an action is right if the individual can will that his maxim should become the universal law. Kant focuses only on the individual's respect to categorical imperative which obliges them to do their duties. According to Blustein (1993: 9), under individual based approach, a person's good is largely opaque to others, where persons have divergent and possibly conflicting plans and interests, and where their capacity for benevolence is extremely limited. But in the community of a close and harmonious family these conditions do not obtain. Rather, the defining features of such a family are mutual sympathy, common ends, a shared identity, love, and spontaneous affection. Through ubuntu, individual patients are not viewed as atomic entities or as monads unbound by communal members. On the contrary, their identity is intrinsically embedded within the web of social relationships. “Certainly, if family members are clearly disregarding the patient’s well-being and known preferences, it may be legitimate or even necessary for caregivers to directly inform the patient or exclude family members from the decision-making process” (Ho, 2006: 28). Furthermore, Charles and others argue that:

> The involvement of family members in treatment decision-making may be particularly important with serious illness because of the stress engendered by the diagnosis, the uncertain outcome, and the potentially major impact of the illness trajectory and treatment management on other family members. These issues have received little attention in the shared treatment decision-making literature which focuses almost exclusively on the dyad relationship of physician and patient in medical encounter (Charles *et al.,* (1997: 685).

The involvement of the family members in bioethics during doctor-patient relationship is not intended to cause undue pressure for the patient, rather to tackle to the illness issues together because illness on its own can affect the mental competence of the patients. This relationality approach is supported by the view that persons by nature are social beings. According to Carolyn Ells *et al.,* (2011: 86) “human’s identity is formed and shaped by their social environment, as well as their experience of embodiment, interactions with others, and possibilities for a good life. Along with interconnection, the fact of interdependence pervades this relational understanding of the self, as people are only dependent and independent relative to the circumstances in which they find themselves.” The similar argument that encourages relationality was also said by Edward Dove. According to Dove *at el.,* (2017: 151) “understandings of autonomy should accommodate the fact that people are rarely, if ever, fully independent individuals. Instead, we are relational beings whose identities and interests are shaped by our connections to others. In other words, it is through relations to our human, natural and artefactual environments that we come to develop our sense of identity as well as capacity for exercising self-determination.” In reality, ill patients are likely to be vulnerable and prone to make decisions that may not be in their best interests hence, the involvement of the family is vital in order to assist in making the better decisions that will serve the best interests of the patients. On this point, Chen and Fan argue that:

> The relationality approach of the family members is helpful in leading to better decisions than would occur in an individualist model. When a family member is ill, he/she is understandably in a weak and vulnerable condition and should be cared for by other family members. He/she should not undertake the heavy burden of making medical decisions independently or bear the major responsibility for such decision making. What is at stake, in such a health care context, is more the responsibility of family members to care for the patient than a "right" of the patient to make autonomous medical decisions by him/herself (Chen and Fan, 2010: 579).

The relationality approach seems to share the burden of stress and suffering among the family members and it aims to find the best medical decision for the patient without necessarily overriding the views of the patient incases whereby there can be a conflict of medical preferences. Kantian approach which puts more authority on individuals ignores the fact that illness can challenge the mental competence of the patients when making decisions alone. Thus, Kant's individualistic approach may lead to poor medical decisions that could have been avoided through the relationality approach which is meant to give social support to patients in order to make sound medical decisions about their lives.

In addition, Kant's autonomy places a moral premium on independence because he argues that "autonomy of the will is the property of the rational will by which it is a law to itself independently of any property of objects of volition. A being with an autonomous will, then, is one who is self-legislating, rather than subject to pre- or other-given laws" (Kant, 1959: 59). Kant's deontology in bioethics "reflects a patient-centred approach in which the doctor– patient relationship excludes others who are closely related"; while ubuntu advocates for the relational perception in bioethics. As Alastair Campbell explains that "if autonomy is morally valuable, and if autonomy is equated with independence, then dependence is regarded as morally inadequate and, consequently, those who are dependent are devalued" (Campbell, 1991: 105). Since Kant ground autonomy as the source of dignity because it enables rational agents to formulate their own laws, then it reflects that those who are mental incapacitated are below the borderline of dignified people and do not play any role in the kingdom of the ends. In Kant's deontology, rational agents do not depend on each other, rather each formulate his own laws autonomously. Furthermore, the whole idea of self-legislative rational agents does not provide any solution for the patients who are incapacitated because they are unable to exercise their practical reason to make medical decisions; or even those who are mentally competent but who seem to make medical choices that do not serve their best interests. In contrast, ubuntu considers every human being within the web of relationality and these harmonious relationships include respecting others as well as taking care of their welfare.

Chen and Fan (2010: 574) argue that "on the modern western model; the locus of the moral responsibility for medical decision making is the individual, namely the patient. Under this model, the family plays the active role as decision makers on behalf of the patient only if the patient has become incompetent but has not prepared a detailed advance directive or signed a durable power of attorney to appoint another individual to serve as the proxy decision maker." In contrast, "on the Chinese model, the locus of moral responsibility for medical decision making is the family. The patient in this model is always treated as a member of a family with a result that the family plays a cardinal role in decision making for its sick members in grave medical contexts in order to achieve harmonious agreement for the health care of patients" (Chen & Fan, 2010: 574). As it has been discussed in chapter three, ubuntu on the same point has some similarities with Confucianism because it also encourages harmonious relationality among human beings within their families and communities.

The individualistic approach by Kant's philosophy alters the social nature of human beings whom are relational to each other. His approach fails to ground the interdependency of human beings. Kant's philosophy in doctor-patient relationship also fails to acknowledge that patients' autonomy can be rendered by illness and therefore, they need social support from the family members to choose the best medical treatment. "The adage *umuntu ngumuntu ngabantu* (persons depend on other persons to be persons) radically alters the terrain of the doctrine of individualism because the assumption of this adage is that personhood is derivative from relationship with other persons, hence it is not an incorrigible property of the individual but something that is shared with others and finds nourishment and flourishing in relationships with others" (Murove, 2012: 42). This means that ubuntu perceives patients as always integral and interdependent to the family. It is considered to be anti-ubuntu for a patient to be left alone by the family members and deal with his/her illness. Ubuntu encourages one’s family members to be involved because the family members also play a major role after the patient has been discharged from the hospital because the family continues to take care of the patient.

6.5. Emotional Support for Patients

In ubuntu, caring for the sick is considered as a shared responsibility amongst the family members irrespective of whether the patient is mentally competent or not because of the saying that “whatever affects the individual is considered to affect the entire family.” Ubuntu encourages harmonious social relationships that include respect for one another, having a sense of empathy and taking care about other people’s quality of life. Whereas, Kantian formulation of categorical imperative disregards the emotions as part of moral actions, instead rational agents are expected to follow the moral rules. In medical setting, “challenges of treating and healing the patient can also take their toll on the mind and the heart. Practicing patient-centered care means recognizing the patient as a whole person, having a multi-dimensional human experience, eager for knowledge and human connection, who may need extra, specialized help in keeping up the spirit of optimism” (Davis, Schoenbaum and Audet, 2005: 955). Consequently, interrelationality and interdependency forms the pillars of ubuntu among human beings. In this approach, a person is never perceived as a being that exists independently from others, but always as a self that is in relation with others within the community. Prinsloo stipulates that:

> Ubuntu involves compassion and social responsibility, which are expressed in caring for the less privileged, the poor and orphans. As African humanism, ubuntu involves being sensitive to the needs of others, alms-giving, and demonstrating an attitude of sympathy, consideration, patience and kindness. Empathy, as directed to putting oneself in the shoes of a person in need, entails that each person must be viewed holistically by focusing on his/her physical, emotional, social and spiritual needs. The ultimate expression of regard for another is by showing spontaneous concern and voluntary assuming a self-imposed sense of duty towards the needy, destitute or bereaved (Prinsloo, 1998: 42).

Patients that have been diagnosed with chronic diseases cannot just rely on the medication given to them by doctors, but they also need to be given the social and emotional support by the family members. Such emotional support is very vital for the recovery of the patient as well as the decreasing the chances of depression that may lead to suicide. Furthermore, "family members help patients manage and cope with illness. They also can be valuable sources of health information and can act as collaborators in making an accurate diagnosis and planning a treatment strategy" (Omole, Sow, Fresh and Babalola, 2011: 781). The current application of Kant's deontology in doctor-patient relationship is viewed as a contractual-based relationship strictly driven by individual patients expressing their preferences regardless of the conditions they are going through whereby, healthcare providers make sure that patients sign the consent form whether they accept or reject the prescribed prognosis. This procedure is mainly done as a way of protecting themselves against the possible litigation. In contrast, ubuntu promotes that "a caring relationship characteristically is one in which a person feels a certain way consequent to the attentive awareness just adumbrated. Upon imagining what it is like to be the other, one develops a sympathetic reaction to that condition, a feeling that is of a similar kind and normally of comparable proportion. If one becomes aware that the other is flourishing, then one feels good for him, and if one instead learns that the other is floundering, then one feels bad" (Metz, 2013: 79). In addition, ubuntu perceives healthcare professionals as integrally connected in social relationships whereby people feel morally obliged to care for others' welfare. "One has a moral obligation to be concerned for the good of others, in terms of both one's sympathetic emotional reactions toward other people and one's helpful behaviour toward them" (Metz and Gaie, 2010: 276). Ubuntu takes cognizance that healthcare professionals are not just care providers serving their clients, but they are also entrenched in social relationships with patients and their family members.

6.6. Ubuntu as a Relational Approach in Bioethics

It is unrealistic to reduce bioethics issues to questions of individualism and capacity for decision-making only because bioethics issues such as gene editing and biobanks even though they may result from the individual choices, they can affect the entire society, its values, and its social institutions. On the same issue Dhai (2013: 88), argues that "biobanks research implies risk for identifiable groups and communities because anonymity of the individual does not necessarily translate to anonymity of the group." This point indicates clearly that it is not up to the individuals alone to give consent to participate in biobanks research, but the communal consent plays a vital role because the results of the individual can affect their communities. Frank disclosure of the risks and benefits entailed in biobanks or gene editing can give the communal members an opportunity to express their views if the research violates their moral norms, cultures/religions or not. "Community consultation is important to avoid group harms which have adverse effects on the entire group to which the research participants belong" (Dhai, 2011: 176). Ubuntu takes more precautions than deontology when it comes to social relations that can be hampered by an individuals' participation in genomic due to the consequences that can affect one's tribe communal moral norms. "The human genome, which by its nature evolves, is subject to mutations. It contains potentialities that are expressed differently according to each individual's natural and social environment, including the individual's state of health, living conditions, nutrition and education" (United Nations Educational, Scientific and Cultural Organization, Article 3: 2003). Since an individual's participation on human genetic research can affect the entire family or the community, then it is not a matter of considering the individual autonomy and consent alone, but familial involvement must be considered and all the frank disclosure of the consequences pertaining to genetic research ought to be shared with the family members or community so that they can decide whether they want to participate in that kind of research or not. If individual's participation in human genetic research can negatively affect the entire family, then this depicts the reality that human beings are by nature socially related and interdependent on each other.

The importance of relational approach in bioethics can be seen during the breaching of participants' confidentiality in biobank research whereby stigmatization and discrimination could arise and affect a particular tribe or society if the research results reveal that members of that tribe or society's genotype entails an increased risk of disease or other traits. This point illustrates that even in cases whereby individuals have chosen to participate in a biobank research autonomously, but the fact is that the results from the research can affect other persons, both family members and the community. Autonomy of the individual does not supersede the communal welfare. Ubuntu is preferred to Kant's deontology because it considers individuals as interrelated and interdependent to one another; unlike Kant's deontology which encourages individuals to be self-legislators. Hence, ubuntu is much less vulnerable than Kant's deontology in bioethics. According to Callahan

(2003b: 496) “human beings are social animals and our nature is distorted if we think of ourselves only as co-existing social atoms. The field of bioethics in the 1980s and 1990s became focused on autonomy and individual rights, and liberal individualism came to be the dominant ideology.” The unavoidable nature of human beings as socially connected with others was also pursued by Tutu when he says “human beings are social beings that are in constant communion with one another in an environment where a human being is regarded as a human being only through his or her relationships to other human beings” (Tutu, 1999: 36). Therefore, the existence and welfare of a human being is considered integrally dependent on others. Metz (2013: 85) further elucidates that “identifying with others or sharing a form of life with them involves forms of emotion, conation and intention that differ from those inherent to a caring relationship”. He also says:

> One identifies with others insofar as one thinks of oneself as a common member of a group with them. Part of considering oneself part of a group will involve a tendency to refer to oneself as (part of) a ‘we’, and not merely as an ‘I’. In terms of emotions, one who identifies with others has a sense of belonging or a feeling of togetherness. With respect to conation, or desire, one who identifies with others wants to be with them, and, indeed, to be closer to them, not merely or strictly in terms of spatial location, but also projects undertaken. And this inclination to participate with others in their doings characteristically leads to the adoption of an intention to do so (Metz, 2013: 85).

Ubuntu’s account advocates for interdependence and interrelationships among the members of the community. This argument supports the act of helping and considering the human welfare of others because it displays how human beings are deeply embedded in social relationships and dependent to one another in order to help them in achieving their goals. The deontological individual capabilities’ approach has been an influential theory in bioethics. “Deontology conceptualizes human wellbeing in terms of an individual’s ability to achieve as a reason for value. In contrast, the ethic of ubuntu views human flourishing as the propensity to pursue relations of fellowship with others, such that relationships have fundamental value. While the capabilities’ approach seems to focus on individuals as the locus of ethical value, an ubuntu ethic concentrates on the relations between individuals as the locus” (Hoffmann and Metz, 2017: 153). This point can also be narrowed down to the level of family-setup as a small community and be articulated that patients' medical decisions have the potential to affect the entire family, hence why ubuntu is encouraging harmonious social relationships. Ubuntu encourages people to live "a life of mutual concern for the welfare of others. Solidarity refers to promoting others' well-being, being sympathetic, acting for the common good and showing concern for others" (2010a:51). In the "African tradition, the word 'community' usually is used not merely to signify some existing group or society and is instead used to refer to an ideal regarding the way the members of a group ought to relate to each other" (Metz, 2013: 81). In doctor-patient relationship, ubuntu does not view adherence to health ethics guidelines as a mere check list, but healthcare providers ought to act benevolently towards their patients and the community at large. "A caring relationship is widely taken to include a certain kind of awareness of the other, not only considering his outward appearance and listening to what he says, but also thinking about what he might be holding back" (Metz, 2013: 79). Ubuntu encourages people to assist others in achieving their goals instead of being egoists. The reason behind this motive is based on the fact that persons are viewed to be inextricably embedded within the society. Etieyibo articulately says "the individual qua human being is in a relational existence with others by virtue of his social nature, that is he or she is implicated in his or her community as a social being." (Etieyibo, 2014: 78). The relationality and dependency approach in ubuntu have been well articulated by Tutu when he says:

> We belong in a bundle of life. We say, 'a person is a person through other people'. It is not 'I think therefore I am'. It says rather: 'I am human because I belong'. I participate, I share . . . .Harmony, friendliness, community are great goods. Social harmony is for us the *summum bonum* – the greatest good. Anything that subverts or undermines this sought-after good is to be avoided like the plague . . . .We are different so that we can know our need of one another, for no one is ultimately self-sufficient. A completely self-sufficient person would be sub-human (Tutu, 1999: 35).

Through ubuntu, human beings are considered to be integrally relational to one another. Social harmony helps us to love, care for others' welfare as well as giving them respect. Both Sartre (1943: 413) and Murove (2004: 195) have raised a similar argument explaining the social essence of human beings which is relational. For Sartre (1943: 413) the "we' includes a plurality of subjectives which recognise one another as subjectivities." He further argues that the *being-for others* precedes and founds the *being-with-others*. Murove on the other hand considers "existence-in-relation, being-for-self-and-others. Human interrelationship within society is a microcosm of the relationality within the universe." This simply means that human existence cannot be like atoms or monads which are not related to each other. "Ubuntu is based on a worldview of relationality; its main insight is consequently based on the idea that human beings depend on others to attain ultimate wellbeing. The definition of ubuntu as humanness is dovetailed by this presumption – namely that humanness is our existential precondition of our bondedness with others" (Murove, 2012: 37). Human's existential relationality is in such a way that it recognises the other self by caring and sharing a way of life. In contrast, Kant's account in bioethics which gives authority to individuals is very limited because it lacks the intention of attaining the communal common good of sharing and caring for others.

The moral theory of ubuntu considers dependency, interrelationality, identity and solidarity as core values found in harmonious relationships. The notion of doctor-patient relationship should be based on the theory that also apprehends the value of social relationships. As a matter of fact, deontology presents a mistaken view and picture of the self and persons as atomistic because patients are simply viewed only as autonomous individuals exercising their medical preferences. Kantian approach is likely to promote a situation whereby patients can be regarded by their healthcare providers as clients to be served with medications because it promotes individualism and autonomous decisions without any assistance in healthcare service delivery. So, even if healthcare professionals can detect that patients are choosing treatments that are not in their best interests, they simply cannot interfere, but to provide them with what they want. Medical conditions that lead to vulnerability continue to be the reality that is experienced by the majority of patients and somehow impacts their medical choices. "Illness is not an isolated or time-limited event, but a highly stressful situation that evolves from the family's history and contributes dynamically towards its future" (Ho, 2008: 130). In addition, the interrelational care that entails the element of interdependency which is found in ubuntu is not based on temporary contracts signed during informed consent procedures at the hospitals but grounded on enduring empathy, caring and promotion of the welfare of the family members.

Ubuntu's core emphasis in doctor-patient relationship is premised on social relationships as well as taking care of the welfare of others as the core elements that ought to guide the involved parties namely; healthcare practitioners and family members in the healing processes of the patients. Patricia Banner (1997: 48) argues that "relational approach is characterized by the virtues of openness and responsiveness." Also, Reich (2001: 71) avers that "caring relationships are a moral necessity that precede other moral concerns, e.g. . . . if people don't have a . . . concern about other people and their needs – then no moral principles, like beneficence or mercy or justice or autonomy will make any difference."

Kant's autonomy in doctor-patient relationship revolves around the wellbeing of the individuals in exclusion of the 'we' part. Kant's concept of self is not relational, but self-legislative and it respects only the laws that it gives to itself. His concept of self is premised on individualized capacities of one-to-one approach. In contrast, Martin Woods (2012: 59) says "a relational care focuses on character traits such as sympathy, compassion, and friendship." In this view, identity and solidarity in relational caring relationships are cardinal values in ubuntu; whereas Kant's deontology only focuses on the individuals' autonomous decisions which cannot be interrupted in as far as they conform to the rules of categorical imperative. Ubuntu encourages actions that promote social harmonious relationships. In addition, "harmony is considered as a comprehensive African worldview which pursues primary value that pursues the community life in a family spirit or atmosphere" (for representative statement, see Andoh, 2016: 6; Okoro, 2015: 4). The act of feeling compassionate or caring about another person's life is considered to be a sign of humanness. Relational autonomy views individuals in a socially integrated network with others. "Relationships, care and interdependence are considered to be key attributes of relational autonomy: people develop their sense of self and form capacities and life plans through the relationships they forge on a daily and long-term basis" (Dove *at el.*, 2017: 153). In relation to this point, Gilbar (2011: 198) says "relational autonomy is thus a reciprocal process because it places the individual in the context of a dynamic balance between people who are closely involved in each other's' lives. Relational autonomy is also collaborative in that the individual recognises his/her dependence on close intimates when trying to achieve a goal."

Kant's deontological approach in bioethics which relies on the autonomy of individuals does not realistically represent the experiences of the patients and relatives as socially interconnected beings. For Gilbar (2011: 193) "English law and professional ethical guidelines rely heavily on an individual, rather than relational, perception of autonomy." Gilbar further argues that:

> There are at least three forms of family support: informational, functional, and emotional. Informational support provided by the family refers to the provision of knowledge to the patient, for example, attending medical consultations with the patient and listening to the information communicated by the doctor. Functional support refers to the assistance that the family provides to the patient, such as financial help or transportation to medical appointments. Emotional support is letting the patient know that she/he is loved, appreciated, and cared for, regardless of his/her condition (Gilbar, 2011: 195).

In African context, it is recognized that there is no self without other persons who are considered to interrelational by ubuntu. Boon argues that "one's humanity can, therefore only be defined through interaction with others…..the group is as important as the individual and a person's most effective behaviour is in the group. All efforts working towards this common good are lauded and encouraged, as are all acts of kindness, compassion and care, and the great need for human dignity, self-respect and integrity" (Boon, 1999: 32). Ubuntu considers an action to be "right just insofar as it positively relates to others and thereby realizes oneself; an act is wrong to the extent that it does not perfect one's valuable nature as a social being. In addition, an action is right just insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community" (Metz, 2007: 328-334). Ubuntu is viewed to be the capacity "to express compassion, reciprocity, dignity, harmony, and humanity in the interests of building and maintaining community. Ubuntu calls on us to believe and feel that: your pain is my pain; my wealth is your wealth and your salvation is my salvation." (Nussbaum, 2003: 21). Following the same approach, Gilbar says "ultimately the fact that a medical decision-making process is a social process which involves not only the patient, but also his/her family must lead to the conclusion that a delicate balance between individual autonomy and family involvement should be applied" (Gilbar, 2011: 203). On the very same view, Catriona Mackenzie (2008: 519) argues that "relational views are premised on a socially embedded conception of agency and argue that an adequate theory of autonomy must be based on recognition of the ways in which, as agents, our practical identities and value commitments are constituted in and by our interpersonal relationships and social environment." Through the communitarian approach, autonomy is not considered as an authority for individuals to pursue to their own good in an exclusion of others, but as a capacity that enables individuals to relate harmoniously with others within their communities and attain the common good.

According to Tsai (2009: 172), "when a doctor approaches his patient from a relational personhood perspective, he sees not only a person whose autonomy and dignity are to be respected, but also a relational being with a family, a community and social-historical context encompassed by many greater selves." Ubuntu similarly perpetuates that loving and caring for other human beings emanate from the web of interconnected relationships. As Mokgoro (1998: 3) has rightly pointed out that "harmony is achieved through close and sympathetic social relations within the group. This however implies that the common good of caring and loving one another can be attained through communal relationships." Through ubuntu, the sentiment of love and care is experienced within the communal harmonious relations with others. For Sartre, "the 'we' includes a plurality of subjectives which recognise one another as subjectivities. The 'we' is a particular experience which is produced in special cases on the foundation of *being-for-others* in general. He further argues that the *being-for others* precedes and founds the *being-with-others* (Sartre, 1943: 414)." The self, according to Sartre exists within others and it promotes the welfare of other. Moreover, Tsai (2008: 172) further stipulates that Confucianism in "East Asian culture views a person not only as a rational, autonomous agent but also as a relational, altruistic identity whose self-actualization involves participating in and promoting the welfare of fellow persons." That is, patients' sufferings are inclusively considered to be a matter of the family and community. The relationality aspect in ubuntu also includes the promotion of the welfare of the patients who are deemed to be mentally incapacitated to decide on their own.

According to Charles *et al.,* (1997: 684), "many patients faced with a serious illness, substantial uncertainty as to the outcome, and a time pressure to make a treatment decision among several competing alternatives, feel extreme psychological and/or physiological vulnerability, which may make it difficult for them to participate in treatment decision-making no matter how well informed they may feel." Their argument explains a challenge the patients are facing when making medical decisions alone while going through critical health conditions. This point also illustrates the necessity for an approach that is relational prior to individualist approach. With the application of ubuntu, we do not need to refer to the legal guidelines when dealing with mentally incompetent patients and look for the procedures for including the surrogate-decision makers because ubuntu's relationality approach encourages the involvement of the family members in the clinical settings as a way of giving social support to their patients. Whereas, deontology as a moral theory fails to account for the harmonious relationships in healthcare delivery services for both mentally competence and incapacitated patients. Kant's deontology is formulated within an assumption that competent patients can cope with medical facts alone without any assistance from of the family members. Ubuntu considers the concurrence of the family members to be vital in doctor-patient relationship because family members through ubuntu have a duty to care for their sick patients; the family is always there to give social support to weak and vulnerable patients during the times of illness. Thus, ubuntu involves a vibrant equilibrium among interdependent people who are engaged in intersecting projects.

For Andrew Fagan (2004: 19), "deontological account of personhood and autonomy unduly abstracts individuals from the constituents of their personal identities. In contrast to the deontological account individuals are ontologically embedded within specific social and cultural structures and frameworks." Ubuntu as a moral theory does not only focuses on the self-determination of the patient and it does not perpetuate a view of the improvised self or persons that sees the self as atomistic, rather it considers the interests of the patient within the integral relationships with the family memebrs. Roy Gilbar and Jose Miola argue that:

> Cultural values influence the way that people conduct themselves in the health care system and they provide patients a set of ethical priorities when making decisions about diagnosis and treatment. Studies have been indicated that whereas people from a western background may prioritize self-determination, rights, and open communication with clinicians, people from non-western cultural backgrounds may be more likely to be guided by family-determination, moral responsibility to others (2014: 377).

In relation to the above-mentioned cultural differences, ubuntu seems to be more preferable to deontology because it considers human beings through the web of social relations where patients are allowed to express their medical choices and be able to involve the family members to share their views. On the same point, John Christman (2004:143) argues that humanity itself is based on the "relational approach which recognizes that social relationships constitute the individual's identity and that in reality people's lives are interconnected." He further illustrates that "the community is not perceived as a unit of its own but as a group of individuals with different personal interest and desires; while at the same time the individual needs to belong and have relationship to shape the person s/he is" (2004: 143). Ubuntu similarly says that there is not vacuum within the space of human beings because inter-relationships are not accidental, but they substantially form the essence of persons. In addition, Shutte (2001: 30) argues that "our deepest moral obligation is to become more fully human, and this means entering more and more deeply into community with others. So, although the goal is personal fulfillment, selfishness is excluded." The act of being in harmonious relationships with other human beings does not only help others to feel a sense of empathy and taking care of others, but it also helps in the development of one's moral character.

Kant's deontology in bioethics can lead the healthcare practitioners to abandon their patients to make poor medical decisions under the influence or respect for autonomy. Furthermore, the categorical imperative rule that says 'we should always act in such a way that our maxims should become the universal law' is basically based on the assumption that individuals will make right decisions; whereas individuals are likely to make mistakes when deciding in isolation with existing relationships. Due to lack of relationality in Kant's philosophy, his deontology seriously undermines the welfare of the family members because it supports the ideology of individualism that cuts so deeply into family's social relationships and focus only on the life of the patient (Blustein, 1993: 7). Relationality approach considers the interests of patients and family members as bind up together instead of focusing only on the capacities of the individuals to express their medical preferences in exclusion of others' interests. Ubuntu seems to be a plausible moral theory in doctor-patient relationship because it considers other social determinants of health that can affect the well-being of the patients such as social conditions, economic environment, level of education and other factors that can affect the mental competence of the patients; while deontology is only focusing on self-determination. “The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels” (Sanders, 2006: 166). That is, social relationships are not only constituted by the capacity alone, but there are other socio-economic factors entailed.

The social determinants of health have the ability to affect the individuals’ decision making when carried out without the involvement of the social relationships. In addition, Azetsop and Rennie (2010: 3) argue that “autonomy based-bioethics has a tendency to distort the relationship between individuals and the world. On one hand, it exaggerates the power and range of individual agency; furthermore, it underestimates the impact of society, culture and environment, both on individual decision-making and on health.” I do agree with their argument because Kant’s deontological influence on autonomy has considered human beings as atoms which have no relationality to one another, hence, it lacks social rootedness. Ubuntu allows self-determination within the link of the communal relationships; while deontology allows total individualism in decision-making.

The moral theory of ubuntu cogitates relationality and interdependence as the factors that need to be incorporated in bioethics. According to Van Staden (2011: 14), Kant’s deontology is in a form of “person-centred practice which is about the rights, interests and values of the individual and if the commitment is regarded as liberal individualism, one may consider societal or other collective interests and values as being of secondary concern. In deontological terms, one may take person-centred practice in health ethics to be about the duties accruing in serving particularly the individual.” In contrast to deontology, he further elaborated that:

> The spirit of ubuntu entails that decisions are to be made in partnerships between health care worker, health care user and family members, which contrasts with an ethics model by which the health care worker(s) provides the information and ultimately the health care user has to decide (as for example a predominantly deontological rights-based ethical approach may suggest) (Van Staden, 2011: 16).

The point above illustrates that ubuntu’s ontology of the self that is embedded within others is manifested in such a way that care and illness are not considered to be the patient’s matter. This approach by ubuntu in bioethics does not pose any problem when dealing with the patients because their best interests are already entailed in social relations; unlike in the Western practice where they have to look for the advance directive standard which was signed by the patients while mentally capacitated. The application of ubuntu in doctor-patient relationship can also enhance the harmonious relations between the healthcare workers, patients and their family members because ubuntu's relational approach minimizes the rate of conflict of medical preferences because all the parties will be involved and be informed about the medical procedures to be taken. In this case, the decisions are made together in mutual respect. For example, ubuntu encourages relationality and interdependence among the human beings, for to take persons as dependent on one another is to help them achieve their goals as well.

Through ubuntu, human beings are not treated in an atomistic manner; instead, each and every person identifies himself/herself with other persons as integrally connected in the social relationships. Another similar argument to the one above was also raised by Blustein (1993: 9) when he says, "in families that are genuine communities, individuals identify with one another, such that the well-being of one is part of the well-being of the other." In bioethics, especially under the notion of doctor-patient relationship, ubuntu is relevant because it encourages health care workers and the surrogate decision makers not to isolate themselves from their relationships with patients; it encourages them to consider themselves as a unity to an extent that they should be able to intervene and advice accordingly whereby patients are making medical choices that do not serve their best interests. All involved parties in the health care sector need each other and ubuntu's approach shows support to the patients during the weal and woe. This kind of support can be attained through the social relations and interdependency. The individualistic approach by the Western moral philosophy has also been explained explicitly by Ho when she points that:

> In Western moral philosophy and bioethics, the self is often considered the locus of autonomous agency and responsibility. From Descartes to contemporary theorists, many philosophers consider the self as individualistic, isolated and ahistorical, assuming that the criteria that determine one's moral identity over time are independent of the social context in which they are situated. One of the effects of such a contextual notion of identity in moral philosophy is the refutation of the inherent

> significance of intimate relationships, which are characterized by collectivity. Individuals, including patients, are considered separate from others by boundaries that can be justifiably breached only by the explicit and voluntary consent of self-determining subjects (Ho, 2008: 129).

This influence can also be seen clearly on Kant's deontology whereby individuals are perceived to be self-legislative and autonomous beings that give laws to themselves. In contrast, the exhibition of solidarity by ubuntu is meant to benefit those that are going through the hardships in life as a way of showing care about their lives. It should be noted that solidarity does not swallow the autonomy of the individuals to express their preferences, but this element helps them to make decisions that will serve their best interests. Since pain or anxiety can affect the mental competence of the patients, it is clear that there is a need to opt for the moral theory that is relational rather than the one that leaves the decision making only to the individuals even when they are going through the critical health conditions. Blustein says:

> If the patient belongs to a close-knit and harmonious family, for example, it is the family as a whole whose values and goals may diverge from those of professional caregivers because such a family is a genuine community, not a mere collection of separate individuals with their own private and possibly conflicting interests. United by common ends and a common identity, the threats that work against the autonomy of some work against the autonomy of all. (Blustein, 1993: 9).

According to Murray Bowen (1985: 82), "family systems theory viewed individuals as inseparable emotionally from the family. The family was more than a mere backdrop; it was an integral guiding aspect of the individual's emotional life." The statement made by Mbiti (1969:108) which says "I am because we are and since we are, therefore I am" connotes that in an African context, to be is to belong because by nature human beings are interconnected and socially relational. This argument by Mbiti is also affirming the point that an individual existence is within the communal relations. Unlike the individualistic argument that was once raised by the French philosopher Rene Descartes who first proved his own existence as a substance that is not in relation with any other beings. Through ubuntu, persons are not regarded as monads which were described by Leibnitz to be simple (not constituted of parts) and not relational to the other. “The individualistic account of a being with an autonomous will, then, is one who is self-legislating, rather than subject to pre- or other-given laws” (Kant, 1959: 59). That is, rational agents formulate their own laws independently in as much as they will that their maxim should become the universal law. There is no relationality among human beings in Kant’s deontology; instead, rational agents simply use their practical reasons to legislate their own laws. Kant considers an autonomous person as the one who is self-legislating. However, in bioethics, patients frequently may be incompetent and as a result be unable to act or make choices even though they have been deemed to be mentally competent to express their preferences, and assistance from the medical proxy to decide on their behalf, but for Kant’s deontology any interference on autonomous patients is considered to be using such patients as the means to an end.

In relation to the above example, ubuntu considers an action to be acceptable “insofar as it positively relates to others and thereby realizes oneself; an act is wrong to the extent that it does not perfect one’s valuable nature as a social being; Also an action is right just insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community” (Metz, 2007: 328). On the similar idea, Setiloane puts this well when he says: “this manner of understanding human personality explains the interplay which takes place when people come into contact or live together. The essence of being is participation in which humans are always interlocked with one another” (1986: 14). Human beings through the moral theory of ubuntu are considered within the web of relationality, not as self-legislators who make their own laws independently without considering the welfare of others. Ubuntu does not consider human beings as atoms that exist independently from the other, but humanity for this moral theory is relational by nature. The situation that patients are going through makes them to be dependent, and their medical choices are not always based on pure practical reason as Kant has claimed to be the case for rational agents. There are situations whereby patients who have been deemed to be competent can fail to make decisions.

6.7. Ubuntu as a Moral Character-Based Theory in Doctor-Patient Relationship

A sustainable approach in healthcare delivery should be character-based. That is, healthcare providers should be driven by a moral character and ethical standards and not only by compliance motives. According to Etieyibo (2014: 74), ubuntu "as a character-based theory is said to hold the view that the quality of the individual's character is the most fundamental in our moral life. That is, good character is the essence of the African moral system. One has a good character when that person exhibits certain character traits like honesty, generosity, benevolence and loyalty where these traits are congenial and conducive to human flourishing and the maintenance of social order." A similar point is also made by Ramose (1999: 42) when he says, "ubuntu understood as being human (humanness); a humane, respectful and polite attitude towards others constitutes the core meaning of this theory." In addition, Teffo also articulated on the human being's moral nature. He says "morality is acquired during a progressive process of socialization which includes accepting obligations to others, which is the basis of morality. Social relations are internalized in the extended family experience and during contact with distant relatives and friends. Such groups form a closely-knit social web which brings about solidarity between persons" (Teffo 1992 in Prinsloo 1998: 42). On the same point, Metz and Gaie (2010: 275) argue that "in a typical African ethic, the only way to develop one's humanness is to relate to others in a positive way, which means that one cannot realize one's true self in isolation from others." This implies that human beings are encouraged to develop their moral characters in order to attain the status of *Botho* which is translated to mean humanness. Letseka (2013: 340) says, "personhood is linked to humane conduct, and that humane conduct is synonymous with good moral conduct. Concomitantly, good moral conduct implies treating others at all times with fairness, dignity and justice." In healthcare delivery services, Davis, Schoenbaum and Audet (2005: 955) argue that "every aspect of care depends on the character as well as every other aspect working as efficiently and effectively as possible. Treatment and patient experience must be considered as an integrated whole, with different moving parts working in concert. Healthcare providers must cooperate in the interest of the patient's overall well-being with the family support." Ubuntu becomes a favorable theory in doctor patient-relationship than deontology because it is a moral character-based theory that promotes communal harmonious relationships where everyone is respected, taken care-off and assisted to achieve his/her best interests. Kant’s deontology focuses much on the individual capacity to be self-legislative beings as well as following the rules of categorical imperative.

Consequently, people with ubuntu act humane towards others and they feel interlocked with one another without necessarily treating them as loners to make their decisions even when their medical conditions may render them. The justification of ubuntu on the humane relationships depicts that human beings ought to respect others. Through ubuntu, deception in medical practice is not only considered to be unacceptable because it fails to be willed to become the universal law, it fails to treat an individual as an end in himself or it breaches the ethical guidelines. In contrast, such an act is considered to be bad mainly because it distorts the essence of promoting harmonious communal relationships. Ubuntu in itself entails the element of unity whereby people are expected to develop and portray a moral character. It is through such virtuous acts that enable them to share and care for other people’s lives. On the same point Metz says:

> This Afro-communal ethic includes everything that care ethicists prize, as it prescribes acting to improve others’ quality of life consequent to certain attitudes of sympathy and altruism. However, it also includes a certain kind of relationship that care ethicists typically do not prize. Ubuntu values both caring for others’ quality of life and sharing a way of life with others, where the latter is more or less the combination of enjoying a sense of togetherness and participating in cooperative projects (Metz, 2017: 116).

The notion of doctor-patient relationship needs to be grounded on the theory that recognises the fundamental value of social relations and portrayal of moral character during the delivery of healthcare services. Through ubuntu, persons are encouraged to act benevolently towards each other as well as helping them to attain their interests. According to Broodryk (2002), “ubuntu/botho is based on the values of humanness, caring, sharing, respect, compassion and associated values, ensuring a happy and qualitative human community life in a spirit of family.” For Masolo (2004: 27) “African morality is both character-based and relational category because the moral potentialities we bear enable us to imaginatively project ourselves into the situation of others, making it possible for us to make positive judgments about others’ cases as if they were our own.” This however means that Afro-communitarian theory encourages family members to take part in the healing process of the ailing member of the family. On the moral character subsumed by ubuntu, Khoza (2006: 6) says, ubuntu is about harmonious relationships and focuses on mutual respect and care that people should display to one another.

6.8. Medical Case Studies of Mentally Competent and Incompetent Patients

6.8.1. Case study 1: Mentally competent patient

The patient was a twenty-eight-year-old woman at term in her second pregnancy. She came to the hospital in labor, with regular contractions and her cervix dilated 3 centimeters. When the obstetrician examined her in the labor, he discovered that the fetus had a breech presentation. An ultrasound examination was performed, confirming a frank breech presentation. Based on the ultrasound, the fetus was estimated to weigh approximately seven and half pounds, but no congenital anomalies detectable by ultrasound could be seen. With breech presentation, cesarean section would be preferable to virginal delivery. However, when the patient was informed about the situation she refused to go under cesarean section because she was afraid of the needles and opted for the natural delivery.

First, there had been concern that natural delivery involves increased risk for breech fetuses, compared to cesarean section. One problem is that, the fetus's head emerges from the uterus after its body; the fetal head can become entrapped behind a pelvic opening that allows passage of the body but not the larger head. Because the fetal umbilicus emerges from the uterus before the head, it becomes compression persists, cerebral anoxia (lack of oxygen) resulting in fetal death or brain damage can occur in the breech presentation, compared to vertex. A prolapsed cord can also become compressed between fetus and mother, resulting in anoxia. Risks of spinal cord injury resulting in death or paralysis are particularly great if the head is hyperextended (tilted back). Another impairment that can occur is brachial plexus palsy, consisting of arm paralysis caused by stretching or tearing of the brachial plexus (nerves from neck to arms) caused by lateral force on the head (Ackerman and Strong, 1989: 194).

Discussion

Mental competence enables patients to authorize the treatment that they prefer. The notion of competency has also been discussed by Etieyibo. He says:

> It is broadly construed as the ability of a patient to understand the information that he/she is presented, to appreciate the consequences of acting or not acting on that information, and to make a choice based on such information. Simply put, competency is about understanding and choice; understanding the medical condition, the natural course of the medical condition, the proposed treatment intervention, the risks and potential benefits, the consequences of treatment or intervention refusal, viable alternatives and choosing according to one's understanding (Etieyibo, 2013: 2).

The stipulated medical case study reflects the fact that it is not always the case that patients who have been deemed to be mentally competent can autonomously make medical decisions that will serve their best interests. This case depicts a scenario whereby due to anxiety the patient expressed awful medical preferences. Beforehand, the consequences of delivering the baby naturally had been clearly disclosed to the patient but surprisingly the patient was adamant that the baby be delivered naturally even though the baby could consequently suffer from severe mental disability. The deontological approach of leaving the medical choice solely in the hands of the patients without the concurrence of the family members seem to cause harm to the patients because anxiety can lead them to make detrimental medical decisions. In contrast, ubuntu caters for such unplanned medical conditions because it's ontology considers a person within the web of social relationships. Thus, such conditions are handled well through the Afro-communitarian theory because illness is regarded as a matter that affects the entire family instead of an individual condition. The application of the 'self' that is intrinsically perceived to be socially integrated with others is aimed to help other persons in achieving their best interests. Thus, ubuntu is preferable to Kant' deontology since it promotes the interests of every person regardless of his or her mental conditions.

6.8.2. Case Study 2: Mentally Incompetent Patient

In November 1997, 78-year-old Earle Spring suffered a mild scratch on the in-step of his foot. A fiercely independent outdoorsman, he left the cut unattended until his foot finally became gangrenous. Hospitalization was followed by pneumonia and then a diagnosis of kidney failure. After undergoing three five-hour dialysis sessions a week, Spring soon improved enough to return home. Meanwhile, his mental deterioration, which had been diagnosed before his injury as chronic organic brain syndrome, became markedly pronounced. After more than a year of treatment, the nephrologist informed Spring's son, Robert, that his father was not benefiting from dialysis. He suggested it may have been a mistake to have initiated it on a man of his age and that it might be best if the treatment were ended. The son and the wife agreed with the physician and requested that the treatment be stopped (Beauchamp and Childress, 2001: 422).

6.8.3. Case Study 3: Mentally Incompetent Patient

Mrs. Helga Wanglie, an 85-year-old resident of a nursing home, was taken to Hennepin Country Medical Center on January 1, 1990, to receive emergency treatment for her dyspnea that resulted from chronic bronchiectasis. Emergency intubation was provided, and Mrs. Wanglie was placed on a respirator. During the period that followed, she was not able to communicate clearly, but she did occasionally acknowledge discomfort and she recognized her family members who visited. The staff was unable to wean her from the respirator, and in May she was transferred to a chronic care hospital. A week later, during another effort to wean her from the respirator, her heart stopped. She was resuscitated and then taken to another hospital for intensive care. When she did not regain consciousness, a physician indicated to the family that it would be appropriate to consider withdrawing the life-support systems (Beauchamp and Childress, 2001: 423).

Discussion

The above two (2) cases on mentally incompetent patients are well covered by ubuntu because it advocates for interrelationality through all the health states of one's life. Ububtu encourages people to solidify with one another and "this means that they "engage in mutual aid, acting in ways that are expected to benefit each other. Caring is a matter of people's attitudes such as emotions and motives being positively oriented towards others, say by sympathizing with them and helping them for their sake" (Metz, 2010a: 51). Whether the patient is mentally competent or incompetent, ubuntu classifies them as inextricable bound-up in social relations as well as interdependent on others. A human being is never perceived as a loner through the lens of ubuntu. Thus, the welfare of those deemed to be incapacitated will always be promoted and protected under ubuntu because it places the fundamental value of the essence of human beings on social relationships. In regard to Kant's deontology, patients discussed in case 2 and 3 are not covered at all because they lack the capacity to express their medical preferences autonomously. It is even worse because Kant's deontological notion of dignity is accorded to those who have rationality and autonomy, hence those who are mentally incapacitated fall below the borderline. Kant's deontology is completely silent about the procedures to be taken when dealing with the mentally incapacitated patients. With all the above stated reasons in support of ubuntu, the Afro-communitarian theory therefore, appears to be more favorable than deontology in issues pertaining to the notion of doctor-patient relationship.

6.9. Summary of the Key Points in this Chapter

This chapter has shown that the sub-Saharan ethic of ubuntu is a relational humanistic ethic which can enhance the notion of doctor-patient relationship. Ubuntu does not consider a person as isolated from others; instead it apprehends individuals as integrally dependent and interrelated to one another. At the centre of Ubuntu is harmonious relationships that show respect and care to others. This African theory which is also relational, advocates for the loving and caring social relationships where people consider themselves as integrally connected with each other. This moral theory has a rich perspective of self because it takes the view that individuals are socially embedded and that caring relationship is holistically constituted by many role players such as health care professionals, patients, family and the community.

This relational approach in doctor-patient relationship provides social support to ailing patients both whom are considered to be mentally competent or incompetent. The reason behind this relational approach is mainly to share and care for others' wellbeing under the slogan of 'unity is power'. Due to social interconnectedness of persons, it is argued that illness and medical choices of the patients in doctor-patient relationship can affect the entire family members, hence, why ubuntu considers "an injury to one, is an injury to all" because a person is not considered as an atom but as a self-that is interrelational with others. Ubuntu in doctor-patient relationship is preferable than Kant's deontology whereby the latter grounds autonomy as the source of human dignity. This approach sends a bad message to those who lack autonomy. The likely conclusion would be that they are below the border line of those considered to have dignity. Kant's approach also ignores the fact that mental competence is relative and not global. As a matter of fact, it commits a fallacy of assumption that all individuals have the capacity to make their decisions. Therefore, I fully agree with Anita Ho's' view when he says "contemporary patients are faced with increasingly complex data and choices, some of which are expensive and/or existentially tragic, such that patients who are already burdened by illnesses and the unfamiliar medical culture may feel even more overwhelmed when they have to analyse complex medical information and make decisions on their own. Ironically, the decision-making process that sees contemporary patients as the only legitimate decision-makers has led some to feel more helpless and isolated" (Ho, 2017: 131).

Kant's deontology does not also aim to attain the common good of living in harmonious communal relations; hence, individual patients can be allowed to make medical choices even when they make decisions that do not promote their welfare in the name of autonomy. In contrast, ubuntu's relational approach does not wait for the patients to become mentally incapacitated so that surrogate decision makers can be consulted. Rather, it simply advocates for the concurrence of the family members to be considered because each person depends on others. This concurrence of the family members starts way back from the family level whereby members begin to take care of the ailing member of the family even before they can take him/her to the hospital or clinic. Ubuntu's moral obligation involves doing things for the benefit of others and to think of oneself as bound up with others through identity and solidarity in harmonious relationships. It is opposite to Kant' moral obligation which only focuses on the capacities of the individual who is expected to formulate his/her own laws autonomously. Ubuntu regards the concept of the self as interdependent and interrelated with others. The value of caring for one another is manifested from the family settings, up to the communal level. For instance, members of the family have to take part and responsibilities when one member of the family is ill. Their concurrence is not meant to paternalise the ailing member, but simply to give the social support and help the sick member to make informed medical decisions that would be in his/her interests. Ubuntu encourages humane relationships and promotion of mutual respect and mutual care. The act of caring for others is based on the fact that illness on its own is a condition that can affect one's mental competence and renders patients to make sound decisions about their lives. Illness and medical decisions under ubuntu are considered to be a family matter not only and individual concern because illness is considered to affect the entire family because persons are considered within the web of relations.

Chapter Seven: Objections and Responses

7.1. Introduction

In this chapter, I raise some objections against the moral theory of ubuntu and respond to them. The main target is to argue that ubuntu does not paternalise the individuals within their communities and families. It is also argued that this theory does not breach the privacy of the individuals. Lastly, it is argued that ubuntu is different from utilitarianism. As I have discussed in chapter one and three, there is a vital difference between this Afro-communitarian theory and Kant's deontology. As a matter of fact, neo-Kantians among others such as Beauchamp and Childress view communitarian approach as a threat to individual's autonomy and paternalistic.

7.2. Objection from Paternalism

In response to the objection that ubuntu is paternalistic, I argue that ubuntu does not operate in a paternalistic manner, but it simply encourages the harmonious communal relations whereby humanity is not considered to be embedded in the individuated self or solely in the individual, but in one's humanity which is shared with others. In African context, paternalism is also frowned because it has the potential not to enhance harmonious mutual respect and reciprocity. This however means that in Afro-communitarian theory, the individual consent is aligned with the consideration of other persons' welfare. Individuals under this moral theory are considered to have their own views, consent and plans, but these are aligned with those of the others such that their independent views do not negate the fact that they are social beings by nature and they are embedded with others. Gbadegesin has provided some idea about how to view the person as having free will in African philosophy.:

> The term autonomy in African culture can be put in perspective and explored within the Yoruba linguistic context. For instance, the concept or term for 'personhood' is '*eniyan*' which means 'he who chooses'. The word '*eniyan*' has two syllabi: '*eni*' meaning 'person' and '*yan*' meaning 'choice'. This means that the concept of 'person' in the African culture is somebody who has the 'free will' to make choices (Gbadegesin, 2002: 228).

This point clarifies that persons in African context are considered as rational agents that have the capacity to make choices. The concurrence of the family members when the other member is sick is not meant to dictate the treatment on behalf of the patient, but simply to explore with him/her the options that can best serve everyone's interests including his/her interest and promote his welfare during that stressful period of illness. Jegede puts the point thus: "This collective decision serves as a protective measure for the individuals in order to avoid injury because nobody is above mistake" (Jegede, 2009: 247).

The main values of ubuntu are basically instilled in sharing and caring through solidarity and identifying with others. The notion of mental competence is not considered as a condition for individuals to make right decisions all the time hence, illness is regarded as a collective matter. The point that ubuntu recognises the welfare and value of the individuals can also be seen clearly from the point made by Andoh. According to him "ubuntu acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being" (Andoh, 2016: 5). His point illustrates clearly that ubuntu considers the individual's well fair and free expression of preferences; while also aims to attain the common good for the community. Another point that depicts the fact that ubuntu also values the practice of informed consent in medical research is the one raised by Metz where he says ubuntu values the practice of free and informed consent. Metz says that:

> It would be unfriendly to treat or study a person without his free and informed consent. Think about what is involved in genuinely identifying with others; one cannot share a life with others in a meaningful way when they are unclear about the basic terms of one's interaction with them, or when one uses force or exploitation to pressure them into doing one's bidding. Friendly relationships require not only transparency between actors about their goals, but also willingness on the part of each to achieve them. This rationale, too, is a fair account of the moral importance of free and informed consent (Metz, 2010a: 54).

It would be anti-ubuntu for the community to force its members to participate in clinical trials against their autonomy or informed consent specifically because that act will distort the harmonious relationship that is expected to reign within the researchers and the participants. Ubuntu frowns upon paternalistic measures in medical research or any form of medical treatment because such acts dismantle the mutual respect in doctor-patient relationship. “Ubuntu prescribes respect for sharing a way of life in the sense of relationships that are knowingly and willingly adopted and are central to people’s self-conception as members of a group. Part of what makes a friendly relationship an important value is the fact that two people have come together, and decided to stay together, of their own accord” (Metz, 2010: 55). Instead, ubuntu considers a person both as autonomous individuals whose existence in coined within the web of relationships with other persons, and their autonomy is not viewed as an element that makes them to live in an atomic manner from others. Therefore, Ubuntu could be said not to be operating through the maxim of paternalism because that would be contrary to mutual respect and harmony in social relationships.

7.3. Objection from Responsibility

Another criticism of ubuntu as a theory that takes away the individuals’ autonomous responsibility is the one raised by Stephen Theron (1995). Theron specifically rejects the expression *umuntu ngamuntu ngabantu* “on the grounds that the ethical implication of the proverb simply teaches Africans to evade responsibility and to hide behind the collective decision of the community.” Theron’s critique focuses on the assumption that ubuntu considers individuals as wholly the subjects of the community to an extent that their moral development is controlled by the community. Most possibly this critique might have been influenced by Menkiti’s view which says that “in the African view it is the community which defines the person as person, not some isolated static quality of rationality, will, or memory” (Menkiti, 1984: 173).Theron’s understanding of the African’s notion of self has led him to classify ubuntu under extreme communitarianism which I have already clarified its elements or factors that makes it different from moderate communitarianism. This point by Theron does not do justice to the formulation of ubuntu because individuals are allowed to develop their moral character on their own. The fact is that an individual can develop his/her moral character as well as realizing his moral potential better while being in harmonious relationships with other persons. Hence, the notion of interdependency and interrelationality found in ubuntu should not be confused to mean that individuals defer their responsibilities to the community. The afro-communitarian theory views individuals as wholly accountable for their actions, that's why they are encouraged to be engaged in harmonious aiding relationships. In addition, there is praiseworthiness and blameworthiness within ubuntu because individuals are regarded as responsible moral agents, otherwise it would be unjust to praise or blame individual's acts if ever they were not responsible for such acts.

Harmonious relationships and interconnectedness are advocated by ubuntu without necessarily determining what should be done for the members of the family or community. Mutual decision making is exactly what ubuntu is encouraging among the communal members. On the same point of viewing ubuntu as a theory that values the individual's will within the communal relationality approach, Gyekye says:

> The community allows an individual to actualize his or her potential and develop personality in the social world without destroying his or her own will. Individuals have particular attributes, which they often exercise in contrast to the community. He further posits that: Individuals have a rational, moral sense and a capacity for virtue and judgment that the community nurtures. Individuals can also question what they do not agree with. Individuals are self-directing and self-determining and for that reason possess autonomy (Gyekye, 1988: 188).

The individual's will to be engaged in harmonious communal relationships is not infringed by the communal belonging. Rather, each person is given a chance to exercise his/her rationality to develop the moral sense of recognising the value of others and aims to attain the common good with other persons.

7.4. Objection from Privacy

A third objection against ubuntu is the one about its potential violation of the individual's privacy due to its emphasis on communal relationships whereby individuals are viewed as interconnected with others. In response to this objection, I argue that this objection has mostly been influenced by

Kant’s individualistic approach whereby individuals have been given all the authority to decide on their own and to be given information regarding their illness to the exclusion of family members. On ubuntu’s relational approach, illness is regarded as a matter that affects the entire family and not only the sick individual. Chuwa puts the mater in this way: “Caring for the sick is not charity but an ethical obligation among people of Sub-Saharan Africa. Therefore, for the sick person, the empathic and supportive presence of the community confers a feeling of belonging and sharing in the life of the whole community, even as their individual life seems to be declining” (Chuwa, 2014: 39).

Based on this relational approach, privacy according to the Afro-communal theory is upheld within the family because the family members are there to share the burden of illness together as well as seeking for the help of the ailing member of the family. Western founders of Principlism namely; Beauchamp and Childress (2001: 14) have acknowledged that “there is no principle that takes precedence over the other when people are faced with the conflict of obligations; instead rational agents should be able to use their discretion by weighing the balance of right and wrong.” Therefore, Afro-communitarian theory is also aware about the conflict of obligations between common good and individual good, that’s why it considers the moral duty to promote the welfare of others and consider their sickness to be indispensable to the well-being of others and takes this as more obligatory than leaving patients alone during their illness to deal with their matters privately.

The African communitarian approach in bioethics is also different from the Western’s perspective “when it comes to the issues of confidentiality in the medical practice. For example, it is standard in the West to think that a patient has the right to confidentiality with regard to her healthcare, either because it would be degrading to reveal intimate details without her consent (Kantianism) or because such revelation would damage trust between her and healthcare workers and hence impair her health (utilitarianism)” (Metz & Gaie, 2010: 278). In the case of ubuntu, “it is not merely up to the individual what she does with her body and mind. Since other members of the community have a stake in the individual’s health, many Africans would think that they ought to be aware of her illness and play a role in discussing how she ought to treat it. It does not mean that paternalism is justified, but an individual illness is a collective affair to some degree” (Metz & Gaie, 2010:

278). The significance of the Afro-communitarian theory can also be seen on the current approach towards HIV and AIDS pandemic whereby openness and disclosure are encouraged and viewed as an important approach to give each other the social support.

Ubuntu's relational approach encourages members of the family to be involved during the treatment of their family member in order to give social support to the vulnerable individual and help him/her to make the best medical decision for his welfare. "Since character or personhood on the present African moral theory is itself a matter of esteeming communal relationship, construed as the combination of identity and solidarity, it follows that another, substantial part of the point of medical treatment is enabling the patient to identify with others and exhibit solidarity with them. That is, one proper aim of a healthcare worker is fighting those illnesses and injuries that substantially prevent a patient from both sharing a way of life with others and caring for others' quality of life" (Metz, 2010: 54).

The reason behind the family involvement is basically to help the ailing member to re-cooperate with other persons in harmonious relationships. Their involvement is not taken as a breach to privacy, but as a way of sharing agonies that the family member is going through as well as taking care of the patient. Home based care by family members plays an important role in the healing of the patient because family members would have been familiarized with the medical treatment of their patient. Hence, after the discharge of the patient from hospital, family members would be in good position to care for the patient at home. Unlike in an atomistic situation whereby patients are left with making the decisions during such hard times of illness and they deal with the end of life issues alone. Such an approach can lead to patients' denial due to lack of social support and this may delay the healing process.

In African moral theory, maintaining privacy would restrain the members of the family from caring for their loved ailing patients. The harmony and commitment of the family members can also be seen clearly during home based care, where family members treat and nurse their ailing member of the family. This commitment goes beyond the extreme situations whereby the patient can be informed by the physicians that s/he has reached medical futility, but family members will still continue with home-based care on their own till the last moments of the life of the sick member.

They never abandon their responsibilities towards one another because they believe in the motto that says an injury to one is an injury to all.

In support of the above point, Francis Rakotsoane and Anton Van Niekerk have discussed an African proverb about the value of human life and we can apply this proverb in the context of privacy. According to them there is a proverb that says "*Ha le fete khomo le je motho*". Literally translated: "Let it not go past a beast to kill a human being" (the *it* refers to a spear used in killing). This proverb refers to human life invaluableness (2017: 253). They further illustrated that "when the proverb is uttered today, the purpose is to indicate that every effort should be made to save human life and that no resource can ever be considered more important than human life. The proverb points to the invaluableness of human life as the principle that should govern people's behaviour and attitudes when dealing with human health and safety" (Rakotsoane & van Niekerk, 2017: 254). In other words, this proverb reflects that the illness is regarded as a family matter because the family plays a key role in order to provide care for the sick member. Hence, the privacy of the ailing member of the family is maintained within the family not only by the one who is sick.

It is a normative practice in African context that when a patient requires medical attention "his or her family members often accompany the patient to the hospital or clinic (Murove, 2009: 170). The information given during the consultation process is disclosed in the presence of the family. This is done with the purpose of sharing the way of life and helping the sick and weak person to make sound medical decisions. Murove further says in "Western bioethics, the patient and the doctor maintain an exclusive individualistic relationship whereby the information of the patient is confined to him or her alone and, therefore, not divulged to anyone without the consent of the patient" (Murove, 2009: 170). This Western approach emanates from Kant's view of autonomy which I have criticized so far in this research.

7.5. Objection from Utilitarianism (what makes Ubuntu different from Utilitarianism)

The relational approach of ubuntu which is basically grounded on the harmonious relationships that promote the welfare of other persons is different from utilitarianism (whether utilitarianism generally or act and rule utilitarianism considered specifically). In terms of act utilitarianism for example, ubuntu is different from it. Utilitarianism considers “actions to be judged right or wrong solely by virtue of their consequences; nothing else matters. In assessing consequences, the only thing that matters is the amount of happiness or unhappiness that is created” (Rachels, 2007: 100). Furthermore, ubuntu does not consider the end results alone to be a reason behind harmonious relationships, but it focuses on the inner moral character of the individual within their own communities as well as encouraging caring relationships with others. Thus, “harmony is achieved through close and systematic social relations within the group. Individuals consider themselves as integral parts of the whole community, and a person is socialized to think of himself, or herself, as inextricably bound to others. (Metz, 2011: 539).

Ubuntu considers harmony as the final good. In ubuntu, it is not a matter of maximizing the good for many, but the objective is to promote communal harmonious relationships among human beings. Although this moral view has element so consequentialism it is not utilitarianism, and if one goes with Metz’s formulation of ubuntu, then one may even say that ubuntu present a deontological worldview. For as we have seen with Metz’s formulation of ubuntu it prescribes respecting, not maximising, relationships of identity and solidarity, which is a sensible way to respond to them. Respect for harmonious relationship would generally forbid using a very discordant means (involving division and ill-will) to realise a harmonious end. Being unfriendly so as to promote friendliness does not normally honour friendship (Metz, 2010: 54). An act, he argues, is good in so far as it enhances the communal harmonious relationships and promoting the welfare of others.

On both the consequentialist and deontological picture of Ubuntu it is different from utilitarianism. The difference between ubuntu and utilitarianism on this aspect is that ubuntu aims towards the common goal of harmonious relationships and it disregard the unjustifiable means aimed to promote the welfare of others insofar as such acts fail categorically to enhance the harmonious relationships. Whereas, under utilitarianism such acts are considered to be good in as much as they maximize good results for many.

According to Macpherson and Macklin (2010: 32), the application of African theory by Metz in medical treatment does not raise any moral dilemma because if the African and two Western moral principles all point to the same outcome of an ethical issue, what does it matter (except to philosophers) if the underlying justifications differ? According to them the point of medical treatment is, plain and simple, to treat the sick and either cure or palliate the patient's condition. The approach of Macpherson and Macklin is basically on maximization of the welfare of the patients as well as abiding by the binding obligations. This approach is different from how ubuntu approaches issues in doctor-patient relationship because their view is basically based on utilitarianism. For instance, a mandate to focus only on the cure of patients has the potential to lead to unjustifiable means which can be used in as far as they promote the welfare of the patients. In this case, manipulative mechanisms in medical research can be justified as long as it promotes the welfare of the patients. Ubuntu however, considers such a practice to be unfriendly because it fails to promote the mutual respect and harmonious relationships.

On the other hand, Macpherson and Macklin have acknowledged that Metz is certainly correct in pointing out that the two dominant Western moral theories have great difficulty accounting for the intuition that the researcher has a non-contractual duty to aid the participant. The African moral theory points to the relationship that a researcher has created with the participant, and that relationship, sharing a way of life', gives rise to an obligation 'to care for one another's quality of life. Their acknowledgement illustrates that they were backing the question when they claim that there is no difference between ubuntu and two Western moral principles because the outcome is the same. Having the same outcome does not mean that we have used the same approaches because the other approach is basically focusing on the end results without justifiable means; while the other approach aims to enhance social harmonious relationships where people respect and care for other persons' endeavours. It matters a lot not only to philosophers but even to people who are providing health care to the patients or researchers in medical research on human subjects since they see themselves as interrelational and interconnected with the research participants and not only maximizing (utilitarianism) or following some certain obligatory duties (deontology).

Conclusion

In this thesis, I have articulated reasons to think that ubuntu does not only provide a plausible account for doctor-patient relationship, but also is in several ways more promising than Kant's deontology, which is grounded on the value of autonomous individuals. The preferred Afro-communitarian theory considers an act to be right in as much as it promotes harmonious social relationships and takes the self as embedded with other selves; whereby human beings are encouraged to live in integrated relationships. This relational approach is favourable in doctor-patient relationship because it encourages the involvement of the family members when one member of the family is sick and needs treatment. On this approach, sickness on its own can compromise the mental competence of the patients because they might end up making choices that do not benefit themselves if not assisted. Even when they are mentally competent patients cannot be isolated from their embedded social relationships with the family members. This approach seems preferable to Western bioethics, which is dominated by Kant's individual autonomy and rationality. Kant's philosophy in doctor-patient relationship fails to acknowledge that patients' autonomy can be rendered by illness and therefore, patients need social support from their family members in order to make the best medical treatment. Furthermore, it has been argued that solidarity through ubuntu refers to a situation whereby people act benevolently and aim to improve other people's lives.

The moral theory of ubuntu does not focus on the self-determination of the patients alone and it does not perpetuate a view of the improvised self or persons that sees the self as atomistic, rather it considers the interests of the patient within the integral relationships of other members of the family. Ubuntu aims to enhance the harmonious relationships and its emphasis on solidarity and identity as well as caring for others makes it to be a relational ethic that prizes harmonious relationships over the end results or maximization of individual autonomy.

Ubuntu considers the notion of the self as constituted and embedded in and by our interpersonal social relationships. In this account, autonomy is not considered as an authority for individuals to pursue to their own good in exclusion of others, but as a character that enables individuals to relate harmoniously with others within their communities and attain the common good. Kant's deontological approach in bioethics which relies on individual's autonomy and atomistic individuals does not present a rich picture of the self as embedded.

Factors like depression and anxiety can affect the mental competence of the patients hence; leaving all the powers in their hands may lead them to make poor medical choices that may result into harm. It is a challenge for the patients to make medical decisions alone when going through critical health conditions. Hence, ubuntu has a rich account of the self because it considers all the interests which refers to (an account that includes family interests), considerations (an account that considers persons as relational) and other factors referring to an account that views (mental capacity as not global, but relative in the doctor-patient relationship). Unlike Kant's account which promotes the good of the rational agent as a self-legislating being. Kant's philosophy is also very narrow in doctor-patient relationship because it is difficult for the individual patients to formulate the laws or making medical decisions that can be willed to become the universal law because most of their medical conditions and decision making have nothing to do with moral duties due to different illnesses they are suffering from.

In this regard, ubuntu is more favorable to Kant's deontology and fills the gap in doctor-patient relationship because its inclusiveness approach promotes the welfare of both patients who are deemed to be mental competent or incompetent since are considered to be integrally embedded within the social relationships. Thus, the maxim of ubuntu which says "a person is a person through other persons" gives the family members of the ailing person a sense of obligation to further the interest of those who are ill by giving them the social support and find the solution together.

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