INFORMATION MANAGEMENT IN PHYSICIAN-PATIENT INTERACTIONS: TOWARDS A NEW APPROACH

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DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

April 2019

DEDICATION

This essay is dedicated to all researchers who in silent tears, engage in the tedious task of tidy thinking

ABSTRACT

This dissertation argues that a set of guidelines rooted in a particular African ethics, and specifically, a combination of *Ubuntu* and the Yoruba concept of *ootọ́*, can usefully supplement current medical ethics codes and guidelines, and be of assistance in addressing ethical challenges around unsolicited information in a variety of clinical contexts, thereby contributing towards theoretical diversity, enhancing health professional/patient communication, and justifying loss of value in the event of an ethical dilemma. Unsolicited information raises unique challenges for health professionals in the clinical context. For example, withholding information about misattributed paternity accidentally discovered in testing for organ compatibility may be seen by a patient as a violation of his right to know. On the other hand, disclosure when a patient has not requested such information (and where establishing paternity is not the purpose of the patient's clinical interaction with the physician) may be taken by the patient as a violation of his right 'not to know'. My examination of existing regulations and studies reveals that there is a lack of adequate guidance for managing ethical issues around unsolicited information. In the absence of such guidance, contradictory and ethically challenging proposals have been made. Some scholars propose, for example, that the decision to reveal or withhold information should be at the discretion of the physician, but this puts the physician in an omniscient position over the patient whose informational preferences should also count. Principlism has also been suggested as an approach for managing such information, but it is often challenging to decide which principle should take priority when principles conflict. Moreover, principlism does not focus adequately on significant elements of human experience, as well as important background information about the patient, which may complicate a harm/benefit analysis of non/disclosure of unsolicited information within the clinical setting. This point is especially true of Africa, where important cultural inclinations such as an African communalistic outlook on life will complicate how a patient receives, for example, information about misattributed paternity. This dissertation will use philosophical reflection and qualitative research methodology to argue that African moral theory contains an under-emphasized value for addressing these ethical challenges around unsolicited information. Specifically, it proposes guidelines, rooted in an African ethics which I defend, that do not only rely on the health professional's discretion but that also foster the patient's shared decision-making capacity. I am optimistic that if this alternative model is

incorporated into current medical ethics codes and curricula, it will significantly enhance ethical decision-making around unsolicited information in the clinical context, as well as health professional/patient communication in general.

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CHAPTER 1. Introduction

> An 18-year-old woman, Miss P, approaches the transplant centre stating that she would like to donate a kidney to her sick father, Mr P. She appears to be highly motivated to donate, is healthy, and testing indicates that she is medically suitable. The potential recipient, Mr P, is a 50-year-old man who has polycystic kidney disease. He has been on haemodialysis for six months but has noticed that his strength is deteriorating and that he does not feel well on dialysis. Transplantation is considered the best form of treatment for his end-stage renal disease (ESRD). The waiting time for a cadaveric transplant is approximately four to six years and the results of transplantation from living donors are better than those obtained from cadaveric donors. HLA testing shows that Mr P and Miss P are a one-antigen match, which means they cannot be genetically related. The test is repeated and the results are confirmed. Neither Mr P nor Miss P gave any indication that they believe they are not blood relatives. The testing was not done to establish paternity and, from a medical point of view, the findings do not preclude Miss P from donating to Mr P. How should the physicians proceed? (Sokol, 2006b)

Managing information in physician-patient consultative encounters is not always clear cut. Information management in such interactions refers to the physician’s power to control the volume of information that is disclosed to or withheld from the patients (Swaminath, 2008). Current inter/national regulations and professional bodies[1] generally require physicians to disclose full and accurate information with significant welfare implications, whether health[2]-related or of a personal nature, to their patients. Such disclosure, it is widely speculated, would greatly strengthen the patient’s autonomy and enhance informed decision making. This

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[1] For example, the Australian Good Medical Practice: Code of Conduct for Doctors in Australia (2004: 9ff); the Council of International Organization of Medical Sciences (CIOMS) "International Ethical Guidelines for Biomedical Research Involving Human Subjects" (2002, Commentaries on Guidelines 5, 16, 18 & 21) and “International Ethical Guidelines for Epidemiological Research" (2009, Commentaries on Guidelines 4, 5, 21); the World Health Organization's (WHO) "Draft Guidelines for Adverse Event Reporting and Learning System" (2005: 12ff) and "Ethical issues in Patient Safety Research" (2013: 30ff); the American Medical Association's (AMA) Code of Medical Ethics (Council on Ethical and Judicial Affairs, 2001:1ff); the World Medical Association's (WMA) International Code of Medical Ethics (1995); the Nigerian Code of Medical Ethics (2004); and the South African Guidelines for Good Practice in Healthcare Profession (2008, Booklet 3: 2; Booklet 9: 4) to mention but a few.

[2] I am keenly aware of the challenges associated with defining health and disease in bioethics literature. In this dissertation, I will use "health" to refer to physical, mental and social well-being and not merely the absence of disease or infirmity.

obligation is a matter of ethics and law. Withholding relevant information from patients, which may guide them in making informed decisions about what therapy or course of treatment to pursue, is regarded as a violation of the duty to respect persons. A failure to disclose information could also expose a physician to legal liability in that it could constitute a breach of fiduciary duty or professional negligence. However, other regulations such as The Health Care Professions Council of South Africa's Guidelines for Good Practice in the Healthcare Professions (2008, Booklet 4:3-4), permit a physician to withhold information in circumstances where disclosure is medically contraindicated[3], that is, where disclosure may lead to harm or compromise the patient's recovery process.

However, there are some consultative encounters in physician-patient relationships where deciding what course of action to take remains a herculean task. This is the case when unsolicited information, or a finding of significant health or personal value,[4] is accidentally discovered during a physician-patient encounter. The opening case is a quintessential example of this. Existing studies on information management, particularly those regarding the management of unsolicited findings of significant import in doctor-patient interactions, may be broadly categorized into studies which support disclosure of such information to patients and studies which argue that physicians may withhold such information from their patients.

In favour of disclosure, some scholars argue that "a patient's right to be informed takes precedence over any doctor's exercise of discretion" (Edwin, 2008: 157ff). This absolute right is taken to be the basis for the disclosure of information to patients. This right therefore, morally obliges a physician to disclose all information to patients (Abdi et al., 2012: 172-3). Other scholars support disclosure from a utilitarian perspective. Truth telling, they argue, not only shows respect for patients, but also promotes patients' wellbeing, furthers patients' life choices and reduces the doctor's liability. Holding back health-related or other important

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[3] Disclosure is medically contraindicated if it would cause a depressed patient, for example, to become actively suicidal or compromise a patient's recovery process such as telling a hypertensive patient receiving critical care in the Intensive Care Unit that his/her spouse has just died.The American Medical Association (AMA) Code of Medical Ethics (2010), for example counsels that physicians have a "sacred duty . . . to avoid all things which have a tendency to discourage a patient's recovery and depress his spirits." Disclosing news of the death of a loved one to a patient recieving care in an intensive care unit, is medically contraindicated since such news may quickly hasten the death of patient or harm him in other ways. Confer Guidelines for Good Practice in the Health Professions (Booklet 4(3:3))

[4] Information is said to have health or personal value if it could be used as a basis for an intervention directed towards improving someone‘s health status, avert serious adverse health conditions or enhance life choices.

information from competent patients, Bostick and colleagues (2006) add, would not benefit them in the long run, and can actually cause more harm than good. A doctor who withholds information from a competent patient, except in the exceptional case of patient waiver – that is, when a patient has formally indicated, through a signed document, that they prefer not to be informed – therefore violates the ethical principles of autonomy, beneficence and non-maleficence.

Disclosure of information, as agitated for by these scholars, cannot be easily applied to the example of the opening case. Disclosure in this case may result in the following outcomes: the father and/or daughter may experience psychological distress, Miss P may refuse to donate her kidney, Mr P may reject the kidney, and finally, the bond in the family may be permanently severed. In order to avoid such challenges, some scholars argue that non-disclosure in such circumstances may be ethically justifiable.

Non-disclosure of health information, Cote (2000: 203f) observes, is one way doctors can avoid conflict with the most fundamental portion of the Hippocratic Oath: "*primum non nocere"*- do no harm. In order to protect the patient, physicians may consider it the best option in a given situation to hold back or universalize[5] disturbing information which is judged to pose serious risks to their patients. According to Cote (2000: 199), the general standard of information revelation encouraged by the World Medical Association (1995) cannot always be obeyed in every situation. Therapeutic privilege remains an exception to this general requirement. Therapeutic privilege refers to lying or the withholding of information by the clinician in the belief that disclosure would harm the patient or be counter-therapeutic (Chiodo and Tolle, 1994; Etchells et al., 1996; Fried and Perlis, 2012). For example, one may invoke therapeutic privilege by lying to a patient about a poor prognosis in order to minimize a patient's associated psychological stress.[6] However, Dickens (quoted in Cote, 2000: 205) counsels that this privilege should not be invoked simply because physicians believe that the patient may make bad choices. The harm involved in order that

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[5] Information is universalized or generalized, within a physician-patient encounter, when a physician speaks vaguely or presents information to a patient in such a way that the patient does not immediately see how that information specifically applies to him/her; or in such a way that the patient does not immediately perceive the specific imports (health or personal implications) of such information

[6] According to De Pentheny O'Kelly and colleagues (2011), concealing information from a critically ill patient is an instance of therapeutic privilege, since it is a humane and ethically justifiable way of avoiding loss of hope of recovery and unnecessary emotional distress associated with disclosure.

non-disclosure of information could be ethically acceptable must be substantial. It must be the case that revelation of such information would adversely compromise the physical or mental health of the patient, or jeopardize the outcome of an intervention.

Non-disclosure for therapeutic reasons, as proposed by these studies, also holds ethical challenges. It may be viewed as a violation of the patient's autonomy or a diminution of the existing trust relationship between the physician and the patient. As Swaminath (2008: 83) puts it, "[a]ccess to truth - full information - is a right (because respect for patients demands it), a utility (to enable making of informed judgments) and a kindness (as lies poison relationships, resulting in withdrawal from constructive liaisons)". Thus, critics argue, withholding information without the patient's consent, even for therapeutic reasons, is a dangerous practice (Abigail, 2011: 2); risks undermining trust in physician-patient interactions (Cole and Kodish, 2013: 640); is a form of medical paternalism[7] which gives rise to avoidable conflict between the physician's obligations to promote patients' welfare and respect for their autonomy by communicating truthfully; and is therefore ultimately, ethically unacceptable (Bostick et al., 2006: 305).

Non-disclosure of information also raises legal issues: the physicians may be accused of medical negligence or exposed to other forms of legal indictment and litigation. Miss P, in the opening case, for example, is donating her kidney to Mr P on the assumption that Mr P is her father. Not informing her that the genetic test reveals otherwise would adversely compromise her right to make an informed decision. She may, if she eventually discovers the truth, take legal action against the physicians and hospital for failing to warn her.

A final and perhaps the most important problem with arguments for non-disclosure is that there are no adequate guidelines for invoking therapeutic privilege, except that physicians should use their discretion (Samanta and Samanta, 2011; Van den Heever, 2005: 420; Hurwitz, 1999: 661; Schleiter, 2009: 698). This point is well articulated by Samanta and Samanta in their Book *Medical Law* (2011: 154) when they observe that the use of therapeutic privilege intrinsically involves the exercise of the doctor's discretion. This makes

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[7] "Medical paternalism is the view that medical decisions about diagnosis and prognosis, such as the decision to undergo ground breaking surgery, or decisions around the care of terminally ill patients etc., are best left in the hands of healthcare professionals. This view is often condemned for placing the physician in an omniscient position over the patient who is denied the right to make informed decisions and whose capacity to share in decision making is negated." (Ewuoso, 2018)

it very easy for healthcare providers to abuse their (therapeutic) privilege. In order to overcome the challenges associated with non/disclosure, some scholars propose principlism as an approach for managing unsolicited findings.

Principlism is a framework of four moral principles – respect for autonomy, beneficence, non-maleficence and justice[8] – for making ethical decisions and clinical judgements (Demarco, 2005: 101; Beauchamp and Childress, 2009). Principlism features autonomy, beneficence, non-maleficence and justice because, according to DeMarco (2005:101), they involve nearly universally accepted values. In reaching decisions about non/disclosure within clinical contexts, principlism argues that an action is morally preferable if it enhances a patient's autonomy and appropriately balances benefits against risks or harm. However, principlism lacks a foundational principle for resolving conflicts between its core principles when they arise.[9] The above case-example presents a situation where a physician's obligation to respect Miss P's right to make an informed decision – respect for autonomy – conflicts with the physician's obligation to provide health benefits to Mr P. Principlism lacks a foundational theory for managing such conflicts. Whose rights should count here: Miss P's right to significant information that will enhance informed decision making or Mr P's right to receive a health benefit? The harm/benefit analysis advocated by principlism, is also potentially complicated by cultural diversity. For example, in the West, Gordon and Paci (1997: 1445-52) observe that the candid, individualistic American approach to truth-telling in medical interactions is viewed by many Italians as very harsh, irresponsible, lonely and naïve, for cultural and religious reasons.

In conclusion, unsolicited findings of significant health or personal value which are accidentally discovered in physician-patient consultative encounters can evoke far reaching ethical dilemmas and have legal imports for physicians, relatives, medical staff members and patients. These imports, and ways of overcoming the same, have not been satisfactorily resolved by existing studies or health regulations.

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[8] The principle of respect for autonomy emphasises respect for persons and supports autonomous decisions; the principle of non-Maleficence asks us to avoid causing harm to others; the principle of beneficence pertains to providing benefits and balancing benefits against risks and costs; the principle of justice pertains to the fair distribution of benefits, risks and costs (Beauchamp and Childress, 2009: 12f).

[9] I shall defend this position properly in the third chapter

1.1 Stating the Problem

My examination of existing regulations and studies reveals that there is a lack of adequate guidance for managing unsolicited information of significant health or personal value which is accidentally discovered in physician-patient relationships. This study will investigate and develop a set of considerations for managing such information. As stated above, in the absence of adequate guidance, contradictory and ethically challenging proposals have been made. Some scholars propose that the decision to reveal or withhold information should be at the judgment or discretion of physician (Wynia, 2004). But this raises the following questions: Is a physician always in the best position to make value judgments about what is good for a patient, and is he justified in doing so? Shouldn't the patient have a say on how his health is managed? The proposal that the physician should use his discretion puts the physician in an omniscient position over the patient whose informational preferences should also count. Additionally, harm may result from withholding information from a patient and the physician may be exposed to litigation for professional negligence as a result. Principlism (Baines, 2008; Macklin, 2003; Stanley, 1998; Valenstein, 2008) has also been suggested as an approach for managing dilemmas raised by unsolicited information. However, as argued in the previous section, it is often challenging to decide which principle should dominate when principles conflict. Some critics (Westra et al., 2009; Fiester, 2007; Gardiner, 2003; Arries, 2005; Gordon, 2011) also suggest that principlism does not focus adequately on significant elements of human experience such as a patient's faith or religious beliefs, or cultural values. The emphasis on autonomy within principlism also fails to appreciate fundamental importance of understanding persons as embedded in communal relationships (Behrens, 2017: 2). These aspects of human experience, as well as important background information about the patient, may complicate any harm/benefit analysis of non/disclosure of unsolicited information within the clinical setting.

This point is especially true in Africa where important cultural inclinations such as the African communalistic outlook on life, religious worldviews, marital status, gender, and/or age, to mention but a few, will complicate how a patient receives, for example, information about misattributed paternity. As Jegede (2009b: 239-250) observes, communalism is the basis of existence in many African societies. An individual exists through his community. Amongst the *Yoruba* people of South-Western Nigeria, for example, an individual is considered a person because of her/his community. Disclosing information about misattributed paternity to a typical *Yoruba* can cause great psychological and emotional distress, and affect their sense of community, ethnic identity and personhood. A framework for decision-making which takes into account such morally relevant information would assist in dealing with the above challenges. The current absence of such a framework is a significant gap.

This study aims to contribute towards the management of unsolicited information in physician-patient consultative encounters. The particular aim of this study is to bridge the above gap by developing some considerations for decision-making, rooted in African ethics, and specifically, a combination of a particular theoretical formulation of *Ubuntu* and a communicative ethics modelled around the Yoruba concept of *ootọ́*, which do not simply rely on the discretion of the physician and which may be used to address ethical dilemmas around unsolicited information in a variety of clinical contexts (in Africa specifically, and more globally). This will entail proposing an approach that is sensitive to the patient's background, as well as their cultural and religious inclinations.

1.2 Aim and Objectives

This study will carefully reflect on the core ethical and legal dilemmas raised by unsolicited information in physician-patient encounters, and propose a new approach, deeply rooted in African[10] ethics, for managing the same within clinical settings. Specifically, this study will argue that a set of guidelines, rooted in a combination of *Ubuntu* and a model for truth-telling developed around the Yoruba concept of *ootọ́*, will provide a useful supplement to current medical ethics frameworks, and assist in addressing ethical challenges around incidental information in certain physician-patient clinical interactions.

The African ethics I put forward in this dissertation is specifically appropriate for the set objectives. It emphasises important values – such as harmony, community, relationships, interconnectedness and so on – that are important in addressing ethical issues around unsolicited findings. Moreover, the broad range of ethical issues this moral theory may be used to address have not been adequately emphasized. I am optimistic that this African

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[10] I am not claiming in this study that there is a "single" African perspective. I am deeply aware of the challenges associated with talking about 'an African perspective', given the diversity of Africa and African culture. I will reflect on this limitation later in this dissertation.

ethical theory, if incorporated into ethical codes and guidelines, will rival current (Western) ethical frameworks for addressing global bioethical issues in general, and issues around unsolicited information in particular. I propose to use this African ethical theory to highlight the point that in genuine moral dilemmas between the physician's duty to disclose information and to conceal information, any course of action may be pursued, if this can be supported with arguments which avoid merely relying on the physician's discretion but also consider the patient's values, cultural and religious inclinations, and embeddedness in communal relationships. This new approach will be a product of careful consideration of all morally relevant information, knowledge of various concealment strategies and knowledge of the patient's background. Criteria for the new approach will be highlighted and discussed in this study. Other specific objectives of this study include:

i. A careful examination of the concepts and challenges associated with managing moral dilemmas, particularly unsolicited findings in physician-patient interactions.
ii. An evaluation of the various proposals for managing moral dilemmas associated with (unsolicited) information in physician-patient encounters.
iii. Making recommendations to mitigate the identified legal and ethical issues raised by unsolicited findings of significant health or personal value.
iv. Making recommendations for future studies.

1.3 Ethical Framework

In keeping with the dissertation objective, which is to develop a set of guidelines deeply rooted in African moral theory for considering ethical issues around unsolicited information, this study will necessarily be situated within the framework of such a theory, and this will involve an attempt to identify the core aspects of *Ubuntu* which would be accepted by most scholars working in this field. This choice of ethical framework is deeply motivated by the belief that moral reflection that is deeply grounded in indigenous African thought is likely to contribute fresh insight to existing literature on how to manage ethical issues around unsolicited information, both within the African context and more globally, have not been adequately emphasized. This dissertation will attempt to fill this gap, as well as greatly enrich the discourse on the management of unsolicited findings.[11] I shall also supplement the theoretical formulation of *Ubuntu* by combining it with a model for truth telling developed around the Yoruba concept of *ootọ́*. The combination of these two properly constitutes the African ethics I shall apply and defend to achieve the objective of this dissertation.

A theory is to be considered African, Metz explains, if it is informed and defended by beliefs that are common among sub-Saharan Africans (Metz, 2007c: 321). It is equally to be considered distinctive insofar as it differs from what is dominant in contemporary Western society (Metz, 2007d: 375). In Metz's (2007d: 375) opinion, it is common to describe African ethical theory, particularly theories prevalent in sub-Saharan Africa, as communitarian, and Western ethical theory as individualistic.[12] This is related to the fact that community is a core ethical value amongst sub-Saharan Africans. Common amongst sub-Saharan Africans, Behrens (2013) observes, is the belief that a person is a person through other persons. In other words, my humanity is inextricably linked or bound up with others. Metz (2007c: 323) calls this *Ubuntu*.

In his article, "Toward an African Moral Theory"(2007c: 324), Metz affirms that *Ubuntu* is found across a wide area of sub-Saharan Africa, recurs more often in literature on African ethics, and cuts across a long span of time (Metz, 2011b: 532-558),[13] from traditional societies to contemporary African intellectuals. He describes *Ubuntu* as a relational theory which grounds authentic personhood, as well as the moral appropriateness or inappropriateness of an action, in the extent to which it promotes harmonious relationships - relationships in which individuals identify with others and care for their well-being. As he says, "An action is right just insofar as it promotes shared identity among people grounded on good-will; an act is wrong to the extent that it fails to do so and tends to encourage the opposites of division and ill-will"(Metz, 2007c: 338).[14] The emphasis on harmonious

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[11] Behrens (2013), argues in this regard that ethical reflection grounded in indigenous African philosophy, values and thoughts is not only more likely to be accepted by Africans and to restore dignity to the African people, but will also enrich bioethical discourse in general.

[12] In the fourth chapter, I shall answer the question as to the ways in which African moral theory is communalistic and Western theory individualistic.

[13] Metz presents a good explanation in his article "Ubuntu as a Moral Theory in South Africa" (2011), of how Ubuntu finds a timeless application in many sub-Saharan African societies, and is as such, not anachronistic as some have argued.

[14] Also confer Metz's article on "African and Western Moral Theories in a Bioethics Context" (2010: 49-58) where he also says, "An action is right just insofar as it is a way of living harmoniously or prizing communal

relationships - on community - makes this African ethical theory an appropriate ethical framework for this study, since it echoes the call for physicians to take seriously the fact that human beings are embedded in certain realities beyond themselves. As a result, certain actions, and the receipt of certain kinds of information or news, will have implications not only for the individual, but also for others.

Using this African ethics, I shall develop some considerations for managing unsolicited information in ways that are less damaging to patients and that will reduce harm to healthcare professionals. In line with this vision, three hypotheses will be highlighted in this study: first, physicians have a *prima facie* duty to disclose information. Second, in a clear case of therapeutic privilege, concealment is permissible albeit ethically challenging. Finally, in a situation where there exist compelling arguments to either withhold or disclose information, a decision may be reached if the preferred course of action can be proven with arguments which avoid merely relying on the physician’s discretion but also consider the patient’s values, cultural and religious inclinations, and communal relationships. The considerations for reaching such a decision will be highlighted and discussed.

1.4 Methodology

I propose to use philosophical reflection and a systematic review to achieve the study aims and objectives. In the next chapter, I shall attempt a clarification of key concepts; present two case reports and highlight ethical challenges associated with managing (unsolicited) information in physician-patient relationships. In this chapter, I will define physician-patient relationships; describe the different forms of information delivery in physician-patient relationships; and highlight ethical duties regulating these relationships. In the third chapter, I shall proceed to evaluate proposed strategies for managing ethical dilemmas around unsolicited findings. Specifically, I shall examine the adequacy of these strategies for analyzing moral dilemmas such as the one generated by unsolicited information; and by extension for clinical decision-making in tough contexts generally.

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relationships, ones in which people identify with each other and exhibit solidarity with one another; otherwise an action is wrong"

In the fourth chapter, I shall define an ethical framework for managing ethical dilemmas around unsolicited findings that is rooted in a particular interpretation of African Moral theory. Specifically, I shall use a systematic review to answer the research question: “Is there a theoretical formulation of Ubuntu that exists in current literature that is likely to be accepted by (nearly) all Ubuntu scholars as constituting this ethical theory?”

Finally, in the fifth chapter, I shall supplement the theoretical formulation of *Ubuntu* discussed in Chapter 4 by combining it with a model of truth telling developed around the Yoruba concept of *ootọ́,* and use this combination to address a variety of ethical issues around unsolicited information within the clinical context. Specifically, the fifth chapter will focus on the research question: How do we apply this model to address genuine dilemmas around unsolicited information within the clinical context? Finally, I will summarise my conclusions in Chapter 6.

1.5 Impact and Significance

As argued above, approaches for managing moral dilemmas caused by the discovery of unsolicited information of significant health or personal value in physician-patient encounters, do not adequately take into account important elements of human experience such as the patient’s faith, belief system, cultural background or values, gender, and so on, which may complicate how information is delivered to a patient. Some of these approaches also ignore the shared decision making capacity of the patient. Moreover, none of the existing approaches has sufficiently reflected on these issues from an African perspective. This study, in addition to providing guidance for resolving moral dilemmas in physician-patient relationships, will develop a set of considerations enriched by African experience and ethical theory, which would be useful for considering issues around unsolicited findings in Africa and more universally. I am optimistic that this study will make a significant contribution to Bioethics literature by drawing attention to how African ethical theory, and specifically *Ubuntu*, can help us to overcome the problems associated with unsolicited information.

The absence of adequate guidance for managing unsolicited information has left many physicians in a quandary and exposed them to the possibility of wrongdoing. My suggested approach seeks to give greater confidence to physicians in navigating the complex ethical and legal challenges posed by such dilemmas, as well as greatly enhance their information management skills in a variety of contexts, African or Western. It is equally expected that the results of this study will further enhance healthcare delivery, maximizing health benefits to patients and protecting physicians from lawsuits and other legal indictments.

Finally, I would like to state at the outset that a significant part of this dissertation has been published in different peer-reviewed journals. These publications emerged from research conducted as part of this dissertation, and are included in the bibliography, as well as listed here[15]. Parts of the dissertation rely heavily on these articles and I have at times included text from these articles verbatim.

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[15] EWUOSO, C. 2018. Managing Ethical Challenges around Misattributed Parentage within the Clinical Context: Insights from an African Moral Theory. *Dev World Bioeth*, EWUOSO, C. 2017. Models for Truth-Telling in Physician-Patient Encounters: What Can We Learn from Yoruba Concept of Ooto? *Dev World Bioeth*, EWUOSO, C. O., HALL, S. & KRIS, D. 2017b. How Healthcare Professionals Manage Information and Challenges in the Clinical Context: A Review of Empirical Literature. Center for Applied Ethics, University of Stellenbosch, EWUOSO, O. C., HALL, S. & DIERICKX, K. 2017d. *How Do Healthcare Professionals Manage Ethical Challenges Regarding Information in Health Care Professional-Patient Clinical Interactions? A Review of Concept/Argument-Based Papers and Case Analyses*, EWUOSO, C. O. 2016c. Beneficial Coercion in Psychiatric Care: Insights from African Ethico-Cultural System. *Dev World Bioeth*, EWUOSO, C. 2016a. A Systematic Review of the Management of Incidental Findings in Genomic Research. *BEOnline*, 3**,** 1-21, EWUOSO, C. O. 2016b. Beneficial Coercion in Psychiatric Care: Insights from African Ethico-Cultural System. *Developing World Bioethics*.

CHAPTER 2. CONCEPTUAL CLARIFICATIONS, CASE REPORTS AND ETHICAL CHALLENGES

Information management is key in every physician-patient relationship. It is the basis of the good clinical practice. Mismanaged information may undermine a patient’s faith in the healthcare system or lead to catastrophic consequences for the patient and physician. As previously noted, Swaminath (2008) describes information management in doctor-patient interactions as the physician’s power to control the volume of information that is disclosed to or withheld from the patient. Such information encompasses diagnosis, prognosis, and possible interventions (Swaminath, 2008: 1). This study defines diagnosis as a distinctive identification of an illness. This identification may be by way of medical examination of the presented symptoms, or via laboratory tests. I define prognosis as the identification as well as prediction, based on medical experience, of the likely outcome of available treatment options, while an intervention is a medical action taken to overcome illness or prevent death.

In this chapter, I will lay the groundwork for the rest of this dissertation in the following ways. Firstly, I will provide conceptual clarifications by providing working definitions of frequently occurring key terms and expressions in this dissertation. I will also differentiate unsolicited information from other terms with which it bears some similarity. Secondly, I will carefully define the context which is the focus of this study, and differentiate this from other contexts where unsolicited information may raise ethical challenges.

In accordance with the above aims, I will in the first section of this chapter provide a working definition of unsolicited information, and differentiate unsolicited information from medical errors, honest mistakes and professional misconduct. I will then highlight the different forms of unsolicited information, and conclude the section with a discussion of the significance of unsolicited information. In the second section, I shall describe the principal contexts where unsolicited information raises ethical challenges. I will highlight the context which is the focus of this dissertation, which is the physician-patient relationship, and discuss the duties which arise in such a relationship. In the final section, I shall provide some reasons as to why unsolicited information is especially problematic within the clinical context, and introduce two additional case examples by way of illustration.

I state from the outset that this study will limit itself to considering the management of unsolicited information in physician-patient relationships. For the purposes of this study, all information within the clinical context may be classified into solicited information and unsolicited information. Solicited information is primary information or a primary finding; it is directly related to the primary aim of a test or medical procedure. In my review of the management of incidental information in genomic research (Ewuoso, 2016a: 5), I observed that the term unsolicited information is used in a variety of ways. It is sometimes referred to as unexpected information, extra information, incidental information, information beyond study aims, and so on. In particular, the term 'incidental information' appears to be widely used to refer to unsolicited information in Bioethics literature. Where the term incidental information is used, the emphasis is always on intention. Patients come to the hospital to seek medical help for specific ailments, and physicians request a medical procedure, or undertake surgical operations with specific aims and objectives in mind. Any information which falls outside of these specific intentions is defined as incidental.

Current definitions of incidental information (or unsolicited information)[16] take their cue from the definition provided by Susan Wolf and colleagues (2008). Their 2008 article, "The Law of Incidental Findings in Human Subjects Research" (Wolf et al., 2008: 363), defines incidental information as "a finding concerning an individual that has potential health or reproductive importance and is discovered in the course of conducting research but is beyond the aims of the study". It is important that I clarify two important aspects of this definition; especially as they relate to the aims of this study. These aspects have to do with the nature of unsolicited information and the context in which it may arise. I will provide further clarification on each of these aspects in the following sections.

2.1 The Nature of Unsolicited Information

The definition of unsolicited information offered by Wolf and colleagues (2008) suggests that unsolicited/incidental information must be clearly distinguished from medical errors or misconduct. In what follows, I will explore these distinctions in greater detail to shed further light on the nature of unsolicited information, and will also elaborate on possible forms of unsolicited information, and the significance of this kind of information.

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[16] For the purposes of this study, incidental information and unsolicited information will be used interchangeably.

2.1.1 Unsolicited Information vs Medical Error

Herbert and colleagues (2001: 509) define a medical error as a preventable[17] adverse medical event. This definition is consistent with the description of medical error provided by Levinson and Gallagher (2007: 265). Some medical errors are harmful, while others do not cause harm, either by chance, or because the error was corrected before harm occurred (Levinson and Gallagher, 2007: 265). Non-harmful medical errors are called near misses.

Unsolicited information is not a medical error. A medical error, however, may become a piece of unsolicited information. When a physician makes a mistake, and information about this mistake has not been requested by the patient, then the information is unsolicited or incidental to the clinical interaction between the physician and patient. Let us consider, for example, a case of a surgeon who schedules an operation for retinal detachment for a 76-year-old man with long-term visual impairment. The patient consented to the procedure. After anaesthesia was administered, the surgeon observes an acute vitreous haemorrhage and a retinal cut consistent with needle injury. He proceeds swiftly to stop the haemorrhage and completes the surgery with no other mishap. The iatrogenic retinal injury may be considered a medical error, which may have occurred when anaesthesia was administered. Information about this error remains unsolicited since the patient has not asked about it nor is this information related to the purpose of the surgery.

2.1.2 Unsolicited Information vs Professional Misconduct

Medical errors may be the result of deliberate acts or omissions, or unintentional errors. When they are the result of intentional actions, they are called misconduct; while unintentional errors are described as honest mistakes. In other words, some errors represent a wilful departure from acceptable standards and may be termed misconduct, while others are not directly intended, and are called honest errors. There are standard ethical guidelines for detecting and correcting misconduct.

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[17] Whether all medical adverse events are preventable is debatable. This question is, however, outside of the scope of this study..

Misconduct is defined as “a negligible offence; and a wilful deviation from acceptable scientific standards either by way of what is not done but should have been done to prevent harm – error of omission – or by way of what is done to patients but should not have been done – error of commission” (Hebert et al., 2001: 509). In other words, professional misconduct occurs when reasonable expectations of acceptable professional standards enjoined on physicians by Health Regulatory bodies are breached. Some common forms of ethical misconduct include dishonesty in reporting medical events, professional negligence, or a breach of a patient’s autonomy, to mention but a few.

International and national guidelines recognize that physicians are humans. They are not immune to mistakes. However, these guidelines disapprove of dishonesty in reporting these events. For example, an orthopaedic surgeon accidentally operates on the wrong disc. Rather than honestly disclose this error, he lies to his patient about it and then tries to convince his patient to undergo another surgery to correct the error. This is considered a fraudulent concealment of important information which is owed to a patient, who ought to be informed of the event. Resnik and Stewart (2012: 2-5) seem to have this kind of example in mind when they describe professional misconduct as a deviation from acceptable standards with the intent to deceive.

Unsolicited information, on the contrary, is not necessarily dishonesty or deception. With unsolicited information, there is no intention to misrepresent medical events. In the next section, I shall attempt to distinguish the different forms of unsolicited information.

2.1.3 Forms of Unsolicited Information

The United States Presidential Commission for the Study of Bioethical Issues distinguishes between two forms of unsolicited or incidental information - anticipatable and unanticipatable findings (2013: 3). Since both forms of unsolicited information fall within the area of consideration of this study, I shall use the generic term unsolicited information.

The commission defined anticipatable unsolicited information as information that is known to be associated with a test or procedure. Since the physician is not entirely oblivious to the possibility of coming across anticipatable unsolicited information, it is possible for him/her to make plans for how to manage such information. For example, a family of four approaches a general surgeon for blood screening and other basic medical check-ups. Blood samples were drawn and other tests were conducted. The test results show that the family is in good health. However, the physician also discovers something else. The genotype test result reveals that both husband and wife are AA, while one child is AS. The couple did not give the physician any impression that the children are not biologically related to them. This is a piece of incidental information which is anticipatable within the context of a family medical check-up.

The Commission also defined unanticipatable unsolicited information as “a finding that could not have been anticipated given the current state of scientific knowledge.” (United States, 2013: 3) Contrary to anticipatable unsolicited information, health professionals cannot plan for this type of unsolicited information specifically. However, given that genomic and genetic tests, for example, are likely to generate unexpected findings in general, they can think consider in advance what they might do if an unexpected finding should arise, especially one that may be clinically actionable.[18] For example, a physician orders a test or procedure for the purpose of learning about A, and then he discovers C. C, based on existing medical knowledge and expertise at the time this test took place, is a result not known to be associated with the primary purpose of ordering the test or procedure (Bücher and Verlauf, 2015: 172). Here, C is said to be a piece of unanticipatable unsolicited information. Let us examine another example: a pregnant woman undertakes genetic testing to ascertain if her fetus has Down-Syndrome. The test revealed that the fetus has Down’s syndrome. During the course of analysis of data provided by the mother, the (health) professional also discovers that the mother carries a risk for BRCA 1 and BRCA 2[19] later in life. Given the state of scientific knowledge at the time this test took place, this is a result which was not previously known to be associated with analysis for Down syndrome in a prospective child or fetus. However, given that genetic testing is likely to generate unexpected findings in general, the health professional may be able to plan in advance for this kind of information, especially since it could be life-saving. This final point brings us to an important information about unsolicited information: some may be life-saving while some is not. In what follows, I shall consider the significance of unsolicited information.

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[18] I shall explain what is meant by "clinically actionable" in the following section.

[19] Breast Cancer Type 1 and 2

2.1.4 The Significance of Unsolicited Information

The web of ethical or legal difficulties raised by unsolicited information is often associated with the significance of this information. Unsolicited findings raise challenges for physicians because this information is often clinically actionable, or has some personal value.

Information is said to be actionable if it has clinical utility. Clinical utility is defined by Ferreira-Gonzalez and colleagues (2008: 3) as “a balance between health-related benefits and the harms that can ensue from a test”. The balance must favour the likelihood that the finding would lead to an improved health outcome. If such information could be used as a basis for an intervention directed towards improving someone’s health status or preventing premature death or substantial morbidity, then such information has clinical utility. Other conditions for determining clinical utility have also been highlighted by Bookman and colleagues (2006). They include the following:

- There is a significant risk for disease
- The disease should have serious health implications.
- There is a proven therapeutic or preventative intervention available

The clinical action-ability of information can influence the decision to disclose such information. But action-ability within a clinical context is determined through substantiation and validation to reduce the likelihood of returning false positive results to patients. The current standard practice within clinical care requires all diagnostic tests to undergo substantiation and validation in laboratories optimized for clinical care, or clinically approved laboratories (CLIA) – such as CLIA laboratories in the United States – before returning them to patients. Against this background, unsolicited information may have varying degrees of significance:

a) Clinically actionable information (the individual is at a high risk for a future preventable or manageable health problem, or already has a health problem for which a clinical action is available). Genetic predisposition to breast cancer types 1 and 2 accidentally discovered in a woman who enrolled for genetic testing to inquire if her fetus has Down-Syndrome, is an example of this.

b) Not clinically actionable (provides information for which there is no clinical action available, or which has no implications for the individual’s health status). For example, an individual approaches a geneticist to have his genome sequenced. During the sequencing, the geneticist discovers that this individual has Huntington's disease. There are no options for effective clinical management, so this information is not clinically actionable, but it may be of personal value for life planning and making reproductive decisions.

c) No known clinical significance (the implication for the individual's health is at the moment unknown). For example, clinical genome sequencing would yield enormous information; some of this information would be clinically significant while the clinical significance of others, given the limitations of science, would be unknown.

As is the case with b), certain findings may also be of value, not because they have clinical utility, but because of their personal utility. Controversies regarding unsolicited information with personal value are not uncommon within the clinical setting. For example, owing to the sense of heritage, unsolicited information about misattributed paternity has been known to generate controversies within clinical settings (Schroder, 2009; Adlan and ten Have, 2012b; Jegede, 2009a). Such findings may lead to a loss of identity, the loss of rights to inherit, stigmatization and expulsion from the community. The individual may be labelled illegitimate. Similar labels have been known to cause great psychological distress for individuals. But there may also be other (positive) effects of returning unsolicited information of misattributed paternity: knowledge of one's true family background, for example. This study will concern itself primarily with unsolicited information that has clinical and/or personal value.

In light of the preceding clarifications, this study defines unsolicited information broadly as "a finding (or information) – anticipatable or unanticipatable – with or without clinical or personal utility, about a subject or subjects, discovered in the process of a systematic and methodical analysis of data, which is not directly related to the aims and objectives of the test or procedure". Similar to the definition provided by Wolf and colleagues (2008), this definition acknowledges that unsolicited information is information which goes beyond the aim or objectives of conducting a test or undergoing a (medical) procedure.

Wolf and colleagues focused on unsolicited or incidental information which may arise within research context. Since context is also important for a good ethical evaluation of the difficulties around the management of unsolicited information, in what follows I shall identify one other context in which unsolicited information may also arise, and differentiate this context from the research context, while paying attention to how each context influences the ethical evaluation of the disclosure of unsolicited information. The section will close with a discussion on why unsolicited information is especially problematic within the clinical context. However, before this differentiation, I would like to clarify how the term 'unsolicited' is used in this study as opposed to how others have understood this term.

Unsolicited is taken by some to mean not requested, but given nonetheless, because of the context in which individuals usually use the word, such as when someone says, "why am I receiving these unsolicited mails?" Evidence from my systematic review (Ewuoso, 2016a: 5) of the management of unsolicited information in genomic research reveals a different understanding. The literature in this area, as I have pointed out already in this section, often use the term interchangeably with incidental findings. In many cases, when the term is used this way in the literature, authors are considering precisely whether such findings *should* be revealed, which indicates that unsolicited does not refer exclusively to findings or information that has already been revealed or provided (Bijlsma et al., 2016). In other words, the precedent in literature is that the term unsolicited does not imply that the information or finding it describes has already been provided. Hastings and colleagues (2012) in fact observe that the terms unexpected or incidental findings are in themselves misleading, as it is a matter of statistics if and when a certain result will occur. Thus, they suggest that perhaps the terms additional information or unsolicited information are more appropriate.

Having differentiated between how the term unsolicited is used in everyday language and in existing literature, I now turn to the next section to differentiate between two common contexts where the challenges around unsolicited information often arise.

2.2 Ethical Evaluation of Unsolicited Information: The Clinical Context vs. the Research Context

Context may complicate the evaluation of ethical difficulties around unsolicited information. Two common contexts should be differentiated: the research and clinical contexts. This study will focus on anticipatable and un-anticipatable unsolicited information which often arises within the clinical context.

"Research is defined as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to knowledge" (Levine, 2003:103). Research is either therapeutic, if it provides direct benefits for the research participants, or non-therapeutic, if there are no direct healthcare benefits for the research participants.

Returning unsolicited or incidental findings is a contentious issue within the research context. Research aims at creating generalizable knowledge. Research subjects who take part in research know they "are contributing to the creation of generalizable knowledge and might not receive any benefit from" participating in the research enterprise.

A few practical issues may influence how a researcher manages unsolicited information within the research context. The researcher, for example, may not have the required expertise to detect and interpret anomalies; the research may have been conducted in facilities not optimized for clinical care; or the cost of confirming, analysing and returning unsolicited finding or information may undermine research (United States, 2013: 16 & 91), or the ability of the investigator or researcher to complete the research project For these reasons, some scholars such as Solberg and Steinsbekk (2012: 195f) argue that researchers are not necessarily required to act for the health benefits of research participants. Moreover, as previously stated, the goal of research is to generate generalizable knowledge – not clinical care – and the possibility of false positives may be higher (which can cause avoidable panic for a participant). There are also advisory committees, such as the Singapore Bioethics Advisory Committee, which discourage the return of incidental or unsolicited findings by researchers, in order to prevent therapeutic misconception – which is a situation whereby a research participant "inaccurately attributes therapeutic intent to research procedures" (Zawati and Knoppers, 2012). According to this committee:

> Donors should not expect any personal or direct benefit from the donation of tissue, including information of any medical condition or predisposition or likelihood of such discovered in the course of research on the sample. Likewise, researchers and tissue bankers should not be under an obligation to disclose such information to the donors, unless they have agreed to do so in advance of the donation (2002).

It is not clear, however, if the committee's recommendation extends to primary researchers who have a direct relationship with research participants.

On the other side of the divide are scholars who believe that researchers ought to benefit research participants by returning life-saving, albeit incidental/unsolicited, information to the same. For example, based on the duty of reciprocity, if an enterprise such as the research enterprise has benefited from the contributions of research subjects, it is only appropriate that researchers benefit their participants in return by returning results of potential clinical value. From the Kantian perspective, this would ensure that participants are not used as mere means to the researcher's goal of generating generalizable knowledge (Beauchamp and Childress, 2001). “It would be disrespectful to treat research volunteers as conduits for generating scientific data without giving due consideration to their interests in receiving information about themselves derived from their participation in research.” (Shalowitz and Miller, 2005)

The duty to benefit research participants, Wolf and colleagues (2008) also add, “is a part of a broader duty of beneficence: to secure participants’ well-being by maximizing benefits and minimizing harms”. The researcher’s duty to reciprocate kind gestures is a necessary consequence, flowing from the recognition of what research participants have contributed to the scientific enterprise. Illes and colleagues allude to this principle as the basis for grounding the duty to return clinically significant information to research participants (Illes et al., 2006).

Finally, there are scholars who believe that returning unsolicited and clinically significant findings to research subjects is a way of honouring participants’ rights to self-determination. Knoppers and Chadwick (2005), for example, argue that informing participants, during the process of obtaining informed consent, that the researcher will be reciprocating their kind gesture by returning clinically significant findings, is indeed a way for researchers to treat research participants respectfully.

However, it is outside the scope of this dissertation to explore in details the issues generated by unsolicited information within the research context. I focus mainly on the clinical context. There are important duties which complicate how unsolicited information is managed within the clinical context. In the next section, I shall specify these duties, as well as define the clinical context.

2.3 The Physician-Patient Relationship: Defining Context and Duties

In every physician-patient relationship, there is a patient and a physician (Solberg and Steinsbekk, 2012: 195). A patient exists because an individual has contacted the health care system in order to receive help for a disease or medically related condition. In other words, with every patient, the intention to get help for a physical or mental ailment exists. For the purposes of this study, I shall define a patient as any recipient of healthcare services. Patients are either competent or incompetent. Different regulatory ethical and legal codes have varying standards for assessing in/competency. Generally, a competent patient must have the legal capacity to provide consent; evaluate relevant information[20] (Richard et al., 2010); understand the consequences of actions; and reach a voluntary decision after careful rational reflection. Otherwise, the patient is incompetent. Some examples of incompetent patients include children, and psychotic or mentally disabled persons. This study will focus primarily on competent patients.

In a physician-patient relationship, there is also a physician whose primary training compels him/her to render medical help, when he can, to those who seek it. In this dissertation, I shall describe a physician as any authorized practitioner in medicine who is concerned with providing healthcare through diagnosis and treatment of physical or mental ailments. When a patient and a physician meet – usually within a clinical setting – a physician-patient relationship emerges (Solberg and Steinsbekk, 2012: 195). In effect, a physician-patient relationship may be described as an encounter between a physician and a patient in a clinical setting. The goal of this encounter is the provision of healthcare.

This relationship is often described as a consensual, contractual relationship. However, this consent does not need to be expressed formally. It is generally assumed that a physician-patient relationship exists as soon as a physician takes an affirmative action in a patient's case by either examining, diagnosing, treating, or agreeing to do so. "Once the physician enters into a relationship with a patient in any of these ways", Blake (2012: 404) argues, "a legal contract is formed in which the physician owes a duty to that patient to continue to treat or properly terminate the relationship". The common cited case law to support this general assumption is *Mead v Legacy Health System*[21] (2009a; Blake, 2012: 404; West, 2010).

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[20] According to medical standards, material or medically relevant information must contain diagnosis, prospsed intervention, risks and benefits associated with intervention, other alternatives to intervention and consequences of non-intervention

[21] In Mead v Legacy Health system, a neurosurgeon was consulted by an emergency room doctor who suspected a severe neurological disease was causing a patient's low back pain. The neurosurgeon briefly examined the patient and recommended that the patient should be admitted. But he added that surgery was not needed. However, it turned out, four days afterwards, that surgery was in fact required. But the damage had been done. The patient was permanently impaired. The patient sued the neurosurgeon who was originally consulted for damages but he defended himself himself by arguing that he owed her no duty because a patient-physician relationship had not been established. The court, however, decided otherwise; the court held that in the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred "when a physician takes an affirmative action regarding the care of an patient". But it is important to also note that the Mead v Legacy Health Systems was heard in Oregon, USA, and does not

Once a physician-patient relationship is formed – either because the physician took an affirmative action in rendering an opinion or in a more formal way – that relationship continues until it is terminated by the consent of the parties; or until the physician's services are no longer needed. Revoking this relationship without giving the patient ample opportunity to seek alternative care may be considered a negligent offence. In other words, in nearly all international and national medical ethics codes and guidelines, the physician-patient relationship creates unique duties for the physician. These duties include: the duty to rescue; a duty of care; a duty to uphold respect for persons; a fiduciary duty; and a justice duty. In what follows, I will explore these duties in detail.

2.3.1 Duty to Rescue

The duty to rescue is very often described in existing literature such as Scanlon (1998) and Schöne-Seifert (2009), as a duty to help or to be helpful. The duty to rescue states, *inter alia,* that when one is in a position to help, and the risk to the helper is minimal or involves only slight sacrifice, then one has a moral duty to offer such help. For example, in Scanlon’s opinion (1998: 224), if one has a piece of information which may be of value – clinical or personal – to another person; regardless of whether the individual is desperate for such information;

> It would surely be wrong of [one] to fail (simply out of indifference) to give her this information when there is no compelling reason not to do so. It would be unreasonable to reject a principle requiring us to help others in this way, since such a principle would involve no significant sacrifice on our part. Call this the Principle of Helpfulness. (Scanlon, 1998: 224)

The physician-patient relationship is a contractual relationship in which the principle of helpfulness applies. In this contractual relationship, the physician has a duty to help a patient, whenever he can; and if doing so would be at the cost of a slight or moderate sacrifice. Within the clinical context, and specifically within a physician-patient relationship, the physician’s medical skills and training renders him/her more capable of rendering help to patients than others. And owing to the very nature of this relationship as a contractual

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bind universally. Not only does this case not have any standing in South African law, but there is in fact a case law that establishes exactly the opposite principle: namely that tacit consent is not acceptable: it must be explicit. (See Stoffberg v Elliott 1923, CPD 149). This requirement for explicit consent in South Africa is confirmed in HPCSA Booklet 9.

relationship, the physician is, therefore, more responsible than others for honouring this contract by providing help to his patient. In general, the duty of rescue incorporates five features (Schöne-Seifert, 2009: 423):

- The victims' visibility or identifiability;
- Acutely impending death of the victims
- A reasonable chance of effective rescue;
- Acceptable risks or costs to the rescuers;
- Exceptionality of occurrence.

These features are consistent with the second article of the Quebec *Charter of Human Rights and Freedoms* (2005) and other International guidelines. For example, the Quebec charter states that "every human being whose life is in peril has a right to assistance...Every person must come to the aid of anyone whose life is in peril, either personally or calling for aid, by giving him the necessary and immediate physical assistance." Following this principle, when a physician stumbles upon important life-saving data; he has a duty to communicate such information to the concerned subject. Furthermore, within the physician-patient relationship, the physician is morally obliged to use sound medical judgment, while putting the patient's interests first. To this end, an important legal duty incorporated in the duty to rescue, is the duty to warn.

The duty to rescue, however, has its own limits. There is no obligation to rescue if the cost of intervention is high; or if the likely gain thereof is too small (Schöne-Seifert, 2009: 424). In addition, "the duty to rescue", Ulrich observes, "compels no one to actively search out harm in order that they may be able to alleviate pain or save lives" (2013: 50).

2.3.2 Fiduciary Duty

The fiduciary duty – from the Latin word *fides* meaning "faith" or "trust" – is a core value in most medical ethics codes. Bernabe and colleagues (2014: 4) describe "a fiduciary relationship as a service relationship that is meant for the provision of a service that public policy encourages". Specifically, I describe a fiduciary relationship as a relationship in which someone places confidence or trust in another, who has a duty to act to benefit the trusting agent.

In a fiduciary relationship, two persons are principally involved: the fiduciary, who occupies the position requiring trust, and the entrustor or patient. A fiduciary duty presupposes a power imbalance between the fiduciary and the entrustor. Bernabe and colleagues (2014: 4) believe that this power imbalance, as well as the service of care which a fiduciary provides through this power, differentiates a fiduciary relationship from a contractual relationship (Bernabe et al., 2014: 4). I would argue, however, that the power imbalance in a physician-patient relationship does not negate the contractual nature of such a relationship, so that such a relationship may be both contractual and fiduciary. Moreover, there will never be a time within the physician-patient context when the lopsidedness in power distribution between the physician and his patient is removed. Patients will always be vulnerable and physicians will always be knowledgeable. A power imbalance arises in a physician-patient relationship as a result of an illness which places patients in a vulnerable, dependent posture against the superior knowledge, training, and clinical experience of the physician.

However, power-balance is not necessary to create a contract between a physician and his patient. The consensual nature of the physician-patient relationship, formally expressed or implied, creates this contract, and requires trust that the other person will fulfill his duties. In a fiduciary relationship, the patient is also required to answer the physician’s questions truthfully; and never to conceal relevant information that may assist the physician in providing necessary care due to the patient.

This contract equally makes it possible to impute culpability on a physician when he abandons these duties. From the moment that contact between the physician and the patient has been established, a fiduciary duty has also been created. This point is well established by *Norbery v. Wynrib* (1992). In *Norberg v. Wynrib*, the Canadian Supreme Court, while recognizing the power imbalance between doctor and patient, nonetheless unequivocally characterized the physician-patient relationship as contractual and fiduciary in nature. The fiduciary nature of this relationship, is what in fact, redresses this power imbalance by requiring the physician to act in the best interest of his patient. Specifically, it obliges the physician to subordinate his individual preferences to the patient’s interests and values.

The fiduciary relationship between the physician-patient has a two-fold implication: the duty of loyalty and right to receive care. The duty of loyalty – which is the basis of a trust-based approach to patient care within the clinical context – holds the fiduciary, as Margolis (2015: 1819) observes, to the highest standard to honour the trust reposed in him/her by the entrustor; to disclose conflicts of interest; to safeguard confidential patient information;[22] and to inform the patient of his medical condition. Secondly, the fiduciary relationship implies the right of the entrustor to receive quality – interpreted as evidenced-based – medical care from the fiduciary.

2.3.3 Respect for Persons

Respect for persons, Lysaught (2004: 668) observes, was first articulated as a principle in the Belmont Report. This principle implies two ethical convictions: to treat individuals as autonomous agents, and to protect individuals with diminished competence from harm. This ethical principle implies the physician's duty to respect the interests, autonomy, and right to self-determination of a patient; as well as to create conditions for autonomous choices. In other words, respect for persons, as outlined by the Belmont Report, requires one to acknowledge individuals as autonomous agents; as well as to protect those with diminished or absent autonomy from harm. The principle of respect for personhood applies to all individuals with diminished autonomy or absent autonomy. This is one very important distinction that one finds between the Belmont Report and Beauchamp and Childress' *The Principles of Biomedical Ethics*: while the Belmont Report (1979: 4) used the expression "Respect for Persons", Beauchamp and Childress (2001: 57) prefer the expression "Respect for Autonomy". In the former, respect is conceived of as inclusive of all human beings, and as promoting autonomy as well as protecting the vulnerable, while in the latter, it is conceived of in a narrower sense as noninterference. In the next chapter, I shall discuss Beauchamp and Childress' treatment of respect for autonomy.

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[22] For more than 2,000 years, physicians have taken the Hippocratic oath which states that "whatever in connection with my professional practice..I may see or hear...which ought not to be spoken abroad, I will not divulge." (Miller, 1983:161) This oath has a fiduciary quality to it, since by means of this oath, physicians pledge themselves to secrecy and to the protection of patient's confidential information. MILLER, F. H. 1983. Secondary Income from Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior? *In:* GRAY, B. H. (ed.) *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment.* Washington: National Academy Press.

For the purpose of this discussion, respect for persons requires that physicians communicate truthfully. The goal of this truthful communication is the enhancement of a patient's informed decision making capacity. Trust is also enhanced in a physician-patient relationship when patients know that their views and opinions are respected, as well as not taken for granted. Respect for persons requires more than just non-interference in a patient's personal affairs. It includes creating or maintaining the capacity to make autonomous choices. Truthful communication is essential to building this capacity. Patients depend on receiving the correct information regarding their diagnosis and prognosis in order to make an informed decision. The need to communicate truthfully is very well articulated by the case *Natanson v Kline* (1960). In this case, the Supreme Court of Kansas found that physicians are obliged to:

> disclose and explain to patients, in language as simple as necessary the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body.

How much information a physician has to disclose depends greatly on applicable guidelines or national laws. However, a 'lay' or reasonable patient standard of information disclosure was used in the *Canterbury vs Spence* (1972)[23] federal case decided by the United States Court of Appeals for the District of Columbia Circuit. Since this case, the reasonable patient standard has been the acceptable legal and ethical standard of information disclosure. The reasonable patient standard simply states that a physician must disclose all material risk information which would influence a patient, or any other reasonable person, in deciding whether or not to go ahead with a medical procedure or test. Failure to disclose all material risk information constitutes professional negligence (Raab, 2004: 226f). Patients need to be able to rely on their physician's word. Truthful communication is an important way of ensuring this; and enhances shared decision making capacity within the clinical context. From the Kantian perspective, this shows that patients are not mere conduits; their values and interests are acknowledged and respected by their physicians.

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[23] The Cantebury v Spence (1972) case is a case of a physician who failed to disclose the potential risk of a back surgery which he performed on a patient. The judges ruled in favor of the patient; they determined, inter alia, 'that a physician has a duty to convery the risks of an operation when a reasonable person would be likely to attach significance to the risk in deciding whether or not to forgo the proposed therapy'. The judges equally highlighted two exceptions to this rule: a) where the patient is unconscious and harm from a failure to treat is greater than any harm threatened by the proposed treatment and b) where disclosing the risk to the patient poses a threat to the patient's well being.

2.3.4 Duty of Care

The ethical duty of care incorporates beneficence and non-maleficence. These two require the physician to act for the patient's health benefit; and second, *primum non nocere* – to do no harm. The duty of care involves taking reasonable action that will enhance the wellbeing of patients, and removing or limiting the amount of harm patients are exposed to. The United Kingdom General Medical Council's *Good Medical Practice* (Council, 2012: 3) (hereafter – the GMC) requires all physicians to make the care of their patients a primary concern. The GMC describes good care as generally including: assessing the patient's condition, values and interests; promptly arranging suitable treatment or advice; and referring a patient to a more qualified practitioner in the event that a patient's condition requires a more qualified consultant.

It is important to note here that some regard this duty to apply only to established physician-patient relationships. Some courts, for example, have ruled that physicians are not legally required to provide care for new individuals who seek it. According to this view, the physician-patient relationship is a voluntary contract between autonomous individuals. The 6th principle of the American Medical Association's *Principles of Medical Ethics* reiterates this point in the following words: the "physician shall, in the provision of appropriate patient care….be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" (2001: Principle VI). Hence, physicians are free to enter into this relationship. Other international bodies such as the GMC (Sokol, 2012: 1; Dean et al., 2013) may require physicians to provide care wherever it is needed.[24] But the court has not always followed this rule. A physician who declines to enter into a contractual relationship with an individual who requires medical care has not committed any illegal act. For example, a physician taking a walk around an accident site, according to international bodies such as the GMC, is not legally required to provide care to the victims. Others may condemn the physician for not acting in an emergency situation, but there are no liabilities involved.[25] It is

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[24] The General Medical Council's Good Medical Practice states: "In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care"..

[25] To encourage physicians to assist in emergency situations, many States in the United States enacted what is called a 'Good Samaritan Statute'. The Good Samaritan Statute is a principle of Tort Law which states that a person who sees another individual in imminent and serious danger or peril cannot be charged with negligence if the person attempts to aid or rescue the injured party, provided the attempt is not made recklessly.

clear from the preceding discussion that the law and ethical codes and guidelines do not always accord. Before proceeding to discuss the duty of justice, I shall therefore briefly differentiate between legal and ethical standards.

2.3.4.1 Legal vs. Moral Standards

In this section, I note the distinction between ethics and legality. Thomas Aquinas[26] defined law as “an ordinance of reason promulgated by one who has the authority over a community of the common good”. Laws are usually codified, enforced by authority and backed by penalties. In the case of criminal law, the penalty may be a jail term; and in the case of civil law, the penalty may be a fine awarded to those whose rights have been violated. Morality, on the other hand, is concerned with basic human conduct – from the Latin *moralis,* pertaining to the character or behavior of an individual. Unlike laws enforced by government, morality is usually governed by the individual or a dictated by a body of norms and/or customs. Moral guidelines are developed to help individuals decide between right and wrong actions; or appropriate and inappropriate actions. Finally, there are no legally enforced punishments, such as a jail term, for the violation of moral norms. Notwithstanding this, sanctions of some sort may exist for the violation of some moral norms, such as interpersonal disapproval, shunning and even expulsion from a society or professional body.[27]

There is a relationship between laws enacted by states and morality. Morality can influence what is determined to be legal or illegal, in the sense that it can provide the basis for making a

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[26] St Thomas Aquinas, Summa Theologiae, II-I, Q.90 a.1

[27] Even though these two terms – morality and ethics – are generally used interchangeably in this dissertation [in fact Peter Singer's article on "Ethics" in the Encyclopedia Britannica (1985) conceives ethics and morality to be the same as moral philosophy]. Morality is, however, distinct from ethics. Ethics – from the Greek word ethos meaning “character” or “habit” – is a set of rules that governs an individual’s conduct or behavior. Both morality and ethics have something to do with distinguishing between good and bad; or right and wrong. However, some scholars conceive of morality as something normative and/or personal - that is, one's personal sense of right and wrong which is not imposed by anyone; while ethics refers to the standards of right and wrong, distinguished by a community or social setting. Notwithstanding the preceding differentiation, when these two terms are used, philosophers are generally talking about what is right or wrong; while some argue that right or wrong is determined by one's culture (relativism), others argue the view that right or wrong is determined by one's personal feelings towards those actions (emotivism). However, philosophers hardly use both terms to indicate different concepts. Both terms, in essence, have something to do with 'how' one ought to act or behave in certain context or situation. This dissertation shall adopt this essential description of ethics and morality, and thus, leaves the distinction between these two terms for a future study. Specifically, this dissertation seeks to highlight a set of principles which may guide behaviour in the event of an ethical dilemma; and/or form one's conscience to face ethical challenges.

whole group of immoral actions such as murder, rape, fraud and so on, illegal. In other words, some laws may exist to defend basic moral values by criminalizing their violation. Law and morality are, however, distinct: while the law refers to what a person must do or must not do, morality refers to what a person ought to do. The degrees of emphasis between “must” and “ought” are different: “must” is more emphatic; in this case, to stress that something is required by law. One uses “must”, for example to describe something which has to be done or avoided because it is compulsory or obligatory; a violation or non-performance of such duties could attract legal penalties. “Ought”, on the other hand, is not used to describe what is compulsory, hence it is less emphatic that “must”.[28] It is used here to describe moral duties, obligations, or the appropriateness of an action; in short, the view that something is the right thing to do, since it is morally correct.

Following the previous paragraphs in this section, what is immoral may not necessarily be illegal, and what is legal may not necessarily be moral. Abortion within the first trimester, in some legal codes, is a right of a woman; whereas, in some cultures or religions, abortion is *semper et pro semper intrinsice malum* (always evil). Additionally, sometimes professional bodies, as a matter of professional principles and ethics, may require their members to act in one way, such as the duty to rescue and the duty to provide care for those who need it. A failure to fulfill these duties may constitute a legal breach in some states such as Quebec, Canada (Walker, 2002; Davies and Shaul, 2010),[29] where the duty to rescue or provide care is a legal requirement. However, in some other states, a failure to fulfill these duties may not necessarily constitute a breach of any legal code (Davies and Shaul, 2010; Walker, 2002).

It is equally important to note here, as Lo (2005: 158) rightly observes, that a physician’s legal right to decline a contractual relationship with a patient may be limited by employment contracts. For example, a fire-fighter cannot refuse to enter a burning building simply because the building is on fire. Entering a burning building is dangerous, but this duty is included in the employment contract. Similarly, some employment contracts may oblige physicians, in countries or regions where it is legal to refuse, to care for all qualified persons

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[28] The least emphatic is "should", which is used to express one's subjective opinion about what one thinks is the right or correct thing to do. For example, all workers should be provided with a job description..

[29] In Quebec, Canada, there is legislation which requires every health professional to come to the aid of anyone whose life is in peril, unless it would put his or her life or another’s life in jeopardy.

who seek treatment (Walker, 2002: 467). Within such contexts, a physician-patient relationship would mean a hospital-patient relationship.

A legal responsibility to provide care exists where a physician-patient relationship (or hospital-patient relationship) has been established[30] (Pandit and Pandit, 2009). Once this relationship is established, either formally or informally (sufficient proximity suffices in circumstances where the physician-patient relationship is understood as the hospital-patient relationship), the physician is legally required to apply his requisite knowledge to the care of his patient – requisite knowledge expected of a reasonable practitioner in the same specialty; or that a reasonable person in the same situation or in the community, would expect. This is the legal expectation arising from the physician’s duty of care. To do otherwise will expose the physician to liability for negligence.

The duty to offer care has limits. Physicians, in providing care, are not obliged to compromise their religious or moral views (Lo, 2005: 158). This is described as conscientious objection. A Catholic physician, for example, is not obliged to perform abortion (although they may be obliged to refer such patient to another clinic or doctor). Additionally, some courts in the United Kingdom have equally confirmed that the duty of care does not extend to third parties. For example in Palmer v Tees Health Authority (1999; Sokol, 2012),[31] the United Kingdom Court of Appeal found that health authorities, including physicians, do not have any duty of care to a third party – in this case a child who was later murdered – since there was insufficient proximity between the health authority and the third party (the murdered child) (Sokol, 2012: 1). Sufficient proximity[32] for establishing a duty of care was also reiterated in the 1993 British Columbia Court of Appeal case of *Egedebo v. Windermere District Hospital Association* (Walker, 2002: 466). In this case, the British

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[30] In a tort case for professional negligence, the first duty that must be established before such a case may proceed is the duty of care.The duty of care is one of the basic duties a physician assumes once the contractual physician-patient relationship is established. In addition to this duty, to prove a tort case in professional negligence, the counsel must show that there was a physician-patient relationship; that there was a recognized reasonable standard of care owed to the patient; that the physician failed to meet this reasonable standard; that this failure resulted in harm to the patient; and that this harm to patient was a reasonable foreseeable consequence of the physician failing to meet this standard of care.

[31] In this case, a physician was sued for discharging "a psychiatric patient who went on to murder a 4 year old child. The child’s mother sued the health authority on the grounds that those responsible for the murderer’s care had failed to recognise and to act on the patient’s real risk of harm to children." (Sokol, 2012)

[32] In addition to the physician's proximity to the patient, the court equally considered the patient's degree of need; the physician's capabilities, and the absence/presence of other sources of aid.

Columbia Court of Appeal found that a physician, albeit not on call, has a duty of care to patients who present themselves at the emergency unit of an hospital, since there exists a “sufficient relationship of proximity between the patient and the doctor such that, in the reasonable contemplation of the doctor, his acts or omissions would be likely to affect the patient”[33] (Walker, 2002: 466; Dean et al., 2013).

The differentiation I made between legality and morality above is important for this study. Since this dissertation seeks to highlight a set of guidelines rooted in African moral theory, I shall principally focus on ethical duties around unsolicited information non/disclosure. However, I hope this set of ethical guidelines can influence legislation or legal duties around the same in regions and countries where no legislation for managing ethical challenges around unsolicited information exists; and where legislation may exist, I hope that the insights I offer here may be useful for improving such legislation. Additionally, where legal duties or precedence may have influenced the ethical discussions around unsolicited information non/disclosure, I shall also highlight this, as well as ways in which the ethical discussion around unsolicited information non/disclosure has been influenced. Furthermore, this study aims for a global reach, hence the discussion which follows is not confined to any country or region. The statutes and case law examples, however, are not universally binding, except within their own jurisdiction. The country-specific case examples are only illustrative or informative from an ethical perspective. In other words, the case (law) examples do not have legal standing outside of the country in which the judgment was made; and even then, depending on the level of the court, they might not even apply in all cases.

2.3.5 Justice Duty

The duty of justice relates to the equal, fair and appropriate distribution of medical benefits and burdens. Emmanuel (1991: 8) divides issues implied in the duty of justice into two different but related dimensions: access and allocation. Primarily, the duty of justice affirms a patient’s rights – rights to receive care; to be rescued; to self-determination, and so on – to

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[33] This is quite different from a physician taking a walk around an accident site. Here, there is no duty of care to assist victims. However, if someone had shouted, 'Is there a physician around?' and he responded affirmatively, a sufficient proximity standard therefore applies such that he is now bound to provide care to the victims who then become his patients.

what is owed to him/her by physicians (Edwin, 2009: 35). In other words, a breach of any of the other duties is itself regarded as a breach of the duty of justice, since patients are thereby denied what is due to them.

The first dimension of the duty of justice concerns access to health care, which should not be determined by one's identity, age, quality of life, socioeconomic status, religious beliefs, or political or tribal affiliations. The duty of justice requires physicians to provide medical care for patients who need it. This does not contradict our understanding of the physician-patient relationship as a voluntary contractual relationship. A physician is indeed free to enter or to decline to enter into a contractual relationship with any patient. For example, a physician may decline to enter into a physician-patient relationship with a patient, if what the patient seeks violates his religious/cultural beliefs (conscientious objection), or if he (the physician) lacks the requisite knowledge for providing due care. However, the ethical duty of justice dictates that a physician should not refuse an individual medical care because the physician dislikes the individual or finds the individual's actions – such as smoking or drinking alcohol – unpleasant (2005:157; McKoy, 2006). In the same vein, it will be objectionable for a physician to deny an individual medical care based on social class, age, ethnic background, or religious or political views.

The second related issue in the duty of justice is allocation. Three principles are of material relevance to our consideration of the duty of justice with respect to allocation. The basic assumption of allocation is that a single physician may have multiple co-existing contractual relationships with a number of patients. Acting justly would imply equitable distribution of medical resources to all of them. Profoundly egalitarian in nature, the first material principle of (distributive) justice is: "to each person an equal share". However, in the event of limited medical resources, due to macro, meso or micro related factors (Trotochaud, 2006: 165; Gaze, 1993);[34] distributing medical resources may become challenging. Such circumstances may result in a catch 22 situation for a physician, who is faced with a tough decision to make with regard to who gets the available medical resources. The ethical duty of distributive

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[34] Trotochaud (2006) and Gaze (1993), believe that allocation questions exist at three levels: macro, which relates to the amount of government resources allocated to healthcare as opposed to other departments; meso, which relates to the amount of resources available at the point of healthcare service to specific patient groups or field of medicine; and micro, which concerns the individual patient's actual access to the limited resources.

justice allows physicians to allocate scarce resources (Scheunemann and White, 2011),[35] to those in critical need of the limited resources. This is the second material principle of (distributive) justice: “to each according to their needs”. For example, a physician may remove a patient with a very poor prognosis from a hospital’s only ventilator, if a patient with a better prognosis requires it.

This material principle of prioritarianism has helped networks such as the United Network for Organ Sharing (UNOS), to come up with policies which allow physicians to allocate organs based on specific criteria, such as time on the waiting list, severity of illness and other considerations (Scheunemann and White, 2011: 1626). To each according to need is also central to many disaster or emergency response schemes such as the Canadian Triage and Acuity Scale. Here, the duty of justice allows paramedics to prioritize care for those who urgently require it. Following this principle, paramedics are permitted to transfer critically ill patients to the nearest emergency unit, regardless of how busy the hospital is, and the less critically ill patients to hospitals providing the most appropriate care (Walker, 2002: 466).

The final material principle of (distributive) justice, as highlighted by Bernstein (2010: 463), is utility. Often defined as the maximization of social welfare, the principle of utility compels the physician to consider the net benefit, using cost-benefit or cost-effectiveness analysis, of a given medical resource on the larger population, in order to produce the greatest health benefit for the money expended (Beauchamp and Childress 2009: 245). For example, in an emergency room with 50 patients, 25 patients have conditions requiring one pill, while 25 others have similarly severe conditions requiring two of the same pill. If there are only 25 pills available, the principle of maximization of social benefits would permit a physician to dispense the pills to those who require only one, thereby helping more patients. In other words, a physician may deliberately withhold medical resources from individual patients if this has a better overall effect on the population.

In sum, important duties arise in the context of the physician-patient relationship in the clinical context. These duties are prima facie obligations, which require physicians to place

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[35] I am aware that there are different proposals for prioritizing needs or quantifying related health benefits. Some have proposed Quality-Adjusted Life Years (QALY). QALYs involve two steps: selecting outcome measures that adjust life-years for quality, and then allocating so as to maximize QALYs. However, the debates and evaluation of these proposals are beyond the scope of this study.

the welfare and the best interests of their patients at the centre of every clinical encounter. This is a matter of justice, and is implied by the duty of respect for persons, the duty of care and the duty to rescue. In what follows, I shall evaluate how well physicians are able to fulfill these ethical duties in a variety of clinical situations involving unsolicited information. It is often difficult to plan for unsolicited findings. But when they arise, as they often do, applying these normative guidelines in context may lead to severe ethical and legal difficulties. In what follows, I will consider an additional two case examples, and use these cases to highlight the difficulties around managing incidental information in practice.

2.4 Case Scenarios

Case One: Jehovah's Witness

J was involved in a major car accident and rushed to the trauma unit by paramedics. J was unconscious at the time of admission and had lost a massive amount of blood. The trauma surgeon judged that the best chance of saving J's life would be a blood transfusion along with surgery to stop the bleeding. He quickly ordered these interventions, and J survived his injuries.

About five days after this intervention, J regained consciousness, and thanked the surgeon for working hard to save his life. J also informed the surgeon that he is a 'Russellite' (a member of the Jehovah's witness community). J has not asked about how the physician saved him (and J has no other way of finding out about the transfusion) and the physician had not previously been aware that J was a Jehovah's Witness.

Case Two: Sero-Discordant Couple

In a certain town, T, live a couple, W (wife) and H (husband), with core traditional African values. They approach a physician, P, for basic check-up procedures. Blood samples are drawn from both and other tests are conducted. The test results from the blood samples show that the husband H is HIV positive. P (the physician) informs H about the test result and explains his options to him. But, H, out of fear of losing his wife (W) who is HIV negative, asks P not to reveal his test result. Moreover, they are his own test results (raising privacy concerns). P has information not solicited by W which could nonetheless significantly help her. But the information is about H who wants his privacy protected and respected by his physician P (who is not only medically obliged to respect the rights of his patients to privacy, confidentiality and so on, but must also act for their health benefits). Both are his patients, so how does he help one, without harming the other?

2.4.1 Case Analyses/Discussions

Case One is unique in several ways. This case focuses on issues raised by unsolicited information arising from an intervention in an inpatient-trauma and emergency unit where decisions are taken on the spot with little or no contributions from the patient.

The unsolicited information involved in this case has personal value. J was unconscious at the time of his admission, thus there was no way the physician could have known that J holds a religious view which forbids blood transfusion. In retrospect, this was an honest mistake. The surgeon would not have included blood transfusion as part of the intervention if he knew J was a Jehovah's witness. J has not asked for details about the intervention, so there is no dishonesty yet. The main dilemma in this case concerns the surgeon's decision about whether or not to truthfully communicate full details of the medical intervention to J. There are respectable argument for both disclosure and nondisclosure. Disclosure would fulfil some ethical duties, such as the duty to respect the patient, and breach others, since disclosure may cause harm or sever family ties. Non-disclosure would also yield a similar result: it may fulfil some ethical duties, such as the duty to avoid harm, and violate others, such as the ethical duty to respect the patient. Other critical questions which may be considered regarding Case One include the following:

- How should the physician manage this information without failing in his fiduciary duty or duty of care to J?
- What would a reasonable physician do in this context that would not undermine J's right to self-determination?
- What would a reasonable patient expect to be told in this context?
- What is the preferable option that will avoid or minimise harm in this situation?
- What action(s) would respect J's religious views?

Case Two is also a case of unsolicited information – W does not know about her husband's diagnosis, and she has not asked for this information. This information has personal value, as well as being clinically actionable. Within the context of a family health check-up, this could have been anticipated by the physician. Despite this, it would still have been difficult to plan for the management of this information. The main moral dilemma in this case concerns whether to breach H's right to confidentiality for the purpose of fulfilling the duty of care to W. Other critical questions which may be asked include the following:

- How does the physician rescue W without failing in his duty of loyalty to H?
- What, if anything, should W be told about the results of the check-up?
- What is the best way for the physician to fulfil his duty of care to W that will not harm H's personal and cultural values or the global efforts to combat HIV/AIDS?
- What would a reasonable physician do in this context?
- What would a reasonable patient expect in this context?

In response to the questions raised by these cases, two broad positions may be identified: that of clinical libertarians, and that of clinical empiricists. Both clinical libertarians and empiricists are committed to ensuring that trust is not undermined in physician-patient encounters, safeguarding the patient's right to self-determination, reducing the doctor's liability, and avoiding medical paternalism. They differ, however, on how to apply these prima facie obligations in the context of the physician-patient relationship. In the following sections, I will examine the basic arguments for each of these positions, and highlight the dilemmas associated with applying the duties guiding the physician-patient relationship, as discussed above, in these situations. The focus will be upon whether these duties provide useful guidance, without conflict, for reaching sound ethical decisions in these cases.

2.4.2 Clinical Libertarians

Libertarianism is a (negative) rights-based theory which affirms strong non-interference rights to life, liberty, and property. As Ruger (2008: 1753) observes, under libertarianism, "individual freedom and autonomy are the predominant societal values, and government's role is to protect these values". Libertarianism, for this reason, is often said to be antithetical to authoritarianism.

Clinical libertarians – also referred to as patient advocates – believe that no patient should be denied access to all the information a physician has about them. “Unless in the exceptional case of patient waiver, it is never justified”, Edwin (2008: 156) argues, “to intentionally withhold information from a competent patient”. Thus, physicians have a general duty to disclose both unsolicited and solicited information to patients. This, they believe, will enhance trust, and contribute greatly to overcoming the power imbalance between patients and physicians. Some prominent libertarians include Buckman and Baile (2007), Abdi and colleagues (2012), A.K Edwin (2008), and G. Swaminath (2008). These libertarians generally base their arguments for full disclosure on four important considerations:

- The physician’s general legal and ethical duty to warn.
- The right of the patient to be fully acquainted with any health or personal information that concerns them.
- The importance of utility.
- The importance of the value of kindness.

Physicians have a duty to warn unsuspecting parties, libertarians believe, about impending perils posed by a clinically validated[36] diagnostic test, as in Case Two. In what follows, I will discuss each of the above considerations.

2.4.2.1 Duty to Warn

The duty to warn follows naturally from the rescue principle. As previously stated, if a physician or health professional stumbles upon important life-saving information, signifying that his patient is at risk of death if he is not given clinical care, the health professional has a duty to immediately inform such a patient.

Although I want to focus principally on how the duty to warn specifies ethical duties, it is important to note that the duty to warn also has support in law. In this regard, a violation of the duty to warn may attract legal and/or ethical sanctions. For example, the duty to warn is a

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[36] Clinical validation is a process of clinically reviewing - through clinical criteria generally accepted by the (medical) community - a test outcome in order to determine whether or not a patient truly has the condition that a previous test outcome has revealed. This process will reduce the likelihood of returning false positive results to patients.

concept which sometimes arises in law of torts; and it states that “a party will be held liable for injuries caused another, where the party had the opportunity to warn the other of impending danger and failed” (Ferris et al., 1998: 1474). The important features that give rise to the duty to warn include: a communicated threat, impending danger to an unsuspecting third party, and harm to the third party being foreseeable. Once these conditions are present, Laberge and Burke (2009: 657-659) argue, physicians have an ethical and legal obligation to inform the at-risk party. For clinical libertarians, information is power, since it contributes significantly to informed decision-making, and enhances the individual’s capacity for self-determination and free choice. In this regard, the duty to warn accords with the libertarian’s emphasis of the importance of individual freedom and autonomy. In the context of Case Two, this would mean informing W about H’s HIV sero-conversion.

Clinical libertarians often trace the duty to warn to the 1974 Supreme Court of California Tarasoff case (Laberge and Burke, 2009; Ensor, 1988). This was a case of a student in Berkley University, who revealed to his psychotherapist that he intended to kill an unnamed woman, identified as Tatiana Tarasoff. The psychotherapist informed the police about this, but the police only warned the young man (Poddar) to stay away from Tarasoff. After a while, Tarasoff returned from a trip, and Poddar murdered her as he had threatened to do. Tarasoff’s family sued the campus police and the University Health Service. The Supreme Court of California, while arbitrating this case in 1974, found that a physician has a duty to warn a threatened individual. The duty to warn was extended by the same court in 1976 to include a professional duty to protect an intended victim. The famous line in this ruling is: protective privilege ends where public perils begins (California. Supreme Court, 1976; California. Supreme, 1974; California. Court of Appeal, 1973; Daley, 1975; Warren, 1998; Ferris et al., 1998: 1474). This line has been interpreted to include the notion that a professional may breach a patient’s right to confidentiality in order to save others or enhance their decision-making capacity. The professional may discharge this duty in different ways, not excluding verbally informing the victim.

However, the application of the duty to warn (or inform) to Case Two raises important ethical difficulties. Disclosing information about the HIV sero-conversion of H would lead to the breach of a core duty in the physician-patient relationship: the fiduciary duty of loyalty – and specifically, in this case, to maintain patient confidentiality – which is mandated by the medical profession[37] and the law.

Non-disclosure, on the other hand, has its own fatal consequences, since it will expose W to potential harm which may result in death. Effectively, the duty to warn, applied in Case Two, will eventually lead to a catch 22 situation. In the following paragraphs, I will highlight other difficulties involved in navigating the complex difficulties around Case Two, specifically associated with the application of the ethical duty to warn.

First, the legal duty to warn, as upheld by Tarasoff decision, is contextual. The 1974 Tarasoff duty to warn decision was used to highlight the legal duty to warn at risk parties within the context of mental health care. This decision, however, does not have universal applicability in all clinical contexts. While such a legal duty may exist within the context of mental health care, this is not necessarily the case within the context of the care of HIV/AIDS patients. The duty to warn within this context is related to partner notification and contact tracing. Partner notification and contact tracing are processes by which "physicians directly or indirectly disclose the HIV-sero-conversion of patients to the patient's sexual partners in order to protect the partners from becoming infected" (Odunsi, 2007: 298). International Guidelines such as the Health Professions Council of South Africa Guidelines (Booklet 12) and the World Health Organization's "Guidance on Couples HIV Testing And Counselling Including Antiretroviral Therapy For Treatment And Prevention In Serodiscordant Couples: Recommendations for a Public Health Approach" (WHO, 2012: 3-5, 20-25), encourage partner notification or contact tracing. For example Rule 9 of the Health Professions Council of South Africa (Booklet 12), recommends contact tracing and partner notification when a

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[37] Here I must supplement the distinction previously made between legality and morality by mentioning another set of norms which are relevant to the clinical context: professional ethical codes. Professional ethical codes, in this dissertation, refer to the standard of behavior that is expected by the profession to which an individual belongs. Hence, medical professional code(s) refer(s) to the standards of behavior expected by the medical community from its members. In other words, professional ethics entails special rules governing members of a particular profession: lawyers, doctors, nurses and so on. Sometimes, these professional codes are drawn from, or based on, existing moral norms and/or legislation. In addition to the potential conflict which may occur between morality and legality, I also note here that one's personal system of moral values can come into conflict with one's professional ethics. For example, a health professional may not personally be convinced that the treatment regimen chosen by a patient is the right one, and may as a matter of personal morality wish to refuse to provide such a treatment. S/he, however, has a duty – according to medical professional ethics – to honour the patient's right to self-determination (assuming of course that this treatment is not clearly futile, or otherwise inconsistent with medical professional ethics).

patient has refused to disclose information to their partner themselves.[38] However, a legal duty to warn W (Case Two) by disclosing confidential information about her husband's HIV test result, would find no support in the United States', Nigeria's, Canada's and South-African's[39] common or case laws (Odunsi, 2007: 303). In fact, according to a Newsletter Report (1996) for United States Nurses, many U.S. States have enacted laws which explicitly hold that healthcare professionals have *no* duty to warn a spouse about his partner's HIV sero-conversion without the patient's expressed consent. Many states in the U.S generally consider a failure to keep information about a patient's HIV status confidential as a breach of the fiduciary duty of loyalty. This point is well established by cases such as N.O.L. vs. District of Columbia (1995), in the United States. The breach of confidential information is also frowned upon by many laws aimed at the protection of privacy. For example, section 29 of the *Personal Health Information Protection Act* of the Province of Ontario, Canada stipulates that a "health information custodian...shall not collect, use or disclose personal health information about an individual unless it has the individual's consent" (Freedman, 2004; Odunsi, 2007: 300).

Even in mental health care where there is a legal duty to warn third parties, Soulier and colleagues (2010: 469-472) observe that clinicians are rarely found to be negligent on the grounds of a failure to warn or protect. This is probably because common law considers it a sacred duty to preserve patients' confidential information. Moreover, in order for the duty to warn to exist, the patient must communicate a threat (Soulier et al., 2010: 469). Although harm is possible in Case Two – HIV is a contagious disease for which there is no known cure and which could lead to death – H has not communicated a threat to the physician. In the absence of a communicated threat, the physician is incapacitated, even if he suspects that harm may result from his not telling W.

The American Society for Human Genetics (Laberge and Burke, 2009: 658) and the Health Professions Council of South Africa (Booklet 12: Rule 9) make some suggestions for

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[38] Certain case laws, such as Australian case law, appear to be favorably disposed towards partner notification and contact tracing. An example is the Australian case between PD and Harvey and Chen. PD v Harvey and Chen (Zinn, 2003; p. 1286, McSherry, 2003) is a landmark case in which two general practitioners in Australia were successfully sued for breach of contract and for negligence for failing to ensure that a man who tested positive for HIV told his wife about the result.

[39] It is important to mention that the duty to guard patients' confidential information is recognized by South African's common law and has been reiterated by land mark cases such as Jansen van Vuuren v Kruger and NM v Smith (Roux-Kemp, 2013; pp. 209-211).

navigating this challenge. They recommend that a physician may disclose when attempts to encourage the patient to do so have failed; when harm is serious and likely; when the at-risk relative(s) are identifiable; and when prevention is possible or treatment is available, because this is what a reasonable physician in similar circumstances would do.

It is very difficult to determine whether a reasonable physician would notify a partner or trace contacts in this situation. As stated above, the current legislative and legal climate seems to favour confidentiality over a breach of the same. This can come into conflict with professional ethical codes or guidelines and recommendations which favor disclosure to at risk (third) parties. Moreover, disclosing a husband's HIV status to his wife, without his consent, may lead to negative consequences. The violation of a patient's right to privacy may be inimical to controlling the spread of HIV/AIDS. Medical confidentiality is widely considered to encourage patients to get tested for HIV/AIDS. Individuals may refuse to get tested if they realize that their partners will be notified or their contacts traced. It is hard to believe that a reasonable physician would want to jeopardize the global effort at controlling the spread of HIV/AIDS in this way.

2.4.2.2 Patient Rights

Thomasma articulates other principal reasons clinical libertarians[40] support full disclosure of information to patients. According to him, "[i]t is a right, a utility and an act of kindness to be told the full truth" (cited in Stewart, 2010: 2-8). In this section and the next, I shall focus on rights and utility.

Patients have a right to full disclosure, according to the clinical libertarian perspective, as respect for persons demands truth telling. Truthful full disclosure is a prima facie obligation that physicians owe to patients. "As a fiduciary", Edwin adds, "the doctor's relationship with his or her patient must be one of candour, since it will be impossible for the patient to trust the doctor without regular candid information regarding the patient's condition and its outcome" (Edwin, 2008: 156). From a Kantian perspective, disclosure shows that the patient's views are valued by physicians.

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[40] Although Thomasma was not a clinical libertarian himself, he lucidly explains the principal reasons why clinical libertarians support full information disclosure.

In light of the above, physicians who withhold information or lie to competent patients fail to respect them as persons; such physicians fail to acknowledge the patient’s right to make choices, hold views and take actions based on personal beliefs and values. Furthermore, concealing information from competent patients neither promotes their shared decision-making capacity nor contributes to patient-centred care in the physician-patient relationship. In other words, a physician who conceals information from a patient denies that patient an opportunity to contribute towards his care. Other forms of harm may also result. Hebert and colleagues (1997: 226) identified three other ways in which lack of disclosure may harm patients. According to them, uninformed patients may be denied the opportunity to obtain medical attention when they should. Second, they may also make decisions affecting their lives that they would not have made if they were informed. Finally, patients generally find comfort in the knowledge that physicians can name their problem, a feeling which is removed by non-disclosure. Reasonable patients, libertarians argue, expect honest, full disclosure from their physicians. This way, patients will feel involved in their clinical care.

From the point of view of a rights based approach, communicating truthfully would mean informing J that a blood transfusion was included in the intervention in Case One; and in Case two; notifying W of H’s HIV seroconversion. There are certain significant ethical difficulties with this. Notifying W about H’s HIV seroconversion may empower W to make important life changing decisions to avoid contacting the virus. However, such disclosure, without consent, would violate H’s autonomy and the trust relationship with his physician. This is effectively another catch 22 situation.

Furthermore, a harm-benefit analysis seems to support non-disclosure rather than disclosure. Concerns still exist that in many societies, those whose HIV/AIDS seroconversions are public knowledge still face discrimination, loss of employment and a host of other disadvantages. This is well established in cases such as the Witwatersrand (South Africa) High Court Hoffman v South African Airways case (Ngwena, 2001). Though Ngwena made this observation several years ago, the situation has not changed much today, for example in Africa. But medical confidentiality has significantly helped in stemming the spread of HIV/AIDS. It is the reason (HIV) patients confide in physicians and seek advice. Partner notification may harm H or expose him to potential discrimination. H may be forced to relocate as a result; he may refuse to confide in any other physician and may have other sexual partners who are unidentifiable. In the long run, the physician may end up saving the wife, and exposing others to harm. Thus, it appears that full disclosure in Case Two would be counter-productive. It may also lead to harm or breach the duty of care, as in Case One. Informing J that a blood transfusion was included in the medical intervention which saved his life may lead to social alienation, psychological or spiritual harm. It is hard to believe that a reasonable patient would want to be harmed in this way.

Blood transfusion is considered by Jehovah's witnesses to be a sinful violation of divine law,[41] and, according to this group, "cannot be a morally acceptable means of ensuring health" (Molinelli et al., 2009: 319). Jehovah's witnesses' reasons for rejecting blood transfusions are deontological in nature; it is more about the rightness of means (the action itself) rather than the rightness of the end, which in this case is health. A blood transfusion, Jehovah's witnesses argue, may ensure temporal prolongation of life, but at the cost of eternal life (Petrini, 2014: 395). There are other temporal implications of receiving a blood transfusion. The individual witness who receives a blood transfusion may be shunned by their relatives and expelled from the God's community through excommunication and disfellowship. Such treatments are not unknown to have caused psychological and spiritual trauma for the sufferer (Barker, 2000). To avoid this trauma; and being transfused while unconscious, believers are often encouraged to carry a card on them indicating their preference not to be transfused. The card reads:

> I direct that no blood transfusions be administered to me, even though others deem such necessary to preserve my life or health. I will accept non-blood expanders. This is in accord with my rights as a patient and my beliefs as one of Jehovah's Witnesses. I hereby release the doctors and hospital of any damages attributed to my refusal. This document is valid even if I am unconscious, and it is binding upon my heirs or legal representatives (Barker, 2000).

J in Case One most likely did not have this advance directive on him at the time of the accident and his admission into the trauma unit, and patients admitted in the trauma unit are not generally asked to provide consent before treatment. In the trauma and emergency unity, life and death usually hang by a thread. Thus, obtaining a patient's consent is rarely a priority for trauma surgeons and/or health professionals.

Since it was impossible to determine the patient's religious preference, a surgeon who administered a transfusion to an unconscious patient has not committed any legal

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[41] They claim that blood transfusion involves eating blood which is forbidden in Genesis 9:4 and Acts 15:28-29.

wrongdoing. Put differently, no physician has been successfully sued in the past for transfusing an unconscious patient who had no card indicating their preference for non-transfusion on them. The closest was Mallette vs. Schulman (1990; Siebrasse, 1989).[42] However, in this case, the physician was aware of, but ignored the unconscious patient's card indicating her preference not to be transfused for religious reasons. In Case One on the other hand, transfusing this unconscious patient who had no card on him was an honest mistake which is nonetheless pardonable under some legislation, such the state of necessity clause (art. 54) (Petrini, 2014)[43] in the Italian Penal Code and court decisions such as Decision n. 4211 where the Italian Court of Cassation decided that; "in very different clinical circumstances, with the patient's life in immediate danger and with no means of consulting the patient…..the doctor acts legitimately (when he administers the most appropriate treatment in order to save the patient from danger)" (Petrini, 2014: 397f).

Some scholars such as Buckman and Baile (2007); Schleiter (2009); Gao and colleagues (2015); and Herbert and colleagues (2001) argue that such errors, albeit honest ones, should be disclosed to patients. Hebert and colleagues (2001: 510) argue for example that "the law recognizes that physicians may make mistakes without negligence, but it frowns on dishonesty – understood as lying, non-disclosure and deception". According to Abdi and colleagues (2012: 173), physicians have a moral duty to disclose truths that patients could reasonably be expected to be told about. Empirical studies, these libertarians claim (Gallagher et al., 2006: 2; Hebert et al., 2001: 511; Stewart, 2010: 3; Hagerty et al., 2005: 1280-83), indicate that patients prefer accurate and honest information about *all* adverse events which took place while physicians were caring for them. Patients who are not told the truth about an intervention, "experience a loss of that all important trust which is required for healing"

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[42] Malette v. Shulman was an Ontario Supreme Court case of a Jehovah's Witness who was involved in a car accident. She was unconscious at the time she was brought to the hospital. Shulman was the surgeon on duty. Shulman was informed of the patient's preference, stated on a card found on her, not to be transfused. But Shulman ignored the instruction on the card, and ordered a blood transfusion. The transfusion saved Malette's life. However, Malette sued Shulman for battery after her recovery. The judge found that "[a] doctor is not free to disregard advance instructions any more than he can disregard instructions given at the time". Malette was awarded 20,000 US Dollars as compensation.

[43] The State of Necessity in article 54 of the Italian Penal Code implies that anyone who has committed an act because they were obliged to do so by the need to save themselves or others from immediate danger of serious bodily harm not caused wilfully by themselves, and not otherwise avoidable, is not punishable; provided that the act is proportionate to the danger.

(Drane, 2002: 1). Hence, wilful non-disclosure represents an unethical violation of the duty of care and a deviation from a patient-centered approach in medical care.

As indicated in previous paragraphs, given the enormous psychological and spiritual harm that information about a blood transfusion could inflict on a Jehovah's witness, it is hard to believe that J, being a reasonable patient,[44] would want to be harmed in this way. In complex circumstances such as this, nondisclosure may, in fact, be a very good way of fulfilling the duty of care. It is extremely doubtful if disclosure would provide any health benefit to this patient. Additionally, disclosure may lead to a complete loss of respect between J and his physician: J may lose his respect for the physician, for taking advantage of his moment of weakness due to unconsciousness, to impose a form of treatment totally at odds with his religious beliefs (Petrini, 2014).

2.4.2.3 Utility

A second reason advanced for full disclosure is that telling the truth is demanded by utility (Stewart 2010: 2-8). Utility is distinguished as a libertarian principle in the following ways: truth is useful because a patient's judgment or choice cannot be truly informed when such judgment is based on lies or incomplete information. As Edwin (2008: 158) puts it, patients rely on doctors to provide them with the information on which they can base decisions about their health. Truthful disclosure is key to a patient's governance of their care or themselves; anything less than honest communication will compromise a patient's right to self-determination or governance, as well as constitute a breach of the ethical duties of justice, care and respect for persons or autonomy (Tuckett, 2004: 505; Williamson and Livingston, 1992: 53-64; Downs, 1999: 30-34). In addition, honest communication will foster the patient's choices, enhance the shared decision making capacity of the patient, and contribute to overcoming the power imbalance in the physician-patient relationship.

Both in medical professional ethical codes and law, two standards are often used to determine the volume of information which may be disclosed to patients: the reasonable patient standard, and the reasonable physician standard. Both standards, as indicated already in this

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[44] A reasonable patient or a reasonable patient standard is used here to indicate the amount of information that a rational patient would want before making a choice to pursue or reject a treatment or procedure

chapter, refer to what a reasonable patient in the same situation would expect to be told and what a reasonable physician, in the same situation, would do or disclose, respectively. However, some radical rights-based libertarians reject the latter standard. They go as far as eliminating the notion of the physician’s discretion in communicating information, thus requiring physicians to reveal all information. According to them, the only one truly qualified to make good subjective judgements about their care, is the patient.

This extreme subjectivism is naive, and not consistent with some empirical studies such as those conducted by Schildmann and colleagues (2013); Cassileth and colleagues (1980); Jenkins and colleagues (2001) and Marzanski (2000b). These studies show that some patients, by showing limited interest in the details of their surgical and medical treatment, repose a great deal of trust in their physicians to use their discretion when disclosing information to them (Schildmann et al., 2013: 2; Marzanski, 2000b: 108-113; Cassileth et al., 1980: 832-36; Jenkins et al., 2001: 48-51). Moreover, in some complex clinical situations, it may be difficult to evaluate the usefulness of information. Utility is rarely a matter of mathematical certainty, as some libertarians may want us to believe. For example, there is much empirical uncertainty about how J will react to the news that a transfusion was included in the medical intervention which saved his life. Will he find the unsolicited information useful or harmful? Hence, should all information be disclosed to the patient? Telling the truth is an ethical obligation in the care of patients. But not all information will lead to useful benefits. To determine the volume of information to be disclosed, a reasonable physician will carefully weigh its likely benefits against the potential harm it could cause (psychological and spiritual). This evaluation is what a reasonable physician will do because it accords with what a reasonable patient may want to know, for example, about the decisions a physician made while they were unconscious. As Drane (2002: 3) points out, “reasonable persons do not always want full disclosure even if such were feasible”. It is possible that the patient in Case One may not desire full disclosure; this may explain why he informed the physician that he was a member of the Jehovah’s witness community. This way, the physician will be careful in what he says about the interventions used in J’s care.

Secondly, even where information may appear useful, and where a reasonable patient would expect to be informed, as is the case in Case Two, a reasonable physician must ask two important questions: is this expectation a reasonable one? Secondly, does a benefit to one person outweigh the potential risk or harm to others? An action is said to be useful if it protects the overall interests of all those involved. Given that full disclosure in Case Two may likely cause harm to the husband, and could also potentially escalate the spread of HIV/AIDS and compromise international organizations' efforts at reducing the spread of HIV/AIDS; it may appear that the good to be derived from disclosure is minimal when compared to the harm caused and thus, not worth it. In a pluralist moral framework, the right to be informed is not an absolute one. If informing W will likely cause far-reaching harm, then the duty of care must override respect for persons. Given the grave consequences of full disclosure in this situation, the obligation not to cause harm appears to be a stronger duty.

In light of this counter-argument, the expectation to be informed appears not to be a reasonable one. In fact, given the overall impact of full disclosure, a reasonable belief may exist that W may expect not to be told. It is extremely doubtful that arguments for disclosure, based on utility, would help much in deciding these cases. Arguments for non-disclosure have equal merits to those for disclosure. Reasonable evidence exists to support the belief that J and W, in both cases, can expect both to be told and not to be told. This is effectively another catch 22 situation which further renders the duties mandated by the medical profession and law redundant in reaching a sound ethical judgement in these cases.

2.4.3 Clinical Empiricists

Both arguments for and against the full and truthful disclosure of information are based upon the ethical duties of the physician. Clinical libertarians argue that all information should be returned to patients because it is a right (respect for persons demands it), and a utility (to enable informed judgments) (Swaminath, 2008). Non-disclosure, except in the exceptional case of patient waiver, is a breach of the ethical duties inherent in the physician-patient relationship, according to this school of thought.

Empiricism – one of many epistemological positions – is the view that knowledge comes primarily from sensory experience. In the philosophy of science, empiricists emphasize the importance of empirical evidence. Clinical empiricism, adapted from philosophy of science (and within the context of this discussion), is the view that ethical decisions such as the decision to disclose or not disclose should be based on evidence. Clinical empiricists would encourage empirically validated procedures or intervention methods. As such, they are not utterly against the disclosure of information to patients. As Cassell (1997) explains, clinical empiricist focus their gaze on the impact of the physician's action(s) on patients themselves, rather than primarily on their (patients') diseases. Will disclosure or non-disclosure likely improve a patient's health outcomes? What does evidence from the literature reveal about the impact of disclosure or non-disclosure of accidentally discovered information? Clinical empiricists want evidence that disclosing certain information will not lead to harm or impact patients negatively. Against this background, the right to information, they argue, may be infringed in favour of patients' best interests, if and only if, there is evidence to support the same.

According to this view, physicians need not feel that they are obligated to always disclose information to a patient, especially when such information may cause distress (Sprigler, 1996: 56; Rosner et al., 2000); or lead to anguish, depression and pain (Downs, 1999: 30-34; Andrews, 1996: 22-24; Reeder, 1988: 1306-10). Harmful information, empiricists believe, may be generalized, euphemized or withheld from patients if it poses serious harms to patients themselves, or to the public. As previously noted, this is called therapeutic privilege. Therapeutic privilege is a way in which some health professionals can prevent conflict with the most fundamental portion of the Hippocratic Oath; do no harm (Cote, 2000: 199), thus upholding their duty of care. In what follows, I will examine whether therapeutic privilege provides useful guidance for navigating the complex issues raised by the case examples.

2.4.3.1 Therapeutic Privilege

Therapeutic privilege is the only exception, both in medical professional guidelines and the law, to the requirement to obtain informed consent. Its basic assumption is that certain information may be counter-therapeutic or negatively affect a patient's health. Physicians are justified in withholding such information. In fact, some empiricists argue that the physician-patient relationship requires a special sort of truth telling. This relationship obliges a doctor to do whatever he deems necessary to minimize harm – harm to the individual patient and others (Lantos, 1996: 78-92; Vandeveer, 1980: 596-601). To this end, paternalistic lies, concealment of information and deception are justified means of avoiding harm to self and others; or of fulfilling the duty of care (Drickamer and Lachs, 1992: 947-51; Hebert, 1994: 2105-13; Marzanski et al., 2002: 103ff; Tuckett, 2004: 507; Palmieri and Stern, 2009: 165). Van den Heever (2005) describes therapeutic privilege as a situation in which "a medical practitioner…at his discretion withhold[s] information from a patient…when the practitioner is of the opinion that the patient's state of mind is such that full awareness of the gravity and severity of his condition or the drastic nature of the treatment indicated could be therapeutically detrimental to such a degree that his recovery may be prejudiced" (Van den Heever, 2005: 420).

Cote (2000: 203) traces the history of this privilege to the legal case between Canterbury and Spence (1972). In Canterbury vs Spence (1972) by the United States Court of Appeals for the District of Columbia Circuit, the adjudicating judge declared that if information is threatening to a patient, it need not be disclosed. Since Canterbury vs. Spence (1972), case law's disposition to therapeutic privilege in many countries has generally been favourable. This is confirmed by cases such as *South African Medical and Dental Council v McLoughlin* in South Africa (cited in Van den Heever, 1993: 624) and *Reibl v Hughes* in Canada (cited in Cote, 2000: 204). For example, in the Canadian case between Reibl and Hughes, the presiding judge maintained that:

> It may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommend surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific (cited in Cote, 2000: 204).

Away from case law, therapeutic privilege also seems to find acceptance in many medical guidelines and codes, as noted in Chapter 1, such as The Health Care Professions Council of South Africa Guidelines for Good Practice in the Healthcare Professions (2008; Booklet 3:2; Booklet 9:3). Van Oosten (cited in Cote, 2000: 205) identifies six situations in which many medical guidelines counsel that physicians may invoke therapeutic privilege. They include situations:

- Where disclosure would endanger the patient's life or affect physical or mental health
- Where disclosure might prevent rational decision making because the information is confusing or frightening
- Where disclosure causes such anxiety and distress that it might jeopardise the outcome of the intervention
- Where the patient is moribund and disclosure would be inhuman
- Where the risks of disclosure are as much as or more serious than that of intervention
- Where disclosure would seriously prejudice third parties.

This list however, does not clarify how severe harm needs to be in order to invoke therapeutic privilege. A range of responses – distress, depression, shock, pain and anger, or mental, social and spiritual harm – are possible, for example in Case One. It is a breach of respect for persons to withhold information merely because the information is upsetting, painful or emotionally distressing. It is equally a breach of respect for persons to invoke therapeutic privilege merely because the patient will make an inappropriate or bad choice (Cote, 2000: 205). The point I wish to make here is this: on the one hand, clinical libertarians may not have evidence that full disclosure – of an intervention, such as in Case One – will not lead to harm, but on the other hand, clinical empiricists also cannot provide sceptic-proof arguments or empirical evidence to support the contrary.[45] A certain amount of emotional response should be expected from patients who are told, for example, that they have stage II cancer. Patients will always react to such 'bad news', since this information will affect the patient's perception of his future. However, the way in which, or degree to which, a patient will react to such bad news is always difficult to determine. Since a patient's response to such bad news cannot be accurately assessed, there will always be the potential to underestimate or overestimate this reaction: will the patient find the information merely upsetting or psychologically incapacitating? There is the likelihood that the invocation of therapeutic privilege may entail an overestimation of a patient's reaction to bad news. In fact, some patients believe that their emotional response to bad news was directly affected by the way physicians disclosed such information. They believed that they would have been less upset if information was disclosed honestly and compassionately (Edwin, 2009: 37). Without being able to correctly predict a patient's reaction, the use of therapeutic privilege may end up being a violation of the patient's right to information. In the light of this potential to overestimate a patient's reaction to bad news, harm therefore, may not be an adequate criterion for invoking therapeutic privilege. At the very least, what is meant by harm needs to be clarified.

This study appreciates the (legal) restrictions which have been placed on therapeutic privilege to prevent its misapplication. *Inter alia*, the onus rests on the physicians to provide a heavy burden of proof that nondisclosure was in the best interest of the patient. In some complex

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[45] Two contraries may be deduced here: first, empirical uncertainty exists both as to whether full disclosure will lead to harm and secondly, as to whether non-disclosure will not lead to harm. For example, how likely is it that patients in both cases will find out about the nondisclosed information? Upon discovery, will the information necessarily lead to harm or loss of trust in their physicians? There are no straightforward answers to these questions. At best, present studies may provide some guidance for physicians on how to proceed, but they cannot say for certain that their patients will follow the existing trend in present empirical studies. In a manner of speaking, both disclosure and non-disclosure may lead to undesirable consequences. This empirical uncertainty makes it difficult to evaluate the harm/benefit to be gained from non/disclosure; it also makes harm/benefit an inadequate criterion for decision making in this regard.

situations where this privilege is commonly invoked, this may be a very difficult hurdle to scale, since the input of the patient is important in order to determine what exactly is in a patient's best interest. Yet therapeutic privilege largely involves the clinical judgement of a physician, in which the patient has no input. A clinical judgment in which the patient's input is missing may result in the misapplication, indiscriminate use or overuse of therapeutic privilege. Such a judgement will further widen the power differential between physicians and their patients, and undermine respect for persons and shared decision making within the clinical context. Finally, such a judgement will be more likely to serve the physician's interest than the patient's. This seems to be Richard and colleagues'(2010) point when they remark:

> One must realise that when one resorts to therapeutic privilege, one is performing an action that: (1) denies the patient's right to know and does not respect the patient's autonomy; and (2) may result in the patient making poor decisions based on this altered information (Richard et al., 2010: 355).

Since patients are in the best position to know what is in their best interests, a clinical judgement, in order for it to truly serve a patient's interests and contribute to shared-decision making, must involve the patient's subjective input.

2.4.3.2 Disclosure to a Third Party

The first five contexts of Van Oosten's six instances where a physician may invoke therapeutic privilege focus on harm to the patient. In the final context, Van Oosten believes that therapeutic privilege may also be invoked when disclosure would seriously prejudice third parties such as where disclosure may undermine the social good or public interest: for example, the global effort of eradicating a virus (HIV/AIDS in Case Two). Some core clinical empiricists would go as far as recommending deception to protect social good/utility. Deception, Williams and Fost (1992: 217-31; Tuckett, 2004: 506) recommend, may be used in teaching hospitals to serve social utility. For example, disclosing to patients who are admitted to a teaching hospital that novice doctors may operate on them may discourage patients, reduce learning or negatively affect the training of surgeons.

Non-disclosure of H's seroconversion to W in the second case, will not only honour H's right to confidentiality, but also the global effort of preventing the spread of HIV/AIDS. Some scholars (Njozing et al., 2011: 6f; Kamanga et al., 2015: 140; Laar et al., 2015: 4; Xiao et al., 2015: 73; Gillon, 1987) believe that medical confidentiality is the reason patients confide in their doctors and/or seek medical help. Patients may refuse testing if they realize that health professionals can freely disclose their confidential information to others such as their partners. Compromising confidentiality may therefore harm the global effort of ending HIV/AIDS by 2030.

Yet, Case Two presents a scenario where W is not just a third party, but also P's patient. Effectively, a physician-patient relationship with all its duties exists between P and W. Sufficient proximity exists between P and W for there to be a duty of rescue and care towards W. Not acting for W's health interest constitutes a breach of duty of care and may result in a tort case for professional negligence. W is also clearly identifiable; nondisclosure for therapeutic reasons would constitute a breach of the physician's duty to rescue. W may discover, as rightly pointed out by clinical libertarians, that P knew all along about H's HIV seroconversion. Nondisclosure risks undermining W's right to self-determination and jeopardizing the trust relationship between P and W. One cannot deny that a reasonable patient in W's position would expect to be informed of such vital information. In fact, empirical studies exist (Hebert et al., 1997; Marzanski, 2000a; Sullivan et al., 2001; Tuckett, 2004) which support the view that patients want information that may have significant health or personal implications for them. Other studies (Vincent et al., 1994: 1609-13; Edwin, 2009: 36) indicate that patients often sue physicians out of a desire to have information about their health. Some patients complained that physicians rarely gave them information about their health, and others found information provided by physicians rather insulting (Marzanski, 2000a: 319; Norrish, 2015).[46] In the light of these considerations, invoking therapeutic privilege would not yield a useful outcome since equally good arguments exist to support

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[46] I must note here that studies exist which in fact suggest that patients are less likely to initiate legal proceedings, for example, following a medical error, against a medical professional if there has been full disclosure (Norrish, 2015; 286; Mazor et al, 2005; Wu et al, 1997). In light of such studies, one may reasonably argue that disclosure may likely reduce litigation in physician--patient relationships. However, preference may not always translate into practice. The fact that patients have indicated a preference not to initiate legal proceedings against phyisicians who disclose errors, does not mean that they will follow this through. A gap sometimes exists between preference and practice. There is no denying the fact that the statistical relationship between non-disclosure and the patient's desire to sue the physician, is significant. But, the practical effect of full disclosure on litigation must be carefully studied, by asking the question: will disclosure actually reduce litigation in clinical care. Some scholars in fact believe that disclosure could provide an otherwise uninformed patient a basis upon which to seek compensation or to pursue claims. It is not within the scope of this study to empirically verify this claim. What is clear, however, is this: the fact that there are some empirical studies which indicate patients' preference for full disclosure shows how difficult it is to argue for therapeutic privilege on the basis that it will serve the patient's best interest.

disclosure and non-disclosure. Invoking this privilege may further the global effort of ending HIV/AIDS by 2030, but seriously prejudice W. On the other hand, disclosure may prevent harm to W, but seriously prejudice the global good, such as the global effort to stop the spread of HIV/AIDS.

2.5 Concluding Remarks

Roger Higgs (2007) in the opening words of his article on "Truth Telling" remarks: "Telling the truth is one of life's basic rules." We all grow up knowing that it is wrong to lie and good to tell the truth, and Higgs therefore asks: "Why should this subject still be of concern in medicine?" (Higgs, 2007: 88)

In this chapter, I have shown that telling the truth is not always easy in medicine because not all clinical contexts are black and white. After clarifying the concepts to be used in this dissertation, I have discussed the physician-patient relationship as the context in which this study situates itself, as well as the ethical duties which are associated with this relationship. By way of two case examples involving unsolicited information. I have shown that the prima facie obligations mandated by ethical guidelines and law offer little guidance for navigating some complex clinical situations. There exists a sufficient level of ambiguity in the current form of these duties for there to be a compelling case in favour of disclosure and non-disclosure. Thus, adopting a blanket attitude towards non/disclosure, based on these obligations, towards information management, or arbitrary regulations mandating full truthful disclosure in all circumstances, will not always yield a useful outcome. Conversely, this may further complicate ethical judgements, wreak havoc upon the physician-patient relationship or unnecessarily endanger a patient's life or well-being.

Besides, empirical studies on information management are not definitive or conclusive on this issue. Studies exist which show that patients want full disclosure of information. There are, however, other studies which show that some patients consider full disclosure a breach of their right not to know. In addition, these empirical studies – which examine patients' information preferences and emotional reactions – are probabilistic in nature. They can only predict but they cannot determine for certain that future patients will always follow the general trends which they observe.

Clinical empiricists often base their decision to invoke therapeutic privilege on the need to avoid harm or psychological morbidity. Yet it is not clear that nondisclosure itself would not lead to harm. In fact, some studies indicate psychological disturbances in patients who were not informed about their condition, but had to guess their diagnosis during the course of their treatment (Atesci et al., 2004).

Since the duties guiding the physician-patient relationship discussed in this chapter may not always yield a useful outcome, without conflicts, especially in complex situations like those generated by unsolicited information of personal and/or health value; and empirical studies cannot be relied on for navigating these complex challenges, there is effectively a hole in the existing frameworks for managing information in physician-patient relationships. Unfortunately, legislation and/or legal decisions have not helped much in blocking this existing hole, and especially taking into account that what is legal may not necessarily tell us what is ethical. Where legislation acknowledge the patient’s right to receive information, these same pieces of legislations and/or legal decisions also admit that physicians may invoke therapeutic privilege if there is a reasonable belief that disclosure will harm a patient, or jeopardize a patient’s recovery. However, without setting conditions or clarifying ‘harm’, such discretional use of therapeutic privilege is open to abuse and may undermine patient-centred care.

This existing hole, both in existing ethical guidelines and in legislation, may further expose physicians to the possibility of wrongdoing. In light of the above, there is a need for; first, clarification, identification and regulation of the grounds for not/communicating information to patients, and secondly, a set of considerations for justifying a breach of any of the duties identified above in the event of a conflict. Some attempts have been made in this direction. The next chapter will focus on the examination of these attempts.

CHAPTER 3. A MORAL EVALUATION OF STRATEGIES FOR MANAGING MORAL DILEMMAS WITHIN THE CLINICAL CONTEXT

The existing dilemmas around unsolicited information, as identified in the previous chapter, expose physicians to the possibility of legal and professional wrongdoing. In this chapter, I will discuss the strategies that have been proposed for the resolution of these dilemmas, as well as their underlying principle(s). Specific emphasis will also be placed on how successful these strategies and their underlying principles are in clarifying or justifying the breach of ethical duties that is often required in the event of a genuine moral dilemma within the clinical context. In other words, I shall focus on examining the adequacy of these strategies for analyzing moral dilemmas such as the one generated by unsolicited information; and by extension for ethical decision-making in tough contexts in general. First, however, I shall define dilemmas, distinguish between the different types of dilemmas, highlight the type of dilemmas generated by unsolicited information, and explore the frequency of this type of dilemma within the clinical context.

3.1 Moral Dilemmas: Definition

Beauchamp and Childress (2009: 10f) define a moral dilemma as a puzzling circumstance “in which moral obligations demand or appear to demand that a person adopt each of two [or more] alternative but incompatible actions, such that the person cannot perform all the required actions”.[47] In other words, a moral dilemma refers to a situation of conflict[48]

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[47] See also confer Gowans (1987) and Statman (1995).

[48] It is important to note here that the term 'conflict' has, in some literature, been distinguished from 'dilemma'. A dilemma, Statman (1995; pp. 5f) observes, refers to a situation where two considerations clash, and where this clash weighs heavily on the heart of the agent and threatens him or her. In a moral dilemma, the nature of the clash is so intense that it leaves the agent, in most cases, at a loss as to what s/he ought to do. Conflict, on the other hand, refers to the clash itself. I do not, however, think that this distinction is necessary for the purpose of this study. In other literature, the term 'dilemma' is used to refer not only to the situation of being at a loss to know which path or action to follow, but also to the clash as well.

between prima facie obligations or duties (Lemmon, 1987; Christensen and Gomila, 2012)[49] that arise from following general principles. Plato[50] gives an example of a man who leaves a weapon with his friend, who promises to give back the weapon when he returns. However, the man returns in a distraught condition, announces his intention to kill his wife for being unfaithful to him, and demands his weapon. The friend is obliged to return the weapon since he has promised to do so, yet in doing so this friend may be indirectly responsible for a murder, which nearly everyone believes to be intrinsically wrong. In this scenario, whatever the friend does, it would always involve doing something he ought not to have done, or not doing something he ought to have done.

Jean-Paul Sartre (1946: 35) offered an example of a more complicated dilemma in his public lecture *L'Existentialisme est un Humanisme*. In this lecture, Sartre described a young man – his student – who feels obligated to join the Free French Forces to avenge the death of his brother, who was killed in Germany. However, to do so would mean abandoning his elderly mother, who relies on him for daily care. He cannot fulfill both obligations. As is clear from the above, dilemmas generally involve conflicts: conflicts of duties, of obligations, or beliefs.

3.1.1 Types of Moral Dilemma

Two types of moral dilemmas may be differentiated: apparent and genuine moral dilemmas. All moral dilemmas pose some difficulties for the agent or individual since they involve values, duties and obligations which come into conflict. However, some of them are

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[49] In Lemmon's (1987; p. 107) view, a moral dilemma entails a situation of conflict. The conflict may take different forms. Lemmon (1987; p. 102 & 104) makes a distinction in this regard between duties, obligations, and moral principles. One knows what one has to do, and does it, because one knows it to be one's duty to do it. An example is a soldier who acts on on order. Second, one knows what to do and does it, because one knows oneself to be under an obligation to do it. For example, the physician-patient relationships implies certain obligations such as honouring the trust of patients. Finally, one knows what one must do, and does it, because the individual holds it to be the right thing to do in view of some moral principle. For example, a woman knows that she ought not to lie and refrains from doing so because she holds a moral principle that one should not lie. Duty and obligation are not correlates. A physician may be under an obligation to get food for a patient, if he has given his word to do though it is not his duty to do it. In the same vein, in a physician-patient relationship, a physician has certain duties towards his/her patients, however, he is under no obligation to begin a physician-patient relationship with potential patients. Duty is related to one's profession or job, while obligation is related to contractual relationships. One's duty may conflict with one's obligations and thus, give rise to a dilemma. Similarly, one's duty may conflict with one's moral principles; and one's obligations may conflict with one's moral principles, and also give rise to a dilemma. The example given by Plato and cited in this chapter, presents a dilemma arising from the conflict between one's moral principles, and obligation.

[50] Plato, The Republic, 331c

resolvable. For example, a promise to be in church on Sunday may be overridden by a duty to help an accident victim. These resolvable[51] moral dilemmas are called apparent moral dilemmas. Others are not resolvable and, are called genuine moral dilemmas.

Nearly all moral theorists now believe in the existence of apparent and genuine moral dilemmas. But this was not always the case: the existence of genuine moral dilemmas, in particular, was once a subject of great controversy amongst scholars. Regarding the existence of genuine dilemmas, Kant (1996: 39) argued that:

> A collision of duties and obligations is inconceivable. However, a subject may have, in a rule he prescribes to himself, two grounds of obligations, one or the other of which is not sufficient to put him under obligation, so that one of them is not a duty; when two such grounds conflict with each other, practical philosophy says, not that the stronger obligation takes precedence but that the stronger ground of obligation prevails.

In other words, moral norms regulating duties are such that they often necessitate one action over the other. If this is the case, two rules necessitating moral actions cannot conflict. If it is a duty, and thus, a moral necessity to perform action A, then it cannot also be a duty and a moral necessity not do A or to do something incompatible with A. For example, if a physician has a necessary duty to inform a patient of all morally relevant health information, he cannot also have a necessary duty not to inform the same patient (Gowans, 1987: 6). Kant’s denial of genuine moral dilemmas, as Gowans (1987: 6) observes, is puzzling. First, he says that there are no conflicts of obligations but there may be conflicts of *grounds of obligations.* Questions may be raised here about the status of these grounds and the basis for resolving conflicts among them. For example: what are these grounds of obligations? How important are they to decision-making? How are conflicts between these grounds resolved? If an individual, as Kant claimed, could be subject to competing grounds of obligation (following a rule which he prescribed for himself/herself), how does the individual decide which ground has a stronger claim on his conscience, when the individual cannot act on both such grounds? For example, as a result of a rule I prescribed for myself (not to make fraudulent promises, but to honour my promises), I may be faced with two grounds of obligations: to fulfill a promise to pay back a loan at a certain time, and second, to fulfill a

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[51] Hursthouse (1999: 44) speaks of apparent moral dilemma as resolvable 'with remainder'. In this sense, Hursthouse believes that the agent is eventually forced to take a decision thereby resolving the dilemma, but certain moral residue such as guilt, regret, shame, and so on, inevitably remain for failing to fulfill other obligations.

promise to give financial assistance to a friend in need, whenever he requires it. How do I decide which ground has a stronger claim on me if the only way to honour my promise to help a friend in need is to fail to honour my promise to pay back a loan at the time promised? It appears that Kant's denial of genuine moral dilemma is itself a tacit admittance of one.

Other scholars deny the existence of genuine moral dilemmas based on the fact that they involve three irreconcilable deontic premises:

1) I *ought to do* A = OA; ii) I *ought to do* B = OB; iii) But I cannot do both A and B = ~ ◊ (A & B).
2) Ought implies can – if I ought to do A, then it must be because I can do A.
3) Principle of agglomeration – if I ought to do *both* A and B, it must be because I can do both.

The three premises lead to self-contradiction, these scholars (Schroeder, 2011: 13-20) conclude. According to the definition of a moral dilemma in 1, you cannot do both A and B, but I ought to do *each* of A and B. This definition is irreconcilable with the principle of agglomeration in premise 3, which is built on the principle of ought implies can in premise 2 – since it states that if I ought to do each of A and B, it must be that I can do both A and B.

In other words, if ought implies can, this means that if one has two obligations that one ought to fulfil at the same time, it is because one can do both at the same time. By this logic, there can never a situation where doing A will make doing B impossible, if we ought to do both A and B. Following the principle of agglomeration, an individual can and ought to fulfil both obligations. Conversely, if I cannot do both A and B, then it is not the case that I ought to do A and B. In both cases, the conclusion is the same: genuine moral dilemmas are non-existent. But there may be situations, these scholars observe, where arriving at a rational course of action may be extremely difficult. Even in such situations, it is possible to reach a decision, and hence, there are no real dilemmas. What we have, these scholars conclude, are apparent dilemmas which can be resolved after due reflection, or after the application of a major ethical theory (Hodkinson, 2008; Macintyre, 1990). According to this line of thought, the claim that an individual confronted with a real dilemma is fated to fail in (an)other equally important obligation(s), or to do wrong in a way which renders guilt appropriate, is false.

The above denial of the existence of genuine or real dilemmas certainly raises a number of questions. For example, consider the following case: A young man borrows money from both

A and B, and promises to return the amount to each person on the same day. The day arrives, but he is only able to refund A, and cannot refund B. If ought implies can, and this man cannot fulfill his promise to refund B, does that mean he is no longer obligated to return the borrowed money to B? In other words, ought may not always imply can (Kuhler, 2012: 6).

However, it is beyond the scope of this study to investigate whether genuine moral dilemmas exist or not. As there is widespread agreement amongst scholars that real or genuine moral dilemmas do in fact exist (Nichols and Mallon, 2006), this study will accept this general view and take the existence of genuine or real dilemmas for granted. We can and often do experience genuine moral dilemmas. Many of the ethical challenges generated by unsolicited information, however, are apparent moral dilemmas, which could be resolved after due reflection. Others are genuine dilemmas, which by the definition I provide here in this chapter, are irresolvable. Apparent dilemmas may be addressed by providing justification for the violation of other duties or obligations in the event of a conflict. Such a justification for violation would negate the bindingness of the violated duty, or avoid a direct confrontation between two (binding) duties. Furthermore, irresolvable genuine dilemmas may be addressed by putting in place guidelines for anticipating these, and avoiding their future occurrence, thereby reducing distress to the health professional.

This study reaffirms the definition of genuine moral dilemma as a situation in which an individual competently judges that they are morally obligated to perform A, but cannot due to other compelling arguments mandating not A, or something incompatible with A. Other contingent circumstances also negate performing A and not A at the same time. Unlike apparent dilemmas, genuine dilemmas do not arise from the individual’s ignorance of morally relevant facts; rather, they arise because the cosmos is so structured that notwithstanding this epistemic awareness, the individual is still fated to fail in at least one or more ethical obligation or duty. For this reason, Statman (1995: 8) adds, dilemmas are genuine, when even for the most imaginative agents, “all escape routes are blocked, and a direct confrontation between two alternatives can neither be avoided nor reduced.” I shall argue that some of the ethical dilemmas generated by unsolicited information, may be resolved by providing a foundational moral rule or principle justifying the violation of certain duties and/or obligations (and that they are therefore apparent dilemmas). However, other ethical challenges generated by unsolicited information are irresolvable, in that some duties are fated to remain unfulfilled. However, these may be anticipated or prevented from occurring in the future. In addition, I shall show how such irresolvable dilemmas may be addressed in ways that mitigate distress to the health professional and foster respect for persons as much as possible.

3.1.2 Nature and Characteristics of Genuine Dilemmas

As noted above, scholars believe that in order for a dilemma to be truly genuine, it must be irresolvable. The ir-resolvability of genuine moral dilemmas, Lemmon (1987) points out, arises as a result of inconsistencies[52] in general principles, which can only be resolved by adding clauses to the current principles in force. Here, a principle is said to be inconsistent when there is a sense in which it is obey-able and not obey-able at the same time, or in the same situation. For example; there is a sense in which providing information to J is the right thing to do, such as in Case One; since it will enhance his right to self-determination; yet providing information to J may also be a breach of J’s right to self-determination; his right not to know. Against this background, Lemmon (1987: 108-114) argues that the very existence of (genuine moral) dilemmas is an indication of an implicit inconsistency in our existing moral code; that we are forced, if we are to remain both moral and logical, by the situation to restore consistency to our code.

Generally, scholars have differentiated between two ways in which inconsistency leading to such genuine moral conflicts between prima facie obligations or duties may arise: first, there is evidence supporting the view that an action is morally permissible; and also evidence supporting the contrary. And this evidence – in support of or against moral impermissibility –

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[52] In fact Kant's denial of the existence of genuine moral dilemmas boils down to this singular point. In Kant's opinion, ethical theories cannot allow for genuine dilemmas without running the risk of being inconsistent. If our moral theories allows for inconsistencies, then they are useless for decision-making. Michael Kuhler (2012) advances a different argument which affirms the existence of real moral dilemmas that are not the result of inconsistencies in our moral theories. Kuhler (2012) differentiates between moral theories making descriptive or normative claims. Descriptive claims describe what the world is; in which case when a description does not conform to the world, then it is false. On other hand, normative theories refer to what the world can be, but is not yet. The fact that they are not fulfilled yet, does not mean these claims are inconsistent. In Michael Kuhler's (2012) opinion, moral theories make normative claims since they set normative standards for decision-making; they also set the standard with respect to which the world and our actions can be evaluated. If there is lack of conformity now, this does not mean that such a theory is inconsistent. Hence he concludes, real dilemmas exist, but this is not due to inconsistencies in moral theories. It is not within the scope of this essay to determine whether dilemmas exist as a result of inconsistencies in our moral theories or not. However, I do want to state that the existence of dilemmas does show that there is indeed a gap in our moral theory that should be bridged. Bridging existing gaps in normative theories this way, does not necessarily mean that this will resolve all dilemmas. This may resolve some, and prevent the irresolvables ones from occuring in the future.

is inconclusive (Lemmon, 1987: 108-114; Prasad, 2015: 1; Sinnott-Armstrong, 1988; DuVal et al., 2004: 252). In other words, there is a sense in which one ought to do A, since some of its features oblige one to do it. There is also a compelling reason not to do A, since some of its other features oblige one to avoid doing it. And both doing A and not doing A are incommensurable. For example; empirical evidence and moral arguments in Case One, where the physician needs to decide whether to inform Jehovah's Witness J of his life-saving blood transfusion, seem to support the view that the physician is professionally required to honour the fiduciary relationship via disclosure. Evidence also supports the view that the physician is professionally required not to cause harm: disclosure to J may cause significant psychological or spiritual harm. This will be a breach of the physician's duty of care. Yet arguments in support of or against disclosure are not conclusive in themselves. Clinical empiricists may advice the physician to invoke therapeutic privilege in such a situation; yet it is not entirely clear whether informing J of the blood transfusion will lead to harm or not. On the contrary, J may discover that this information was concealed from him. In itself, this knowledge may cause severe emotional and psychological distress. In sum, neither the obligation to disclose or not to disclose takes priority in this situation.

Second, inconsistency leading to genuine moral dilemma may also occur when an agent feels obligated to perform two or more mutually incompatible and incommensurable actions (Torjuul et al., 2005a: 2); moral arguments in favour of both mutually incompatible actions are weighty and neither outweighs the other. There are two ways in which moral arguments supporting both actions may be weighty: either moral reasons supporting both actions compel one to perform each one, but, they cannot both be performed, or moral reasons do not support any of the actions but a decision nonetheless, has to be made, such as in tragic dilemmas.[53] As Macintyre (1990: 376) explains, in typical genuine moral dilemmas, an individual finds themselves in;

> a type of situation in which they have arrived at a pair of conclusions, each derived from premises of a kind on the basis of which they have often constructed sound practical arguments, and each derived by modes of inference whose validity they have no reason to doubt, but which jointly are

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[53] In a tragic dilemma, even a decision not to make a choice is itself a choice. Consider the example of a mother who sees two of her children drowning but can only save one. Whatever horn of action, she chooses, she would by reason of that choice be doing something wrong, that is, allowing the other child to drown. And if she decides not to act, this in itself is an action.

> or entail a contradiction, a contradiction such that, had reason exhausted its resources in affording them this pair of conclusions, no course of right action would be open to them.

In light of the above, other scholars such as Foot (1983: 395) describe genuine moral dilemmas as incommensurable - that is, they often involve strong values with no common basis for preferring one to another. Regardless of what the individual does, he will not be able to arrive at a compelling reason to prefer one decision to another. In this regard, real dilemmas effectively create a situation of inescapable failure. This explains the nature of some of the dilemmas generated by unsolicited information within the clinical context: inescapable failure. A situation of inescapable failure is a situation where an individual is unable to choose between two incompatible but equally compelling actions: the moral reasons supporting each horn of action would be partially morally acceptable by some ethical standards; and partially morally unacceptable by other ethical principles. Similarly, notwithstanding what the health professional faced with certain kinds of unsolicited information does, his actions would always be supported by some ethical standards and disapproved by others.

Confronted by the reality of choosing between two incompatible but equally compelling actions, the agent may believe that there is a way out of the quagmire. The uniquely painful feature of the dilemma lies in the truism that notwithstanding this belief, the individual as yet cannot find one. The pain is further intensified if the dilemma involves making a tragic decision, such as Sophie’s Choice.[54] Guilt, regret, shame, and so on, are inevitable moral residues which result from facing this form of dilemma (Schroeder, 2011; Foot, 2002; Foot, 1983). For this reason, Dworking (cited in Statman, 1995: 89) defines a moral dilemma as a situation “where an agent faces a difficult practical question, to which no (absolutely) right answer exists.”

I do, however, observe at least one objection by Foot (1983; p. 382; Schroede 2011: 54) to the necessary connection between moral residues and genuine moral dilemmas. In Foot's opinion, it is possible for guilt, regret or shame to occur without necessarily experiencing

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[54] Sophie's choice refers to a situation in a Nazi camp where a mother was told to choose between two of her children: one will be sent to the gas chamber and the other saved. If she refuses to choose, both will be sent to the gas chambers. The mother chose to sacrifice the younger one, and saved the elder. Eventually Sophie committed suicide herself following the guilt and regret she experienced from her inability to save her younger daughter.

genuine moral dilemmas. A moral agent can experience moral residues in a non-moral situation. Similarly, it is possible to experience a genuine moral dilemma without experiencing any regret or guilt. What we in fact call moral residue is nothing but obligation or duty left undone. But it is doubtful, according to her, that we would always regret or feel ashamed for not fulfilling these duties. Hence, she concludes, it is wrong to think that moral residues are a necessary consequence of genuine dilemmas.

I quite agree with Foot (1983) that moral residues may be experienced in a non-moral situations; however, I believe that genuine dilemma very often lead to moral residues. Individuals, for example, are motivated to follow norms because of the guilt or shame they will experience for violating the same. Professional obligations are in some way institutional norms enjoined on individuals by the group. Part of the complexity generated by genuine dilemmas is explained by the fact that the individual is motivated to fulfil all obligations in order to avoid the guilt or shame that follows violation or non-fulfilment of any of these obligations. It is this avoidance of shame or guilt which keeps the agent committed to looking for solutions to the dilemma.

3.1.3 Moral Dilemmas within the Clinical Context

Studies (Mercuri et al., 2015; Monrouxe et al., 2015; DuVal et al., 2004; p. 251; Lo and Schroeder, 1981; Torjuul et al., 2005a; p. 1; Hurst et al., 2005; p. 7; McLean et al., 2013; p. 350) have now shown that dilemmas occur regularly within the clinical context. Medical professionals today, as Torjuul and colleagues (2005a: 2) observe, face more ethical dilemmas than in previous years due to a growth in scientific knowledge, an increase in the availability and efficiency of medical technology, and increased focus on the shared-decision making capacity of patients, among other factors. For example, recent advancements in biomedical technologies have given rise to new ethical concerns around gene editing and the possibility of genetic enhancement, and an increased focus on the shared-decision making capacity of patients also increases the possibility of conflicts between the wishes of patients and medical advice.

In two systematic reviews (Ewuoso et al., 2017a; Ewuoso et al., 2017d), we identified some broad types of ethical challenges regarding information that arise within the clinical context. These include ethical dilemmas related to confidentiality, decision-making, communication, value-differences, treatment plans, and professional duty. These dilemmas have been experienced in a variety of clinical contexts such as gynaecology, obstetrics, sport medicine, oncology, family medicine, and paediatrics, to mention but a few.

Each broad category can be further delineated. The broad issues in communication-related challenges are: how much information to disclose; to whom to disclose; what to disclose and when to disclose. For example, when clinically significant (and hereditary) information is discovered, clinical geneticists (Lisker and Carnevale, 2006; Falk et al., 2003; Alliman et al., 2009; Erde et al., 2006; Bower et al., 2002; Akpinar and Ersoy, 2014; Elger et al., 2015; Lapid et al., 2009; Fennig et al., 2004) often face the difficulty of deciding how much of this information to disclose, and to whom to disclose. For example, should individuals of over 50 years be informed if a condition is not clinically actionable? Should patients younger than 12 be informed about adult onset diseases? Is there a duty to warn at-risk relatives? Would warning third parties lead to a breach of their right not to know?

Four main sub-categories in confidentiality related challenges include decisions regarding informing patients about the limits of confidentiality; disclosing patient health information to an insurance company, public authority or employer; breaching patients' confidential information to benefit significant others or at risk third parties; and maintaining confidentiality of patient information. Mental healthcare professionals (Malcolm and Scott, 2014; Lisker and Carnevale, 2006; Falk et al., 2003; Alliman et al., 2009; Erde et al., 2006; Bower et al., 2002; Akpinar and Ersoy, 2014; Elger et al., 2015; Lapid et al., 2009; Fennig et al., 2004), for example, often report that decision-making about breaching patient's confidential information to benefit third parties or to prevent harm to others is a major challenge that they commonly experience within the clinical context.

The broad issues involved in professional duty-related challenges include conflicts between expressing emotions and fulfilling obligations towards patients. Yang and colleagues (2016), for example, discovered that nurses are sometimes unable to express their personal beliefs regarding abortion. The delivery room routines and norms sometimes require nurses to participate in abortions, such as in cases of abortion due to non-chromosoma abnormalities.

Other professional-duty related challenges include conflicts between reporting a colleague's error and maintaining their trust/friendship; and value conflicts such as disagreements between professionals and patients/family members over termination of pregnancy or presymptomatic testing of minors (Bower et al., 2002; Groepper et al., 2015). Honouring one's duty to report abuse can also be a nightmare for professionals. For example, in Sweden (Kvist et al., 2014) where studies have linked poor child maltreatment/abuse to poor oral health, dentists are required to report any suspicion of child abuse in any child with poor oral health. Professionals, however, experience ethical difficulty in distinguishing parental concern for a child's wellbeing from child maltreatment; or child abuse from poor parenting

Treatment plan-related challenges generally arise through a lack of appreciation of the imports of information or a failure by a patient and/or family members to make sense of information provided (for example, that a particular treatment option is futile); by way of communication[55] breakdown when conflicts between a physician's expert opinion and family wishes regarding treatment arise; ethical difficulties with regard to going ahead with a treatment plan when a patient is undecided, ambivalent or cannot communicate his decision regarding treatment in a timely manner (Tully et al., 2016); and conflict between patient wishes and the physician's opinion regarding treatment. As these systematic reviews showed, dealing with an ambivalent patient can be an ethical nightmare for Trauma/Emergency unit health professionals; since this often stalls required treatments, frustrates important clinical decisions, or leads to communication break-down (Tully et al., 2016).

Finally, in value-difference related dilemmas, one frequently occurring issue is how communication between a physician and his patient may easily break down (or be compromised) owing to cultural and/or religious differences between them (Magnavita and Bergamaschi, 2009; Surbone, 2006; Kasman, 2004; Westra et al., 2009).

In the two systematic reviews, the above ethical challenges regarding information are discussed as ethical dilemmas which can lead to communication breakdown amongst professionals or between professionals and patients. Thus, the potential for communication breakdown amongst professionals or between professionals and patients/family, is a theme which underlies all the broad types of genuine ethical challenges within the clinical context.

Good communication is key to patient care - a breakdown in communication could jeopardize the patient's care; or lead to the provision of information to a patient who is neither ready nor sufficiently prepared to receive such information. In the next section, I will discuss how

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[55] I define communication broadly in this study. It encompasses the content of communication; necessary communication skills; as well as the judgement required for determining when communication is appropriate

health professionals within the clinical context typically address these genuine dilemmas, as well as whether these strategies are adequate for clarifying or justifying the breach of ethical duties that is required when a moral dilemma – such as those generated by unsolicited information – occurs within the clinical context.

3.2 Strategies and Approaches to Dilemmas within the Clinical Context

Medical professionals have a wide range of strategies which they use to deal with dilemmas regarding information. Some of these strategies include consultation; negotiating differences; using professional/prudential judgement; and resolution.

Consultation is the most widely suggested strategy for managing information and the related challenges discussed in the preceding section.

Consultation includes seeking the professional advice of colleagues within, or outside of, the field of practice; consulting an ethics committee or group; and consulting with team members. For example, oncologists, intensivists, paediatricians, and nurses who face the ethical difficulties of communicating the futility of treatment to patients/family members, or with whom patients/family members have a disagreement over treatment plans, are encouraged to consult with their experienced colleagues within or outside of the hospital. It is believed that these experienced colleagues can provide useful insights for professionals who struggle with the above ethical difficulties (Kasman, 2004; Gutman, 2005; Petrik et al., 2015).

Negotiating differences involves engaging in active dialogue with patients/family members to reach common ground when there is a difference of opinion; or holding a discussion with team members with whom there is a disagreement over a treatment plan. This strategy is widely used for resolving disagreements between professional(s) and patients/family members; such as when parents do not consent to disclosing information to their sick child, or when professionals and patients are motivated by different values. It may also be used to resolve conflicts regarding treatment. For example, when family members cannot agree about whether to withdraw life support, or when family members/proxies hold contrary views regarding withdrawing treatment, nurses and intensivists are encouraged to negotiate these differences through active dialogue with family members/proxies (Olsen, 2010; Hatano et al., 2011; Surbone, 2006; Hyde et al., 2013; McGowan, 2012).

Professional judgment involves the use of discretion to decide upon non/disclosure according to the preferences and/or values of patients and/or family members, since insensitivity to the patient's values can lead to the provision of information to one who is not ready to receive it, causing distress for him/her. This strategy is frequently adopted in clinical situations where patients and professionals are motivated by different values; it could also be used to manage information when a patient is incapacitated or *non-compos mentis*. For example, when family members request a patient's confidential information, and the patient is incapacitated, critical care nurses and/or mental health care professionals are often encouraged to carefully judge whether disclosure would violate prevailing regulations, or whether it would lead to benefits for patients (Gold, 2004). Additionally, in regions where non-disclosure of life-threatening conditions is acceptable, or where patients consider it a taboo to talk about death, reviewed studies also suggest that professionals would be ethically correct to use their discretion to filter disclosure according to the cultural values and practices of patients or family, provided that the decision not to disclose does not in any way jeopardize the treatment of patients or their best interests (Gupta et al., 2008).

Finally, resolution, which involves shifting the dilemma from oneself by passing on decision-making responsibility to others when there is a conflict could involve seeking legal or court orders when patients do not consent to providing their health information to parties who may be at risk of infectious diseases or preventable/manageable health conditions; referring patients to another hospital when differences in a professional's values and the patient's cultural beliefs cannot be resolved; and having a discussion prior to diagnosis or treatment to elicit the patient's wishes. For example, radiologists and geneticists who frequently face the challenge of managing unsolicited or incidental information are encouraged to hold a discussion with the patient at the onset of the clinical relationship to elicit their wishes/preferences regarding non/disclosure of such information (Lucast, 2007; Brown, 2010). In addition, military psychologists or psychiatrists who often engage patients in different contexts and roles (as military colleagues and as patients) are urged to avoid this conflict of duties by referring patients/colleagues to independent experts who might be able to offer appropriate care (Johnson et al., 2006).

It is unclear whether these adopted strategies lead to satisfactory outcome where all stakeholders in the clinical care of patients were made better-off. However, enquiry shows that regardless of the strategy they adopt, health professionals still experience a variety of emotions, such as frustration (Sørlie et al., 2000) and stress (Torjuul et al., 2005b). Some complain that these challenges often lead to burnout (Nordam et al., 2005), and were negative experiences for them (Elger et al., 2015). Other emotions and consequences reported include anger, anxiety, exhaustion, depression, devastation, distress and guilt, to mention but a few (Faith and Chidwick, 2009; Beng, 2006; Bell et al., 2015; Magnavita et al., 2009). These emotions and feelings have been associated with moral distress in the clinical context, by Prentice and colleagues (2016); Epstein and Hamric (2009); and Thomas and McCullough (2015).

These systematic reviews (Ewuoso et al., 2017a; Ewuoso et al., 2017d) also considered the moral reasoning behind the use of these strategies, and revealed that one or more of the key principles of principlism – autonomy, beneficence, non-maleficence and justice – supported the underlying moral justification for adopting these strategies. I will consider a few examples of this by way of illustration.

In Kagan and colleagues (2008), the majority of physicians and nurses said they would require their blood-borne pathogens-infected colleagues to disclose their blood-borne infections to patients before surgery; the majority of these professionals – in their own professional judgment – also believed that it was prudent, as well as a matter of professional obligation, to restrict such infected colleagues from performing invasive surgery since they constituted a danger to patients. Such disclosure or restriction is justified by the principle of nonmaleficence, as it will prevent harm to patients. Mental health professionals in Elger and colleagues (2015) maintain that they would anticipate and resolve ethical dilemmas around confidentiality by having prior discussions with patients to inform them about the limits of the same. Patients, these professionals claim, have a right to know that some information may not be covered by confidentiality rules. Such prior discussions, these professionals maintain, will help patients make informed decisions about continuing with clinical interactions with the physician, and this would honour the requirement to respect persons or autonomy. Similarly, empirical studies show that general surgeons and mental health professionals also employing the strategy of resolution frequently seek legal advice or a court order to allow them to breach confidential information, in order to benefit at-risk parties in accordance with the principle of beneficence (Kipnis, 2006; Agyapong et al., 2009).

In other examples, surgeons in Torjuul and colleagues (2005a) said that consultation with senior colleagues would provide insights for them on how to handle incompetent colleagues or disagreement with patients/family members over treatment. Consultation will benefit patients by ensuring that patients receive best care, and this is in accordance with the principle of beneficence. Finally, paediatricians in Sorlie and colleagues (2000), said when there is pressure to continue futile treatment of seriously ill newborn babies, sometimes, they stall – that is, pretend to have a solution – or actively engage parents and/or family members to reach common ground. Such dialogue, in their opinion will give dying children and parents time to achieve death with dignity, as well as ensure fair or just distribution of resources to sick children who could still be saved, in accordance with the principles of respect for persons and justice.

The above empirical evidence supports the claim of some scholars such as Lawrence (2007), Cahana and colleagues (2008) and Page (2012) that principlism is the dominant ethical foundation of modern medical and research practices. In other words, the general view in published empirical, as well as concept papers, is that health professionals and ethicists analyze genuine dilemmas by adopting principlism (Hurst et al., 2005: 11; Gardiner, 2003: 297; Ewuoso et al., 2017b; Ewuoso et al., 2017c). In the next section, I shall focus on the principal form of ethical reasoning – that is principlism – underlying these strategies, with the specific aim of highlighting why, regardless of the adopted strategy, health professionals still experienced the emotions described in the previous paragraphs. I state from the outset that principlism is a valuable ethical approach for addressing moral issues, thus the purpose of this dissertation is not to ask that this ethical approach should be replaced. Rather I shall argue for its supplementation with more specific guidelines.

3.3 Principlism and Moral Dilemmas within the Clinical Context

As previously noted, principlism is a pluralistic approach to moral decision-making based on four key principles: autonomy, beneficence, nonmaleficence, and justice. Many scholars generally believe that principlism is a combination of a number of moral theories such as deontology and consequentialism. This is what gives the approach its pluralistic framework. This ethical theory has been highly influential in Bioethics over the last twenty years, and is frequently employed in the analyses of ethical dilemmas (Lawrence, 2007: 34 & 36; McCarthy, 2003: 65-66). Childress (1994: 72-98) believes that this approach is the most helpful for illuminating complex decisions in biomedical ethics; or for directing physicians in morally conflicting situations. The popularity of this theory declined in the early 1990s due to a variety of criticisms, but surged back soon afterwards thanks to the work of Raanan Gillon

(2003ba; 2003ab; 1994; 1987), Ruth Macklin (Metz, 2010d; Macklin, 2003), and other defenders of this approach to clinical decision-making.

In Bulger's (2007: 81) opinion, principlism is both descriptive and prescriptive in essence. The principles not only describe how people do make moral decisions, they also prescribe how one ought to act in particular situations based on some intersubjective agreements of common morality. It is this intersubjectivity, in Bulger's (2007: 81) opinion, that makes principlism such a successful approach in interdisciplinary environments. Principlism was first formalised as a guide for decision-making in the Belmont Report of 1979. The Belmont Report itself was the United States of America's (Kanniyakonil, 2007)[56] response to the infamous Tuskegee Syphilis Trial which took place in Alabama. The Report is a foundational document which provides ethical guidance for human subject research in the United States. In the Tuskegee Syphilis Trial (1932-74), some poor, largely illiterate African American farmers in Alabama were deceived and denied proper treatment for syphilis. Critical information about the study, as well as information necessary for making informed decisions, was also not made available to the subjects. Many of the research subjects suffered needless pain and died as a result. This horrific study led to the commissioning of the National Commission for the Protection of Human Subjects for Biomedical and Behavioral Research by the United States Government, to formulate ethical guidelines for principled research. These guidelines are now known as the Belmont Report.

This document's principlistic approach marks the beginning of what is now known as 'principlism'. Callahan (2003: 288) describes this approach as "culture congenial". Its rather brief history reflects the core liberal and individualistic culture from which this approach emerged, as I will argue below. Since the development of this approach, it has had a special appeal for physicians who needed a method to navigate their practical ethical conundrums (Callahan, 2003: 287).

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[56] There is an attempt by Kanniyakonil (2007; pp. 81-84) to distinguish an American model of principlism from a European model of the same. Kanniyakonil believes that this differentiation is important however, I do not think this is necessary. The historical beginnings of principlism are not in doubt. Current literature generally agree that principlism can be traced to the Belmont Report. There may have been several adaptations of this approach, this does not negate their common origin.

3.3.1 Key Principles

The Belmont Report specifies three core principles for ethical human research. They include: respect for persons, beneficence, and justice. Today these principles have evolved into guides for clinical decision-making, principally through the works of James Childress and Thomas Beauchamp, who continue to revise and nuance these principles in light of various criticisms against the approach from different scholars.

In their formulation and discussion of principlism, Beauchamp and Childress (2009) replaced the principle of respect for persons with respect for autonomy. They then added another principle – the principle of non-maleficence – which was not present in the Belmont Report, but implied by the Report's principle of beneficence. These principles, Beauchamp and Childress (2001: 3) claim, are consistent with most cultural, ethical and theological practices, since they involve universally accepted values (Demarco, 2005; p. 101; McCarthy, 2003; p. 66.). This universal applicability to a variety of contexts is a basic assumption of principlism, and is offered as a fundamental reason for putting this approach forward for decision-making in clinical practice and research. The principles, Beauchamp and Childress (2001: 3) claim, are consistent with common moral norms all morally serious persons share, and thus, are useful for solving ethical problems across a variety of contexts. In their words, "these principles contain moral norms that bind all persons in all places; no norms are more basic in the moral life". These authors ground their choice of the four principles – respect for autonomy, beneficence, non-maleficence and justice – on the argument that these are the four common guides for clinical decision-making that can be found in medical codes throughout history. According to Beauchamp and Childress, these principles offer an expedient way for evaluating the morality of any action in any given situation.

The process of moral decision-making within principlism requires what is called reflective equilibrium, which is the weighing and balancing of conflicting principles[57] on the basis of reasoning, experience, rules, relevant background theories and all plausible judgments; in order to reduce conflicts and fit them into a coherent whole (Beauchamp and Childress, 2001: 399; Childress, 1994: 81). In other words, these principles can only be applied in concrete

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[57] In McCarthy's (2015; p. 70) opinion, the weighing and balancing act requires some set of skills; analytic skills to identify ethical issues and apply particular principles; deductivist skills to apply general principles to particular cases; and critical skills to reflect and reason from particular cases to general rules

situations through further specification, that is, by taking into account the context, background theories, and other elements.

Beauchamp and Childress (2001: 398) emphasize that the order in which they present their principles should not be taken as hierarchical. These are *prima facie* principles; and as *prima facie* principles they are useful for providing guidance in concrete situations. *Prima facie* is defined as the obligation that must be fulfilled, unless this obligation conflicts with other obligation(s). In morally complex situations when two or more obligations conflict, none is to be regarded as more important or more morally weighty than the others, but both obligations must be specified and the weight of each determined and balanced. This requires judging which principle should be given importance on the basis of the individual patient's needs, values, preferences and so on, in order to arrive at which obligation must be overridden. For this reason Beauchamp and Childress (cited in Ebbesen et al., 2012: 2) define further specification as the "process of reducing the indeterminateness of general norms to give them increased action guiding capacity, while retaining the moral commitments in the original norm." For example, in a complex moral situation, autonomy may take precedence over the rest of the principles; and the same may apply to beneficence, or any of the remaining principles. Further specification within complex situations or within the context of moral dilemmas will determine which principle should take priority, rather than some abstract a priori ranking. In what follows, I shall endeavor to present an unbiased exposition of each of these principles and the moral duties implied by them, with the specific aim of understanding why, notwithstanding the adopted strategy, health professionals continue to experience the emotions mentioned in previous section.

3.3.1.1 Respect for Autonomy

Two key duties in the physician-patient relationship are founded on the principle of respect for autonomy. They include the duty to respect patients and the fiduciary duty – that is, the duty to honour an ethical relationship of trust. The principle of respect for autonomy, in the physician-patient relationship, is not merely an ideal physicians are encouraged to strive for; it is a professional obligation enjoined on them. Beauchamp and Childress define autonomy – from *autos* 'self' and *nomos* 'rule' – as self-rule that is free from manipulation or external coercive measures (1994: 120)

An autonomous person acts freely in accordance with his set priorities and goals, in the same way that an autonomous state determines its own direction in accordance with its set objectives and goals. The three key constitutive elements of an autonomous agent, as identified by Beauchamp and Childress, include understanding, freedom from controlling influences and capacity/competence for acting with intention (Beauchamp and Childress, 2001: 58). In the light of these important constitutive elements of an autonomous agent, Beauchamp and Childress define the principle of respect for autonomy as the acknowledgement of an individual's "right to hold views, to make choices, and to take actions based on personal values and beliefs" (2001: 63).

In medical ethics, the duty to respect patients (discussed in Chapter Two) is based on this principle; and it requires physicians to consult patients before taking action concerning them. Hence the necessity of obtaining informed consent. This is consistent with the ethical convictions[58] of respect for persons as autonomous agents, as highlighted by the Belmont Report (1979: 4-6). As the Belmont Report specifies, respecting persons implies allowing individuals to enter into any relationship voluntarily, without coercion, as well as letting them determine the course of their own life. For this reason, invasive disclosure, that is, disclosing when J, for example, in Case One, has not requested it, may be interpreted by J as a forced choice. The forced provision of information, following the principle of autonomy, is a violation of an individual's right to self-determination.

In light of the above, important moral rules supported by the principle of respect for autonomy include:

i) Maintaining and enhancing the decision-making capacity of patients when one is asked to do so
ii) Truthful disclosure
iii) Protecting patients' confidential information
iv) Obtaining consent for interventions
v) Respecting patients' privacy
vi) Honouring patients' trust

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[58] These convictions have already been discussed in the second chapter. They include "first, that individuals should be treated as autonomous agents and second, that persons with diminished autonomy are entitled to protection." (The Belmont Report [NCPHS BBR, 1979])

Autonomy, in Beauchamp and Childress' analysis of the word, recognizes an agent's capacity for self-determination. Respect for autonomy thus means doing all one can to enhance the agent's capacity for self-determination.

However, the professional requirement to respect an individual's autonomy has its limitations. This probably explains why mental health professionals who believe that patients have a right to know in advance that some information may not be covered by confidentiality rules, still experience moral distress. The principle of autonomy, for example, does not apply to all patients, and does not gives rise to unqualified obligations on the part of physicians. Beauchamp and Childress (2001: 65) identify certain instances where this obligation cannot be extended to patients, such as situations where the patient cannot sufficiently act in an autonomous manner due to immaturity, incapacitation, or ignorance, for example, as in the case of children and some mentally ill patients.

Applying this principle to resolve the dilemmas generated by unsolicited information, generates other serious ethical difficulties, even before one balances this principle against competing principles which may be relevant here. Applied to the cases discussed in the second chapter, one may ask for example, which decision – disclosure or non-disclosure – exactly constitutes respect for autonomy? This is not entirely clear since confusion can arise while applying this principle to address these cases. Disclosure to J would be supported by the principle of autonomy, since this may be adjudged as maintaining honesty in the physician-patient relationship, and is consistent with the second moral duty implied by this principle – truthful disclosure. Moreover, some scholars such as Macklin (2003: 276) have already observed anecdotal evidence that some Jehovah's Witnesses do in fact waver in their views about blood transfusion. Legitimate exceptions exist, she points out, in that some Jehovah's witnesses, while asserting their refusal not to be transfused in the presence of friends and family members, do secretly consent to transfusion. J may just be that exception, hence, disclosure may be one way of respecting him as an autonomous agent.

On the other hand, non-disclosure to J could also be supported by the principle of autonomy for the reason that J has not requested this information. Disclosure would, in this regard, constitute invasive disclosure, which is inconsistent with the first moral rule implied by the principle of autonomy – maintaining and enhancing the decision-making capacity of patients *when asked to do so*. Specifically, this moral rule prohibits interference or invasive disclosure without consent or invitation. In this instance, disclosure is permitted on the condition that J, for example, requests such information. Hence, disclosure, as well as non-disclosure, would partly be supported by the principle of autonomy, and partly be forbidden by it. This is in essence an impasse capable of generating emotions such as frustration and depression, as discussed in the previous section.

Furthermore, in the second case,[59] both H and W are P's patients. The principle of respect for autonomy means P must protect H's confidential information; in other words, P cannot disclose this information without obtaining H's permission. This is consistent with the 3rd, 4th and 5th moral rules supported by the principle of autonomy. There is also a sense in which honouring H's request will also enhance trust in physician-patient encounters, which is the 6th moral rule supported by the principle of autonomy. However, since W is P's patient, P also has a duty to tell W the truth (moral rule 2), especially if such information will significantly contribute to her well-being. So how does P respect H's choices without disrespecting W? More importantly, how does the physician reach a decision based on a principle which apparently supports a variety of contrasting actions? The principle of autonomy has no unifying element for resolving such dilemmatic situations generated by unsolicited information; it has no unifying element for resolving conflicts when they occur amongst its own moral rules. I shall turn now to the second principle: the principle of beneficence.

3.3.1.2 Principle of Beneficence

The duty of care in the physician-patient relationship, as well as the duty to rescue discussed in the second chapter of this work, is based on this principle. It is also possible to link the duty to warn to this principle, when warning is considered one way of providing beneficial care to patients, for example, warning a diabetic patient about the dangers of consuming chocolate.

The term beneficence – from *bene*, meaning 'good', and *facere*, meaning 'to do'; thus, to do good – is defined by Beauchamp and Childress (2001: 166), as "an action done to benefit others". By extension, the duty of beneficence implies the moral obligation to act for the

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[59] To recap, in Case Two, a physician discovers an information about H's HIV seroconversion which would be of great health benefit to his Wife, W. But this physician cannot inform W about this information without breaching H's confidentiality. Both W and H are his patients.

benefit of others. Herein, Beauchamp and Childress (2001: 166) distinguish between acts of beneficence and the principle of beneficence. Not all acts of beneficence, they argue, are obligatory. For example, a man walking down the street is not obliged to provide assistance to an accident victim. But the principle of beneficence establishes an obligation for a health professional – as is contained in the Hippocratic Oath – to benefit their patients according to their best judgment and to abstain from actions that may injure them in any way: physically, morally and mentally (Munyaradzi, 2012). This is also the sense in which the Belmont Report understands this term – that is, as an obligation to maximize possible benefits and minimize harm.

In Beauchamp and Childress's *Principle of Biomedical Ethics* (2001), the principle of beneficence is context specific; it only arises in the context of special relationships or relationships of close proximity (for example, relationships between parents and children, between friends, and between doctors and their patients). The obligation of beneficence also arises in contractual relationships – the contractual relationship between the physician and patient, for example, creates a role-specific obligation of beneficence for the physician to act in the patient's best health interest. Finally, this obligation exists in the context of a specific commitment, such as promise-making (Beauchamp and Childress, 2001: 169-173). For example, one who has promised to help others further their important and legitimate interests has an obligation to fulfill such a promise.

Beauchamp and Childress highlight specific conditions – akin to those relevant to the duty to rescue – which must be present in order for an obligation of beneficence to exist. According to them, X has an obligation of beneficence to Y, if and only if:

i) Y is at risk of significant loss of or damage to life or health or some other major interest
ii) X's action is needed (singly or in concert with others) to prevent this loss or damage
iii) X's action (singly or in concert with others) has a high probability of preventing it
iv) X's action would not present significant risks, costs, or burdens to X
v) The benefit to Y can be expected to gain outweighs any harms, costs, or burdens that X is likely to incur (2001: 171).

For example, in the case of a man walking down the road and coming across an accident victim, if all five conditions for the obligation of beneficence exist, according to Beauchamp and Childress (2001: 175), then an obligation of beneficence exists, otherwise he would not be under an obligation to provide help to the accident victim.

But there may be some difficulties involved in applying this principle to manage dilemmas such as those generated by unsolicited information. Case Two presents an example where all the conditions are met: P has close proximity to W; W is at risk of harm if she contracts the virus; and P's action is required to prevent this damage from happening. If P notifies W, there is a high probability that this damage will not result; and notification does not present any significant personal risk to P. Finally, benefits from partner notification to W outweigh whatever burden will come to P. Yet the obligation of beneficence with respect to W cannot be fulfilled by P since he has a similar obligation of beneficence to H, who is also his patient; and for whom disclosure can cause more harm than good.

Moreover, specific moral rules (Beauchamp and Childress, 2001: 167) supported by the principle of beneficence also make it impossible for P to honour his obligation of beneficence to W and H at the same time. These moral rules include: protecting and defending the rights of others (of H, to whom we can expect more harm than good to accrue; and of W, who would benefit from notification); to prevent harm from occurring (to H and W); and finally, to remove conditions – in this situation partner notification or non-notification – that will cause harm (to W and H respectively). Herein, this moral principle will effectively lead to another catch 22 situation, or to distress arising from a professional's inability to fulfill an obligation to one patient without failing in a similar obligation to another patient.

Now someone may advance the view that the principle of beneficence solves the dilemma by requiring others to maximize benefits. Surely, in this context the principle would support telling W, as this prevents a very great harm to W, which outweighs any effect on H (or indeed, P). I will respond to this by pointing out that since both H and W are P's patients, sufficient proximity exists not only between P and W, but also between P and H; thus, P has a duty of care to both H and W. Following the sufficient proximity standard, P is legally required not only to apply the requisite knowledge to provide care to W by preventing harm to her, but also to H by preventing harm to him, such as psychological harm that can result from telling W. This is effectively the catch 22 situation that can generate distress for a physician. Moreover, an argument in favour of maximizing benefits to W, based on the principle of beneficence, faces another difficulty. As stated in the previous chapter, medical confidentiality is widely considered to encourage patients to get tested for HIV/AIDS. Individuals may refuse to get tested if they realize that their partners will be notified or their contacts traced. Thus, notifying W of H's HIV seroconversion can lead to negative consequences, since it can greatly jeopardize the global effort at stopping the spread of

HIV/AIDS. A risk/benefit calculation may reveal that benefit brought about by the global effort to stop the spread of HIV/AIDS would outweigh the benefit to W and that therefore, from a consequentialist perspective, this would be ill-advised.

Other specific moral rules implied by the principle of beneficence include: to help persons with disabilities and to rescue persons in danger. Following these rules, as well as the differentiation between acts of beneficence and the principle of beneficence, Beauchamp and Childress (2001: 165) identify two norms in the principle of beneficence: positive beneficence and utility. Positive beneficence requires agents to prevent and remove harms such as removing harm from W and H, in the second case. The duty of care in physician-patient relationship, discussed in the second chapter, is based on this norm.

Utility, on the other hand, asks agents to produce the most overall benefit or best result, by carefully weighing potential advantages and risks inherent in a given moral action. Herein, we must differentiate utility in Beauchamp and Childress's *Principle of Biomedical Ethics* and the classical utilitarian view of the same. In Utilitarianism, utility or the greatest happiness principle is taken as an absolute or a preeminent principle for evaluating the morality of an action. To this end, actions are right to the extent that they promote happiness for all creatures, and wrong if they cause the reverse. However, in Beauchamp and Childress's (2001: 166) formulation of the same, utility is not absolute, but only limited to specifying probable outcomes in order to achieve the best result. This is consistent with their argument that no principle has prior or overriding importance: sometimes utility may be trumped by positive beneficence, or by the need to remove harm to patients, or to respect a patient's right to self-determination. Consider the example of a patient in a coma: harvesting his organs to save five lives is a necessary and sufficient condition to justify transplantation with or without the donor's consent, under classic utilitarianism. Even if the patient has indicated his preference not to donate, a surgeon is justified in overriding this preference if this would save more lives according to this theory. However, for Beauchamp and Childress, utility is not absolute; it is not a sufficient condition for justifying an action. Utility could be trumped by a patient's rights, such as the right to self-determination. A physician is obliged to honour a patient's wishes, under this view, even if this will omission will indirectly lead to the death of five others.

A general overview of Beauchamp and Childress's (2001) formulation of the principle of beneficence gives us the impression that this principle is an outcome-seeking, result-seeking, benefit-seeking principle. It is doubtful whether an outcome-seeking or benefit-seeking principle would be of any relevance in a situation – such as those that arise with regard to unsolicited information – where outcomes are largely unpredictable, and therefore an attempt to apply this principle, in light of an inability to determine in advance the outcome of a decision, could lead to emotions such as confusion and frustration. For example, it is largely unpredictable how J in the first case would react to the news that he has been transfused. For this reason, we cannot be sure whether concealment is a better approach, based on the principle of beneficence, as the outcome of concealment is unpredictable.

Moreover, how does the physician evaluate utility? As previously stated, utility is sometimes distinguished as a libertarian principle because a patient's judgement about what would lead to his health benefit cannot be truly informed when such a judgement is based on lies or incomplete information. Hence, disclosure is supported by utility, at least for the patient. As Edwin (2008: 158) puts it, "patients rely on doctors to provide them with the information on which they can base decisions about their health". Disclosure is key to a patient's governance of his care. To assess utility, Beauchamp and Childress (2001: 195-214) propose cost-effective analysis, cost-benefit analysis and risk-benefit analysis. Benefits must outweigh risks or costs. With this emphasis on results and outcomes, the principle of beneficence carries with it some risks. For example, in the event that a patient's health condition has become problematic, or if a patient is no longer responding to treatment, a physician will be justified in ending his relationship with such a patient and applying his medical knowledge and expertise to other patients, who are more likely to benefit from his expertise. In other words, on the basis of this principle (beneficence), a physician will be justified in abruptly ending his relationship with a patient if he judges that his expertise would yield more benefits in other relationships.

Finally, applying the principle of beneficence to address the issues around unsolicited information, such as those generated by the two cases, is also open to abuse by the physician or medical team. In most cases, the risk-benefit analysis – or cost-benefit analysis – is done by the physician with little or no consultation with the patient. In other words, cost-benefit analysis is mostly at the discretion of the physician or medical team with little or no input from the patient, and this is specifically the case with regard to ethical issues around unsolicited information, where it is difficult to consult with the patient about the burdens or benefits that disclosure of information would impose, without revealing such information. For example, how does one consult J in a risk-benefit analysis, without conveying the truth about the transfusion? One is left to conclude here that this analysis is best carried out by excluding J. Similar to the weaknesses already identified with the argument put forward by clinical empiricists in the second chapter, one may ask; who is in the best position to determine what constitutes benefits or risks for the patient: the physician or patient? It is doubtful that a risk-benefit analysis which excludes the input of a patient, who would be impacted by the same, can truly lead to a state of pareto efficiency where the patient is better-off.

3.3.1.3 Principle of Non-Maleficence

In the Belmont Report, the principle of non-maleficence was considered as a single entity with the principle of beneficence. But in Beauchamp and Childress's (2001) Book, *The Principle of Biomedical Ethics*, both principles are treated as separate entities; the principle of beneficence as a positive principle – which obliges health professionals to maximize benefits – and the principle of non-maleficence as a negative principle – which obliges professionals to minimize burdens. According to them, when one treats the principles of beneficence and non-maleficence as a single entity, one risks losing the relevant distinctions that apply to each of them.

The principle of non-maleficence supports the same ethical duties in the physician-patient relationship as the principle of beneficence. These include the duty of care, the duty to warn and the duty to rescue.[60] While the principle of beneficence requires physicians to actively pursue the health benefits of others, the principle of non-maleficence requires them not to intentionally cause harm to others. Avoiding harm – related to the maxim *primum non nocere* first do no harm – is therefore at the core of this principle. Harm, Omonzejele (2005: 23)

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[60] Nonmaleficence and beneficence are really two sides of the same coin. While nonmaleficence requires one not to intentionally (and wrongfully) cause harm (do no harm), beneficence requires one to further a patient's interest (bring about benefit). Sometimes one way of providing benefits to an individual is by removing harm from his/her way. Harm is also sometimes removed from an individual by providing beneficial information, such as providing W with life-saving information. Thus, some duties which fall under the principle of beneficence could also be evaluated under a principle which requires physicians to remove harm from their patients' way.
However, non-maleficence is distinct from beneficence. As stated, the principle of beneficence requires physicians to actively pursue the health benefits of their patients. The principle of non-maleficence, on the other hand, requires them not to intentionally cause harm to others, which is proscriptive. Not providing beneficial information (which is a feature of the duty of care) may be considered as one way of intentionally causing harm.

says, “brings about pain and pain brings about distress”. *En effet,* Beauchamp and Childress (2001: 114f), maintain that a reason for treating the principle of non-maleficence as a separate entity is the risk of losing the relevant distinctions that apply to harm. The requirements of not causing harm to others are quite distinct from the requirements of helping others. This important and sharp distinction is often missed in literature which considers both principles jointly.

Although Beauchamp and Childress (2001: 115) argue that the principle of non-maleficence, like all other principles, can be overridden in particular situations, they tend to believe that the obligations implied by non-maleficence are generally more stringent than the obligations implied by the principle of beneficence, for the reason that this principle requires individuals to refrain from intentionally and wrongfully causing harm to others (Omonzejele, 2005).

Jonsen (cited in Omonzejele, 2005: 24) itemizes four duties implied in the obligation not to cause intentional harm:

i) Not to intentionally cause harm to others
ii) Provide adequate care
iii) Properly assess the situation
iv) Make proper detriment-benefit assessment.

A physician who believes he could save four innocent lives by killing and harvesting the organs of a prisoner on death row, cannot on the basis of producing an overall net benefit (beneficence) deliberately murder another person (non-maleficence). His action will be morally indefensible, since he has a duty not to wrongfully (and intentionally) cause harm to others.

I believe the important challenge that this principle faces is defining harm. As Omonzejele (2005: 24) rightly observes, physicians in reality do intentionally inflict some form of harm which may qualify as a breach of the principle of non-maleficence, and yet this is acceptable within clinical practice. Beauchamp and Childress (1994: 193) propose a normatively neutral definition of harm, which is “thwarting, defeating or setting back the interests of one party”. Joel Feinberg (quoted in Kleinig, 1986: 4) makes a distinction between (a mere) setting back of others’ interests, and a wrongful setting back of others’ interests. Harm in the latter sense features in Mill’s harm principle, while harm in the former sense is the way Beauchamp and

Childress define harm. However, the obligation of the principle of non-maleficence is not to wrongfully and intentionally cause harm to others.

In Beauchamp and Childress's (2009) opinion, all forms of harm involve setting back someone's interests - in every case of harm, someone's interest is set back by another/something. One can however, be harmed without being wronged. Similarly, one can also be wronged without being harmed. In the first instance, individuals can be harmed without being wronged, such as in natural disasters. In the second instance, if an insurance company refuses to pay a patient's health bill, one may say the patient has been wronged (Beauchamp and Childress, 2001: 193). However, if the hospital decides to pay this bill, rather than the patient, here one can conclude that the patient has been wronged (by the insurance company), but not harmed (since the bills were settled by the hospital).

Some thwarting of other's interests, Beauchamp and Childress (1994: 193) argue, may be justified, while others are not: putting someone in jail for committing a crime is a form of thwarting that is justified under most penal codes. In the same vein, inflicting a surgical wound for example, in order to achieve the overall net health benefits of patients is justifiable; since in this regard, benefits outweigh the harm inflicted. This is an aspect[61] of the principle of double effect which Beauchamp and Childress (1994: 210) accept, while jettisoning the rest. However, an intentional and wrongful infliction of harm is never justified, for example, harvesting a patient's organ without consent, with the aim of saving other lives.

It is important to note that in Beauchamp and Childress's (2001: 117) description of the principle of non-maleficence, the setting back of others' interests could come in different forms: physical, psychological, financial, etc. However, Beauchamp and Childress (2001: 117) limit their consideration of harm involved in the principle of non-maleficence to physical harm, especially pain, disability and death, without denying that other forms of harm

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[61] There are other equally important conditions which must be satisfied in order to justify double effect. In addition to this, "the agent must intend only the good and not the bad effect. The good effect must be achieved directly by the action and not by way of the bad effect. And finally, the good result must outweigh the evil permitted." (Omonzejele, 2005:24)

are possible. Physical harm, in their opinion, is the paradigm instance of harm.[62] Following this delimitation, specific *prima facie* moral rules supported by this principle include:

i) Do not kill
ii) Do not cause pain or suffering
iii) Do not incapacitate
iv) Do not cause offense
v) Do not deprive others of the goods of life. (Beauchamp and Childress, 1994: 194)

In addition to the above, the principle of non-maleficence also involves the obligation not to carelessly or unreasonably impose risks that could lead to any of the above. A careless – intentional or unintentional – imposition of risks is described by Beauchamp and Childress as negligence. The duo explain how negligence can occur. According to them;

i) The professional must have a duty to the affected party
ii) The professional must breach that duty
iii) The affected party must experience a harm
iv) The harm must be caused by the breach of the duty (2001: 118)

The preceding description of the principle of non-maleficence has some ethical difficulties. First, it is possible to intentionally cause harm in order to produce an overall net benefit. And based on the moral rules supported by the principle of non-maleficence, one would still be partly justified and partly unjustified in inflicting such harm. Let us consider the example of a hospitalized severely ill five month old baby with far-reaching physical deformities and severe mental retardation. This baby is born to a couple who lives on a R1000 monthly income and who have four other children to feed. The pediatricians suggest that the baby can live to see his sixth birthday, and no more, if only the parents are willing to set aside R850 monthly for his required special diet and hospital admissions. Upon careful consideration, this couple decides to inform the pediatrician to discontinue treatment since such treatment

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[62] I think it is not a wise decision to adopt physical harm as the paradigm instance of harm as Beauchamp and Childress do. In the Belmont Report’s categorization of harm into social, economic, legal, psychological and physical, there is no attempt to place one form of harm over the other for the reason that each has unique features and none can reasonably be said to be more harmful than the others. Psychological harm, for example, can be as damaging as physical harm. In fact, it is well documented in empirical studies (Christensen and Gomila, 2012) that psychological harms are as significant, and sometimes even more significant, than physical harm. Thus, by adopting physical harm as the paradigm instance of harm, Beauchamp and Childress miss an opportunity to enrich their approach with the relevant distinctions that apply to each form of harm.

will come at a great risk of malnutrition to the entire family, or lead to the other children having to drop out of school. Moreover, even with treatment, this infant would still not be able to live a normal life. The pediatrician obliges the parents, following their explanation that continuing treatment will deprive their other children of the goods of life, and based on his assessment of the severity of the baby's illness, as well as the quality of life open to this child. Following these considerations, the pediatrician judges that the harm brought about – to the child and family – from continuing treatment would be greater than the harm caused by discontinuing treatment, and thus, he discontinues treatment. Yet intentionally discontinuing treatment in order to avoid depriving others of the goods of life (Rule 5) and causing future pain to the child (Rule 2) is itself an intentional infliction of harm, as it allows death to occur (Rule 1). Here the discontinuation of treatment is both justified by this principle (Rules 2 and 5) and partly not justified by the same principle (Rule 1).

Similarly, on the basis of the moral rules supported by this principle, it would be impossible to navigate the challenges generated by unsolicited information in Case Two. Disclosure to W could harm H (forbidden by Rule 2), but non-disclosure to W could be interpreted as putting W at great risk of being deprived of the goods of life, that is, of living a virus-free life (forbidden by Rule 5), and at risk of death (forbidden by Rule 1). Herein both disclosure and non-disclosure seem to be partly supported and partly prohibited by the same principle.

Finally, one may also ask: Are there some standard criteria for determining overall net benefit; or do some standard criteria exist to determine when a wrongful thwarting, defeating or setting back of someone's interests has occurred? Is there a universally accepted standard criterion for harm? How would a psychopath define harm? And this leads us to an important conclusion: that harm may in fact be a relative term. Thus, the description of harm provided by Beauchamp and Childress (2001) is thoroughly vague without specification in a particular context or set of circumstances, and without reference to subjective perspectives which differ from one person to another: what a hedonist considers as harmful will be different from what a masochist considers harm.

For this reason, in a dilemma such as those generated by unsolicited information, it may be difficult to determine what exactly will lead to the wrongful thwarting, defeating and setting back J's interests: disclosure or non-disclosure. This is because we do not always know what other people's real interests are. An inability to predict what a patient may likely consider harmful – disclosure or non-disclosure - can also result in moral distress for a physician. In other words, interests are subjective values; and they vary from one person to another; what J, for example in Case One, will say constitutes harm will be different from the physician's conception of the same. In addition to this, harm may also depend on context. For example, while killing – as specified in the moral rules supported by the principle of non-maleficence – may be considered morally reprehensible in some cases, in other cases, killing such as physician-assisted dying, may be considered justifiable if certain conditions are met. These are some of the ethical difficulties the principle of non-maleficence faces. I shall turn now to the principle of justice.

3.3.1.4 Principle of Justice

The principle of justice supports all duties in the physician-patient relationship such as the duties to honour or respect rights. These rights may include the rights of patients to receive good health care, the rights of patients to have their confidential information protected, the right to be rescued, and the right to self-determination. In sum, a violation of any of these rights is in itself an issue of justice. As the Belmont Report (1979: 8), and Beauchamp and Childress (2001: 226) observe, an injustice is a "wrongful act or omission that denies people benefits to which they have a right without good reason or imposes burdens unjustly."

Fair and equitable distribution of burdens and benefits, along with respect for individual rights, are pivotal aspects in the principle of justice, and specifically, of distributive justice, as presented by the Belmont Report and Beauchamp and Childress's *Principles of Biomedical Ethic* (2001). The scope of distributive justice extends to a variety of contexts: from decisions on property, privileges, and opportunities to taxation policies, and so on. In biomedical ethics, however, Beauchamp and Childress (2001: 225-272) claim that modern clinical discussions regarding justice are generally focused around, first, how to achieve a just and equitable distribution of benefits and burdens when medical resources become scarce; and second, how to establish a valid claim to health care. But no single principle can independently resolve all the issues around distributive justice (Ebbesen et al., 2012: 3).

The two pivotal aspects of the principle of distributive justice – fairness and equitableness – appear to lack substance. One may ask: How do you define fair or equitable? How far-reaching is equality? Fair and equitable say nothing about how equals ought to be treated equally in a specific context, or whether two or more persons can in fact be equals (Chabon et al., 2011: 301). Fairness and equitableness, like other moral principles, need to be further specified within the context of other theories such as libertarianism, utilitarianism, egalitarianism, or communitarianism, to name but a few. Notwithstanding this, Beauchamp and Childress defend a principle of justice which incorporates both utilitarian (maximal benefits to patients and society) and egalitarian ideals (equal worth of individuals and fair opportunity) (Ebbesen et al., 2012: 3).

Beauchamp and Childress (2001: 226-229) identify some material principles of justice which have been proposed for decision-making in practice. Material principles, unlike formal principles, Beauchamp and Childress (2001) maintain, add relevant characteristics for making justice claims. One of these material principles is the principle of need; specifically the principle of fundamental need, which according to Beauchamp and Childress (2001: 228), "declares that distribution of social resources based on need is just….and to say that one has a fundamental need implies that one will be harmed or detrimentally affected in a fundamental way if that need is not fulfilled". Yet, even these material principles also require further specification; otherwise they remain abstract rules which offer little help until they have been integrated into a systematic framework or theory (Beauchamp and Childress, 2001: 236f). For example, when there is pressure to continue futile treatment of seriously ill newborn babies, as some paediatricians in Sorlie and colleagues (2000) have experienced, how do you ensure a just distribution of resources (based on the principle of need) to other sick children without making parents of dying children feel abandoned, or wronging in a fundamental way the dying child? Watching a dying child gradually slip away in a slow and painful death, after the removal of a medical ventilator for example, can be traumatic both for parents and health professionals.

For further specification of these material principles, Beauchamp and Childress propose the fair opportunity rule, which holds that:

> no persons should receive social benefits on the basis of undeserved advantageous properties (because no persons are responsible for having these properties) and that no persons should be denied social benefits on the basis of undeserved disadvantageous properties (because they also are not responsible for these properties (2001; pp. 236f).

If they were, however, responsible for these properties, then the fair opportunity rule does not hold.[63] Following the fair opportunity rule, distribution of benefits and burdens based on gender and race, is unjust. Everyone should be able to access health care, including insurance coverage without temporal gaps or unjust exclusionary clauses. Beauchamp and Childress (1994: 338-358) describe this as the "decent minimum of health care", which implies two things: enforced social coverage for basic and catastrophic health needs, and second, voluntary private coverage for other health needs and desires (Beauchamp and Childress, 2001: 244).

Beauchamp and Childress (2001: 225-272) are optimistic that this proposal for the principle of justice will find support from current theories of social justice in force such as egalitarianism, since, as they claim, this obligation of the principle of justice guarantees minimum healthcare for all on the basis of equal access, while at the same time allowing individuals, who possess the wherewithal to do so, to make unequal additional purchases, which neither overburdens nor harms the social structure, nor limits individual rights. However, they also admit that their decent-minimum proposal is only programmatic, and may experience implementation problems, at least until society delineates a decent-minimum in operational terms (Beauchamp and Childress, 2001: 245). Public preferences, they recommend, as well as cost-effectiveness or cost-benefit analysis, can play different roles in this delineation.

In my opinion, the specification involved in the obligation of the principle of justice appears to be endless. Beauchamp and Childress (2001: 245ff) acknowledge this problem in their admission that the proposal for the decent-minimum may experience implementation problems unless society delineates what exactly constitutes a decent-minimum. This defect applies not only to the principle of justice, but to the other principles as well. These principles are generally plagued by practical problems, and are therefore, limited for justifying actions in moral dilemmas, such as the dilemmas generated by unsolicited finding. For example, whose rights ought to win out in Case Two, H's right to confidentiality or W's rights to important information with clinical/personal significance? Both can make a legitimate claim

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[63] Beauchamp and Childress (2001) hypothesized that all abilities and disabilities are products of natural and/or social lotteries: heredity, natural environment, education etc. Since talents and abilities are not deserved, it would therefore be unjust to distribute goods on this basis.

to have rights honoured based on Beauchamp and Childress' (2001: 228) definition of fundamental need, which implies that one will be harmed or detrimentally affected in a fundamental way if that need is not fulfilled.

As I have demonstrated in the previous sections, the principles lack internal coherence and a unifying rule, such that when moral rules supported by these principles conflict, it is impossible to reach an amicable resolution. Indeed the aim – both in the Belmont Report and Beauchamp and Childress's (2001) formulation – is to provide a set of rules for navigating ethical issues, all things being equal. But the moral dilemmas discussed show that when all things are equal, ethical decision-making can be frustrating or lead to distress for the health professional. In other words, when there are equally compelling arguments supporting two contrasting actions, decisions can be difficult to take. Even with further specification, as proposed by Beauchamp and Childress (2001), one could still legitimately appeal to any of the moral rules implied by each principle, to support incompatible outcomes.

There are other limitations or ethical difficulties that principlism also faces, I shall turn now to the next section to highlight some of them.

3.3.2 General Criticisms and Concluding Remarks

There are other ethical difficulties involved in applying the general principles in particular contexts. Let us consider a hypothetical case of a physician who is asked by a transportation company to provide information – which his patient has asked him or her not to reveal – about his patient's drug or alcohol abuse. There is obviously a conflict here between preserving the patient's confidentiality, which could harm others, and disclosing information and preventing harm to the public. In theory, these principles are fine; however, in complex situations where key principles can come into fierce conflict, the divide between theory and practice becomes evident. It is for this reason that DeMarco (2005: 101) argues that principlism, as it is currently structured, cannot prevent loss of value in moral dilemmas and therefore, must be supplemented by other theories or guidelines. In application, as DeMarco (2005; p. 103) explains, principles can conflict; when conflict occurs, one or more principles may be violated; violation of any principle inevitably results in loss of a value. This is the case whenever principles conflict. But there may be one way of dealing with such loss of value in the event of a conflict: DeMarco proposes a mutual enhancement principle. This mutual enhancement principle means that the enhancement of one value should not be at the cost of another. According to him, moral dilemmas arise as a result of either inherently conflicting principles or due to applicability problems. However, future loss of value can be avoided by amending our rules in order to avoid or eliminate conditions which gave rise to that dilemma. DeMarco (2005; p. 103) calls this principle a "watchdog principle" which constantly leads us to reform our rules after each episode where a dilemma arises.

This approach is a further improvement on principlism. DeMarco (2005; pp. 101ff) mentions that this approach greatly complements principlism by anticipating dilemmas and avoiding their reoccurrence. This, in my opinion, is one way of addressing ethical dilemmas. Although this may not necessarily resolve the dilemma, especially if it is a genuine dilemma, it can at least prevent its occurrence or mitigate its consequences. Thus this suggestion should be taken seriously. However, there are certain limitations to this improvement: the mutual enhancement principle is not a useful approach for dealing with dilemmas in the present. It is rather, a future dilemma-avoiding principle. Hence a physician who struggles with how to manage an ethical dilemma in the present can find no guidance in this approach. Secondly, this approach also presumes that the clinical context is static. This is a myopic view of the clinical context. The clinical setting is marked by change and development. New technologies are evolving, as well as innovative methods of dealing with diseases. This development brings with it new experiences and questions previously not considered. These features are what essentially bring about new forms of dilemmas not previously experienced within the clinical setting. Hence, developing a future-oriented strategy by reflecting on current dilemmas may only help to eliminate or avoid that particular dilemma from reoccurring in the future, and not new dilemmas.

In theory, Harris (2003: 303) also observes, principlism “constitutes a useful checklist approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise [for] approaching new problems….however, it is an approach which if followed by the bioethics community as a whole would, I believe, lead to sterility and uniformity of approach of a quite mind bogglingly boring kind.” Hence, there is need for theoretical diversity within the clinical context.

Beauchamp and Childress do observe in *The Principle of Biomedical Ethics* (2001: 398) that the principles are only prima facie principles; and none of them has priority or precedence over others. Although the principle of autonomy is explained first, and as previously noted, there is no hierarchical order to the arrangement of these principles. Further specification through reflective equilibrium, as well as the consideration of circumstances, will determine which principle must take precedence and what other principles may be breached. However, the proposal for further specification faces some practical difficulties: for example, in some contexts, autonomy would be understood as social autonomy and not individual self-determination (Jegede, 2009). Westra and colleagues (2009) have also remarked that in non-religious ethics, the principle of non-maleficence may be used to justify withholding or withdrawing futile or damaging treatments, whereas Islamic ethics applies this principle to forbid all actions that may harm life. These are a few practical problems with this weighting process. Ilties (2000: 273f) identifies others: in his opinion principlism is an attempt to theorize without a (foundational) rule. In other words, principlism is a theory or method for resolving ethical issues without a foundational theory. Yet theorizing without a foundational theory is a difficult, if not an impossible endeavor. For example, how do we specify principles in the event of a conflict, without a foundational theory to tell us how to go about this specification? How do we in fact, go about addressing conflicting specifications of principles without a background or foundational theory to guide this process?

Beauchamp and Childress in fact acknowledge some of the practical problems associated with applying their theory to concrete issues in the following words:

> We have not attempted a general ethical theory and do not claim that our principles mimic, are analogous to or substitute for the foundational principles in leading classical theories….even the core principles of our account are so scant that they cannot provide an adequate basis for deducing most of what we can justifiably claim to know in the moral life.(Beauchamp, 1999: 22; Beauchamp and Childress, 1994: 106-107)

Principlism, no doubt, may be able to maximize a patient's health benefits; enhance rights of individuals to basic health care; and reduce risk in some clinical contexts; but the principles themselves, as the authors admitted, are incomplete, and thus, should be supplemented. As I shall argue in the two subsequent chapters, a particular African ethics can supplement principlism, provide guidance for ethical decision-making; and contribute towards achieving theoretical diversity or multiculturalism within the clinical context.

I note here another attempt to supplement principlism by Gardiner (2003): he proposes virtue ethics. The Aristotelian view of virtue as the means between two extremes, is the predominant understanding of virtue amongst virtue ethicists, who adapt this methodological approach for decision-making. Gardiner (2003; p. 298), for example, argues that in order to achieve *eudaimonia* – which is a deep and lasting happiness – a person must possess virtues and exercise them with practical wisdom in order to make good choices in acting well. “Virtues benefit the possessor as they become deeply entrenched in a person’s character such that he deeply desires to live well or do what is good.” (2003; p. 299) Against this background, a virtuous doctor, Gardiner (2003; p. 299) confronted by ethically challenging situations, must examine the facts of the case, identify his emotional responses which may illuminate or deepen his assessment of the situation, and while assessing the motivation of the patient and himself, must carefully select those virtues pertinent to his particular predicament. He may feel disappointed that his professional recommendation was rejected by the patient or that his ethical decision did not remove harm or alleviate pain, he would at least be glad that he has done what a virtuous person in his situation, given all the present variables, would have done (Gardiner, 2003: 299).

On this view, moral dilemmas can be resolved by asking the question: what would a virtuous agent, who finds themselves in this situation, characteristically do? Virtue ethicists, generally present the virtuous agent as the exemplar of right action, who through his moral wisdom and insight can be relied upon to act well in tough situation (Hursthouse, 1999). This argument is not significantly different from the reasonable physician standard already discussed in Chapter Two of this dissertation. The argument begs two important questions: who is a virtuous agent? And what would a virtuous agent do in a moral dilemma? The latter is vague, since it is extremely difficult to know what a virtuous physician, confronted by two or more incompatible but morally compelling actions, will do in such situation. In such a situation, the agent could perform A rather than B or vice versa, and would be virtuous for performing A based on the morally compelling argumentations supporting the same and vice versa. Thus, if a virtuous agent can reach a plurality of diametrically opposed decisions, all equally motivated by their virtuous characters, how can they become a guide for right action? This ambiguity about who a virtuous person is, is a pressing limitation virtue ethicists must endeavour to address.

Perhaps the most pressing ethical difficulty that principlism faces is its inability to resolve conflict at the micro and macro levels. As I have shown in the previous sections, moral rules supported by each principle do in fact come into conflict at the micro level, and these conflicts are irresolvable using the principle-based approach to decision-making. If such conflict cannot be resolved at the micro level, in other words, where there is internal conflict between the demands of a single principle, it is doubtful that such resolution will be possible at the macro-level; that is, at the level at which the principles themselves conflict.

In addition to Beauchamp and Childress' acknowledgement of the practical weakness inherent in this theory (as well as the incompleteness of the principles), there are also empirical and non-empirical studies which query principlism's claim to universal applicability – that is, the view that the principles reflect common morality. To recall, Beauchamp and Childress claim that the principles are consistent with common moral norms all morally serious persons share, and thus, are useful for solving ethical problems across a variety of contexts. Specifically, common morality "contains moral norms that bind all persons in all places; no norms are more basic in the moral life" (Beauchamp and Childress, 2001: 3). According to Beauchamp (2003: 259-274), the moral standards set by common morality are products of human history, experience and so on. Human nature is, in their view, similar enough that we will make similar judgments when we face ethical issues. Beauchamp (2003: 260) gives some examples of moral rules which all morally serious persons share: do not kill; respect the privacy of others; rescue persons who are in danger; protect and defend the rights of others; and so on. Different cultural, religious and/or social commitments will determine how each of these moral rules are interpreted, specified, balanced and applied in each context (Ebbesen et al., 2012: 2). Hence, the moral rules may be interpreted and applied differently from one culture and/or society to another.

However, in one study, Brown and colleagues (2016), found that many patients and families in other climes such as Asia, Africa, and so on, do make decisions using different models of decision-making to those proposed by principlism. For example truth telling and patient autonomy is encouraged by the Anglo-American model, principlism, whereas in other parts of the world like Asia and Africa, the "cultural norm is protection of the patient from the truth; decision-making by the family; and a tradition of familial piety, where it is dishonorable not to do as much as possible for parents." (Brown et al., 2016: 1902)

In another empirical study conducted by Christen and colleagues (2014: 5-10) to investigate the relationship of the principles to other moral and non-moral values "that provide orientations in medicine, these scholars discovered that the principles of biomedical ethics serve primarily as instruments in deliberated justifications,[64] but lack grounding in a universal common morality," as Beauchamp and Childress claim. In other words, the principles are not inbuilt or internalized principles as claimed. Since they are not as inbuilt or internalized as claimed, they are thus less likely to affect decision making. This finding confirms Page's finding who also discovered that people "value these principles, but do not actually use them directly in the decision-making process." (Page, 2012: 7) This finding also seem to confirm many of Behrens' students' view that the principles as described do not entirely resonate with their (the students') basic moral convictions (Behrens, 2017: 2).

In relation to other values, Christen and colleagues (2014: 5-10) also found that the principles received lower ratings in a study which asked medical students and professionals to rate these principles across several dimensions which characterize morality: such as whether the value is universally valid; community-oriented; cooperative; and principle-focused. Interestingly, participants in this study raised doubts as to "whether non-maleficence and autonomy are part of common morality." (2014: 5-10) Christen and colleagues (2014: 5-10) hypothesize that these two principles – autonomy and non-maleficence – may not be as grounded in the moral psychology of medical professionals as other moral values which received higher ratings, such as loyalty, responsibility, honesty and respect (but not respect for persons or autonomy).[65]

One commonly occurring view expressed by health professionals who experience ethical dilemmas around value differences in two systematic reviews (Ewuoso et al., 2017d; Ewuoso et al., 2017b), is that current medical ethics framework, and specifically principlism, are inadequate to manage culturally and religiously diverse clinical contexts; or clinical contexts where physicians and patients are motivated by different religious or cultural values (van Zuuren and van Manen, 2006; Krautscheid and Brown, 2014; Sørlie et al., 2000; Magnavita and Bergamaschi, 2009; Surbone, 2006; Kasman, 2004; Westra et al., 2009; Ewuoso et al., 2017b; Ewuoso et al., 2017c).

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[64] This may appear to contradict the earlier claim by scholars such as Cahana that health professionals analyze ethical dilemmas by appealing to principlism; I contend that it does not. Probably one way of reconciling these two studies is to say that health professionals, retrospectively, considered principlism as the justification for adopting one strategy rather than another. This is what is meant by deliberated justification: providing justification for a previous action.

[65] In this study, autonomy was defined as "respet [for] the self-determination; [which]...avoids putting pressure on others to reach goals; [and]....supports others such that they can make their own decisions"; while respect was described as accepting people's individual differences; and encountering patients respectfully.

In addition to the above, Callahan (2003) believes that there are two key problems which stand in the way of any serious embrace of principlism: its individualistic bias and its capacity to block substantive ethical inquiry. Although the proponents of principlism claim that none of the principles take priority, Callahan (2003: 288) believes that all the principles inevitably lead back to autonomy. He points out that non-maleficence, for example, comes down to the right not to have our body harmed by others. Beneficence, which obliges physicians to work for the health benefit of their individual patients, is only useful when we know what this benefit is; and since the patient, rather than the physician, is in a better position to determine what is of benefit to him/her, discussions around health benefits must of necessity engage the individual patient's opinion about what may or may not contribute to his health benefit. The principle of beneficence, therefore, comes down to informed consent. Finally, justice, according to Callahan, also comes down to the right (of an individual) to access basic health care without discrimination and immoral restrictions. As all the other principles lead back to autonomy in Callahan's (2003) opinion, the thrust of principlism is to give individual's maximum liberty in devising their own lives and values. But such an individualistic outlook on life may be out of place in contexts which emphasize community, connectedness, togetherness, social cohesion, and so on.

However, this is a criticism that Gillon (2003a: 310) has addressed. Although he does not deny that autonomy[66] is often given a central place in principlism, he remarks that this four-principled approach to moral decision-making, with its emphasis on autonomy, is not in-compatible or inconsistent with communitarianism or other theories which emphasize social cohesion and/or the social good. The actual use or practical applications of the principles can vary from person to person and culture to culture. Those who advocate for communitarianism can argue for a different balance between the principles, such as prioritizing beneficence over autonomy. I think this is disingenuous, since there are indeed empirical studies, as quoted in the preceding paragraphs, which affirm the practical difficulties health care professionals

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[66] In fact Gillon (2003; pp. 310f) provides some reasons why autonomy should be primus inter pares - first among equals - in his article on "Ethics needs principles - four can encompass the rest - and respect for autonomy should be "first among equals". First the ability to think for oneself , and act based on this thinking is what makes morality possible. Based on this reason, autonomy is morally very precious and not merely to be respected but also extolled above others. Second, justice, beneficence and non-maleficence all require respect for the autonomy of agents. Individuals are in a better position to decide on what is good for them or what may harm them. In addition, responding to people's needs justly, will also require respect for those people's autonomous views, including autonomous rejections of offers to meet their needs

experience when applying the four principles to certain cultures with paternalistic or communitarian outlooks. For example, as Behrens (2017: 2) observes from his students, the principle of autonomy seems to fly in the face of sub-Saharan African notions of persons as essentially relational beings.

The practical difficulties health care professionals experience when applying these principles in certain cultural contexts show that principlism, in the opinion of these professionals, is difficult to apply in these cultures because of its emphasis on autonomy and the rights of the individual. This is the practical challenge these professionals face when applying this approach to make an ethical decision. Case One, for example, proves to be a difficult hurdle for the physician largely because he is unsure of J’s individual interests – that is, he is unsure of J’s personal views about blood transfusion, even with knowledge of his religious convictions – in other words, whether J is absolutely opposed to, or indifferent to blood transfusion. Without this knowledge, disclosure may significantly harm J; or J may consider such disclosure invasive. Non-disclosure is equally problematic without the knowledge of J’s moral position regarding transfusion. He may discover through other means that this information was concealed from him, and this could be considered as a denial of his rights to important information. However, if principlism were not to attribute so much significance to the principle of respect for autonomy, the physician would have no problem in making a judgment that non-disclosure may be an appropriate way of resolving this particular situation; since in this way, J’s fellowship in the Jehovah’s Witness community will be maintained and his personal hope of gaining eternal happiness kept alive.

In addition, its preoccupation with autonomy and individual rights leads to a failure of principlism to accommodate the experiences, values and beliefs of other cultures and religions. This point has been raised in the previous paragraphs. The Western values from which principlism emerges often conflict with other worldviews, which place great emphasis on family, culture, religious beliefs and social networks (Hoehner, 2003: 589). Rather than accommodate these divergent views, principlism tries to force an understanding of autonomy as individualism, which can cause conflict. Holm (1995: 114) expresses this point well when he remarks that principlism is taken from the American context and is thus incompatible with other cultures other than its original culture. Patients also bring to the clinical encounter their own views, values and beliefs, which may be at odds with the values promoted by principlism; and acknowledging these patient’s values is key to respecting persons. For example, the emphasis placed on truth-telling and thus respect for autonomy in principlism may not be at home in a culture where beneficence or family involvement in decision making takes priority.

Other studies have also demonstrated that certain cultures, such as the Japanese culture, exist where the family is the “locus of clinical decision-making” (de Pentheny O'Kelly et al., 2011: 3839ff). In such cultures, family members are ready to conceal information – and often prohibit physicians from revealing information about a loved one’s terminal illness. For individuals who come from such cultures, clinical decisions are regulated by other principles such as beneficence, rather than autonomy. Physicians are also influenced by the culture in which they practice. Some studies, such as O’Kelly (2011: 3839) have in fact demonstrated that physicians often face personal difficulties – and are plunged into moral distress – when applying principlism in concrete clinical contexts, due to the cultural values of patients which are often not accommodated by the ethical principles they (the health professionals) were taught in medical schools to always adopt when experiencing ethical challenges. Ogundiran and Adebamowo (2010: 90.) for example, observe that in the empirical study they conducted, the majority of (Nigerian) medical professionals encounter ethical challenges in clinics which they have not been adequately trained to resolve. Perhaps an understanding of autonomy as “self-determination” rather than “individual self-determination” may resolve these concerns around autonomy. In this way, “self” may be taken as the “cooperative self”, “community” or “culture”. Behrens’ suggestion that “respect for autonomy” in principlism, should be replaced with “respect for persons” may also address the ethical concerns around autonomy. The former, in Behrens’ (2017: 2-6) view, is too grounded in an individualistic worldview. Respect for person is, according to him, capable of acknowledging both individual decision-making capacity, as well as the essential relationality of person. Moreover, respect for persons is more likely to be said to be grounded in common morality (Behrens, 2017: 6).

Finally, I propose that new/additional frameworks are needed to supplement principlism and contribute theoretical diversity to ethical decision-making in clinical care. This will address recommendations made by (Westra et al., 2009; Genuis and Lipp, 2013; Jegede, 2009a), who call for multiculturalism and diversity of theoretical and ethical frameworks in clinical ethics support systems (CESS) around the world. This, they argue will optimize health care delivery and improve patient-care. In order to achieve multiculturalism or cross-cultural and theoretical diversities in CESS, there is a need for a respectful engagement between medicine and social sciences and the humanities. This engagement is mutually beneficial: the social sciences and the humanities can contribute a lot to medicine; similarly the humanities and social sciences can equally benefit from medicine. Medicine can share with the social sciences and humanities some of the ethical challenges it contends with daily, and the social sciences and humanities can contribute – to medicine – rigorous scientific methodologies and moral reasoning derived from different cultures and traditions. This dissertation generally aims to show that such engagement is desirable.

The need for new or additional framework is also a view that is shared by several health professionals who face these clinical difficulties. In a systematic review (Ewuoso et al., 2017b) of how health professionals manage information and ethical challenges within the clinical context, the majority of health professionals within the reviewed studies recommended additional guidelines/frameworks and/or more trainings for health professionals. In addition, a significant number of health professionals strongly recommended that these framework(s) or ethics education should also focus on enhancing professionals' competence in managing clinical contexts where professionals and patients are influenced by significantly different cultural or religious values.

Further clarification on how these new or additional framework(s) can supplement principlism is certainly required. It remains doubtful whether a loss or a violation of values – such as respect, loyalty, relationship, autonomy, beneficence, justice and so on - in moral dilemmas is absolutely preventable. Recent proposals, such as the mutuality enhancement principle (Demarco, 2005) have largely failed to prevent this loss or violation. Evidence from the systematic review cited in previous sections indicates that loss or violation of value can be expected when a genuine dilemma occurs within the clinical context. When values conflict, some must be breached or suppressed in favour of others. I agree with Ilties (2000) that what is needed – while not entirely foreclosing the possibility of developing a framework for preventing loss of value – is an adequate foundational rule for justifying a violation or loss of value. Thus, these new/additional guideline should also focus on highlighting grounds for justifying the loss or violation of values in the event of a dilemma. There should also be an attempt to accommodate other communication models used by patients and their families in non-Anglo-American contexts; or which at least take very seriously the genuine differences which often exist between professionals and patients.

The remainder of this study will work towards advancing such a guideline, as well as contribute towards achieving theoretical diversity or multiculturalism within the clinical context. Specifically, this study will propose a guideline – for enhancing health professional/patient communication; addressing loss of value; contributing towards achieving theoretical diversity in clinical care – that is grounded in an African ethics, and that is sufficiently sensitive to important elements of human experience (such as the fundamental importance of understanding persons within an African communitarian context), and that would be useful in a variety of clinical contexts for ethical decision-making.

In summary: in this chapter, I defined a moral dilemma as a situation in which moral obligations demand or appear to demand that one adopts each of two alternative but incompatible actions. I also distinguished between irresolvable or genuine dilemmas and resolvable or apparent dilemmas. I identified that some of the ethical challenges raised by unsolicited information are genuine, while others are apparent dilemmas. In the second and third sections of this chapter, I evaluated strategies medical professionals often adopt to address the moral challenges regarding information in the clinical context, as well as the underlying ethical approach behind these strategies. I noted in the final section, that though this underlying approach – principlism – is useful for addressing moral issues, it nonetheless, has certain limitations. I proposed to supplement this by showing how an African ethical theory may be used to manage ethical challenges around unsolicited information within the clinical context. In the next chapter, I shall put forward a definition of the African ethics by means of which I seek to supplement existing ethical approaches. Specifically, I shall contribute this by systematically answering the question: *Is* there a theoretical formulation of *Ubuntu* that exists in current literature that is likely to be accepted by (nearly) all Ubuntu scholars as constituting this ethical theory? In Chapter 5, I shall evaluate the usefulness of this theory for resolving or addressing specific ethical dilemmas around unsolicited information.

CHAPTER 4. CORE ASPECTS OF *UBUNTU*

Information and communication are intrinsically linked. Information is expressed or managed within the context of communication. Poor communication between a health care professional and a patient, or amongst important stakeholders in patient care, could quickly jeopardize the patient's health, cause significant harm, or lead to the provision of information to a patient who is neither ready nor sufficiently prepared to receive such information.

In the previous chapter, I highlighted evidence from studies (Brown et al., 2016; Magnavita and Bergamaschi, 2009; Surbone, 2006; Kasman, 2004; Westra et al., 2009; Ewuoso et al., 2017d; Ewuoso et al., 2017b; Ewuoso, 2017) that shows that many patients communicate or make decisions based on models other than the Anglo American model of truth-telling and patient autonomy. These studies also reveal that current medical ethics frameworks and recent proposals for enhancing communication in health professional/patient relationship are limited in some ways. In clinical contexts where health professionals and patients are motivated by certain cultural and/or religious values, existing frameworks for decision-making do not seem to be able to prevent communication breakdown, which could in turn jeopardize patient care, or cause undue distress to patients.

In order to prevent communication breakdown, as well as to supplement current standards for making ethical decisions in the clinical context, there is a need for additional frameworks[67] to be developed around other models of truth-telling, which take very seriously other elements of human experience such as relationships and connectedness, as well as the significant value-differences which sometimes exist between health professionals and patients. This chapter will contribute towards bridging this gap. In the next two chapters, I shall argue that a particular interpretation of an African moral theory may provide a good alternative[68] to current (Western) bioethical frameworks. This alternative moral framework could be useful for enhancing health-related professional-patient communication, and addressing issues

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[67] I define framework in this dissertation as a set of guidelines or standards for decision making.

[68] I wish to clarify the use of this term "alternative": this is another framework which can usefully supplement current frameworks in a variety of contexts.

around unsolicited information, and may also be of use more generally. Specifically in this current chapter, I shall offer a particular definition of Ubuntu, as an African moral theory, and in Chapter 5, I shall evaluate the usefulness of this theory for resolving specific ethical issues around unsolicited information.

Legitimate questions, however, may be raised regarding what is meant by an African moral theory. This concept, some may argue, seems to convey the idea that Africans are a homogenous group. By using the phrase ‘African moral theory’, this study does not mean to insinuate that Africans are, by any stretch of the imagination, a homogenous group. Rather, this study aims to identify an ethical framework that is common to a variety of cultures in sub-Saharan Africa, or which finds expression in a wide range of societies in sub-Saharan Africa; and which has served as an action guide for Africans. A moral theory which satisfies these conditions, and a promising one for contributing towards an ethical framework centred on an African model of decision-making, is *Ubuntu*. *Ubuntu*, Komparic (2015; 608); and other colleagues such as Cilliers (2008; 2); and Gichure (2015; 117f) believe, is an African moral system which has been influential across a wide geographical area, and over a long span of time, south of the Sahara. This philosophy has its origins in the pre-colonial era, but has risen to prominence in philosophical literature in post-apartheid South Africa. Thus, *Ubuntu* is principally a normative ethical system amongst the southern people of Africa (Gade, 2011a; Breems, 2016).

Consistent with the above observation, it must be emphasized that *Ubuntu* is only one representative of ethical thought in sub-Saharan Africa; and should therefore not be taken to represent all ethical thought in Africa (Hoffmann and Metz, 2017a: 157). In addition, the question as to how widely held this theory is (*Ubuntu*), is a researchable one, but outside the scope of this study. Metz (2009b: 184; 2010b: 50), for example has observed that his philosophical construction of *Ubuntu* is not necessarily widely believed or applied. *Ubuntu* nonetheless, encompasses a range of salient behaviours, ways of thinking and favoured norms; which are not necessarily unique to Africa, but neither have these behaviours and ways of thinking come to it from other continents (Metz, 2009c: 526; Praeg, 2008; Migheli, 2017; Haegert, 2000; Metz, 2007aa; Metz, 2007eb; Eze, 2008; Nkondo, 2007: 89). Other scholars such as Shutte and De Beer (quoted in Beer, 2015: 3) also add that although *Ubuntu* contains values which have roots in the oral culture of the southern African languages (Xhosa and Zulu), these (values) are, nevertheless, values of humanity, and thus, universal.

Recently, a flurry of writings has emerged regarding this philosophy, which some scholars such as Matolino (2015: 215) have described as largely confusing and as containing competing interpretations of *Ubuntu*. For this reason, it can be challenging to understand this philosophy. The goal of this present chapter is descriptive: to contribute towards a definition of *Ubuntu* that encompasses the common themes which run across existing, and sometimes competing, interpretations of *Ubuntu*. Specifically, I shall attempt to answer the research question: Is there a theoretical formulation of Ubuntu that exists in current literature that is likely to be accepted by most *Ubuntu* scholars as constituting the core aspects of this ethical theory?

I note here that this chapter is not an attempt to reinvent *Ubuntu;* nor an attempt to rescue the same from its critics who deny its existence. Rather, the chapter will systematically organize existent thoughts on the nature of *Ubuntu* to answer the stated research question. I propose to answer the above research question via the methodology of a systematic review. I am not aware of any study that has directly considered the research question put forward in this way, although some studies (Metz, 2013a; Gade, 2011b; Hoffmann and Metz, 2017b; Hailey, 2008; West, 2013; Gade, 2012) have made some attempts at a narrative literature review of existing writings on *Ubuntu*. In the next few paragraphs, I shall motivate the use of a systematic, rather than narrative, review for the descriptive aim of this chapter

Narrative literature reviews and systematic literature reviews have similarities and differences. They are both described as forms of literature review (Rother Terezinha, 2007: vii), but are differentiated by the methodology they employ for the selection of reviewed studies. A narrative review qualitatively summarizes evidence on a topic using informal or subjective methods to select studies. In a narrative review, the selection process may be arbitrary: the reasons for preferring one study to another are usually not stated. For example, no information regarding inclusion or exclusion criteria for the selection of reviewed studies is provided in a narrative review. Other information such as the method used for searching relevant materials, searched database(s), the material selection process, search strings and so on, are also not provided in such studies. All this can potentially increase study bias, as the researcher may, for example, be more inclined to include texts with which they are most familiar, or which confirm their own views.

Systematic reviews, on the other hand, are regarded to be a thorough, less biased and more objective methodology for answering descriptive questions (Rother Terezinha, 2007: vii;

Russell et al., 2009; Cronin et al., 2008: 39; Collins and Fauser, 2005: 103; Parris and Peachey, 2013), such as the one posed in this chapter. A systematic review is a complex, high-level overview of primary research, which sets out to answer well defined and focused questions by systematically identifying, choosing, synthesizing and assessing all relevant high quality primary studies with pre-specified and explicit eligibility criteria. This methodology ensures that the article selection process is transparent and can be replicated. In other words, a systematic literature review ensures that all relevant studies which ought to be included for review are not excluded without justification, thus minimizing the risk of human bias. Specifically, the purpose for pre-specifying inclusion and exclusion criteria in a systematic review, is to minimize this bias.

In contrast to the narrative reviews of the literature concerning *Ubuntu* offered by some scholars (Hailey, 2008; Gade, 2011b; Gade, 2012), this study will make use of a systematic literature review, in accordance with the descriptive motivation of this chapter. Using a systematic literature review to answer a research question in philosophical ethics is not entirely new (McDougall, 2014; Mertz et al., 2017). Mertz and colleagues (2016: 1,6-7) note that systematic reviews of ethics literature exist (for example, Parris and Peachey (2013) used systematic reviews to empirically examine how the construct 'servant leadership' is morally defined in published ethical literature, and applied to organizational settings) and also encourage such use. Decision-making in clinical care, in their opinion, often strongly relies upon, or implicitly or explicitly includes, normative considerations from external knowledge. As noted above, non-systematic recovery of such external knowledge risks bias, while systematic reviews can help to reduce bias, and are thus more conducive to good evidence-based decision-making (Mertz et al., 2016: 1,6-7).

Mertz and colleagues specifically argue for evidenced-based[69] (normative) inputs regarding standards for evidence-based decision-making in the clinical context. This chapter will contribute towards addressing this recommendation. According to them:

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[69] An eminence-based inputs refers to a decision in clinical care that is reached by relying on the opinion of prominent persons or specialists. By extension, an eminence-based review is a review conducted by prominent persons or specialists, and which does not follow any pre-specified inclusion and exclusion criteria. Its contrary would be evidence-based inputs which makes use of research in a way that is systematic, transparent, and accessible by way of pre-specifying inclusion and exclusion criteria, in order to inform decision and/or clinical care. Using an evidence-based input to set standards for evidence-based decision-making in clinical care will

> It is surprising that modern standards for evidence-based decision making in clinical care and public health still rely on eminence-based input alone regarding normative ethical information, even though [systematic] review methodology has been increasingly used in various disciplines and fields. (2016: 2)

Evidence-based inputs, according to this view, are more conducive to evidence-based decision-making in the clinical context. The information which is most frequently the subject of analysis in some of these systematic reviews of normative ethical literature, according to Mertz and colleagues (2016: 7), include ethical issues, ethical topics or dilemmas, arguments or reasons, as well as ethical principles, values or norms. Since, the goal of this chapter is to contribute towards a definition of *Ubuntu* which embraces relevant core aspects of the theory, in order to ultimately use this theory to reflect upon ethical issues around unsolicited information within the clinical context, a systematic overview of the core aspects of the theory accords with these recommendations by Mertz and colleagues. My goal is to deliver a good, evidence-based (normative) input that could be useful for evidence-based decision-making in clinical care. Here I must note that merely providing (by way of a systematic review) a definition of *Ubuntu* that encompasses the common themes which run across existing, and sometimes competing, interpretations of the same, does not in itself imply that this theory is useful or valuable for supplementing principlism or making ethical decisions in clinical care. The latter requires evaluative argument, which is the task I shall undertake in the fifth chapter. However, adopting this methodology is a step in this direction.

Consistent with the above paragraph, the final aim of this project is to develop guidelines based upon a description of *Ubuntu* which encompasses the core aspects of this theory, in order to enable decision-making around unsolicited information in the clinical context. This will supplement principlism, and contribute towards achieving multicultural plurality in ethical theory within the clinical context. As previously observed by Mertz and colleagues (2016: 1), ethical decision-making within the clinical context is strongly based on external knowledge, such as knowledge from Moral Philosophy and Applied Ethics. According to Pae (2015: 417) and others (Mertz et al., 2016: 1; Mertz et al., 2017: 1), literature reviews such as narrative reviews, eminence-based reviews and so on, which fail to include pre-specified eligibility criteria, can result in methodological shortcomings, leading to bias which may

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involve using normative knowledge that has been generated in a way that is systematic, transparent and reproducible to inform clinical care (Bhandari and Zlowodzki, 2004; 51).

influence an author's interpretation and/or conclusions (Pae, 2015: 417), or reducing methodological transparency regardless of the actual methodological quality of a study (Mertz et al., 2017: 1). Narrative reviews could also, in West's (cited in Naudé, 2017: 9) and Mertz and colleagues' (2016: 1; 2017: 1) opinions, diminish the quality and application of such external knowledge to decision-making within the clinical context. In order to ensure internal validity (reproducibility) and external validity (utility for the intended audience), Mertz and colleagues (2017: 1) suggest accurate reporting of selection and analysis criteria, such as in a systematic literature review. The methodological approach of this chapter fulfills this recommendation, thereby contributing towards the comprehensiveness of my approach.

Moreover, systematic literatures, as observed by Pae (2015: 417), are "rapidly and increasingly replacing traditional narrative (explicit) reviews as a standard platform of providing and updating currently available research findings as confident evidence". This is consistent with Mertz and colleagues' (2016: 2) call for a shift from eminence-based inputs to evidence-based inputs for the purposes of decision-making within the clinical context . A good number of scholars, as shown above, now believe that systematic reviews are more likely to lead to evidence-based inputs. For example in one empirical study (cited in Pae, 2015: 417), some scholars identified seven narrative reviews and two systematic reviews; compared them and found that narrative reviews including the same studies arrived at contrasting conclusions, thus, indicating a difficulty with using narrative reviews to arrive at a conclusion on a given topic. As more scholars renew the call for evidence-based inputs for setting standards for decision-making in clinical care, the use of systematic reviews for developing normative standards intended for decision-making in clinical care may eventually become the norm. This chapter anticipates that development.

In summary, systematic review is suitable for the task of this chapter as it provides a comprehensive overview of the *Ubuntu* literature which minimizes selection bias (by pre-specifying inclusion and exclusion criteria). I shall turn now to the next section, to describe the study methodology.

4.1 Method and Materials

For the purpose of this systematic review, I have adapted four steps from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA). These steps include the following: 1) Framing a research question 2) Systematic search for relevant materials in relevant databases 3) Developing pre-specified selection criteria 4) Presentation of result, which is then followed by a discussion.

In line with the above steps, the research question for this chapter is: Is there a theoretical formulation of Ubuntu that exists in current literature that is likely to be accepted by most *Ubuntu* scholars as constituting this ethical theory? Using a methodological approach for designing search strings proposed by Pillastrini and colleagues (2015), I developed several search strings with which I systematically conducted searches (step 2) in *Philpapers*, *Google Scholar* and PubMed between July 21, 2017 and July 24, 2017. An additional search was also conducted in the Philosopher's index and Stellenbosch University online library database to identify relevant articles. The methodological approach developed by Pillastrini and colleagues (2015) generally consists of: framing a research question; looking up MeSH – (Medical) Subject Heading – terms for the components which make up the research question; reading published literature for alternative terms; and finally combining these MeSH terms with Boolean operators (AND, OR, and NOT) in a database to deliver relevant articles. These search strings generated 1207 hits in total. Detailed information regarding the literature search can be found in Table 1 (Appendix One).

After screenings for English Language requirement (5 articles excluded), title and abstract (952 articles excluded), duplicates (86 articles excluded), and full-text reading (70 articles excluded), 99 articles were included for review. 14 other articles were identified through snowballing, thus, giving a total of 113 articles which were included for review.

4.1.1 Inclusion and Exclusion Criteria

This study seeks to contribute towards a description of *Ubuntu*, which encompasses its core aspects or common themes, as identified in existing literature. Hence, I have included in this review, studies – published in English – which attempt to describe the nature, context or features of *Ubuntu* in ethics literature. Studies which also focused on the ethics of *Ubuntu* with regard to its usefulness and disadvantages were included in this study, if and only if, they provide a substantial and original description of *Ubuntu*.

The focus of this exercise (and of this chapter) is not to review how individual theoretical formulations of *Ubuntu* may be used to address ethical issues. Rather, my goal here is descriptive.[70] Thus, studies which highlight how this ethical theory may be used to address a variety of moral issues, as well as studies which integrate aspects of *Ubuntu* ethics to ground or explain concepts such as justice, rights, capabilities and so on, were included only insofar as they provided a substantial description of the nature and core aspects of *Ubuntu.*

In addition, studies which deny the existence of *Ubuntu* – unless in some substantial way they describe the nature of *Ubuntu* – are excluded from this review. As stated previously, it is not within the scope of this chapter to rescue *Ubuntu* from its critics or to enter the debate as to the existence of an African moral philosophy. Also excluded from this review are books,[71] book summaries, book reviews, and unpublished materials. But book chapters, encyclopedia entries, journal publications, inaugural addresses and conference papers which offer substantial and original descriptions of *Ubuntu* are included for the review. Articles which met these selection criteria were pooled together in EndNote database (version X6; Thomson Reuters).

4.1.2 Data Extraction Process

For the data extraction, this study used conventional analysis. Specifically, this study adopted the Q-methodological approach to conduct this review. I have justified the use of Q-methodological approach for conducting systematic reviews of this nature in two different co-authored studies (Ewuoso et al., 2017d; Ewuoso et al., 2017b), and repeat the same argument here.

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[70] As previously noted, the evaluation of this theory will be done in Chapter 5, where I shall use this definition to address ethical issues around unsolicited information in particular.

[71] Books were excluded from this review owing to their number and the time limitations of this study. I acknowledge that this is a limitation of this systematic review. I shall discuss other limitations in subsequent sections. This systematic review is a contribution towards providing a definition of Ubuntu that encompasses the common themes which runs across existing, and sometimes competing, interpretation of the same. No one single systematic review can complete this enormous objective, but this review seeks to take a first step in this regard. I recommend future studies to further strengthen the outcome of this review. I also propose that the exclusion of books does not significantly affect the quality of the study, as many of the books on this topic have been published by authors who have themselves explained their ideas in articles published in international peer-reviewed journals, and these have been included in this study. Other authors whose works appeared in this review have made significant references to books in their works, and some of these references and quotes appear in this review. Finally, recent engagements with Ubuntu have largely appeared in published journal articles, and many of these have been indexed by the databases in which I conducted my search.

Q-sort technique is designed for qualitatively sorting a number of individual viewpoints into broader categories by identifying similarities. This approach can show us how viewpoints or expressed opinions are interconnected or related. As Watts and Stenner (2005: 74f) observe, Q-methodology is primarily an exploratory technique. Its aim is not to prove hypotheses. It can, however, bring a sense of coherence to individual research questions that have many, potentially complex and socially contested answers. In summary, the Q-sort technique is a useful technique for identifying common themes and sorting them into broad categories. Individual narratives may be used to supplement interpretation or understand the reasoning behind the sorted categories or themes (Roberts et al., 2015; Watts and Stenner, 2005). I am adopting this methodological approach for the reason of its vertical and horizontal usefulness.

On the vertical line, it is a useful way for proceeding from a clearly defined research question to method, result and discussion. The research question plays a very important part in any Q-methodological study, since it dictates the nature and structure of the themes or categories to be generated. On the horizontal line, it is a good approach for generating broadly representative opinions or viewpoints expressed by the authors of the reviewed studies as constituting the core aspects of *Ubuntu*, as well as for highlighting differing views. I am not aware of any published study that has previously used Q-sort technique to highlight the broadly representative viewpoints expressed by authors as constituting the core aspects of *Ubuntu*, and therefore I can fairly claim that this is the first attempt.

The conventional analysis was carried out in ATLAS.ti[72] to answer the primary research question put forward in this study. The eligibility criteria pooled four book chapters, two encyclopedia entries, one conference paper, and 106 articles published in internationally peer-reviewed journals, for review. See Table 3 (Appendix Three) for the general characteristics of reviewed studies.

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[72] Atlas.ti is powerful computer program for the qualitative analysis of large bodies of textual, graphical, audio and video data. This qualitative data analysis software is a useful tool for arranging, reassembling and managing data in creative yet systematic ways.

4.2 Result

In this section, I report only my findings regarding the core aspects of *Ubuntu* identified through the review of written and published discourses on *Ubuntu.*

4.2.1 Genre of (Moral) Philosophy

A significant number of studies (Metz, 2007b: 321; Metz, 2010e; Metz, 2007a: 332; Metz, 2007e; Baker, 2016; Battle, 2000; Beer, 2015; Berghs, 2017; Bernhard, 2011; Bewaji and Ramose, 2003; Binsbergen, 2001; Bohler-Muller, 2007; Breems, 2016; Brock-Utne, 2016; Eze, 2008; Farland, 2007; Gade, 2013; Gichure, 2015; Haegert, 2000; Hailey, 2008; Lutz, 2009; Mnyaka and Motlhabi, 2005; Tschaepe, 2013; Ulvestad, 2012) express the idea that *Ubuntu* is a genre of philosophy one may rightly refer to as African Ethics. African Ethics is described as a set of values distinctively associated with largely Black African people residing in sub-Saharan Africa. These values are based on ethical beliefs, moral judgements, or ideas such as prizing communal relationships, prevalent amongst Black African people in sub-Saharan Africa, rather than themes such as respect for autonomy, or impartial cost-benefit analysis, which are prevalent in the West (Metz, 2010b: 50; Metz, 2009c). In other words, while notions such as a sense of community may also be found in Western societies, the salient philosophies in the West do not conceive of such ideas as core in prescribing duties in the way societies south of the Sahara do.

There are other ways in which these studies distinguished *Ubuntu* as an African Ethics. To call the theory of *Ubuntu* 'African', Metz, for example explains, does not imply that all sub-Saharan societies have believed it or have been aware of it (Metz, 2009a: 339). It is a philosophical construction by moral theorists (Metz, 2013a: 1), which unifies a wide array of the moral judgements and practices found among many Black Africans spanning a large space in sub-Saharan Africa, and over a broad time period, from pre-colonial peoples to contemporary literati.

Consistent with its description as an African Ethics, there are a variety of ways in which this philosophy, *Ubuntu*, has been described by reviewed studies. They include: African humanism (Cilliers, 2008: 3; Berghs, 2017: 2); Afro-communitarian moral perspective or ethic (Metz, 2009c: 518; Metz, 2016a: 89; Metz, 2012b: 101); humanist or communalistic ethic (Tschaepe, 2013: 47); Afro-communalism (Metz, 2017d: 113); African eco-bio-communitarian outlook (Etieyibo, 2017: 143); and harmonious monism (Etieyibo, 2017: 143)

4.2.2 Semantic Analysis and Definition of *Ubuntu*

Reviewed studies generally agree that the term *Ubuntu* has its roots in the South African *Nguni-Bantu* oral traditions, and is made up of the prefix 'ubu' – meaning being in potency, or an enfolded being – and stem 'ntu' – meaning being in actuality or unfolded being. Although the term '*Ubuntu'* has roots in the oral traditions of South Africa, other scholars such as West (2013) and other colleagues (Mabovula, 2011; Plooy, 2014; Mnyaka and Motlhabi, 2005) confirm that what is implied by the term extends to other cultures south of the Sahara.

There is also a general impression from reviewed studies that the term *Ubuntu* cannot be adequately conveyed in English. Nonetheless, two common translations of this term are given in these studies. They include personhood and humanness (Dreyer, 2015: 194; Hailey, 2008: 3; Cilliers, 2008: 1; Lutz, 2009: 315; West, 2013: 48). For this reason, it can be concluded that *Ubuntu* has something to do with what it means to be truly human; what it means to be a person. *Ubuntu,* some studies (Hailey, 2008; Waghid and Smeyers, 2012; Gade, 2012) maintain, refers to the very essence of being human. The antithesis of *Ubuntu* is *'into'*, meaning a thing. *Into* results when an individual distances himself/herself from, or engages in acts which compromise the unity of, the community (Cilliers, 2008: 2).

Dreyer quotes Desmond Tutu as defining *Ubuntu* in the following way:

> when we want to give high praise to someone we say, "*Yu, u nobuntu"*; he or she has Ubuntu. This means that they are generous, hospitable, friendly, caring and compassionate. They share what they have. It also means that my humanity is caught up, is inextricably bound up, in theirs. We belong in a bundle of life…I am human because I belong, I participate, I share. 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 (2015: 195).

In this way, one's humanity is expressed through his relationship with others and the humanity of others is in turn expressed through recognition of the individual's humanity (Hailey, 2008: 3; Muwanga-Zake, 2009: 417f). Hence, the aphorism: (in Zulu) *umuntu* *ngumuntu ngabantu* (in Xhosa *Ubuntu ungamntu ngabanye abantu*). This aphorism has been translated in a variety of ways: 'I am because we are'; 'a person is a person through other persons'; 'a human being is a human being only through its relationships to other human beings'; 'We are, therefore I am, and since I am, therefore we are' (Gade, 2012: 489).

4.2.3 *Umuntu ngumuntu ngabantu:* Meaning and Range of Implications

The broad meanings implied by the maxim *(umuntu ngumuntu ngabantu*) identified in reviewed studies range from metaphysical to prescriptive claims.

First, some reviewed studies argue that the maxim *umuntu ngumuntu ngabantu* expresses a descriptive claim (in part), which is the view that one's identity as a human being causally and even metaphysically depends on a community. Cilliers (2008: 2) and Forster (2010: 8) for example express the view that the aphorism articulates a factual description of humanity as a being-with-others. Individuals cannot survive on their own (Hoffmann and Metz, 2017b: 157); but need others to survive. Hence, to be a human being is to be a being-with-others.

The above descriptive claim is not generally shared by all reviewed studies. What is commonly accepted is the view that the maxim *umuntu ngumuntu ngabantu* expresses a moral principle which prescribes that one ought to exhibit certain characteristics (Metz, 2007b: 323; Hoffmann and Metz, 2017b: 157; Forster, 2010: 8; Bell and Metz, 2011: 82; Nkondo, 2007: 93; Le Grange, 2012b: 334; Makgoro, 2009: 3): to prize harmonious/communal or interdependent relationships (Tschaepe, 2013; Gade, 2011a; Shanyanana and Waghid, 2016); to develop one's personhood through our availability to or affirmation of others (Boissevain et al., 2013); to develop one's humanness through communion with others (or by being a being-with-others); and to live for others or seek goals which do not put others and the community in jeopardy (Metz, 2014d: 6463; Nussbaum, 2003: 21; Metz, 2011a).

In addition, this review also shows that in *Ubuntu*, the expression 'communing with others' is not limited to actual living human beings but also involves a fundamental connectedness of all lives in the natural and spiritual environments. Hence, *Ubuntu* is an ethical theory in which the natural and spiritual worlds are united. This ethical theory is based on a (totemic) system whereby an individual ought to see himself/herself as related and interrelated with the spiritual world – on the vertical line – as well as the natural species and the wider environment – on the horizontal line (Murove, 2012: 44; Forster, 2010: 7; Le Grange, 2012a: 64; Venter, 2004: 151; Breed and Semenya, 2015: 2; Dolamo, 2014: 4; Metz, 2010g: 383; Gade, 2012: 489; Mnyaka and Motlhabi, 2005: 225; Metz, 2017b: 3). Breems (2016: 65) and Dolamo (2014: 4) imply that *ntu* has continuities with other categories – the unborn, plants, animals, spirits, transcendent, supernatural forces and so on. Forster (2010: 8) expresses this differently; "the unity and harmony of personhood expressed in *Ubuntu* stretches from the world seen through the naked eye to the world of ancestors, the spirit world".

Consequently, in *Ubuntu*, personhood/humanness is in a symbiotic relationship, or is inextricably bound up with the dynamic (bio)physical and spiritual worlds. Though an individual is one who is involved in a web of interconnectedness and relatedness with the extended (bio)physical and spiritual worlds, one's present and actual web of communion such as present family ties, some scholars (Metz, 2016c: 144) add, takes priority over future or possible relationships.

In light of this generally accepted prescription to exhibit certain characteristics, the theorization around *Ubuntu*, Koenane and Olatunji (2017: 272) observe, is best classified as a narrative of becoming – as opposed to its classification as a narrative of return. Debate around this classification has caused significant controversies amongst certain scholars (Kubow and Min, 2016: 8; Matolino and Kwindingwi, 2013: 198; Gade, 2011a: 304f; Matolino, 2015: 217; Chasi and Rodny-Gumede, 2016; Metz, 2016a). In other words, disagreement exists amongst scholars regarding the classification of *Ubuntu* as a narrative of return. What 'return' means here is also a source of controversy: while some scholars believe the phrase implies a return to some glorious past (the era of destination being the precolonial period), others argue that the phrase implies retrieving values from the past and adapting them to address contemporary issues. Gade (cited in Kubow and Min, 2016: 7) specifically asserts that *Ubuntu* "functions as a call to Africanization, embodied in an effort to 'formulate a foundation of politics that consists of traditional African humanist or socialist [communal] values'". Others, such as Matolino and Kwindingwi criticize this call to Africanization. According to Matolino and Kwindingwi (2013: 198-199), this call to return to some glorious past is neither new nor successful. Rather it has only led to many citizens living undignified lives: to the suppression of political space and tyrannical dictatorships which are developed in pursuit of the one party state, whereby citizens are denied the opportunity to form political aspirations other than those the leadership has prescribed as the politically correct way of being. Finally, in Matolino and Kwindingwi's view (2013: 198-199), advocates of *Ubuntu* as a narrative of return view African life as monolithic, both in its interpretation, and how it is lived.

Koenane and Olatunji (2017: 272) prefer to classify *Ubuntu* differently. In their words:

> *Ubuntu* is not about the "narrative of return", but constitutes a still-viable way of life in which an individual learns to be human and live responsibly and harmoniously with others….A more plausible, satisfactory description of *Ubuntu* is a "narrative of becoming human", a narrative of seeking the truth, seen in the Truth and Reconciliation Commission, which was underpinned by *Ubuntu* epistemology. (2017: 272)

Koenane and Olatunji's view appears to be the commonly accepted view (and a uniting principle) in reviewed literature. *Ubuntu* is an ethical theory which asks individuals to become a certain sort of person/human being: to exhibit certain virtues or relate communally/harmoniously by sharing a way of life with others (along the vertical and horizontal lines) and by caring for their quality of life; to enhance the relational capacity of others; to live a genuinely human life; and to value relationships of interdependence. Relationality, interdependence, friendliness, communalism, and personhood/humanness, are all value-laden key concepts in this philosophy.

4.2.4 Communal Character of *Ubuntu*

There are two dominant views regarding the nature of community in ethical literature on *Ubuntu*. These concern whether community is ontologically prior to the individual or coterminous with the individual. A is ontologically prior to B, if it precedes B in being or if B depends on A for its existence.

There are two contrary opinions with regard to ontological priority. The first regards the community as a basic value (good for its own sake); and necessary for one's development of personhood/humanness. The second opinion regards the community as an instrumental value (merely as a means to an end such as personhood or humanness) (Gade, 2012: 489; Metz, 2013b: 81; Wareham, 2017: 128).

The view of the individual and the community as coterminous is a mutually constitutive view, in which the good of the individual and that of the community are interwoven such that individual's subjectivity is not solely determined by the community but co-substantively constituted with that of the community (Eze, 2008: 388). This way, by advancing the good of the community, an individual concomitantly advances his own good.

Regardless of the differing opinions regarding the nature of community in the ethical literature on *Ubuntu*, the general opinion in reviewed literature is that communal relationships take priority and are of overriding importance in this philosophy. Note, however, that the term community, as used by reviewed studies, does not refer to an existing society out there. Rather, the commonly expressed view is that it is an ideal way of relating with others in a society (Metz and Gaie, 2010: 276). Similarly, the term community does not imply that moral norms are determined by a group's culture, that is, doing what a majority of people in the society want. According to one study (Metz and Gaie, 2010: 276), these are Western forms of relativism and communitarianism. Rather, community is (an objective) standard that should guide what the majority want; or what moral norms become central (Metz, 2017d: 119; Metz and Gaie, 2010: 276; Nkondo, 2007: 91; Nussbaum, 2003: 21; Metz, 2013a: 5).

In light of the above, the communal character of *Ubuntu*, reviewed studies point out, does not imply that individual rights are subordinated. Rather, it implies that in communal relationships, the individual, as Lutz (2009: 314) and other colleagues (Bohler-Muller, 2007: 155; Bell and Metz, 2011: 86) observe, does not pursue the common good instead of his own good, but pursues his own good through pursuing the common good. In reviewed literature (2017: 1217; Prinsloo, 2001: 54; Bohler-Muller, 2007: 159; Mabovula, 2011: 40; Chisale, 2016: 7276; Shanyanana and Waghid, 2016: 108; Mnyaka and Motlhabi, 2005: 219), the communal character of *Ubuntu* does not wipe away individuality (in the sense of having the same frame of mind as others); rather, one's individuality persists. In this African Ethics, each individual contributes his experience, abilities, knowledge and strategies, to the final social goal. It is in respect of this feature that some reviewed studies distinguish *Ubuntu* as being less individualistic and anti-egoistic, as forbidding the seeking of personal goods without regard for others, and as more communal than Western ethics (Breems, 2016: 59; Plooy, 2014: 92; Venter, 2004: 153). Turaki (quoted in Lutz, 2009: 314) expresses this point well when he remarks: "[In African Ethics] people are not individuals, living in a state of independence, but part of a community, living in relationships and interdependence".

In addition, it is also in this regard that *Ubuntu* is said to be essentially relational. In other words, relationships also have special moral importance; in contrast to other Western ethical frameworks, such as principlism which makes no essential reference to others but the given person, this African ethics requires individuals to interact harmoniously with others. There are other ways in which African scholars distinguish *Ubuntu* from Western ethics. As previously stated, Behrens (2017: 3), for example, argues that the principle of respect for autonomy in principlism "is grounded in an excessively individualistic worldview…it is concerned only with individual decision-making…[whereas] it is central to the worldview of most Africans that community is prized and that individuals are bound up with their communities".

Hence, the maxim *umuntu ngumuntu ngabantu*, Metz notes (2012a: 393; 2013b: 85), is understood to be a claim to live in harmonious or communal relationships "in which people identify with each other and exhibit solidarity with one another". Typical discussions around the nature of community coalesce, a reviewed study (Metz, 2011a: 538) claimed, around these two themes: identifying with others, and exhibiting solidarity towards others.

Identifying with others implies thinking of oneself as a we (cognition); developing a sense of togetherness or expressing shame/pride in what the group does (emotions); engaging in joint projects (conation); adopting goals consistent with those of others (volition); and finally, coordinating behaviour to realize shared ends because this is who we are (motivation) (Hallen, 2015: 3; Metz, 2016c: 138; Masowa and Mamvura, 2017: 35; Breems, 2016: 76; Mabovula, 2011: 38ff; Dolamo, 2014: 4; Metz, 2015a; Metz, 2017e: 289; Bell and Metz, 2011; Migheli, 2017; Muwanga-Zake, 2009: 417; Wyk, 2004: 181; Haegert, 2000: 496; Metz, 2010f: 84; Metz, 2007b: 337; Metz, 2010b; Metz and Gaie, 2010; Tschaepe, 2013; Baker, 2016: 292; Mboti, 2015: 130; Metz, 2017d: 118; West, 2013: 48). Migheli (2017: 1217) classifies the we thinking into we-mode and the pro-group-I-mode. The former is team thinking: here one reasons within and for the group. The latter occurs when one keeps his individuality and his reasoning, but adopts the preferences of the group. Exhibiting solidarity, on the other hand, involves providing mutual aid, empathic awareness of others' conditions, exhibiting positive emotions/motives toward others, helping others for altruistic reasons and acting for the sake of others (which involves acting in ways that are likely to be for the good of others).

Though identity and solidarity are conceptually distinct, the communal character of *Ubuntu*, requires a blend of these two things. A blend of these two is what one reviewed study (Metz, 2012a: 394) referred to as friendship or love. In Metz's (2010f: 92) ethics of friendship, however, ending unfriendliness takes precedence over promoting friendliness, if one must choose between these two. In order to act in accordance with *Ubuntu*, there is a primary obligation to be friendly oneself or end unfriendliness, and a secondary obligation to promote new friendships (Metz, 2007e: 383). Since "relationality requires that relationships or properties of relationships, have moral primacy" (Wareham, 2017: 128), the basic reason why one ought not to engage in unfriendly acts appeals not to facts internal to an individual or the victim, but to facts about the way individuals interact (Metz, 2007e: 383). Unfriendly interactions are inappropriate ways of relating, since they are not other-regarding.

A failure to be friendly with others – along the vertical and horizontal lines – results in alienation, ill-will, and/or the devaluation of oneself to the level of an animal (Metz, 2010f). "A loner", Mnyaka and Mothlhabi (2005: 222) write, "is always viewed with suspicion. He is an *inkomo edla yodwa* (a cow that grazes on its own)".

4.2.5 *Ubuntu*'s Sense of Humanness/Personhood

In many of the reflections on *Ubuntu*, personhood and humanness are essentially moralized, so that one becomes more or less of a person or human; first, by exhibiting moral traits humans are in a position to exhibit in a way no other beings can, and second, through interdependent relationship. The former describes what a real/complete person in the philosophy of *Ubuntu* looks like, while the latter describes how one develops (Metz, 2015a: 76) this personhood/humanness.

In the ethical literature on *Ubuntu*, first, the expression 'a person is a person' in the maxim *umuntu ngumuntu ngabantu* implies that one becomes a person when he displays certain values. Haegert (2000: 499) describes these values in the following words, "a person becomes more of a person through a certain kind of person, one who is himself or herself integrated and self-donating, aware, determining, free and spiritual."

Second, the essential relational character of *Ubuntu* has great significance for this theory's view on how one develops his humanness and personhood. Mboti (2015: 136) and other colleagues (McCluskey and Lephalala, 2010: 23) express this point differently. According to them, the idea of community or relationality is the heart of traditional African thinking regarding humanity and personhood. Humanness and personhood are developed through others, such that one becomes more or less of a human being (person) according to how one values friendship or harmony with others, that is, according to how one values other-regarding behaviours, exhibits solidarity, thinks of oneself as a we as opposed to an I, and so on (Metz, 2010b: 52; Metz, 2009c: 524; Metz, 2011a: 537; Metz, 2016b: 10; Forster, 2010: 8; Tschaepe, 2013: 51; Baker, 2016; Bewaji and Ramose, 2003: 396; Mabovula, 2011: 41; Etieyibo, 2017; Waghid and Smeyers, 2012: 13; Mnyaka and Motlhabi, 2005).

In light of the above, the maxim *umuntu ngumuntu ngabantu* implies that the pathway to authentic development of one's personhood/humanness is never something that can be achieved in opposition to others. Rather authentic personhood/humanness is essentially achieved through others, by relating communally with others, comprising of the world seen by the physical eyes and the spiritual world (Berghs, 2017: 2). One who fails to exhibit humanness/personhood is considered a non-person or an animal. However, one study (Metz, 2016c: 137f) remarks that "[t]his way of speaking does not mean that wicked or unjust individuals are literally no longer human, namely, no longer the subject of human rights; it means rather that they have failed to exhibit what is valuable about human nature to any significant degree".

Humanness/personhood is essentially developed through communal relationships. One does not accomplish this (personhood or humanness) by oneself. The community – in which the physical and spiritual worlds are fundamentally united - must also be involved by requiring individuals to embrace a socially generated body of norms (Hallen, 2015: 3; Mnyaka and Motlhabi, 2005: 223; Metz, 2013a: 3). For this reason, one is not only a subject of relationship, but an object of relationship as well: "we are, therefore I am, and since I am, therefore we are" (Gade, 2012: 489). Thus, participation in the life of the community and reciprocal compassion on the part of the community are two key features of relationship in *Ubuntu* philosophy. Dolamo (2014: 3) argues this point when he says: "[i]t must be recalled that African ethics…..describes a person as a process of coming into existence in the reciprocal relatedness of individual and community, where the latter includes not only the deceased but also God". "Harmony", Tschaepe (2013: 54) adds – in addition to developing the individual – also "provides the community with stability from which persons develop. Solidarity provides the community with identity that contributes to the identification of the person as a person."

Studies, however, express varying opinions regarding the manner in which this development of personhood takes place. Some studies (Metz, 2016c: 137; Hallen, 2015: 3; Forster, 2010:

8; Bewaji and Ramose, 2003: 396; Dolamo, 2014: 4) express the view that the development of personhood follows a certain process. In Ramose's (cited in Bewaji and Ramose, 2003: 396; Gade, 2012: 497) opinion, for example, "personhood is something which has to be achieved, and is not given simply because one is born of human seed…Thus, it is not enough to have before us the biological organism, ... we must also conceive of this organism as going through a long process of social and ritual transformation until it attains the full complement of excellences seen as truly definitive of man." This view has been criticised by Eze (2008: 388), who argues that personhood/humanness is not achieved via a process but, as stated in the previous section, is co-substantively constituted with that of the community. This way, the community guarantees the individual's subjectivity, and the individual guarantees the community's survival by promoting her common good. Finally, the capacity to be both the subject and object of friendship, some studies (Metz, 2012a: 394; Metz, 2010b: 51) point out, is essential for acquiring a higher (full) moral status, which cannot be achieved by being merely the object of friendship. One is a subject if one can think of oneself as a "we"; and an object if other humans can think of one as a part of a "we".

I note here that reviewed studies do not seem to share the same view on how one gains (full) moral status: while scholars such as Mnyaka and Mothlhabi (2005: 222) see actual participation in communal relationship as essential for developing one's status or personhood/humanness; and other scholars such as Dolamo (2014: 4) and Forster (2010: 8) see a continuity in the unity and harmony of personhood that is expressed by *Ubuntu* – from the foetus in the womb to the elderly dementia sufferer and even the world unseen, Metz prefers to limit his view of individuals who have full/partial moral status, only to those who are capable of being subject and/or object of relationship. On Metz's (2012a: 394-395 & 398) account, beings in the womb during the first two months of pregnancy, who merely have the potential for communal relationships and not a capacity for such, lack moral status. To this list, one could also add others who, owing to illness or disease, have lost the capacity to be subject and/or object of communal relationships (this does not include those who do not in fact live in a community, such as hermits, who retain this capacity despite their circumstances). Some examples include advanced dementia patients. One has moral status to the extent that one is capable of being part of a communal relationship of a certain kind – what Metz calls modal relationality (that is, what is required is for one to be capable of being in communal relationship and not that one is necessarily in an actual communal relationship) (Metz, 2012a: 393). As Metz (2014a: 311) puts it, "[t]o be "capable" of being part of a communal relationship means being able in principle, i.e., without changes to a thing's nature" (Metz, 2012a: 394). Furthermore, one has (human) rights to the extent that one is a being that can both "commune with others and…be communed with".

In light of the above, abortion within two months of conception, and not infanticide, is justified. Metz acknowledges (2012a: 395) that his view on abortion is one that may probably be inconsistent with the moral intuition that pro-life activists may live by. There may be other implications of Metz's account of moral status. For example, killing an advanced dementia patient who has lost the capacity for communal relationship, in itself, may not necessarily be morally wrong on Metz's view, since such beings are no longer capable of thinking of themselves as a "we". In addition, given Metz's view of those who have human rights (Metz, 2014a: 311), advanced dementia patients also do not have rights. It may, however, be wrong to kill advanced dementia patients if it will negatively impact others who still think of them (these patients) as a part of a "we". In other words, it is wrong because of the way others are likely to feel about the death of the objects of their communal relationships.

Metz seems to acknowledge this implication by observing that "the African theory does appear to entail that severely mentally incapacitated human beings and extreme psychopaths lack a dignity comparable to ours, for they are incapable of being subjects of a communal relationship" (2012a: 397). This implication is inconsistent with the basic intuition many have about dementia patients, whom most people still think of as persons and to whom they accord a certain moral status in response to this recognition. Perhaps, Behrens' (2017: 8) differentiation between "persons with moral agency" and "persons without moral agency" can better account for this intuition in a way that avoids distasteful implications. Persons with moral agency are those who can be self-determining, as well as capable of relating in appropriate ways with others. Persons without moral agency are those who may or may not be self-determining - that lack the capacity for reasoning or whose capacity for reasoning is severely impaired. On Behrens'(2017: 8) account, both groups of persons have moral status, and we have an obligation – similar to those specified in the Belmont Report's principle of respect for persons – to respect the self-determination of persons with agency, and to protect those without agency from exploitation and harm.

4.2.6 Interconnectedness/Interdependence in *Ubuntu*

In the discussions around interconnectedness and interdependence in *Ubuntu*, there is a consensus that every person forms a link in a chain. Teffo (cited in Venter, 2004: 151) argues this point in the following words: [in *Ubuntu*] “every individual forms a link in a chain of vital forces, a living link, active and passive, joined from above to the ascending line of his ancestry and sustaining below him the line of his descendants”. An interdependent community is one in which – while recognizing the distinctive identity of individuals – individuals can only discover who they are through others (Breed and Semenya, 2015: 3). Finally, interdependence/interconnection, also means that one’s humanity is caught up or inextricably bound up, intertwined with, and in that, of others (Gichure, 2015: 127; Ngwa et al., 2016: 446; Gade, 2012: 491f) . For this reason, when a community is broken, the individual is also broken. Restoration of the community also cannot occur without the healing of the individual.

In summary, this review of existing ethical literature on *Ubuntu* philosophy shows that each person is never alone, but constituted by webs of interconnection (through shared identity), interrelatedness, inter-subjectivity (mainly by cognition, that is, thinking of oneself as a we) and interdependence (whereby one develops his personhood/humanness through others) (Forster, 2010).

4.2.7 Source of Moral Motivation

The overlapping consensus of the theoretical descriptions of published discourses on *Ubuntu*, as evident above, is that this ethical theory is essentially relational. Thus the maxim *umuntu ngumuntu ngabantu* in reviewed ethical literature, implies that the morally right action is one that honours communal relationships, reduces discord or promotes friendly relationships with others, and in which the physical world (horizontal line) and the spiritual world (the vertical line) are fundamentally united. In other words, the morally right action is one that connects, rather than separates.

The above norm captures the core aspects of what most scholars agree would constitute the definition of a morally right action in this ethic. Reviewed studies (Metz, 2011a: 26f; Metz, 2015a: 81) distinguish this norm from Western norms such as Kantianism which defines morally right action as that which enhances others’ capacity for autonomy; or utilitarianism which defines wrong actions as wrong insofar as they fail to promote the general welfare.

Ubuntu, on the other hand, defines right actions as right insofar as they promote friendly relations amongst individuals, enhance friendliness or the capacity for the same; and connect individuals. In this regard, it would be wrong to be hostile towards others, unless such unfriendly action is necessary to counter comparable misconduct on their part, or protect those threatened by their hostility

In light of the preceding paragraphs, the common view in reviewed literature is that fellowship, interconnectedness, interdependence, reconciliation, relationality, community, friendliness, harmonious relationships and other regarding actions have special significance in evaluating the morality of an action (Baker, 2016: 290, 293-294; Etieyibo, 2017: 146; Hoffmann and Metz, 2017b: 158; Koenane and Olatunji, 2017: 274; Letseka, 2013: 337; Makgoro, 2009: 3; Metz, 2007e: 374; Metz, 2009c: 526; Metz, 2009b: 183; Metz, 2010b: 51; Metz, 2012a: 394; Metz, 2014c: 69; Metz, 2014a: 310; Metz, 2015b: 399; Metz, 2017a: 114; Metz and Gaie, 2010: 277; Mnyaka and Motlhabi, 2005: 226; Muwanga-Zake, 2009: 417; Nkondo, 2007: 93; Tschaepe, 2013: 49ff; van Niekerk, 2007: 364; Venter, 2004: 153; Behrens, 2017: 7f; Ramose, 2002b: 386; Metz, 2013a: 4). If the self were to be the ground for right action, then the self could justify any action as long as it benefits the self. On this relational account of morality, an other-regarding view fundamentally determines the way the self should behave (Metz, 2007e: 384ff). *Ubuntu* invites one to develop the self by prizing other-regarding actions. Actions are wrong when they constitute a failure to regard others or jeopardize friendship with others. In Wiredu's view (cited in Tschaepe, 2013: 54f) for example, one is obliged to tell the truth because not to do so would threaten one's very status as person, as well as the very status of the community. On the other hand, the obligation to tell the truth disappears in cases where the disharmony of the community would result from truth-telling. In other words, the obligation to tell the truth exists when communal harmony and/or the individual's personhood/humanness is not threatened by doing so. The immediately preceding point is the humanistic foundation added by Wiredu (cited in Tschaepe, 2013: 54f) to this African Ethics. Unlike Kant who grounds the obligation to tell the truth in his categorical imperative, Wiredu grounds this obligation to tell the truth, as well as other moral actions, in the survival or harmony of the human community. In Wiredu's view (cited in Tschaepe, 2013: 54f), the survival and harmony of the human community is the ground for morally right action. It is in promoting the harmony of the community that individuals develop their personhood and humanness.

Finally, in this essentially relational ethics, emotions are also involved in deciding which actions are appropriate. This review shows that acting rightly and being the best sort of person necessarily involve exhibiting certain emotions such as empathizing with others, showing concerns for others' wellbeing and so on (Metz, 2013b: 84ff).

4.3 Discussion

The presentation of the result as above (and the discussion which follows here) was guided by the chapter's descriptive objective, which is to contribute towards a definition of *Ubuntu* that encompasses the common themes which run across existing, and sometimes competing, interpretations of *Ubuntu*.

The core aspects of *Ubuntu*, as described in the reviewed ethical literature, include the essentially relational nature of this ethical theory, which prizes relationship[s] of interdependence, fellowship, reconciliation, relationality, community friendliness, harmonious relationships, and other regarding actions; and in which actions are morally right to the extent that they promote social integration and interconnectedness, honour communal relationship or the capacity for the same, and reduce discord or promote friendly relationships with others, and in which the physical world (horizontal line) and the spiritual world (the vertical line) are fundamentally united.

This formulation has great potential for contributing towards an ethical framework, developed around this African moral theory, for considering (bio)ethical issues more globally and ethical issues around unsolicited information within the clinical context in particular. In the next chapter, I shall consider how this formulation may be used to address ethical issues around unsolicited information within the clinical context.

I note here that this formulation supplements previous attempts at a literature review of the scope of *Ubuntu* by correcting for the methodological shortcomings inherent in these studies. As I argued at the start of this chapter, my methodological approach is more likely to ensure internal validity (reproducibility) and external validity (rendering this formulation more conducive for external use).

I will argue that the formulation of *Ubuntu* described above may be used to justify a breach of ethical principle(s) – for example where autonomy conflicts with beneficence or any of the other principles – where such a breach favours the action which enhances communal relationships or the capacity for the same. As such, this framework could usefully supplement principlism as the dominant approach to ethical decision-making in clinical contexts. For example, dentists, mental health care professionals and paediatricians who report experiencing conflict between their professional duty to report abuse and honouring the patient's request not to do the same, as reported in some studies (Kipnis, 2006; Agyapong et al., 2009; Lohiya, 2013), can appeal to this formulation for guidance. These professionals can resolve this conflict by appealing to this formulation, which prizes ending unfriendliness (such as the abuse of a minor) since this is an inappropriate way of relating.

Equally, this formulation may be used to ground the global United Nations sustainable development goals (Bhore, 2016) to end poverty, care for the planet and ensure prosperity for all. According to this study's construction of the theoretical formulation of *Ubuntu,* human beings are in a web of relationships and interconnectedness, in which we are to care for others' well-being. The other comprises all beings and things on the vertical and horizontal lines. This framework, it may be argued, is suitable for grounding ethical duties to protect the environment by collectively working towards ending global climate change (Le Grange, 2012a: 334). Based on this construction of *Ubuntu*, a failure to exhibit caring concern for the physical environment (with whom the human person is in a relationship on the horizontal line) is itself a devaluation of oneself, since through such an act one fails to end unfriendliness (towards the environment). Finally, this theoretical formulation also provides justification for actions like rebellion, when it is necessary to end unfriendliness (Baker, 2016: 296), and grounds concepts such as (restorative) justice and appropriate resource allocation (Metz, 2016d: 293; Metz, 2007b: 326ff; Gade, 2013: 12).

In the next chapter, I shall evaluate how this formulation may be used to address the concerns expressed by some scholars (Magnavita and Bergamaschi, 2009; Surbone, 2006; Kasman, 2004; Westra et al., 2009) regarding the limitations of current ethical frameworks, such as principlism, for managing contexts where health professionals and patients are influenced by different cultural or religious beliefs. In such contexts, medical professionals can appeal to this theoretical formulation to make (ethical) decisions which will enhance the patient's relationship with his community.

Notwithstanding the potential advantages and uses of this formulation, as discussed above, I must also acknowledge the limitations of this study, in addition to previously stated. The search for relevant materials was done in PubMed, *Philpapers* and *Google scholar,* with additional screenings in Philosopher's index and Stellenbosch University's online library database. This may have resulted in the unintended exclusion of potentially relevant studies indexed by other databases and search engines. The justification for searching these databases is that a significant quantity of the ethical literature on *Ubuntu* has been published by the *South African Journal of Philosophy* and other journals which are indexed by these databases and search engines – particularly *Philpapers and Google Scholar* - thus leaving very little outside of these databases and search engines. In addition to this, I am also aware that the strict screening process, as well as the eligibility conditions, may have also resulted in the exclusion of other potentially relevant materials. For example, the decision to pool only studies published in English may have resulted in the exclusion of potentially relevant studies published in other languages. Notwithstanding these limitations, I am optimistic that this formulation captures what most *Ubuntu* scholars would accept as constituting the core aspects of this ethical theory. I hope that this formulation can contribute a unique African perspective to global (bio)ethical discourse. Future studies can build on the outcome of this review by strengthening the outcome of this study and/or actually applying this theoretical formulation to various pressing global (bio)ethical issues.

4.4 Concluding Remarks

The review of existing studies on written discourses on *Ubuntu* has identified this ethics as an essentially relational ethics which prizes relationships of interdependence, fellowship, reconciliation, relationality, community friendliness, harmonious relationships, and other regarding actions; and in which actions are morally right to the extent that they honour the capacity to relate communally, reduce discord or promote friendly relationships with others, and in which the material world (horizontal line) and the spiritual world (the vertical line) are fundamentally united.

The above theoretical formulation best captures the core aspects of this theory, and it is an important methodological contribution to the written discourse on *Ubuntu*. Further research, however, is needed to properly highlight the contrasting views amongst *Ubuntu* scholars. Research is also needed to test how properly action-guiding this formulation is in particular contexts, and I shall attempt this in the next chapter. Nonetheless, scholars, health professionals, policy makers and others should be aware that a useful alternative to Western theories of right action(s) exists in the global south that may be embraced to enhance health care professional-patient communication, as well as address a variety of global (bio)ethical issues.

CHAPTER 5. EVALUATING THE USEFULNESS OF *UBUNTU* FOR ADDRESSING ETHICAL ISSUES AROUND UNSOLICITED INFORMATION

In the previous chapter, I answered the research question: ‘Is there a theoretical formulation of *Ubuntu* that exists in current literature that is likely to be accepted by most *Ubuntu* scholars as constituting the core aspects of this ethical theory?’ via a systematic review. In this review, I arrived at a definition of *Ubuntu* that embraces the core aspects of the theory in the ethical literature. In this present chapter, I shall evaluate the usefulness of this formulation for addressing ethical issues around unsolicited information within the clinical context. Specifically, in this chapter, I will argue that this formulation contains useful values for contributing towards guidelines that will enhance health professional/patient communication; address loss of value and moral distress; and contribute towards achieving theoretical diversity in clinical care. These guidelines can assist in addressing bioethical issues more broadly, and ethical issues around unsolicited information in particular.

However, I note here that in the ethical literature on *Ubuntu*, guidelines for ethical decision-making around communication are seldom discussed. As stated in the previous chapter, *Ubuntu* is a philosophical construction by moral theorists which unifies a wide array of moral judgements and practices found amongst the Black population of, and spanning a large area of, sub-Saharan Africa. On the basis of the systematic review of existing studies on *Ubuntu* documented in the previous chapter, it is clear that scholars have not sufficiently reflected on developing an ethical communicative system for decision-making within the context of this theory. This is a significant gap in the literature. In each section of this chapter, I will therefore develop guidelines which could together constitute such an approach, using the case examples discussed in previous chapters to illustrate its different components.

In the first section of this chapter, I shall attempt to contribute towards bridging the gap identified above by supplementing the stated formulation of *Ubuntu* with a model for truth-telling grounded in the Yoruba concept of *ootọ́*. *Ubuntu*, as I have argued in the previous chapter, is an ethical theory whose values and themes are common to a variety of cultures in sub-Saharan Africa – Bantu culture, Ibo culture, Yoruba culture and so on. This ethical theory is influential across a wide geographical area. Although *Ubuntu* is only one representative of ethical thought in Africa, it nonetheless has several correlates in sub-Saharan Africa - although this philosophical construction contains values which have roots in the oral culture of the southern African languages, these values are, nonetheless, values which find expression in several sub-Saharan cultures. The first section will therefore draw on insights from the Yoruba concept of *ootọ́*, in combination with *Ubuntu*, to develop a communicative model, or set of guidelines, for addressing ethical issues around unsolicited information. I shall illustrate this model by way of reference to the case concerning blood transfusion which I have previously discussed, which I will describe again here. In subsequent sections, I shall focus on using the guidelines I derive from a combination of the theoretical formulation of *Ubuntu* and the model for truth-telling I introduce in the first section to address the other case examples previously discussed. In the second section, I shall discuss the ethical dilemmas generated by unsolicited information and misattributed parentage, as well as how *Ubuntu* may be used to resolve the same. Following my discussion in this section, I will focus in the third section on highlighting how *Ubuntu* may also be used to address dilemmas around unsolicited information in serodiscordant relationships. Finally, in the fourth section, I shall introduce my preferred non-disclosure strategy in the event that disclosure is adjudged to be counter-therapeutic, before making some concluding remarks.

Certain mistakes must be avoided from the outset. When scholars introduce alternative normative guidelines, very often critics measure this guideline against the (existing) prevalent norms. This is problematic since the existing paradigm dominates not only the way we address real ethical issues, but also the way we criticize new ideas. This can prevent a fair reading of the framework I put forward in this section. The particular African ethics that I propose and apply in this study is valuable and plausible if one considers this within the purview of an alternative theory for addressing ethical challenges and supplementing current normative theories in clinical care. Thus, consistent with this observation, the aim of this chapter, and indeed the entire project, is not to convince anyone or even to argue that current normative guidelines are completely useless, and should be replaced by the African ethics I propose here entirely. Rather, the objective of this chapter is to show how the model I introduce can supplement current normative frameworks for ethical decision-making, as well as contribute towards achieving theoretical diversity in ethical viewpoints in the clinical context. Specifically, by grounding our ultimate moral obligations in the promotion of what connects, rather than separates, individuals, this ethics avoids several limitations of principlism discussed in Chapter 3 – such as the lack of a foundational principle. This model, may, for example, be able to provide additional guidance about what to do when principles conflict and the way forward is unclear.

5.1 Models of Truth-Telling Within the Clinical Context: Building a Communicative System on the Yoruba Concept of *Ootọ́*

This section shall attempt to supplement current literature on *Ubuntu* by contributing a model for truth-telling that is developed around the Yoruba concept of *ootọ́/ Òtítọ́* (hereafter: *ootọ́*), for addressing ethical dilemmas around unsolicited information. Case One is re-described below:

5.1.1 Jehovah's Witness Revisited

J was involved in a major car accident and rushed to the trauma unit by paramedics. J was unconscious at the time of admission and had lost a massive amount of blood. The trauma surgeon judged that the best chance of saving J's life would be a blood transfusion along with surgical intervention to stop the bleeding. He quickly ordered this, and J survived his injuries.

About five days after this intervention, J regained consciousness; and thanked the surgeon for working hard to save him. Finally, J informed the surgeon that he is a 'Russellite' (a member of the Jehovah's witness community) and an African. J did not ask about how the physician saved him from untimely death (and J has no other way of finding out about the transfusion). The physician had not previously been aware that J was a Jehovah's Witness.

5.1.2 Case Characteristics

The principal ethical difficulties in this case, are: How does the physician communicate with J in a way that respects J's right to bodily integrity and that pays genuine attention to his religious values, without failing in his professional and ethical duties? Secondly: How does the physician communicate with J in a way that does not cause harm to his relationship with the Jehovah's Witness community?

As previously discussed, physicians are generally required to provide relevant information to patients. Such relevant information must encompass diagnosis, details of the proposed intervention, or in J's case, details about the intervention that has been carried out, as well as risks and benefits associated with the intervention. It is assumed that providing such information will enhance respect for persons and contribute to the shared decision-making capacity of the individual patient. As previously stated, this is considered a lay or reasonable patient standard of information disclosure, as set by the Canterbury v Spence (1972) case previously discussed, where a physician failed to disclose the potential risks of a back surgery to a patient. The judges in this case ruled in favor of the patient, and determined, *inter alia*, that a physician has a duty to convey the risks of an operation when a reasonable person is likely to attach significance to the risk in deciding whether or not to undertake or forgo the proposed therapy. The judges also highlighted two exceptions to this rule: a) where the patient is unconscious and harm from a failure to treat is greater than any harm threatened by the proposed treatment; and b) where disclosing the risk to the patient poses a threat to the patient's wellbeing.

In light of the above, the reasonable patient standard simply states that a physician must disclose all material information which would influence a patient or any other reasonable person, or which a patient might consider important. Failure to disclose such information, under law, constitutes professional negligence (Raab, 2004: 226f). However, blood transfusion is considered by Jehovah's Witnesses to be a sinful violation of divine law, since it involves eating of blood which is forbidden in Genesis 9:4, and thus "cannot be a morally acceptable means of ensuring health." (Molinelli et al., 2009: 319)

There are other temporal implications of receiving a blood transfusion, according to this religious persuasion. The individual witness who receives a blood transfusion may be shunned by their relatives and expelled from God's community through excommunication and dis-fellowship. Dis-fellowship and excommunication are not unknown to have caused psychological trauma for many Africans who generally value community life and social embeddedness.

As stated in a previous chapter, Witnesses are often encouraged to carry a card indicating their preference not to be transfused. J most likely did not have this card on him at the time of his admission to the trauma unit. And in the trauma and emergency unity, life and death usually hang by a thread, such that trauma patients are infrequently asked to provide consent before treatment. In light of this, obtaining the patient's consent is rarely a priority for trauma surgeons and/or health professionals in this context. Since it was impossible to determine the patient's religious preference, a surgeon who administered a transfusion to an unconscious patient has not committed any legal wrongdoing. Put differently, no physician has been successfully sued in the past for transfusing an unconscious patient who had no card indicating his preference for non-transfusion on him/her.

Transfusing a patient with no card on him/her indicating his preference not be transfused is a honest mistake that is pardonable under many countries' laws. However, how does the physician do right to J without failing in his professional and ethical duties? The primary ethical dilemma in this case is how to avoid invasive disclosure, when J has not requested such information, while maintaining the duty to enhance a patient's right to information through truthful disclosure of information that a reasonable patient in J's position would be likely to consider important. There are other conflicts which also arise in this case, such as preventing harm versus enhancing a fiduciary relationship; or providing due care by not disclosing information that can compromise patient recovery versus avoiding professional negligence, to name but a few.

In the following paragraphs, I shall highlight how a model for truth-telling based on the Yoruba[73] concept of *ootọ́* may be used in combination with the stated formulation of *Ubuntu* to develop a strategy for addressing such ethical dilemmas, thereby enhancing health professional/patient communication. As previously stated, communication is defined broadly in this study. It encompasses the content of communication; necessary communication skills, as well as the judgment required for determining when communication is appropriate.

5.1.3 New Model for Truth-telling

In the Yoruba language, 'truth' is generally rendered as *ootọ́*. *Ootọ́* implies a host of meanings which include; honesty, sincerity, integrity, and faithfulness. *Ootọ́* is an important moral value in the Yoruba thought system, and it contributes to the Yoruba people's understanding of personhood. In the Yoruba culture, like several thought systems in sub-

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[73] People of south west Nigeria.

Saharan Africa, communities are constituted organically, unlike other Western societies which Battle (2000) says are essentially non-organic organizations of individuals, akin to an association. This organic constitution affects how the Yoruba people understand ‘personhood’.

Yoruba culture shares many similarities with several practices and behaviours in sub-Saharan Africa in general. In Yoruba culture, a person is a person through other persons. The Yoruba people express this in the following words: “*igi kan ko le da Igbo se”* (a tree cannot make a forest). This view of personhood is not one which is independent of relations with others. One is not merely an individual living in independence but part of a community. One’s humanity is inextricably linked to the humanity of others; and the more one exhibits this other-regarding behaviour, the more of a person one becomes. For this reason, the source of normativity in Yoruba culture, like many cultures in sub-Saharan Africa, is deeply rooted in a relationship with others, rather than just in the individual or the lone, self-determined individual as is the case with the Anglo-American moral frameworks. For example in Jean-Paul Sartre’s (cited in Battle, 2000: 179-180) existentialism, each person alone defines his self-existence or personhood. Each person is what he makes of himself. Everyone, in Sartre’s opinion, lives in anguish, not because life is terrible, but because the individual is condemned to be free. We are thrown into existence; become aware of ourselves, and now have to make choices which ultimately make each person what he is. I create myself through what I do; through the existential choices I make in a world without fixed values. This is what makes me, me. I am what I do. This view of the individual flies in the face of many African views which conceive of the individual in terms of their relations with others. In light of this, what is right is what connects persons, and not what separates them. This is the ultimate principle or rule of conduct in many cultures in sub-Saharan Africa, including Yoruba culture.

By insisting on honesty, *ootọ́* connects persons in a trusting relationship, promotes friendliness, and enhances relationships of interdependence. This seems to be Hoffmann’s and Metz’s (2017b: 157) point when they observed that a common maxim associated with ethical thought in some African contexts is that one develops one’s personhood by prizing relationships in which one exhibits a variety of attitudes and virtues, such as honesty, avoiding coercion and deception. An individual who tells the truth enhances his personhood; and is described as an *Olootọ́ or Olotítọ́*. *Olootọ́ eniyan* (a truthful person) tells not only what is true, but also has a reputation for being truthful. The individual’s statements or information can be relied upon.

Sisọ ootọ́ – truth telling – is a moral obligation in the Yoruba-thought system, and complies with many medical ethics codes and common law requirements for honesty in the health professional/patient relationship. Although truth-telling is a moral value and an obligation in Yoruba culture, since it is an important constitutive element of personhood, truth must nevertheless be tempered. *Ootọ́,* for this reason, has an inherent system of communicative ethics, since *òtítọ́ ọrọ korò* (truth is bitter) and could also cause great damage to an individual's psyche. Hence, the saying: *Ki n se gbogbo owun ti oju ba rí l'ẹnu sọ* (it is not everything the eye sees that the mouth speaks). The Yoruba people believe that not all information leads to useful benefits for the recipient or fosters life in the community. In other words, although this model places emphasis on the value of honesty, it also includes the awareness that not all information will positively impact a patient's, such as J's, life in the community.

Ootọ́ is therefore influenced by context in the Yoruba thought system. In other words, in Yoruba culture, context, as well as a careful reflection on consequences, also contribute to whether information should be disclosed or not disclosed to an individual. In this regard, ootọ́ in the Yoruba thought system and Mey's pragmatic act theory are similar. Mey's pragmatic act theory is an approach which seeks "to explain the way pragmemes [situated speech acts] are represented in pragmatic acts in speech situations" (Kecskes, 2010: 2890). Pragmemes are goals for expressing certain pragmatic acts (Kecskes, 2010: 2893). In Mey's view, "human activity is not the privilege of the individual. Rather the individual is situated in a social context" (Kecskes, 2010: 2889). Context largely determines what pragmatic acts an individual employs. Hence, consideration of context is key for understanding acts of speech by individuals. In Mey's (2001: 43) view, "context should determine what one can say and what one cannot say". Attention to context ensures that the health professional takes very seriously the genuine world of differences – cultural, religious, and so on - which may exist between the professional and the patient, and that these differences should be taken into consideration in managing information. Specifically, attention to context ensures that efforts are made to protect and respect a patient's significant cultural and/or religious values.

To apply this insight to the case at hand, we must carefully consider the relevant context. Of note here is that some studies have now observed that certain Jehovah's witnesses do abandon their faith (Fennig et al., 2004) or waver in their beliefs regarding blood transfusion (Erde et al., 2006; Falk et al., 2003: 823) when confronted with life-threatening situations. In addition, truthful disclosure, when J has not indicated a preference to receive information, could constitute a violation of his right not to know. As previously stated, certain empirical studies (Marzanski, 2000a: 322) exist which show that certain patients prefer not to know about their health conditions. The right not to know may also be relevant in this case. Patients may exercise their right not to know for a number of reasons, for example, for religious reasons (information could negatively affect one's relationship with one's religious community on the horizontal line). Or, information could force one to alter his preferred lifestyle, cause harm, and so on. For this reason, it may be a dangerous generalization to assume that all patients want full information. It is possible in this situation that J does not want to know about this transfusion, given the potential psychological impact disclosure will have on him or his relationship with the Jehovah's Witness community. His right not to know, albeit not expressly or formally stated, should also be respected.

On the other hand, it is equally dangerous to assume that J would not like to know the truth. Some empirical studies exist (Atesci et al., 2004), as I have pointed out in previous chapters, which indicate a psychological disturbance in patients who were not informed about their condition, but had to guess their diagnosis in the course of their treatment. There are a number of reasons why patients may want to have medical information. Information is power: it can enhance an individual's ability to make choices or adopt certain lifestyles.

Given the above uncertainty, in addition to context, equally embedded in *ootọ́*'s communicative ethics is *ogbon* – wisdom - which is the synthesis of intelligence and sound judgment, according to Kaufman (2006: 130), and which is necessary for judging when communication is appropriate. A wise person is called *ologbon;* the contrary is *alakori* (a foolish person). Kaufman argues that wisdom must be understood and applied in a particular cultural context (2006: 130). A wise person, by the standards of African moral theory, is therefore one who prudently applies intelligence to achieve goals defined by the society or culture. No matter how learned one is, one's personhood will not be complete if the individual does not apply his wisdom to achieve community goals and objectives. Hence, wisdom is directed towards enhancing community living and relationships of interdependence by requiring individuals to enhance their personhood through participation in the actualization of community objectives and goals.

Equally embedded in *ootọ́*'s communicative ethics is *imo* – knowledge – which entails having the right or correct information. In the Yoruba culture, knowledge is a product of the rigorous search for what is true (regarding communal values, ideals, goals, etc.). *Imo* (knowledge) and *ogbon* (wisdom) work very closely to promote friendliness within the community; while wisdom is the prudential application of intelligence to achieve goals defined by community, knowledge identifies what those goals are, thus making it possible for wisdom to prudently apply intelligence to achieve such goals.

Finally, embedded in *ootọ́*'s communicative ethics is *oye* – understanding - which refers to awareness of the recipient's feelings and disposition. *Oye* is also interpreted as the ability to distinguish a right action from a wrong action. As stated earlier in this section, within Yoruba culture, and according to the theory of *Ubuntu* in general, a right action is one that connects or builds relationships, while the contrary is a wrong action. The combination of *ogbon, imo and oye,* is a supreme human good in Yoruba culture, since it ensures the acquisition of necessary skills for rendering information in ways that foster friendliness within the community, and which honours the value of individuals.

In summary, *ootọ́*'s communicative ethics is one that enhances the individual's capacity to relate; ensures social cohesion; and promotes other-regarding behaviours in the community. These three (*ogbon, imo and oye)* may be employed by *Olootọ́ eniyan* in a variety of ways in this case scenario.

Both *Ubuntu* and the Yoruba model of truth-telling which I offer in this section are essentially relational since they place emphasis on relationships of interdependence and other regarding actions, and both regard actions to be morally right to the extent that they honour communal relationships or the capacity for the same. On the basis of these features, certain guidelines for ethical decision-making around unsolicited information in clinical care can now be highlighted. I state four here, but in subsequent paragraphs and chapters I shall show how other guidelines can arise from these four basic ones. The four basic guidelines are:

a) Disclosure of unsolicited information, in clinical contexts, is advised when, on the balance of probabilities, this is likely to enhance human relationships and interconnectedness, and if disclosure would honour the patient's existing relationships and capacity to relate.
b) Non-disclosure is advised and disclosure ill-advised when it (disclosure) is likely to give rise to disharmony, or undermine a patient's existing relationships or the capacity for the same.
c) The determination of what is likely to enhance or honour the patient's existing relationships or the capacity for the same should be informed by i) knowledge of the

patient's cultural and religious context and ii) engagement with the patient in their individual capacity in a friendly relationship.

d) In making decisions about non/disclosure, existing relationships, or relationships of long-standing, should take priority.

Rules (a) and (b) outline the necessary requirements for non/disclosure: in both the philosophy of *Ubuntu* and the Yoruba model of truth-telling, ethical decision-making ought to focus on promoting human relationships, rather than disharmony. Rule (c) honours the need to acquire knowledge (*imo*), which would be prudently and wisely applied by the health professional, (*ogbon*) leading to understanding (*oye*), which would allow the health professional to discern what the right action would be. Furthermore, rule (c. ii) is in line with a more general suggestion - that the health-professional/patient relationship should move away from a service provider/customer style relationship and more towards a friendly relationship, where the health professional sees, appreciates, and engages with the patient as a rounded individual embedded in a particular context and community. A friendly relationship model, which is in accordance with the African ethics I apply here, and which views the patient as part of a "we", or which engages with the patient as a rounded individual embedded in a particular context and community, is a more conducive model for realistically enhancing health professional/patient communication.

There are other benefits of a shift from a service provider/customer style relationship to a friendly relationship, as recommended by rule (c. ii). Such engagement in a friendly relationship would also ensure that the patient's views and values are incorporated in the ethical decision-making process. Thus, a fifth moral guideline – as I shall show in the next section – that arises from this could be stated as:

e) A law or policy which does not incorporate the views or values of those whose good it seeks to promote amounts to unjustified paternalism.

Engagement with the patient as a rounded being, who is embedded in certain realities, is basic to *ootọ́* in Yoruba culture; it ensures that – when confronted by an ethical dilemma – a person's (and in this case the patient's) important values are honoured, and that their rights (to know or not to know) are respected. It should also enhance the patient's shared decision-making capacity and protect his capacity to relate to or to maintain his relationship with the community. I note here that the engagement with the patient which is implied by rule (c.ii) does not necessarily imply directly eliciting patient's views, such as directly asking J questions about his religious views, and specifically his views regarding blood transfusion; for example, how he may likely react to someone who accepts a blood transfusion; how his specific Jehovah's witness community may likely react to someone who accepts a blood transfusion; whether he shares the same view as his community about blood transfusion; and so on. This could inadvertently reveal the information that is at issue. Engagement, which is embedded in the health professional/patient interaction that is modeled around a friendly relationship, implies appreciating J as a part of a "we" rather than as part of a "they", which is a feature of a service provider/customer style relationship; it implies engaging J in ways that will lead to the acquisition of knowledge about J's context and how deeply committed J is to this context. This knowledge – of J's embeddedness in his context – should then be prudently and wisely applied by the health professional in ways that would lead to understanding and the discernment of the right action that is likely to enhance J's relationships. Herein, engagement naturally leads to judgement: it should give the physician a sense of J's likely attitude towards blood transfusion. This way, the physician can make a sound judgement, which also incorporates J's views and his particular context, about whether disclosure or nondisclosure is appropriate.

There are a variety of ways to engage J in a friendly health professional/patient relationship – which I propose in the previous paragraph – in order to gain knowledge about how deeply embedded J is in the Jehovah's witness community. I suggest here that the health professional may consider approaching J as a 'curious outsider'. The use of the expression 'curious outsider' must be properly understood here. The physician is not a curious outsider to the physician-patient relationship; he has clearly played an important role in the medical decisions that have been made. The physician, however, would typically be an outsider to the Jehovah's Witness community. As a curious outsider, the physician is interested in knowing more about the community's beliefs and about how firmly J holds these values and beliefs. As Kato (2013: 104) has observed, because of the compound nature of religion - because religions are practiced not only privately but also collectively such as through collective activities (services, outreach, belief system, etc.) which cannot be carried out independently by individuals - a believer's religious preference may not necessarily be a true expression of his personal beliefs. As a curious outsider, the physician should aim to gain knowledge about whether J's religious preference truly expresses his personal beliefs.

In addition, it would be odd for the physician to engage J by asking direct questions about his views, right after he had been moved from the trauma and emergency unit. This will likely convey the truth of the transfusion. Rather, a shift towards a more friendly relationship, where the health professional sees, appreciates, and engages with the patient as a rounded individual embedded in a particular context and community, would indirectly elicit J's views about blood transfusion without tipping the patient off.

Finally, I note that approaching a patient as a curious outsider requires certain skills and a certain amount of tact. Hence, engagement also requires *ogbon*. *Ogbon*, as stated previously, is directed towards enhancing community living and relationships of interdependence. *Ogbon* is required to initiate the type of friendly conversation that will most likely foster communal values such as relationship or the capacity to relate with the community. In addition to my previous suggestion about engaging J as a curious outsider, the physician may also consider engaging J by drawing the patient's attention to a recent or past event regarding Jehovah's witnesses in general. He can guide the discussion to communal practices; about eternal life; and about what may likely lead one to lose eternal life. Furthermore, I also suggest that the physician may use Mey's pragmatic act theory to guide this discussion. Pragmatic act in Mey's theory, essentially involves adapting oneself to a context, and adapting the context to oneself (Kecskes, 2010: 2890). In other words, pragmatic acts are derived from one's context or situation, and are restrained by context. As stated, context determines what one can say, as well as how one says it (Odebunmi, 2011: 623). In addition to context, other things are also required in order to successfully express the desired pragmeme. Speech acts never occur in isolation, but are often accompanied by extralinguistic factors such as gestures, facial expressions, body postures, laughter, intonation and so on (Kecskes, 2010: 2891); all of which are essential for a successful friendly conversation of the type I propose here, and for preventing a situation where the physician unintentionally conveys the truth about the transfusion.

The advantages of the engagement with a patient which I propose above, are many. The goal of the process is to foster, or prevent the loss of, J's capacity to continue to relate with the Jehovah's Witness community (in a horizontal relationship), thus fulfilling Rules (a) and (b). Excommunication, as stated already in this paper, frequently causes harm to individuals. This process would also help the health professional avoid making paternalistic decisions on behalf of J, since J's inputs are sourced through this process. Finally, this engagement process is consistent with the ethical value of respect for persons, as it acknowledges J's religious views, and gives J an opportunity to opt out (or in), indirectly, from receiving information.

J’**s** responses in this engagement would determine the next action to be taken, that is, disclosure or nondisclosure. Herein, one sees how *Imo* and *Ogbon* combine to achieve communal goals: while wisdom is the prudential application of intelligence to achieve goals that enhance communal values, knowledge (about J’s context and preferences) identifies what those goals are, thus making it possible for wisdom to make a relevant judgement. Here also, judgment leads to a decision, which is a special feature of *oye* (interpreted as the ability to distinguish a right action that will likely connect, rather than separate, individuals). It is exactly in this way that Rule (c) honours the need to acquire knowledge (*imo*), which would be prudently and wisely applied by the health professional (*ogbon*) leading to understanding (*oye*) which would allow the health professional to discern what the right action would be.

When J’**s** views favour disclosure, information should be disclosed with tact. I note here that disclosure may entail a violation of J’s right not to know (or, if his responses favour non-disclosure, that this would violate his right to know). Based on the moral theory which I apply here, this violation would be justified, since the ultimate moral principle is that what connects, rather than separates, individuals, should be promoted. Disclosure (or non-disclosure), which takes into account J’s responses, is what is likely to foster his values, connect him with the community, or at least not likely to sever his significant relationship with the Jehovah’s witness community. Thus, this is the morally right thing to do, even if it may possibly entail a violation of J’s right to know or not to know, as the case may be. I acknowledge here that this method cannot absolutely guarantee that the right action is taken. Hence, it is not perfect. For example, P may misunderstand J’s preferences. However, this method offers the best chance of making a wise choice, which respects J’s communal relationships.

Where non-disclosure is indicated, *Ootọ́*’s communicative ethics allows the use of a number of non-disclosure strategies to avoid lying to the patient. Lying is forbidden in Yoruba culture. Later in this chapter, I shall properly define a lie and distinguish it from an alternative non-disclosure strategy which I favour. In the interim, I note here that a lie is a false statement, which may intend deception. *Ootọ́* is contrasted with *Irọ́* (lie). Lies, dishonesty and insincerity are described as a devaluation of personhood to the level of *eranko* (animal) in Yoruba culture. Lies and dishonesty can also cause significant psychological harm to the patient, erode a patient’s faith/trust in the healthcare system or harm friendliness within the community. Hence the saying, *Ootọ́ lo ju* (truth matters or truth is imperative). This imperative – to tell the truth – will enhance the value of trust between the health professional and patient. This is how the health professional does right towards J without causing distress to him, or violating his important professional and ethical duties such as the duty of care or the fiduciary duty.

Lies can be avoided by, for example, keeping quiet or jargonizing. The physician may for example, jargonize by informing J that upon his admission to the trauma and emergency unit, he (the physician) had to conduct a life-saving intravascular, intra-operative manoeuvre by cannulating J, in order to increase haemoglobin and prevent pancytopenia, without specifically stating what this entails. Jargonization may be used in this way to prevent psychological harm that can result from expulsion from the Jehovah's witness community (on the horizontal line), and spiritual harm[74] (on the vertical line), that may result from informing J he was transfused. Concealment of information through such veiling would help J to maintain his fellowship with or relational capacity in the Jehovah's Witness community, or keep his hope of making heaven alive. In summary, *ootọ́* satisfies a communitarian role, and is in accordance with *Ubuntu*, since it integrates, in its framework, core values in this ethics such as respect for human connections, social ties, embeddedness in certain social realities, social values/norms, relational capacity of individuals and harmonious relationships within communities.

Critics may argue that patients would have little trust in healthcare professionals if they knew health professionals could freely employ such concealment or nondisclosure strategies to avoid telling the truth. In defence of this model, I argue (and I shall provide clarification in the next paragraph) that in societies such as the Anglo-American society, where the individual is conceived independently of the community, the above strategies may be viewed as actions which do not respect the person. An individual who lives in such a society would

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[74] One may argue here that J has already received transfusion, so jargonization is not likely to prevent spiritual harm, that is, the hope of making heaven according to J's beliefs. It is true s/he received a transfusion, but if s/he did not consent to it, or never knew about it, I think this significantly reduces culpability even though others may describe it as a false hope. I, however, think that most believers would accept that it is only an unjust God who would hold one responsible for an action one never knew about or consented to doing. However, the community may not be so forgiving. Although I argue here that jargonization will be useful in keeping J's hope of making heaven alive, the primary reason for jargonizing, I think, is not because of heaven (since J cannot be held responsible for an action s/he never consented to or knew about), but so that s/he does not spend the rest of his/her life excluded from the community for having been transfused accidentally; or living in regret for the same reason.

be right, therefore, to have little trust in a healthcare system which does not respect his values.

For the purposes of clarification, I wish to note that this does not imply that the model I propose here is not useful in other societies. This model is useful for making decisions, by understanding and indirectly incorporating individual preferences and values, in a variety of contexts. For persons living in societies where individuals are conceived independently from others; and whose values and preferences appear to support disclosure, it would be arrogant not to disclose. However, if the preferences and values of such persons appear to support nondisclosure (even though they live in societies which generally conceive of the individual as independent from others), then it will be arrogant, and disrespectful to the person, to disclose. Similarly, if an individual lives in a society which views persons as existing in relationships of interdependence, and their values and preferences nonetheless appear to support disclosure, it would be arrogant and disrespectful to that person to conceal rather than disclose. It is exactly in this way that this model is able to address the ethical dilemma raised by this case: by indirectly eliciting a patient's preferences in order to make ethical decisions about what is most likely to foster respect for persons by enhancing all that a patient values.

Given the above clarification, a sixth moral guideline for addressing ethical dilemmas around unsolicited information, which arises from the combination of the Yoruba model of truth-telling and the theoretical formulation of *Ubuntu* is:

f) The morally right action is one that most likely fosters an individual's preferences, values, and/or respects the individual's conception of his personhood.

The ultimate moral rule is always to foster what connects, rather than separates, individuals. However, what is likely to connect is not always explicit. The health professional may also not know anything about the patient's cultural affiliation. Hence, Rule (f) offers the health professional the best chance of fostering the patient's capacity for relationships. Respecting persons implies respecting all that they value – including religious and cultural affiliations, and so on. I argue that a patient whose preferences or values support non-disclosure, even if he lives in a society which conceives of the individual independently from the community, will have great faith in a healthcare system which honors or fosters their values or right not to know. Moreover, the goal of these concealment strategies, as Odebunmi (2011) observed in his empirical study on concealment and non-disclosure methods in Yoruba land, is four-fold: preventive – to prevent harm to one's values; palliative – when harm is inevitable, to reduce it; confidential – to restrict information and/or maintain an individual’s private information; and culture-compliant – to respect culture-based norms and avoid cultural taboos. Specifically, culture-compliancy aims at ensuring that an individual’s connection to the community is strengthened or that the individual’s ties with others are not severed.

Second, critics may also argue that this model for truth-telling developed around the Yoruba concept of *Ootọ́* is not any different from a casuistic approach to clinical decision-making, with all its associated weaknesses. In defence against this criticism, I argue that although casuistry generally maintains that one is wrong to lie under oath, the approach in some cases will justify lying as the best moral choice when it saves life. In other words, in a casuistic approach, the end may sometimes justify the means. *Ootọ́* in the Yoruba thought system forbids lies, since lying devalues an individual to the level of *eranko* (an animal). In this sense, *Ootọ́* distinguishes itself from a casuistic approach, since it emphasizes that the means, as well as the end, must be good. I shall expand on this further later in this chapter.

5.1.4 Summary Remarks

The importance of communication to good patient care has repeatedly been emphasized in this study. As previously noted, poor communication could jeopardize patient care or lead to the provision of information to a patient who is not ready or sufficiently prepared to receive such information.

It has now been established in empirical studies that current medical ethics frameworks cannot always be used to manage information and communication in all clinical encounters since some patients make decisions based on models other than the Anglo-American model of truth-telling. Hence, additional frameworks developed around other models of truth-telling, and which pay genuine attention to the value differences – cultural or religious – between health professionals and patients are needed to enhance communication and prevent undue distress to a patient in certain clinical contexts.

In this section, I have introduced six moral guidelines developed around the Yoruba model of truth-telling and a theoretical formulation of *Ubuntu*, to address the recommendations in favour of theoretical diversity in clinical care. A combination of the theoretical formulation of *Ubuntu* offered in Chapter Four, and the model of truth telling discussed in this section, based on the Yoruba concept of *ootọ́*, properly constitute the African Ethics I shall apply and defend in this dissertation. This ethics can complement current medical ethics frameworks in a variety of ways to address the above challenges. It is developed around an African model of truth-telling, and takes very seriously interconnectedness, relational capacity, as well as other important religious and cultural values of patients. This African ethics equally accommodates human beings' embedded-ness in certain realities; and appreciates the damage to an individual's psyche or the health professional/patient relationship that could result when these realities are not taken seriously. Its emphasis on honesty, necessary skills and careful judgement, also makes this model a good communicative model that could be incorporated into current medical ethics codes and curricula. I shall turn now to other sections to apply this ethics to address other cases.

5.2 Managing Ethical Challenges around Misattributed Parentage within the Clinical Context

Unsolicited information, particularly when such information has significant personal or health implications, raises unique ethical challenges for medical professionals. As I have stated in a previous chapter, withholding information about, for example, misattributed paternity accidentally discovered in Human Leukocyte Antigen testing for organ compatibility, may be seen by a patient as a violation of his or her right to know. On the other hand, disclosure where a patient has not requested information – or where establishing paternity is not the purpose of a clinical visit or interaction – may be taken by the patient as a violation of his or her right not to know. Resolving this dilemma remains a herculean task.

I shall argue that African moral theory contains an under-emphasized value for addressing such dilemmas around unsolicited information within the clinical context. Specifically, in this section, I shall argue that the set of guidelines which I highlighted in the previous section can supplement current medical ethics frameworks and assist in addressing the ethical dilemmas around unsolicited information of misattributed parentage within the field of transplantation.

In order to achieve the aim for this section, I shall (re)describe the introductory case-example. This case first appeared in the article "Disclosure of Misattributed Paternity: Issues Involved in the Discovery of Unsought Information", authored by Wright and colleagues (Wright et al., 2002). Subsequently, it was analysed by Sokol (2006b) in another study titled: "Truth-telling in the Doctor-patient Relationship: A Case Analysis" and published by *Clinical*

Ethics. I will highlight where I differ with these authors' analyses of this case. Following this, I shall describe a relevant aspect of *Ubuntu* which I consider appropriate for analysing the ethical dilemma raised by this particular kind of unsolicited information, and combine this with the model for truth-telling in the Yoruba concept of *ootọ́*, to address the case. First I shall discuss the prevalence of misattributed paternity in the field of organ transplantation.

5.2.1 Prevalence of Misattributed Parentage

Unfortunately, cases of misattributed paternity are not uncommon in the field of transplantation (Schroder, 2009; Young et al., 2009), and new studies continue to show that such incidences are likely to increase (Jacobson et al., 2015: 218f). Yet this problem has received little attention in the ethical literature on organ transplantation (Venkat and Eshelman, 2014: 137; Schroder, 2009: 196f). Recent studies (Hercher and Jamal, 2016: 36; Lowe et al., 2017: 234) have equally pointed out that existing guidelines on misattributed parentage offer contradictory advice on how to handle the same. Many transplantation health professionals, as one study (Jacobson et al., 2015: 219f) has observed, lack the necessary (communicative) skills for dealing with the potential emotional and psychological fallout of disclosing such a deeply personal finding. Finally, there has been no attempt to consider how an African moral theory may be used to address the ethical challenges around this issue. I shall contribute this knowledge.

Some studies (Wright et al., 2002; Sokol, 2006b) have suggested that clinicians can resolve the ethical challenges around accidentally discovered information by anticipating such information and informing patients at the onset of clinician-patient interactions about the possibility of such a discovery, in order to elicit their preferences about disclosure. It is not likely that this suggestion (if it has been adopted) has had any lasting impact, since more recent studies (Palmor and Fiester, 2014: 164; Hercher and Jamal, 2016: 36; Venkat and Eshelman, 2014:135) continue to show that accidentally discovered information of misattributed parentage still raises ethical challenges for professionals in the field of transplantation. There are other difficulties with this suggestion. Jacobson and colleagues (2015: 219f), for example, point out that it is difficult to decide when and how to inform patients and potential donors about this possibility in the informed consent process. In addition, I contend in this study that very often this unsought information also has (negative) consequences for other persons who may not be part of the health professional/patient relationship. The safety of such persons, as well as their expectation of confidentiality, also deserves moral consideration. Finally, some systematic reviews (Ewuoso et al., 2017d; Ewuoso et al., 2017b) have shown that unsolicited information also raises ethical challenges in other contexts (other than the area of transplantation) where the possibility of such information arising is not easily foreseeable. Some of these include paediatrics, radiology, andrology, reproductive medicine, immunology, and routine genetic counseling, to name but a few. Palmor and Fiester (2014: 164) are therefore correct to describe the debate around misattributed parentage as an unsettled debate.

Although I focus exclusively on misattributed parentage within the field of transplantation in this section, I contend that the framework which I put forward in this section may be deployed to address ethical issues around unsolicited information within the clinical context more broadly.

I shall now (re)describe the case example below:

> [A full-time student (with a part-time job) of legal age to give consent], Miss P, approaches the transplant centre stating that she would like to donate a kidney to her sick father. She appears to be highly motivated to donate, is healthy, and testing indicates that she is medically suitable. The potential recipient, Mr P, is a 50-year-old man who has polycystic kidney disease. He has been on haemodialysis for six months but has noticed that his strength is deteriorating and that he does not feel well on dialysis. Transplantation is considered the best form of treatment for his end-stage renal disease (ESRD). The waiting time for a cadaveric transplant is approximately four to six years and the results of transplantation from living donors are better than those obtained from cadaveric donors. HLA testing shows that Mr P and Miss P are a one-antigen match, which means they cannot be genetically related. The test is repeated and the results are confirmed. [Miss P is not in contact with her birth mother, since she and Mr P separated years ago]; and neither Mr P nor Miss P gave any indication that they believe they are not blood relatives. The testing was not done to establish paternity and, from a medical point of view, the findings do not preclude Miss P from donating to Mr P (Sokol, 2006b: 1)

5.2.2 Ethical Conflicts and Case Characteristics

Sokol (as well as Wright and colleagues) correctly identify some of the ethical challenges around this accidentally discovered information. A failure to disclose information could expose the medical team to legal liability with regard to breach of fiduciary duty or professional negligence. This may also be described as an unethical violation of the donor's and recipient's right to informed decision-making. Yet disclosure raises ethical difficulties, as it may result in the following outcomes: the father and/or daughter may experience psychological distress; Miss P may refuse to donate her kidney; Mr P may reject the kidney; and finally, the bond in the family may be permanently severed. Hence, disclosure appears to be medically contraindicated in this situation, since it could cause avoidable distress to Miss P, or compromise Mr P's recovery process. Non-maleficence, respect for persons, beneficence, and maintaining the fiduciary relationship, are some of the important values which come into intense conflict in this dilemma.

Non-disclosure, on the other hand, also raises other ethical dilemmas. Non-disclosure, as Cote (2000: 203f) observes, may be one way doctors can avoid conflict with the most fundamental portion of the Hippocratic Oath, "*primum non nocere*"- do no harm. Specifically, Cote (2000: 199) argues that the general standard of information revelation encouraged by the World Medical Association (1995) cannot always be obeyed in every situation. As previously discussed, therapeutic privilege remains an exception to this general requirement. Therapeutic privilege refers to lying or the withholding of information by the clinician in the belief that disclosure would harm the patient or that it is counter-therapeutic (Chiodo and Tolle, 1994). But withholding information without Miss P's consent – even for therapeutic reasons – as some studies argue, is a dangerous practice (Abigail, 2011: 2), since this risks undermining the fiduciary relationship in physician-patient interactions (Cole and Kodish, 2013: 640). In addition, withholding information is a form of medical paternalism. In light of the preceding sentences, withholding information is ultimately, according to this argument, ethically unacceptable (Bostick et al., 2006: 305). Non-disclosure also raises legal issues: the medical team may be accused of medical negligence or exposed to other forms of legal indictment and litigation. Miss P, for example, is donating her kidney to Mr P on the assumption that Mr P is her father. Not informing her that the genetic test reveals otherwise would adversely compromise her right to make an informed decision. She may, if she eventually discovers the truth, take legal action against the medical team and/or the hospital for failing to warn her, thereby denying her the right to make an informed decision.

But the preceding ethical difficulties are only effects of a more fundamental ethical challenge: that is, the relationship between Mr P and Miss P which may be severed by the disclosure or discovery of misattributed parentage. The fears expressed that Miss P would likely decline to donate her kidney or that Mr P might refuse the donated organ are potential consequences of a severed relationship. Olbrisch and colleagues' (cited in Wright et al., 2002: 203) observation – that the sense of a duty to donate decreases as the degree of kinship lessens – is relevant here. Furthermore, psychological harm may occur to Mr P and/or Miss P, since they are likely to be distressed at the news that their relationship with one another has hitherto been based on a false assumption. Similarly, the view that discovery of a vital (but withheld) piece of information may lead to an avoidable future legal action against the medical team and/or the hospital following the discovery that information has been withheld, is based on the view that Miss P and/or Mr P may contend that they have donated or received an organ from someone they falsely assumed was biologically related to them. In this case, the medical team would have known about this, but failed to warn them, which is a breach of an expected level of professionalism or honesty. Miss P may argue for example that her decision to donate was not truly informed, since she was not warned that her assumption (that Mr P is her father) is false. Similarly, Mr P may also contend that his decision to receive an organ from a donor he thought was his daughter was also not truly informed, and that the medical team committed an offence by their failure to inform them. Relationship, and the impact of disclosure or discovery of information on the same, is the core ethical challenge, as well as the most important value, in this case.

Sokol (2006b: 3f) opines in his article that this case is a real dilemma that is best addressed by exercising moral judgment on the part of the agent: something akin to the use of a "moral sixth sense" (Tozzo et al., 2014:179). This proposal, I contend, is significantly troublesome: it likely amounts to (unjustified) paternalism, since there are no adequate guidelines for exercising this judgment except that the agent should use his discretion, and this would not foster Miss P's and Mr P's shared-decision making capacity. There are other ethical issues with this proposal, as illustrated by the following questions: Is a physician always in the best position to make value judgements about what is good for a patient, and is he justified in doing so? And shouldn't Miss P and Mr P have a say on how their health is managed? Thus, such discretionary use of the medical team's intuition or moral judgment puts the agent in an omniscient position over Miss P and Mr P whose information preferences should also count in the decision-making process. I shall describe how to engage with these preferences in the next section. Finally, in my opinion, Sokol's argument fails to give adequate moral consideration to the relationship between Miss P and Mr P.

In the first article where this case first appeared, Wright and colleagues (2002: 204) stated that their decision to eventually disclose this information to Mr and Miss P was not solely based on any personal or professional ethical guidelines (in fact, they found no precedent or adequate guidance in either for addressing such cases), but followed from extensive discussions amongst the team members and with other professionals. Specifically, Wright and colleagues (2002: 204) mentioned that following extensive discussions in-house and with other professionals, "they" (the team) decided that disclosure was best for both donor and recipient. Amongst other reasons, they argued that the mother (former Mrs P) would not necessarily be harmed if Miss P's paternity was revealed, since she had not been involved in their lives for many years. I contend the following: first, their decision-making process failed to properly engage Miss P and Mr P (as well as former Mrs P), and as a result did not foster their shared-decision making capacity. Second, contrary to Wright and colleagues'(2002: 204) view that the former Mrs P would not be harmed by disclosure, theoretical and empirical studies (Balderrama-Durbin et al., 2017; Knopp et al., 2017) exist, which support the view that knowledge of one's own or one's partner's (previous) infidelity is very likely to have significant negative consequences that can persist into later relationships or marriage. In an empirical study conducted by Knopp and colleagues (2017: 2301 & 2303), they found that prior infidelity emerged as an important factor in infidelity in the next relationship. Spouses who became aware of their partner's infidelity in a former relationship were more likely to suspect them of the same in the present relationship with them. With reference to the present case, it is therefore not outside the realm of possibility that this could impact Mrs P. For example, Mr P could have called former Mrs P's new partner and informed him about her infidelity, despite their estrangement, and this could have compromised the trust-relationship former Mrs P enjoys in her new home. In addition, in other similar cases of misattributed parentage, where these is no such estrangement, revelations of this kind could indeed impact upon the relationships of the parent whose presumed infidelity led to this situation. Finally, those who suspected their first or previous relationship partners of infidelity were four times more likely to report suspicion of partner infidelity again in their next relationships (Knopp et al., 2017: 2301 & 2303). As noted above, Sokol's suggestion of the use of a "moral sixth sense" (2006b: 3f) fails to adequately account for these possible impacts. I submit that the mother's (former Mrs P's) current relationship – and the capacity to continue to relate with her new family – as well as Mr P's and Miss P's relational capacities, have special moral status, and should have been given significant moral consideration in the decision-making process.

In what follows, I shall show that an ethical approach which specifically places emphasis on relationships, relational capacities, social cohesion and connectedness, and so on, would be well suited for resolving the ethical dilemma around the above piece of unsought information. I shall support this approach by drawing insight from the African moral theory, *Ubuntu*, which I described in the previous chapter. In the next sub-section, I shall discuss which aspect of the theory I consider relevant for addressing the ethical issues raised by this dilemma.

However, before continuing, I note here one other proposal for resolving ethical issues around misattributed parentage that has been suggested since Wright and colleagues (2002), and Sokol (2006b) published their papers. This is a blanket non-disclosure policy (which is a proposal for an incorporation of a new clause into the consent forms for pediatric genetic testing that clearly states that any incidental information about parentage will not be revealed, regardless of the result) which has been proposed by Palmor and Fiester (2014: 165). A more nuanced proposal for a non-disclosure policy approach was earlier made by Ross (2010), who argues that argues that genetic inconsistencies in HLA testing should only be disclosed to families as variations (2010: 742 & 745). However, families who want to understand the implications of this or who seek further clarification should be referred to a genetic professional, who can explain this to them. Hercher and Jamal (2016: 37) carefully reflect on these proposals and criticize them. Amongst other things, they point out that these approaches presume that decisions around disclosure are reliably in the hands of the clinician. They are not. Hercher and Jamal point out that patients are legally entitled to receive complete test results, and genetically literate patients may realise the import of these results themselves, or discover them later (2016: 37). In addition, current medical ethics codes favour engagement with patients in the clinical decision-making process. Reasonable patients also expect to be given information that would likely influence their decisions or which they may consider important. In this section, I will focus on how to achieve such engagement. In addition, I will focus on one other question which has not been previously considered in the field of transplantation: How can African ethics contribute towards resolving ethical challenges around misattributed paternity in the field of transplantation?

5.2.3 An African Moral Theory

The definition of *Ubuntu* which I put forward in a previous chapter identified certain core aspects or common themes which can be identified in existing literature describing this theory. I found that what is commonly accepted in reviewed literature is the view that the maxim *umuntu ngumuntu ngabantu* expresses a moral principle which prescribes that one ought to exhibit certain characteristics: to prize harmonious communal or interdependent relationships (Tschaepe, 2013; Gade, 2011a; Shanyanana and Waghid, 2016); to develop one's personhood through availability to or affirmation of others (Boissevain et al., 2013); to develop one's humanness through communion with others (or by being a being-with-others); and to live for others or seek goals which do not put others and the community at risk (Metz, 2014d: 6463; Nussbaum, 2003: 21; Metz, 2011a).

In addition, the review also showed that in many variants of *Ubuntu*, the notion of a communal or harmonious relationship is not limited to relationships with actual living human beings but also involves a fundamental connectedness of all lives in the natural and spiritual environments. To this end, in this essentially relational theory, personhood/humanness is achieved by being in a symbiotic relationship with the dynamic (bio)physical and spiritual worlds. Turaki (cited in Lutz, 2009: 314) expresses this point well in the following words: (in African Ethics) "people are not individuals, living in a state of independence, but part of a community living in relationships and interdependence".

In light of the essential emphasis on the fundamental connectedness of all lives in the natural and spiritual environments, following the systematic review, I defined the morally right action according to *Ubuntu* as one that honours communal relationship or the capacity for the same, reduces discord or promotes friendly relationships with others, and in which the physical world (the horizontal line) and the spiritual world (the vertical line) are fundamentally united. In other words, the ultimate moral guideline for right action, based on the philosophy of *Ubuntu* is one that connects lives, rather than separates them. This norm captures the core aspects of this moral theory. In this section, I shall focus principally on the justificatory effect of this definition along the horizontal line by applying the moral guidelines – which I introduced in the previous section – to address ethical dilemmas around misattributed paternity.

Ubuntu shares some similarities to other Western moral theories, such as Kantian deontology and consequentialism, but differs from them in important respects. Like Kantian deontology, *Ubuntu* emphasizes that it is wrong to use people merely as a means to an end. Similarly, like consequentialism, *Ubuntu* emphasizes the need for one to foster particular kinds of consequences. Within *Ubuntu*, these consequences are relationships, fellowship, sharing, interconnectedness and so on. However, unlike Kantian deontology, which defines morally right actions as those which enhance an individual's capacity for autonomy, *Ubuntu* defines right actions as right insofar as they promote relationships of harmony or the capacity for the same, and enhance interconnectedness and social cohesion. Actions are wrong insofar as they separate individuals or cause division (Metz, 2011a: 26f; Metz, 2015a: 81). A failure to relate harmoniously or to promote friendly relationships with others results in ill-will, and/or the devaluation of one's personhood to the level of an *eranko* (animal). In the same vein, unlike consequentialism which considers right actions as those which promote the most happiness irrespective of the means to achieve this, *Ubuntu* insists on certain kinds of values which cannot be compromised even when violating them may lead to greater happiness. Some of these include prizing relationships or the capacity to engage in them, exhibiting other-regarding behaviours, and sharing, to name but a few.

As stated in the previous chapter, there are other ways in which scholars differentiate *Ubuntu* from other Western norms. For example, the term community does not imply the notion that moral norms are determined by a group's culture. According to some scholars (Metz and Gaie, 2010: 276), these are Western forms of relativism and communitarianism. The differences between *Ubuntu* and Western thought that can be identified include, first, that a sense of community is not very often thought of as core in prescribing duties in the way *Ubuntu* does. Second, where a sense of community may be seen as prescribing duty, this is usually conceived as doing what the majority of people in the society want. This is not the way in which *Ubuntu* conceives of this term. Rather, community in *Ubuntu* is (an objective) standard by which to determine the appropriateness of a group's moral norms or what moral norms become central. Is slavery, for example, likely to enhance relationships, even though it may make many happy? Or does it lead to a divided society, where some are considered first class citizens, others are second class and others slaves? In addition to the previously discussed moral guideline, the right action, based on the philosophy of *Ubuntu*, is one that overcomes division by connecting individuals in a friendly relationship. The appropriateness of a group's actions are evaluated, based on this philosophy, by how well these actions are able to overcome division or gaps which exists in the society. On this account, the emphasis placed on communal relationships does not imply that individual rights are of no importance or that they could be subordinated at will. Specifically, the emphasis placed on communal relationships implies that an individual pursues his own good through pursuing the common good. It is for this reason that *Ubuntu* would discourage taking paternalistic decisions[75] on behalf of an individual without actively engaging that individual. Hence the moral guideline (e), which requires a health professional to incorporate a patient's values in the ethical decision making process.

5.2.4 *Ubuntu* and Misattributed Parentage

In the philosophy of *Ubuntu*, communal relationships, relational capacity, fellowship, and harmony have special moral significance and deserve special moral consideration in the moral evaluation of an action. The preceding essential features of *Ubuntu* amount to exhibiting other-regarding values such as honesty, hospitality, caring and so on; developing a sense of we or togetherness; expressing shame/pride in what others do; engaging in mutual aid for altruistic reasons; acting for the sake of one another; and seeking goals which do not put others and the community in jeopardy, to name but a few. This African ethics, I contend in this section, by grounding the ultimate moral principle or guideline in what will most likely connect, rather than separate, individuals, is better able to address the ethical dilemma raised by unsolicited information regarding misattributed paternity than other normative theories.

The central question that must be asked from the perspective of this theory with regard to the case at hand is: what are the potential consequences of disclosure or non-disclosure on Miss P's, Mr P's and former Mrs P's relationships or capacity for the same? In the ethical literature on *Ubuntu*, one's present and existing relationships are regarded as being of greater moral importance than potential and/or future relationships (Metz, 2007e: 383). Hence, the moral guideline to honour present and actual relationship over future and potential ones. When this case was first described by Wright and colleagues (2002: 202), Miss P mentioned that she

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[75] I have argued in a different study (Ewuoso 2016) that taking paternalistic decsion may be justified if certain conditions are in place. For example, non-consensual treatment, continued hospitalization and/or physical restraint of individuals who are gravely disabled due to severe mental illness or chronic alcoholism and in whom biological treatment has failed, are not necessarily tyrannical, but are justified since such coercive measures - though paternalistic - promote individual health by requiring the community to actively work for the well-being of all. Such (coercive) measures are equally respectful of human dignity by prohibiting interference when individuals are seen to be making effort at seeking their own care. Finally, such coercive measures facilitate the public good by ensuring that individuals who pose significant risk to others are involuntarily constrained/confined.

enjoyed a good relationship with her present family – her father, step mother and step siblings. What action – disclosure or non-disclosure – would enhance, rather than cause division or ill-will to arise in this existing relationship?

I have argued in the previous sub-section that a blanket nondisclosure policy approach as proposed by some scholars likely amounts to (unjustified) paternalism; it is equally not consistent with most ethical codes which encourage fostering the shared-decision making capacity of patients and enhancing the trust-relationship between health professionals and patients. Similarly, an arbitrary regulation mandating disclosure of unsought information of misattributed parentage can wreak havoc upon the health professional/patient relationship or expose Miss P, Mr P and/or the mother (former Mrs P) to avoidable negative consequences.

There are multiple examples of cultural contexts in which a finding of misattributed parentage, if disclosed, could have extremely negative consequences to existing relationships; or negatively impact the possibility of new or future ones (relationships). In some Arabian cultures, as remarked by Adlan and ten Have (2012b: 404), infidelity or extra-marital affairs are not very well tolerated. A woman who is convicted of having a consensual extra-marital affair or conceiving a child outside of her legal marriage may face capital punishment at the hands of her father, brother or husband. If these family members refuse to take an action against the adulteress, they face alienation from the community or other severe punishments. Divorce is considered in these cultures to be a lenient punishment for adultery, and some consider only death of the adulteress and her partner to be an acceptable punishment. In this context, knowledge of a woman's infidelity could also have devastating consequences for her siblings. If they are unmarried, their chances of getting married may reduce. Similarly, if they are married, their chances of being thrown out of the house may increase (Adlan and ten Have, 2012b: 404f).

In the Yoruba culture of West Africa, an adulteress or an adulterer – *alagbere* – is a servant of death who has committed a criminal act against the gods that is punishable by supernatural beings along the vertical line. The adulteress or adulterer brings dishonour to his family. Both the adulteress and his partner could also be killed through deadly juju called *magun* – literally translated as 'do not climb'. In the Benin kingdom of West Africa, the children of adultery may be killed if the act was not confessed but discovered (Ojo, 2013: 133 & 136; Familusi, 2012: 304). Equally, in the Yoruba culture of West Africa, an *ọmọ ale* – an illegitimate child – also faces social stigmatization and/or discrimination, loss of ethnic identity through expulsion (or banishment) from the society/culture and consequent emotional or psychological harm. It is for this reason that Jegede (2009b: 239-250) remarks that communalism is the basis of existence in many African societies. In Yoruba culture, for example, an individual's personhood is intimately linked or bound up with other persons. Thus, a disclosure of misattributed paternity to an average Yoruba person can cause great psychological and emotional harm to his sense of community, ethnic identity and sense of personhood.

Wright and colleagues (2002: 204f) reported that they disclosed the information about non-paternity, and that both the donor and recipient thanked the medical team for doing this. I argue that in some other contexts or regions, this could easily have led to the preceding negative consequences. However, guidance for addressing this dilemma is embedded in the theoretical formulation of *Ubuntu* which I put forward in the previous chapter . The theoretical formulation of *Ubuntu* combines well with the Yoruba concept of truth-telling based on the concept of *ootọ́* which I introduced in the previous section. I shall show how this combination may be used to prevent potential harm to all concerned (Miss P, Mr P and former Mrs P), and to enhance their relational capacities and shared-decision making capacities, as well as the medical team's duty to maintain confidentiality and the trust-relationship within the clinical context.

The communicative system, which I introduced in the previous section, requires engagement with patients as rounded beings embedded in certain contexts. The medical team should engage Miss P and Mr P, with whom they have a direct and formal health professional/patient relationship, as rounded individuals embedded in particular contexts and relationships. Though I note that transplant surgeons do not usually order HLA testing with the primary aim of discovering incidental information such as misattributed paternity, the friendly physician-patient relationship that is implied by the African ethics I apply in this chapter will help if a need to make ethical decisions around unsolicited information ever arises in clinical care.

In addition, owing to the significance of unsolicited information like misattributed paternity, engagement (with the aim of incorporating a patient's views) should only occur after the accidently discovered information has been validated in a laboratory optimized for clinical care. The medical team should strive, through the engagement I propose here, to gain knowledge regarding Miss P's and Mr P's cultural, social or religious attitudes toward issues that this discovery may have implications for, such as genetic kinship, inheritance, infidelity, the consequences of adultery, how an adulteress/adulterer is treated in the community, and so on. Engaging Miss P and Mr P in a friendly discussion – either together or separately – would prevent violation of respect for persons by ensuring that both donor and organ recipient participate in the decision-making process, and that their shared-decision making capacities are thus enhanced. This way, the medical team would avoid making paternalistic decisions on behalf of the donor and recipient, since their inputs are sourced indirectly throughout this process. Such engagement will also help to keep their relationship or the relational capacities for the same intact, and could prevent harm that arises from a severed relationship. In fact, in the African ethics I apply here, psychological and physical harm are likely to follow because of a severed relationship. This way of engaging with Miss P and Mr P will ensure that information that could lead to such a severing is avoided or withheld.

I have highlighted in the previous section how a move towards physician-patient interactions modelled around friendly relationships could provide for engagement with patients such as Miss P and Mr P (which indirectly elicits patients' views) without conveying the truth about misattributed paternity or infidelity. I reiterate the importance of that suggestion here. To effectively engage patients, health professionals have to learn certain (communicative) skills which according to some scholars (Alnasser et al., 2017: 37), are not adequately covered in medical school's curricula (for example, in Saudi Arabia). Physicians, as a result, are often unprepared to communicate properly with patients. Alnasser and colleagues (2017: 39) believe that continuous training which aims to enhance physician's communication skills and curriculum reform will address this gap. It is doubtful if this recommendation is sufficient. The key for effectively engaging patients in order to indirectly elicit their views and values without arousing their suspicion in such situations is a good physician-patient relationship. The business-styled physician-patient relationship largely teaches health professionals methods for objectifying and quantifying symptoms, and treating illness. This may increase income, but negatively impact patient-doctor communication, or any attempt to improve the same. A transition to a more friendly-styled physician-patient relationship will lead to a better connection between a health professional and her patient; and is more conducive for engagement with Miss P and Mr P, without arousing their suspicion about the truth of the misattributed paternity.

I have suggested in the previous section a variety of ways of engaging patients to indirectly elicit their views: as a curious outsider and by employing Mey's pragmatic act theory. In addition to that, I note here that the doctor may begin this friendly conversation by drawing the patient's attention to a recent event – regarding infidelity, or the importance of genetic kinship – in the newspaper or in the media. The doctor may proceed from there to share with the patient their own view and/or cultural disposition towards these subjects; he may then invite Miss P and Mr P to share their own attitudes towards the same. In addition, because of the collective nature of cultural values and belief systems, sometimes a person's cultural/religious values and attitudes may not necessarily be the same as his personal values or attitudes. As a curious outsider, the goal of the engagement is to discover whether Miss P's and Mr P's cultural/religious attitudes (towards infidelity and genetic kinship) are the same as their personal attitudes towards the same.[76]

A move towards a friendly relationship will lead to better ethical decision-making around unsolicited information; reduce emotional distress; and ensure better clinical outcomes overall. Based on the ultimate principle embedded in *Ubuntu*, the moral worth of an action is determined by its likelihood to foster social cohesion – rather than ill-will or division – and to enhance relationships. Disclosure is advised if the relationship between Miss P and Mr P or their capacity for the same, following their responses, is unlikely to be severed, thereby exposing Miss P to physical and/or psychological harm. Disclosure is ill-advised if the opposite is likely to occur.

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[76] One may argue here that even if Miss P and Mr P are tolerant of infidelity, they would still be exposed to possible harm as a result of negative cultural attitudes towards the same. Hence, why would eliciting their views make a difference?

First I note here that based on the philosophy of Ubuntu, harm is not only physical harm, but also includes loss of relationships or the capacity for the same. In fact, based on this theory, loss of relationships or the capacity for the same is a highly significant form of harm. As I pointed out in the previous sub-section, physical harm and/or psychological harm are likely to occur because of a severed relationship between the Ps.This harm may be prevented by eliciting their views.

Second, I have noted in the previous chapter that Metz's philosophical construction of Ubuntu allows for various degrees of relationship or communion. In Metz's (2016; 144) philosophical construction, our present and actual web of relationships such as present family ties, blood ties, close friends and so on, has priority and importance over future or distant ties. One's sense of communing with others decreases as the degree of association or closeness lessens. In light of this, invitation will ensure that Miss P and Mr P continues to enjoy their present and actual relationship, which has importance over distant relationships with the larger community or future communion.

Finally, I note here that there are different ways one acquires or loses his/her cultural/ethnic identity in some African cultures: through birth, adoption or acknowledgement of a child such as by paying the mother's bride price in Ibo culture of west Africa, for example (Takacs and Cline, 2015; 32). A legitimate child could lose his/her identity if s/he is disowned by the father in the same way an illegitimate child could gain identity if s/he is acknowledged by the father. If Mr P and Miss P are tolerant of infidelity or place less significance on genetic kinship; and if Mr P acknowledges or accepts Miss P as his daughter after the unexpected information has been disclosed to him, this will legitimize Miss P's status in the community, and thus prevent any harm to her (Miss P) from the community.

Rule (e)[77] suggests that the relationship between Mr P and Miss P, or between J and the Jehovah's witness community, would take priority over the health professional/patient relationship, so that the need to fulfil the fiduciary duty in the health professional/patient relationship (by providing complete and accurate information) would be less important than honouring and preserving the relationships between the Ps, in a situation where these ends are in conflict (where disclosure would be likely to damage these relationships). Guideline (e) also suggests that where there is an existing health professional/patient relationship, this relationship, and the duties which it involves, would take priority over the health professional's duty to third parties where no relationship yet exists. To this end, the medical team does not have a duty to inform former Mrs P, unless severe harm to Mrs P is extremely likely. In this particular case, where former Mrs P is out of contact and out of the picture, I suggest that the medical team may proceed to inform Miss P and Mr P without warning or notifying her (former Mrs P) as it is a very remote possibility that disclosure would impact her or her (possible) relationships. The likelihood of Mrs P finding out or being affected by this information derives only from the possibility that an aggrieved Mr P, who has had no contact with this person for years, would track down her new partner and inform him, if indeed such a person exists.

If non-disclosure has been decided upon, because Miss P's and Mr P's responses do not favour disclosure, the version of African ethics I advance in this study allows for a number of strategies to be used to avoid lying. In Wiredu's opinion (quoted in Tschaepe, 2013: 55), one is obliged to tell the truth because not to do so would threaten one's very status as person, as well as the very status of the community. On the other hand, the obligation to tell the truth disappears in cases where the disharmony of the community would result from truth-telling or where relationships may be significantly harmed. Note here that the absence of an obligation to tell the truth if an individual's relational capacity would be jeopardized as a result, should not be taken as a license to lie. Lies are forbidden both in the description of Yoruba concept of *ootọ́* which I put forward in the previous section and the theoretical formulation of *Ubuntu* which I highlighted in the previous chapter. Lies are considered as a devaluation of one's personhood. This African ethics' insistence on honesty would enhance

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[77] This moral guideline states that in making decisions about the non/disclosure, existing relationships, or relationship of long-standing should take priority.

the trust relationship in health professional/patient relationships. There are a number of non-disclosure strategies that may be used to avoid lying. I mentioned one (jargonization) in the previous section. Other strategies include: keeping quiet, veiling (shrouding the truth), mitigations (deflecting the full magnitude of the test result), or normalization (presenting a mild part of the report or merely saying the report confirms Miss P could donate her organ), to name but a few. I shall shortly discuss another non-disclosure strategy which I favour, which may be used in the case that non-disclosure to the Ps is indicated. Before proceeding to this topic, however, I shall briefly summarise the preceding discussion.

5.2.5 Summary Remarks

I set out at the beginning of this section, to highlight how a combination of the theoretical formulation of *Ubuntu* and the communicative system based on the Yoruba concept of *ootọ́* may be used to address the ethical challenges around misattributed parentage in the field of transplantation. The combination of these two properly constitute the African ethics which I apply and defend in this section. The objective of this section was achieved in different sub-sections. First I (re)described a case example previously analysed by other scholars and highlighted where I differ with the previous analyses of this case example. I identified relationship as the fundamental ethical issue which deserves significant moral consideration. In this section, I argued that by grounding the ultimate moral rule in what connects rather than separate individuals, *Ubuntu* is better able to address ethical dilemmas around unsolicited information of misattributed parentage.

Some scholars have suggested that medical professionals can anticipate unsought information such as misattributed parentage, and elicit information preferences of patients at the onset of clinical interactions. I contend in this study that it is not likely this suggestion would make any significant impact since this kind of unsought information (misattributed parentage) often has real implications for other persons who may not be part of the health professional/patient relationship. What is needed to avoid harm to such persons is a practical approach – of the type embedded in the African ethics I apply here – to decision-making about information disclosure. This ethics, I have shown in this section, has great potential for contributing theoretical diversity and addressing ethical dilemmas around unsolicited information of misattributed paternity in a variety of clinical contexts. In this ethics, the human person is in a web of interrelationships along the horizontal and vertical lines. To this end, an action is right to the extent that it enhances human relationships and interconnectedness; and wrong, to the extent that it causes ill-will and division. In most situations of misattributed paternity, this principle is likely to tip the scales in favour of non-disclosure, given the importance of relationships in this ethics, and the fact that disclosure may result in severed relationships, whereas this is less likely to follow from non-disclosure. The preceding does not imply a blanket non-disclosure policy, since the ethics I apply here also mandates that the decision to disclose or not disclose should also foster respect for persons and all they value, and there may be circumstances in which it is clear that human relationships and connectedness will be promoted by disclosure. .

Future research studies can focus on how to properly integrate this ethics into medical ethics curriculum and codes. I have highlighted in this section how a combination of the theoretical formulation of *Ubuntu* and Yoruba model of truth-telling may be used to address ethical issues around unsought information, specifically for deciding when disclosure is advised or not. In the next section, I shall expand on my application of African ethics to dilemmas associated with unsolicited information, by showing how this theory may be used to address ethical dilemmas raised by serodiscordant relationships.

5.3 Addressing the Conflict between Partner Notification and Patient Confidentiality in Serodiscordant Relationships: How can *Ubuntu* Help?

Discordancy is at the heart of HIV transmission. Recent studies have shown that most new HIV infections occur amongst couples in serodiscordant relationships (Fu et al., 2016: 828f; Kamanga et al., 2015: 140; Ward and Bell, 2014: 314; Onovo et al., 2015: 2). According to these studies, partner notification can help significantly to promote early diagnosis of HIV infections; to expand HIV testing and scale up antiretroviral treatment to prevent and control secondary HIV infection; and to effect positive sexual behaviours.

As previously defined, HIV partner notification is a process of informing partners of HIV-positive patients of their partners’ HIV seroconversion and their own likely exposure to HIV, while at the same time encouraging these partners to seek testing and counselling themselves (Kamanga et al., 2015: 140; Laar et al., 2015). However, partner notification can conflict with the HIV-positive patient’s rights to privacy and confidentiality, especially when it is without consent. The Hippocratic Oath promises rewards to the secret keeper and sanctions for those who fail to honour a patient's confidentiality – "Whatsoever in the course of practice I see or hear….. that ought never to be published abroad, I will not divulge….if I keep this oath….may I enjoy honour…..if I transgress….may the opposite befall me" (Laar et al., 2015: 1). It is often speculated in published literature that the existence of medical confidentiality has led many people to know their HIV status; has helped to maintain trust in the health care system; and is at the heart of the global effort at reducing the spread of the virus. According to some scholars (Njozing et al., 2011: 6f; Kamanga et al., 2015: 140; Laar et al., 2015: 4; Xiao et al., 2015: 73; Gillon, 1987), medical confidentiality is the reason patients confide in their doctors and/or seek medical help. These patients may refuse testing if they realize that health professionals can freely disclose their confidential information to others such as their partners.

In this section, I shall address this ethical conflict (between partner notification and patient confidentiality), and argue in favour of partner notification. Specifically, I shall argue that based on the philosophy of *Ubuntu,* a health provider is obliged to facilitate harmonious relationships in which individuals are subjects and objects of relationships by notifying others (particularly a partner with whom an HIV positive patient has a present and actual relationship) of his spouse's HIV seroconversion, since without such relevant information a partner (subject) of an HIV positive patient cannot appropriately care for the patient (object). Although I focus principally on HIV transmission in this section, I maintain that the moral rule I put forward in this study may be deployed to address similar ethical issues around confidentiality generated by other (incurable and contagious) sexually transmitted infections such as herpes.

5.3.1 Conceptual Clarification and Delimitations

In this section, I focus principally on the ethical conflict between confidentiality and partner notification in HIV serodiscordant relationships. A serodiscordant relationship occurs when one partner in a couple's HIV result is positive and the other negative (Onovo et al., 2015: 2). It is not necessary that the couple in the serodiscordant relationship frequently have sexual intercourse. I shall focus specifically in this section on serodiscordant relationships where there is present and actual cohabitation and frequent contact in a stable and intimate relationship. This focus takes into account the different ways HIV may be transmitted such as through needle-sharing or syringes, getting a cut from an HIV contaminated sharp object, open-mouth kissing with bleeding gums, contact between broken skin or wounds and so on.

The above distinguishes the focus of this study (partner notification) from contact tracing – which is the tracing of individuals who are at risk of infection due to sexual contact with an HIV index patient. Equally, this also distinguishes the relationship of focus in this study from others, such as relationships with colleagues at work or friends where there may be frequent contact, but no cohabitation and no intimate relationship of caring and loving. I focus in this study specifically on serodiscordant relationships in which an HIV positive patient has frequent contact with their partner, with whom they cohabit and where an intimate relationship of caring and loving exists, regardless of whether sexual intercourse frequently occurs or not.

Four types of partner notification are common in published literature (Njozing et al., 2011; Laar et al., 2015; Ward and Bell, 2014): index patient referrals, health provider referrals, contract referrals and dual referrals. Patient referral involves the patient themselves in notifying their partner of their likely exposure to the virus. In a provider referral, the health professional notifies the partner. In dual referral, the patient and health provider jointly notify the partner of exposure, while with contract referral, a patient agrees to notify the partner within a specific time frame before the provider makes contact directly, with or without the patient’s consent.

I argue in this section that dual referral, contract referral[78] and patient referral do not generally create ethical conflict of the type under consideration in this study, since they often occur with the patient’s approval or tacit agreement. However some elements of provider referral do create this conflict, when provider referral occurs without the patient’s consent. In this section, I shall attempt to answer the question: Is a health provider under any obligation to notify a partner of his patient’s HIV serostatus in the absence of the patient’s consent or when the patient has refused to disclose? I answer in the affirmative and justify this answer by showing how an essentially relational ethics, such as the African ethics I apply in this

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[78] Contract referral, as described by published literature, is a contract between free agents. In a contract referral, the patient is not coerced into making this promise. Hence, in my opinion, it does not raise the same ethical challenges as provider or health professional referrals, where decision-making is taken out of the patient’s hands entirely.

chapter, grounds an obligation to notify HIV positive patients' partners without their consent. In what follows, I shall (re)describe Case Example Two, and explore the current outlook on partner notification and confidentiality in existing medical ethics guidelines and legal codes for managing HIV transmission in general, and ethical issues in serodiscordant relationships in particular. As previously discussed, I note here that the statutes and case law examples are not universally binding. Though I have suggested here that the current legal outlook needs to change, it is still important to note that the country-specific law referred to, may only be taken as illustrative or informative, ethically.

Case example Two

> *In a certain town, T, live a couple – W (wife) and H (husband). They approach a physician (P) for basic check-up procedures. Blood samples are drawn from both and other tests are conducted. The test results for the blood samples show that H is HIV positive. P (the physician) informs H about the test result and explains his options to him. But, H, for fear of losing his wife (W) who is HIV negative, asks P not to reveal his own test result. Moreover, they are his test results (privacy concerns). P has information not solicited by W which could nonetheless significantly help her. But the information is about H who wants his privacy to be protected and respected by his physician P (who is not only ethically obliged to respect the rights of his patient's privacy, confidentiality etc., but who must also act for their health benefits). Both H and W are his patients*

5.3.2 Ethical Issues

The preceding case raises very important ethical questions: Does P's physician-patient relationship with H have priority over P's physician-patient relationship with W? What – if anything – does P owe W? What is P's responsibility for HIV prevention to W (on the horizontal line) and future children (on the vertical line)? How important is W's right to be informed that she may be at risk of HIV infection? How does P reasonably balance H's interests against W's? These are no small ethical questions. Other rights-related issues are also involved such as the right of W to remain HIV negative, if she does not have the virus already; the right of the offspring to live HIV-free lives; and so on. This particular ethical dilemma is further heightened by the fact that W is also P's patient. Hence P owes W a duty of care, that is, P is ethically obliged to use his knowledge and power to ensure health benefits to W. The important rights and duties which come into conflict in this case include: the right to confidentiality vs. the duty of care; the duty to warn vs. the duty to maintain trust; the importance of truthful disclosure vs. the duty to prevent harm, to name but a few. However, the principal ethical question in this case is: Does H's right to confidentiality have priority over W's right to be informed of her husband's serostatus? I shall focus on this principal ethical question.

The general outlook in many medical ethics guidelines, as well as legal codes is one that favours maintaining patient confidentiality. Many medical ethics guidelines (for managing HIV transmission) and medical associations such as the Health Professions Council of South Africa Guidelines (Booklet 12), The Belgian Medical Council (Ketels and Vander Beken, 2012: 399) and the World Health Organization's "Guidance on Couples HIV Testing And Counselling Including Antiretroviral Therapy For Treatment And Prevention In Serodiscordant Couples: Recommendations for a public health approach" (WHO, 2012: 3-5, 20-25), recognize an "ethical duty to warn" (notify) or prevent harm to (identifiable) at-risk parties only if certain conditions have been fulfilled. Specifically, Rule 9 of The Health Professions Council of South Africa Guidelines (Booklet 12: Rule 9) permits breaching patient confidentiality only when a patient has refused to consider other options of preventing infection such as active antiretroviral drugs that can reduce viral load, or when a patient communicates a threat (to infect others). In the absence of a communicated threat, or if H promises to consider other options to prevent infection, P is, according to these guidelines, obliged to honour confidentiality. Note also that although these guidelines permit P's breaching confidentiality given certain conditions, this, as pointed out by Ketels and Van der Beken (2012: 412f), does not place P under an obligation to inform W. In other words, conditions justifying provider referral (without patient consent) must be interpreted restrictively. Kalichman (2017: 408) and other colleagues (Masiye and Ssekubugu, 2008: 345) are in fact of the opinion that partner notification still depends very much on the index patient in South Africa (and other resource-limited regions). Similarly, in Cameroon, health care providers who fail to honour confidentiality and disclose HIV-positive patients' results to their partners without their consent could be prosecuted for breaching professional ethics (Njozing et al., 2011: 6). Finally, in the United Kingdom, health providers must carefully judge the reliability of the evidence that an HIV positive patient is really a risk to their partner (Winter, 1999: 356), and when notification is advised, the identity of the HIV-positive person must be concealed from the partner (Laar et al., 2015: 2). For example, P must evaluate the evidence (such as a communicated threat to infect others), and this evidence must be reliable (that H means to see this through) before he can undertake to notify W. In addition, in undertaking a provider referral, P must withhold H's identity. The latter condition is problematic: if W has been a faithful wife, she would know who has exposed her to the virus. Additionally, the former condition would require having access to an individual's true intentions, which is not possible.

It is important to note that a legal duty to inform a partner of his spouse's sero-conversion is absent in many legal codes. Although some penal laws exist which proscribe behaviours that put others at risk of HIV infection, the general outlook of current legal codes is similar to many medical ethics guidelines for managing HIV transmission and care, and is one which considers medical confidentiality a sacred duty health providers owe patients. In the United States for example, many State laws permit – but do not require – health providers to notify HIV positive patients' partners only if they reasonably believe a significant risk of transmission exists (Kausar, 2006: 242; Bernstein, 1995: 131; Lehman et al., 2014). Additionally, the provider is prohibited from divulging the patients' identity. As I observed above, this is problematic: if the partner is faithful he can easily guess who has exposed him/her to the virus. In Belgium, a provider may breach a patient's confidentiality only if the HIV diagnosis has been established in an irrefutable manner, if there is a real danger to an identifiable person, and if partner notification is the only known reasonable way of preventing infection (Ketels and Vander Beken, 2012: 411-422). In other words, a breach of patient confidentiality is not justifiable if an HIV positive patient promises to use powerful antiretroviral drugs and/or other means of preventing transmission. In Malawi, voluntary index patient referral is what the law encourages. Anyone who discloses a patient's sero-status without the patient's consent is guilty of an offence, and liable to a fine and imprisonment (Kamanga et al., 2015).

I contend in this study that this general outlook in current medical ethics guidelines and legal codes, which favours confidentiality over partner notification, is not justifiable. Additionally, this current outlook can jeopardize the global effort at HIV prevention and the United Nations Sustainable Development Goal of ending human immunodeficiency virus/acquired immunodeficiency syndrome by 2030. Partner notification (in general) is supported by good empirical evidence (Fu et al., 2016: 828f; Kamanga et al., 2015: 140; Ward and Bell, 2014: 314; Onovo et al., 2015: 2), in that it is an effective strategy for promoting early diagnosis and preventing transmission. The general outlook (which favours confidentiality over partner notification in current medical ethics guidelines and legal codes) implies that partners of HIV positive patients – as well as their children on the vertical line – will continue to be at a significantly high risk of HIV infection because of patient confidentiality. Similarly, many health professionals, who think partner notification can significantly help in the fight against the global spread of HIV/AIDS, may become unwilling to breach patient confidentiality owing to the legal consequences and current disposition towards the same. Current ethical guidelines and legal codes for managing HIV transmissions need to be revised in light of this empirical evidence.

Furthermore, empirical studies on different forms of notification exist which show that partners in the provider referral (as well as dual-referral and contract-referral) arms are more likely to return for HIV testing and counselling than those in the patient-referral arm (Masiye and Ssekubugu, 2008: 343; Kamanga et al., 2015: 140; Njozing et al., 2011: 2; Kennedy et al., 2015: 7). This implies that it is not very effective to leave notification in hands of the patient alone. Other studies (Ainsile (2002); Garbach and colleagues (2004); Simbayi and colleagues (2007) quoted in Mehta and Padickakudi, 2010: 21) provide reasons why this is the case: some patients who promise to notify their partners sometimes fail to see this through. It is estimated by these studies that between 40% and 65% of these HIV positive patients fail to disclose their serostatus to their partners. The proposal for a revision of current medical guidelines and codes in the preceding paragraph must take note of this evidence. Partners' reactions, such as anger, or family breakups, are some of the concerns often speculated upon in published literature as reasons why HIV positive patients withhold information regarding their serostatus from their partners. As I shall demonstrate in subsequent sub-sections, empirical studies exist which seem to provide evidence to the contrary about the likelihood of these consequences. I contend in this study that in order for HIV care and transmission management to be truly effective, a shift from the question 'When is it ethical or legal to breach confidentiality?' to 'When is it ethical or legal not to notify HIV positive patients' partners?' needs to occur in current medical guidelines and legal codes.

Moreover, current medical ethics guidelines and legal codes for managing HIV transmission have an underlying weakness. They are largely based on principlism, which as I have previously noted, is an Anglo-American ethical approach.[79] As I have shown in a previous chapter, many scholars (Brown, 2010; Westra et al., 2009; de Pentheny O'Kelly et al., 2011: 3839; Callahan, 2003) have criticized this ethical approach. According to these scholars, this ethical approach reflects the core values dominant in the Anglo-American (Western) culture from which it emerged: independence, individualism, and autonomy. These core values are likely responsible for the current favourable outlook towards patient confidentiality in these guidelines and legal code. However, I have previously demonstrated that many patients and families in other climes still make decisions based on ethical frameworks other than the Anglo-American framework. In the next sub-section, I shall show how *Ubuntu* specifically, is a better alternative for bringing about a shift in the current outlook towards confidentiality; and thus, ensuring truly effective HIV care and transmission management. The next sub-section will make an important contribution to the ethical literature by highlighting how this African ethics may be used to address ethical issues raised by serodiscordant relationships.

5.3.3 Grounding an "Obligation to Notify" in the Ethics of *Ubuntu*

I have described the African ethics which I seek to apply here in previous sections. I shall restate here some of its essential features which I consider relevant for grounding an obligation to notify. This African ethics is a combination of the theoretical formulation of *Ubuntu* and the communicative system based on the Yoruba concept of *ootọ́*. However, in this section, I shall focus specifically on how the philosophy of *Ubuntu* may be used to address this ethical dilemma.

Ubuntu is based on ethical judgments or moral ideas such as prizing relationships, social harmony, communalism and so on. This ethics is – in contrast to Anglo-American ethical theories – less individualistic and anti-egoistic (Breems, 2016: 59; Plooy, 2014: 92; Venter, 2004: 153). In *Ubuntu*, "people are not individuals, living in a state of independence, but part of a community, living in relationships of interconnectedness and interdependence" (Lutz, 2009: 314). Hence, the maxim *umuntu ngumuntu ngabantu* - I am because we are.

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[79] I also note that previous studies such as (Umeora and Chukwuneke, 2013, Mehta and Padickakudi, 2010), which reflected on the ethical conflicts between confidentiality and partner notification have considered this issue by using this same ethical approach (principlism).

This maxim is generally understood to be a claim to live in harmonious or communal relationships “in which people identify with each other and exhibit solidarity with one another (Metz, 2012a: 393; Metz, 2013b: 85). Thus, in this ethics, personhood/humanness is always in a symbiotic relationship. Specifically, one is required to develop his personhood/humanness through communion with others; or by identifying with others and exhibiting solidarity.

Identifying with each other, as Metz (2010f: 92) has demonstrated, largely implies thinking of oneself as a we (cognition); developing a sense of togetherness or expressing shame/pride in what the group does (emotions); engaging in joint projects (conation); adopting goals consistent with those of others (volition); and finally, coordinating behaviour to realize shared ends because this is who we are (motivation). Exhibiting solidarity, on the other hand, involves engaging in mutual aid, empathic awareness of or care for the condition of others, exhibiting positive emotions/motives toward others, helping others for altruistic reasons and acting for the sake of one another (which involves acting in ways that are likely to be for the good of others). As I have stated in the previous chapter, a blend of identity and solidarity is what Metz (2010f: 92) calls friendship. In light of this general prescription to identify with others and exhibit solidarity, the ultimate moral guide in this philosophy is that the right action is one which enhances friendly relationships, relationships of interdependence, or the capacity for the same.

Additionally, in *Ubuntu*, one’s present and actual relationships have moral priority over future or potential relationships. In addition, to be capable of being both a subject and object of friendship is essential for acquiring personhood, rather than merely being an object (alone) or a subject (alone) (Metz, 2012a: 394; Metz, 2010b: 51). In other words, one is not a full person when one fails to exhibit appropriate emotions towards others or makes it impossible for others exhibit appropriate emotions towards oneself. In light of this, the definition of *Ubuntu* which I put forward in this study mandates provider-referral – that is, P is obliged to notify W of H’s HIV serostatus if H is unwilling or cooperative – since this is necessary for both H and W to become true subjects and objects of a harmonious relationship, even if this might likely entail a loss of H’s right to confidentiality. Put differently: W and H share an actual and present relationship, which has priority over any past, future or potential relationship(s) with other persons. W and/or H can only (appropriately) fulfill their obligations to be the subject and object of such a harmonious relationship if each has relevant information, since information can enhance decision-making.. Based on the ultimate moral rule of this ethics, disclosure (of H's serostatus) to W is mandated and justified, even if this might likely entail loss of H's right to confidentiality. Maintaining H's right to confidentiality is not likely, or is less likely, to lead to a situation where H becomes a true object and subject of harmonious relationship, since others cannot appropriately care for him. However, partner notification would afford W the opportunity not only to take preventive measures against contacting the virus, but also to exhibit appropriate emotions towards H: to empathize with him, exhibit positive emotions towards him, and care for him, because this is who we are. P's primary obligation in this particular case is to facilitate behaviours where people can become true subjects and objects of a harmonious relationship. A failure to notify W of H's HIV serostatus constitutes a failure to coordinate such behaviours or to facilitate friendly relationships where individuals can appropriately identify with others and exhibit solidarity towards others. Such a failure is a devaluation of one's personhood to the level of an *eranko,* since this is not "who we are".

One may argue here that it would appear that the primary justification for disclosing to W is not to protect her but to enable her to care for H appropriately. If this is the case, one may argue, this seems to mandate far wider disclosure to others who are also in a position to care for H, such as parents, family members, close friends, and so on.

I submit that in the absence of a communicated threat from H, the primary justification for disclosing to W is indeed to enable her to care for H, and only secondarily, to protect her. However, the secondary justification may become the primary justification for disclosing to W, if H were to communicate a threat – of infecting W – to P by refusing to take antiretrovirals (hereafter: ARVs) or to make use preventative methods to avoid infection. This way, disclosing to W or restraining H, will be necessary to counter an unfriendly action on the part of H, based on the philosophy of *Ubuntu* I apply here. Disclosure or restraining H, when H has communicated a threat or refuse to take ARV, would also be justified in this situation, as transmission of the virus to W would also threaten her capacity to relate at all, which is the most basic condition of personhood in Metz's (2012a; 2014b; 2010f; 2017c; 2008; 2007b) philosophical construction of *Ubuntu.*

But does the preceding point mandate far wider disclosure to others (parents, family members, close friends and so on)? I noted in a footnote in the previous section, that Metz's (2016c: 144; 2017a: 117) philosophical construction of *Ubuntu* recognizes various degrees of relationship, and the sense of duty we have to others decreases as the degree of relationship lessens. One’s present and actual web of communion such as present family ties, blood ties, close friends and so on, has priority and importance over future or distant ties. Family first and charity begins at home are relevant sayings here. P’s primary duties in this case are towards those with whom he has an existing health professional/patient relationship, thus to W and H. A duty to warn other persons who are close to H might arise if P has good reasons to believe that they are likely to be harmed by H, given the importance of the duty to end unfriendliness. In addition to sufficient proximity or an existing relationship with the physician, the duty to disclose is further limited by the very nature of serodiscordant relationship I evaluate in this section. P’s obligation to facilitate caring behaviours is only directed to those who are closest to H such as those who actually and presently are cohabitating with him; as well as are in an intimate relationship with him regardless of whether they frequently have sexual intercourse or not. Given these requirements, I fail to see how this may necessarily justify wider disclosure.

Note here that the interpretation I provide does not mandate contacting previous sexual partners if H has no present or actual relationship with them – previously described as present cohabitation and frequent contacts in an intimate atmosphere of caring and loving with a partner, regardless of whether sexual intercourse frequently occurs with such persons. I have shown in a different study (Ewuoso, 2016c) how two powers of a State (the State’s police power – which is the protection of each citizen from injurious actions of others – and the State’s *parens patriae* power – which is the State’s power to protect those who cannot protect themselves or ensure that those who deserve care and support are appropriately cared for and supported) may justify taking coercive measures to prevent harm to others and ensure appropriate care to sick persons within this African Ethics. Within the preceding framework, non-consensual treatment, continued hospitalization and/or physical restraint of individuals who are gravely disabled due to severe mental illness, are justified since through such coercive measures promote the health and well-being of a sick patient; as well as protect others from their (mentally ill patients) injurious actions. Within the context of HIV transmission, one may extend that argument to ground a duty to warn (of a likely infection) those who may have been exposed to HIV infections through the injurious actions of HIV infected patients.

But this is not the argument I consider here. Herein, I seek to highlight how P’s ethical obligation to notify partners with whom an HIV positive patient has an actual and present relationship is grounded in the obligation to coordinate behaviours to realize shared ends and to facilitate the individual's capacity for friendly or harmonious relationships. This is the default position. P, however, may not notify if there is not an existing actual or present relationship of cohabitation and frequent contact.

Against any potential criticism that the mandatory disclosure I propose in this section is likely tyrannical, or may expose H to harms such as stigmatization, discrimination, W leaving H and so on, I note the following. First, some empirical studies exist to negate the claim that disclosure would necessarily expose H to a world of harm. Sagay and colleagues (2006) for example, have found that the reactions of partners of HIV positive mothers are predominantly supportive. In addition, women who disclose their HIV serostatus to partners are more likely to receive support from family and to access available support services. In addition, Smith and other colleagues (2008, quoted in Kennedy et al., 2015: 2), have also found that notification can facilitate an increase in social support and reduce stigma. Moreover, if W leaves H, this is not a failure of the ethical theory I apply here, but a failure of W. Specifically, it is the failure of W to become the sort of being *Ubuntu* mandates becoming. Thus, although this theory is better able to justify the violation of norms, such as confidentiality, this violation is not likely to expose H to harm, following evidence from empirical studies, and also following what is entailed in this philosophy. The above empirical studies further strengthen the claim that *Ubuntu* is a better framework for accounting for norms violations made necessary by a conflict of values, and for addressing ethical dilemmas in serodiscordant relationships, and is also more conducive for realizing the global aim of ending HIV/AIDS epidemic by 2030. This approach also aligns very well with evidence from empirical studies.

Moreover, in *Ubuntu*, individuals are inextricably bound up with each other. To this end, what affects an individual affects the whole community. This suggests that when the individual is sick, the community is affected. A community which does not protect the vulnerable, care for the sick, protect the individual's good, and respect individual rights, etc., devalues its personhood to the level of an *eranko* (an animal) through this neglect. In the same way, an individual who does not seek or work for the community's good, risks compromising their own good and devaluing oneself to the level of *eranko*. Within this framework, non-consensual information disclosure such as disclosure to W, is not necessarily tyrannical but justified and respectful since such measures promote an individual's good by highlighting how relevant others can provide relevant care or appropriately participate in the individual's care.

One may argue here that if H’s community does not adhere to this spirit of *Ubuntu*, even if they ought to do so, this might expose H to significant harm. I have partly addressed this concern in a previous paragraph. However, I also add here that if H’s community refuses to adopt or adhere to this spirit, this will at least not be due to the failure of *Ubuntu* as an ethical theory. Rather it will be a failure of the community to live by the values proposed by this ethical theory. At the beginning of this chapter, I mentioned that the aim of this chapter, and indeed the entire project, is not to convince anyone to accept *Ubuntu* or live by its principles; or even to argue that current normative frameworks are completely useless, and should be replaced by *Ubuntu*. Rather, the objective of this chapter is to show that living by the values and principles of *Ubuntu*, is more conducive for achieving the global goal of ending the HIV/AIDS epidemic by 2030; and resolving the ethical dilemma around unsolicited information in serodiscordant relationships. Notwithstanding the preceding sentences, there are empirical studies, as I have shown previously, which seem to suggest that one can expect supportive and caring reactions from the community towards an HIV patient.

5.3.4 Summary Remarks

To summarize: I have argued (in this section) that based on a particular interpretation of African ethics a health provider is obliged to facilitate harmonious relationships in which individuals are subjects and objects of relationships by notifying others (particularly a partner with whom an HIV positive patient has a present and actual relationship) of their spouse’s HIV seroconversion, since without such relevant information a partner (subject) of an HIV positive patient cannot appropriately care for the patient (as object of the relationship). This was achieved in different sub-sections: specifically I showed that the outlook in current medical ethics guidelines and legal codes for HIV management and care amongst serodiscordant couples, which favours protecting patient confidentiality over partner notification, is never justifiable, given available evidence from empirical studies. Hence, there is need for a shift in emphasis from patient confidentiality to partner notification in these guidelines and codes. Such a shift is necessary for achieving the United Nations’ Sustainable Development of Goal of ending HIV/AIDS epidemic by 2030. I have argued in this section that *Ubuntu* – rather than principlism – will do a better job at ensuring that partner notification (within the context of HIV transmission and care) receives more emphasis.

Although the ethical theory I propose here mandates provider referral with or without a patient's consent (especially given the available evidence about the effectiveness of index patient-referral), dual-referral and contract-referral are still to be preferred. A patient should be encouraged to participate in her own care. The health provider should only proceed to notify if a patient has refused to participate in the information disclosure to the partner. Concealing important life-saving and relevant information from those who ought to care about one's condition, or provide emotional and psychological support, is not an appropriate way of relating according to *Ubuntu*, since this is not who we are. By concealing information necessary for others to exhibit appropriate positive emotions, H has failed to become the sort of person this ethics promotes. Thus, honesty and openness – especially with those with whom one has a present and actual relationship – are prized virtues in this African Ethics. A failure to exhibit such virtues implies a failure to share a way of life that is "other-regarding". It is a failure to think of oneself as a we (cognition), or develop a sense of togetherness – in which we are subjects and objects of relationships.

Extensive research is, however, needed to study how to properly integrate this framework into current guidelines and legal codes regulating HIV care and transmission. I am optimistic that if this framework is integrated into these guidelines and codes, it would significantly enhance the care of serodiscordant couples, as well as further boost global efforts at ending the HIV/AIDS epidemic by 2030.

In the next section I shall discuss, as well as properly ground, the non-disclosure strategy I favour, in the event that disclosure of unsolicted information is ill-advised. I shall differentiate this non-disclosure strategy from lying or other forms of deception, as well as highlight how it may be employed in the event that disclosure is counter-therapeutic. This strategy is called paltering.

5.4 Grounding a Non-Disclosure Strategy in an African Moral Theory

The non-disclosure strategy I introduce in this section is paltering. To date, existing studies on paltering argue that paltering is never ethically justifiable; in other words, that it is akin to deception, since it involves making true statements with the active intention of creating a false impression.

Paltering is common in politics (Rogers et al., 2017; Gino, 2016; Hogenboom, 2017); and in the field of negotiation (Rogers et al., 2017). President Clinton's famous response to Jim Lehrer's question in 1998 about his relationship with the former White House intern, Monica Lewinsky is frequently cited by published literature as a quintessential example of paltering in politics. In response to Jim's question, the President replied: "There is not a sexual relationship" between him and Monica. At the time President Bill Clinton gave this response, there was indeed no sexual relationship between the President and the former White House intern. However, they had had a sexual relationship, which ended months before President Clinton made the statement. Another example of paltering is the then candidate Trump's response in the September 26 presidential debate to a question about a certain discrimination lawsuit against the Trumps. Candidate Trump replied that his company gave "no admission of guilt". Indeed, the case was settled out of court and the Trumps gave no such admission in the final signed legal documents. However, a private investigation sponsored by the *New York Times* into the allegation against the Trumps suggested that Trump's company discriminated based on race (Gino, 2016). Negotiators and business representatives are equally not unknown to palter in order to sell products or to convince an intending buyer to choose a service package (Rogers et al., 2017).

In this section, I argue against the above description of paltering as synonymous with deception. Contrary to the above, this section proposes to evaluate paltering by appealing to a combination of the theoretical formulation of *Ubuntu,* which I identified in Chapter Four and the model for communicative ethics which I introduced in the first section of this chapter. I shall argue that paltering need not always imply an active intention to create a false impression, and that is a justified non-disclosure strategy when, and only when, its purpose is to enhance friendliness or communal relationships, or when it is necessary to avoid causing unfriendliness. This implies that there is no obligation to *always* tell the truth. Lying, as stated in the previous section, is never justified in the African ethics which I favour in this dissertation. I will distinguish paltering from lying or other forms of deception. I am optimistic that this study will contribute a unique African perspective to the ethical literature on paltering.

5.4.1 Defining Palter(ing)

In this first sub-section, I shall argue that the term palter(ing) is not adequately defined in published literature. This sub-section will make a conceptual contribution to the ethical literature on paltering. I note here two important contributions made by Schauer and Zeckhauser (2009) and by Rogers and colleagues (2017) to this ethical literature. In fact, Schauer and Zeckhauser's published article on paltering, as well as Rogers and colleagues' (2017) empirical study on the use of paltering in the field of negotiation, are at the heart of the current discourse on paltering.

In their article on paltering, Schauer and Zeckhauser (2009: 42) define the same as an "act typically intended to mislead or to defraud". Rogers and colleagues (2017: 465) provide a more nuanced definition of this term in their empirical study. According to them, paltering is "an active form of deception that involves the use of truthful statements to convey a mistaken impression". Other available definitions of paltering in published literature do not differ significantly from these two. In other words, the current understanding of paltering in existing studies is that it is synonymous with deception. These scholars (Schauer and Zeckhauser, 2009; Rogers et al., 2017) acknowledge that paltering is distinct from lying (since it involves the use of truthful statements). However they contend that choosing to palter assumes a similar intent to deceive to lying, and that the harms of paltering are as severe as – or sometimes, greater than – lying. In addition, targets of paltering, like targets of lies, will perceive palterers negatively should they detect their deceit, or will blame palterers for actively influencing their beliefs and misleading them. Finally, when paltering is detected, it has long-term reputational consequences for the palterer similar to the consequences for those who lie, either by commission or omission (Schauer and Zeckhauser, 2009: 40; Rogers et al., 2017: 465ff). In other words, paltering may be effective in the short-term, but it is harmful to trust-relationships if discovered.

In this sub-section, I put forward the claim that the current definition of paltering errs in assuming that one always has access to other people's true intentions. Even if one could always gain access to other people's true intentions, I still contend that intention to deceive is not a necessary part of the definition of paltering, and hence not required as part of this definition. I do not dispute the view that negotiators or politicians very often employ paltering to deceive others. Rather, I argue that it is a hasty generalization to claim that an intention to deceive lies behind all acts of paltering, even if the majority of politicians or negotiators frequently employ this method to deceive others.

That a palterer intends to cause her target to have a false opinion by deceiving him/her, belongs neither to the species of paltering nor to its essential nature. Aquinas[80] distinguishes between the essential nature of "an act" and "its end". The essential nature of an act is what an act really is, and what it does not share with others. An act cannot be understood without reference to its essential nature. The end of an act is the goal or the reason for performing that act. For example, one could steal to benefit oneself or help others in need, like Robin Hood. But the essential nature of stealing itself is an act of taking what is not one's own without due permission or consent from the owner. The end of stealing is an accidental property, which describes why one steals.

Similarly, an attempt to avoid a particular subject or question, or to withhold the truth, by stating an irrelevant truth, belongs, in my opinion to the very essence of paltering. It is impossible to understand paltering without this. However, an intention to deceive is an accidental property, or an end of paltering, which merely states why or for what purpose one palters . For example, it states why some negotiators palter in the field of negotiation, or why politicians palter (Schauer and Zeckhauser, 2009; Rogers et al., 2017). But the term 'palter(ing)' could still be understood without these accidental properties. Intention to deceive, I therefore contend, is not an essential part of the definition of paltering.

There are other reasons to support the view that paltering is distinct from deception. Intention to deceive does not explain, for example, why one may palter from habit just as one may lie from habit. As Aristotle observes in his *Nicomachean Ethics,*[81] one who lies (or in this case, palters) from habit delights in nothing else – such as the intention to deceive others, since he knows no one is deceived by his act – other than the act itself. Furthermore, consider another example: snitching in many black neighbourhoods in the US is not very well tolerated. Snitchers may be killed or maimed when discovered by their peers (Woldoff and Wiess, 2010; Swanner et al., 2010; Garland and Wilson, 2013; Dennis, 2013). Now consider the example of a young black boy, who witnesses a robbery at a gas station by two-well known

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[80] Confer The Summa Theologiae II-II, q. 110, a. 1; for how Aquinas distinguishes between what belongs to the essential nature of an act and its effects or accidental properties.

[81] Please confer Nicomachean Ethics. iv, 7

gang members in his community. CCTV footage clearly shows this young man witnessing this robbery. The faces of the robbers in the CCTV footage, however, are blurred. This footage has been circulated in the community, and has been given to the police. Everyone (including this young man and the police) knows that this young man witnessed the crime and saw the faces of the robbers. But, for fear of reprisals for snitching, when asked by the police whether he saw the crime and could give a description that would lead to the arrest of these thieves, this young man replies: “snitchers get killed in my community. I ain’t ready to go to a funeral”. In this example, the intuition that the young man is paltering (evading the question) is clear. He evades the question by stating another truth that does not directly address the question. However, this case illustrates that the palterer does not always intend to lead others to have a false impression. The young man clearly does not intend to deceive anyone (if deception is taken to mean a deliberate attempt to cause someone to believe something that is not true). Rather, the impression that is created here is that he – the palterer and not the targets of paltering – could die for snitching, which is a true impression that is very well documented by different studies (Woldoff and Wiess, 2010; Swanner et al., 2010; Garland and Wilson, 2013; Dennis, 2013). In other words, this young boy is not trying to create a false impression in the police who are questioning him, since it is public knowledge that he witnessed the robbery. He is rather trying to avoid the subject or withhold the truth by stating a truth which does not address the question posed to him. Thus, intention to deceive cannot be a necessary requirement for the definition of paltering. This condition may apply to some acts of paltering, but not all acts of paltering.

I therefore contend, as above, that what unifies all acts of paltering is that the palterer avoids a question or subject or withholds the truth. Hence, I define palter(ing) simply as ‘a deliberate act of avoiding a subject or concealing a truth by stating an irrelevant truth’. As previously stated, paltering could be achieved in a number of ways: by equivocating, prevaricating, evading, selectively reporting, or taking advantage of vague language, to name but a few. In addition, one may employ paltering to achieve a number of ends: just as one could palter with the primary intention of avoiding a particular subject to protect oneself or others from harm, and in the process cause the victim to have a true impression about this intention, one could also palter to cause the victim to have a false impression. Herein, I acknowledge that paltering may become deceptive, if and only if, the purpose for concealing the relevant truth is to deliberately cause the victim or target to have a false impression. I have shown in the CCTV footage example above how paltering may also be used to cause someone to have a true impression. However, paltering, I contend here, should not be reduced to any one of these ends. In the final sub-section, where I shall justify paltering following a particular interpretation of *Ubuntu,* I shall give other reasons for paltering. I shall proceed in the next section to distinguish paltering from lying or deception.

5.4.2 Paltering vs Lying

This sub-section partly challenges the current view in existing studies that the harm and/or the consequences of paltering are as severe as (or sometimes, more severe than) lying. First, I will show how lying is distinct from deception, and then how it is distinct from paltering.

I argue that the existing view that the harm and/or the consequences of paltering are as severe as lying is misleading. Specifically, this is an overgeneralization which could occur when one uses a possible similar effect of two things to link them together in an essential way, that is, to put forward the claim that they are not essentially distinct. For example, lying may be employed to intend deception. Paltering may be employed to intend deception. Thus, lying is not essentially distinct from paltering. In this section, I contend the contrary.

This sub-section resists the subtle attempt in the current literature on paltering which actively seeks to make us believe that lying and paltering are essentially the same. First, I note here that contestations exist in published literature about how to adequately define a ‘lie’. Both Schauer and Zeckhauser (2009: 39), as well as Rogers and colleagues (2017: 456ff), give the impression in their studies that the ‘intention to deceive’ is an important element of a lie, just as is supposedly the case with paltering. Rogers and colleagues (2017: 456ff) also distinguish between lying by commission (which is an active use of false statements to deceive) and lying by omission (which is a passive act of misleading by failing to disclose relevant information). Unlike lying by omission, Rogers and colleagues (2017: 456ff) add, “paltering involves the active use of statements, similar to lying by commission. Unlike lying by commission, paltering involves the use of truthful statements.” However, like lying by omission, paltering represents a failure to disclose information. However, I do not think that the distinction between lying by commission and lying by omission is necessary. Lying by omission is not conceivable unless one were under oath to tell the truth, the whole truth and nothing but the truth. A deliberate failure to tell the truth or the whole truth, while under oath or when one has promised to do so, is, I argue, in itself a form of active deception. This is selective reporting which seeks to deliberately cause the victim to fail to have the right or correct information.

Some scholars (Stokke, 2013; Sorensen, 2007; Wiegmann et al., 2016) believe that a lie does not require an intention to deceive or mislead in its definition. This is the view of this study. Similar to my position on paltering, I argue that intention to deceive is also not a necessary part of lying. Lying involves asserting what one believes to be false. Consistent with my position in the previous sub-section, I define deception here as a deliberate act of causing someone to accept as true or valid what one in fact believes to be false or invalid. In other words, the nature of a deceptive lie is that, first, the target or victim believes the lie to be true, and second, the liar intends to cause the target or victim to accept the lie as true. Herein, I accept Lynch's (2009: 3) observation that "one can lie without deceiving, and deceive without lying." For Lynch (2009: 3), deception depends on success: "I deceive you only in so far as I actually succeed at misleading you or directing you away from the truth." On the other hand, one may deceive or mislead without lying. Consider the example of a woman who is known by her friends to be a good tailor: she sows clothes for a living. A friend enters her office and compliments her on a well-made but store-bought cloth this friend found in her office, and she replies "thank you". She has misled or deceived the friend into believing that she made the cloth herself, though her words do not explicitly state this. It is equally not unknown that some businesses use accounting methods that do not involve stating untruths, but are deliberately convoluted in a such a way that they give a false impression about the financial health of the business. Again, this involves deception without lying.

In light of the preceding, I contend in this section that deception is logically and conceptually distinct from a lie; in the same way it is distinct from paltering. Consider the previous example of a young man who was asked by the police if he witnessed the robbery and could give a description that would lead to the arrest of the two thieves. Imagine that his response was: "I did not see anything". The intuition that he is lying is clearly evident since the CCTV shows that he witnessed the crime. Yet the police are not deceived by his act, since they in fact, know – from watching the CCTV footage – that he witnessed the robbery. Additionally, this young man himself does not intend here to deceive the police, since he knows that they (the police) have seen the CCTV footage, which puts him at the scene of the crime.

Similarly, consider a well-known pathological liar, who according to Sorensen (2007: 261), "has lost control over what he is saying. He has an irresistible desire to lie in the same way a kleptomaniac has a compulsion to steal." An irresistible compulsion to lie would lead a pathological liar to lie even when he knows others would neither be deceived nor misled by his lies. Finally, if lying implies deception then "lying to yourself [would require] navigation through the dilemma of self-deception: Either you believe the deception (and so are not a deceiver) or you do not believe the deception (and so are not deceived)" (Sorensen, 2007: 259). Hence, deception applies to some lies and not all lies, in the same way deception may apply to some acts of paltering but not to all acts of paltering. This dissertation adopts the correspondence theory of truth's definition of truth and falsehood (or lies).

In Epistemology, the correspondence theory of truth defines truths and lies in terms of how well statements correspond with or relate to the actual state of affairs. Hence, to say of what is that it is, and what is not that it is not, is truth. But to say of what is not that it is, and what is that it is not, is a lie. True propositions should correspond with the actual state of affairs. For example, all dogs are animals, is true if, and only if, this statement accurately describes the reality that indeed, all dogs are animals. If one were to find a dog that is indeed not an animal, then this statement is false. The statement 'a cat is on the mat' is true if, and only if, in the world there is indeed a cat and a mat, and both are related by virtue of the cat being on the mat. If any of the three pieces (the cat, the mat, and relation between them which corresponds respectively with the subject, object and verbatim statement) is missing, then the statement is false. In summary, correspondence theory of true tries to posit a relationship with thoughts or statements on the one hand, and things and facts on the other hand.

By this definition, paltering is distinct from lying. A palterer may palter by asserting what he believes to be true, although this truth is not directly related to the subject matter. Lying, on the other hand, implies uttering false statements or asserting what one does not believe to be true. This is a subjective view of paltering, which (indirectly) follows the Wiegmann and colleagues' subjective view of lying, as discussed in an empirical study (2016). According to such a subjective view of lying, the sufficient condition for a proposition to constitute a lie is that the liar believes his statement to be false (Wiegmann et al., 2016: 37). A subjective view of paltering, by extension, implies asserting what one believes to be true. The subjective view of lying, however, has been challenged by others who claim that in order for a statement to count as a lie, it must be objectively false. It is outside the scope of this dissertation to evaluate the subjective or objective view of lying. Rather, I merely wish to highlight here the distinctions between deception, lying and paltering, and lay a foundation for arguing against – in the next sub-section – two theses: first, that the harm and/or the consequences of paltering are as severe as (or sometimes, more severe than) lying; and second, the view that targets of paltering will perceive palterers negatively should they detect their deceit, or blame palterers for actively influencing their beliefs and misleading them.

I have argued in the second chapter that current medical ethics guidelines permit medical professionals to invoke therapeutic privilege when disclosure is medically contraindicated. In the first and second sections of this chapter, I have shown how this privilege may be invoked in a way that does not only rely on the health-professional’s discretion, but also involves patients’ views and values. In other words, a health professional should not invoke therapeutic privilege merely because he thinks that a failure to do so would cause harm to patient; but rather that the patient’s responses during the course of friendly conversation should be the principal determinant of whether information may be withheld or disclosed. Paltering (which I contend in this section, is merely the withholding of relevant truth), rather than lying, may be one way of invoking this privilege when disclosure is counter therapeutic. Paltering, as I shall show in the next sub-section, firstly satisfies the recommendation made by many medical ethical codes to avoid all things that have a tendency to discourage patient recovery, and secondly, can be invoked in a way that does not merely rely on the discretion of the health professional, as I have shown in the first and second sections of this chapter.

I shall now turn, in the next sub-section to specify the relation between paltering and the African Ethics that I describe in this dissertation. I add a note of caution here: this study does not argue that paltering should become a standard way of relating with patients. Rather, paltering may be useful only in exceptional contexts, such as clinical situations where truth-telling (or disclosure) is counter-therapeutic. Honesty should still be the prized virtue in the health professional/patient relationship in general. I shall turn now to the next section to define a framework for employing paltering.

5.4.3 Paltering and an African Moral Theory

In this section, I shall attempt to evaluate paltering by appealing to a combination of the theoretical formulation of *Ubuntu* which I highlighted in the previous chapter, and the communicative ethics which I introduced in the first section. Specifically, I shall argue that based on this African ethics, not all palterers would be perceived negatively by their targets should paltering be detected, nor would paltering necessarily have reputational consequences for the palterer. This section seeks to contribute a uniquely African ethical perspective to the published literature on paltering.

The theoretical formulation (of *Ubuntu*) identified communal relationships and interconnectedness/interdependence as core aspects of this philosophy. These core aspects also have implications for how personhood/humanness is understood within African contexts, as well as for this theory's view of morality. As previously discussed, one becomes more or less of a person to the extent that one prizes communal relationships and relationships of interconnectedness. In other words, to be a person, is to be a being-with-others. The normative implication of this is that the right action is one which connects, rather than separates, individuals. Specifically, the philosophy of *Ubuntu* defines right action as action that honours relationships or the capacity for the same; reduces discord or promotes friendly relationships with others – in which the physical world (horizontal line) and the spiritual world (the vertical line) are fundamentally united; and wrong action as wrong insofar as it promotes division, ill-will and discord. Hence, the aphorism: (in Zulu) *umuntu ngumuntu ngabantu* I am because we are.

The African ethics which I describe above eschews lying, since this is an inappropriate way of relating with others; it is not other-regarding; it is a devaluation of oneself to the level of an *eranko* (animal); and finally, it entails a failure to exhibit the virtue of honesty.[82]

Truth-telling (*Sisọ ootọ́*) and honesty are therefore moral imperatives in the African ethics I describe. These two are important constitutive elements of personhood in this philosophy, which connect individuals in a trust-relationship, promote friendliness, and enhance a relationship of interdependence. Although honesty and truth-telling are moral imperatives in this ethics, they must nonetheless be tempered, since *òtítọ́ ọrọ korò* (truth is bitter) and could

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[82] In this regard, Ubuntu shares some common themes with virtue ethics. Lutz (2009: 315) affirms this point by asserting that "as is the case with traditional ethics elsewhere, traditional African ethics is virtue ethics." Like virtue ethics, Ubuntu prescribes what sort of person one ought to be – one who prizes communal relationships and other virtues such as loyalty. In addition, similar to virtue ethics, this ethics emphasizes doing the right thing for the right reason (having the correct moral motivation). Finally, like virtue ethics, Ubuntu acknowledges that one's sense of duty to others decreases as the degree of relationship lessens (allowing for permissible bias): 'family first' and 'charity begins at home'. However, virtue ethics lacks a hierarchical order for resolving conflicts between virtues: sometimes the courageous thing to do in a particular situation may be to lie, and lying is contrary to the virtue of honesty. Specifically, virtue ethics gives guidance for living life without giving specific rules for resolving ethical dilemmas or justifying the violation of certain values when value conflict arises. Ubuntu, on the other hand, specifies that the most important rule for right action is that it should connect persons

also cause great damage to the individual’s psyche. In other words, and as previously noted, the obligation to tell the truth disappears where relationships of friendliness and harmony may be jeopardized, where fellowships and individuals may be significantly harmed, and where life in the community would be inhibited.

The absence of an obligation to tell the truth where communal disharmony would result, or an individual’s relational capacity may be significantly harmed, should not be taken as a permission to lie. In this way, the African ethics I apply in this study distinguishes itself from consequentialism, which generally argues that one may lie if such an action would produce good consequences. Lies are prohibited in this philosophy (for the reasons already stated above). It is specifically in this way that the African Ethics which I apply in this study distinguishes itself from the casuistic approach. Although casuistry considers context in its moral evaluation of acts, like my approach, and argues that one is wrong to lie under oath, casuistry will in some cases justify lying as the best moral choice when it saves life. In other words, in a casuistic approach, the end may sometimes justify the means. However, the African Ethics I apply in this study prohibits lies, since lying devalues an individual to the level of *eranko* (an animal). Rather, this ethics emphasizes that the means, as well as the end, must be good.

Its insistence that the means must never be wrong in itself, as well as that the end must be good, is also one feature this African ethics shares with Kantianism. Like Kantianism, this moral philosophy holds the view that certain acts, such as falsehood, cannot become an acceptable means of achieving an end, however good. Since this African ethics emphasizes the rightness of the means, as well as the end, it is therefore, a viable third option for addressing ethical dilemmas for would-be Kantians who believe that it is wrong to lie but cannot stomach telling the truth to a murderer, who seeks to kill a fleeing victim. Nevertheless, unlike Kantianism, which defines morally right action as one which enhances an individual’s capacity and independence, this philosophy defines right actions as right insofar as they foster social cohesion, and relationships of interconnectedness and interdependence.

Lying – since it is falsehood in itself – is not consistent with *Ubuntu*’s demand for one to exhibit certain values and virtues such as honesty, as well as for an action (means) to be good or at least neutral. Paltering, on the other hand, as I have shown in the previous sub-section, does not necessarily imply deception. As such, it is not wrong in itself. However, paltering may become wrong if the intention for paltering is to deceive. Deception is an inappropriate way of relating with others, since it is not other-regarding. There are a number of other ways, in addition to the ones already mentioned in this subsection, one can hold back or conceal the relevant truth without lying or deceiving. I have highlighted these in the second section. Some of them include: use of technical terminologies (jargonization); deflecting the full magnitude of information (mitigations); shrouding the truth (veiling), to name but a few. The African Ethics, which I apply in this study, accepts these non-disclosure strategies as ethically justifiable; if they are not wrong in themselves, and intend a good end such as enhancing one's prized values.

I have defended these non-disclosure strategies (within the clinical context) in a different section, against a potential criticism that patients would not have faith in a healthcare system if they knew health professionals could freely employ such non-disclosure strategies to avoid telling the truth. I reiterate that response in my answer to the view that palterers would be perceived negatively by targets should paltering be detected; or that paltering would have reputational consequences for palterers. I contend that it is the patient's own responses, for example, in the engagement, that will determine whether non-disclosure is advised and disclosure is ill-advised, and not solely the health professional's use of his own discretion. A target of paltering would have great faith in a healthcare system (and in a palterer) that incorporates his values in the non-disclosure decision-making process. The target would however, lose faith in a palterer who deliberately ignores those prized values, especially if they clearly appear to support non-disclosure. It is exactly in this way that this ethics is a better ethical theory for addressing dilemmas than the sixth sense suggestion by Sokol, or the moral judgment proposed by Wright and colleagues. This theory specifically, and unlike the proposals by these scholars, incorporates the prized values of an individual in making ethical judgments. Moreover, certain empirical studies exist (Marzanski, 2000a: 322), as I pointed out in a previous section, which show that it is a hasty generalization to assume that all patients – within the clinical context, for example – want full (truthful) information disclosure at all times. Sometimes, patients also wish that their rights, such as their right not to know, would also be respected by doctors even when they (patients) have not formally indicated this in a consent form.

5.4.4 Summary Remarks

I have argued in this section that it is a hasty generalization to conclude that, just because paltering has been employed in the fields of negotiation and politics to deceive, it is therefore synonymous with deception. I have shown that paltering does not necessarily imply deception; that it is distinct from lying; and following a combination of the theoretical formulation of *Ubuntu* which I described in the previous chapter and model of truth-telling based on the Yoruba concept of *ootọ́*, is a justified (as well an ethically acceptable) non-disclosure strategy in exceptional situations where truthful disclosure would harm a person's relational capacity or jeopardize social cohesion. I am optimistic that this study will make a conceptual contribution to the ethical literature on paltering, as well as introduce a fresh perspective to the same by showing how an African moral theory may be used to evaluate paltering.

Truth-telling is one of life's basic rules; children are taught from their early years to tell the truth and avoid lies. Yet this is not always easy; since not all contexts are as clear as deciding between black and white. Some situations exist where (truthful) disclosure may lead to harm, or where it is ill-advised. Paltering, based on the African Ethics I propose in this dissertation, is an ethically justifiable non-disclosure strategy when full (truthful) disclosure is counter-therapeutic. Future studies can focus on studying paltering using other ethical frameworks, such as Islamic Ethical frameworks; and in other contexts, such as in the researcher-participant context or in the field of counseling, to name but a few.

5.5 Concluding Remarks

In this chapter, I highlighted six guidelines for making decisions around unsolicited information based on a combination of the theoretical formulation of *Ubuntu* provided in Chapter Four, and the Yoruba model of truth-telling discussed in the first section of this chapter. I showed in different sections how these guidelines may be used to address the ethical dilemmas around disclosure and non-disclosure of unsolicited information. Specifically, I argued that disclosure of unsolicited information is justified to the extent that it enhances human relationships and interconnectedness; and ill-advised to the extent that it is likely to cause division. In addition, the determination of what is likely to enhance or honour the patient's existing relationships and capacity to be relate should be informed as much as possible by a) knowledge of the patient's cultural and religious context and b) engagement with the patient in their individual capacity in a friendly relationship. Finally, in making ethical decisions about disclosure or non-disclosure, actual or long-standing relationships should take priority over future or potential relationships. I have also argued that in the event these guidelines favour non-disclosure, paltering may be an ethically acceptable strategy to avoid lying.

CHAPTER 6. General Conclusion

A guideline is a statement, a rule, an outline or direction, designed to help others determine a course of action. In this dissertation, I have attempted to ground guidelines for making ethical decisions and addressing ethical dilemmas around unsolicited information in the clinical context in a combination of the philosophy of *Ubuntu* and the communicative system developed from the Yoruba concept of *ootọ́*. This aim was achieved in different chapters. In this first chapter, I introduced the problem statement to be addressed. In the second chapter, I attempted a conceptual clarification of terms. In this chapter, I adopted a definition of unsolicited information as a finding (or piece of information) – anticipatable or unanticipatable – with or without clinical or personal significance about a subject, discovered in the process of a systematic and methodic analysis of data for findings related to the aim and objectives of the test or procedure. I equally clarified how this term is employed in this dissertation, following the precedence in literature. In this dissertation, this term refers to a piece of information or a finding about which there is pressing and real ethical uncertainty as to whether to disclose or not to disclose.

Following this clarification, I identified different contexts in which such unsolicited information may arise, as well as highlighted the physician (or more broadly health professional)-patient context, as my principal context of interest. I defined the physician-patient relationship or context as a context or relationship in which a physician or health professional takes an affirmative action in a patient’s case by either examining, diagnosing, treating or agreeing to do so. Once the physician enters into a relationship in any of the preceding ways, a legal contract is formed in which the health professional owes a duty to that patient to continue to treat or properly terminate the relationship by mutual consent. Some of the duties in a health professional/patient relationship include: the duty to rescue; the duty of care; the duty to uphold respect for persons; a fiduciary duty; and a justice duty. In the rest of this first chapter, I highlighted some ethical issues that can act against a physician’s ability to fulfill these duties, or create ethical, as well as legal, dilemmas for the health profession or physician.

In the third chapter, I defined an ethical dilemma as a puzzling circumstances in which moral obligations demand or appear to demand that a person adopts each of two or more alternatives but incompatible actions, such that the person cannot perform all the required actions. I also highlighted the different types of dilemmas. All moral dilemmas pose some difficulties for agents; some are resolvable and are called apparent dilemmas, while others are not resolvable and are called real dilemmas. Healthcare professionals are often taught to analyse real ethical dilemmas by applying principlism. Principlism, I explained, is a pluralistic approach to moral decision-making based on four key principles of autonomy, beneficence, non-maleficence and justice. This pluralistic approach is the ethical foundation of modern clinical and research practices. However, principlism has certain limitations. When principles conflict, it is often difficult to manage such conflicts without a foundational principle, when they occur. Additionally, empirical studies equally exist to refute principlism's claim to universal applicability or common morality. Other studies have highlighted the limits of current medical ethics framework, specifically principlism, for managing culturally/religiously nuanced clinical contexts, or contexts where health professionals and patients are motivated by different religious or cultural values. Furthermore, I pointed out in this chapter that principlism reflects the core values of the dominant Western culture from which it emerged – independence, individualism, and autonomy. But such an autonomy, individual-centered outlook to life cannot be integrated in contexts which emphasize community, connectedness, togetherness and so on.

Hence, there is a need to supplement principlism by developing alternative frameworks based on other (non-Western) models of decision-making. These frameworks must accommodate other patients who make decisions using different models of decision-making, and should also foster theoretical diversity (in decision-making within the clinical context) which is needed to manage ethical dilemmas around unsolicited information in a variety of clinical contexts.

In the fourth chapter, I introduced an alternative ethical theory developed around a tradition other than the Western model, and that is specifically, based on the ideas, practices and beliefs salient amongst many cultures in sub-Saharan Africa. In this chapter, I highlighted a theoretical formulation of *Ubuntu* that encompasses the common themes which run across existing, and sometimes competing, interpretations of the same. In addition, I also highlighted in this chapter that this theoretical formulation can serve as supplement to current Western frameworks, contribute towards theoretical diversity, and can be useful for addressing ethical dilemmas around unsolicited information in a variety of clinical contexts. *Ubuntu* defines a morally right action as one that honours the capacity to relate communally, reduces discord or promotes friendly relationships with others, and in which the physical world (horizontal line) and the spiritual world (the vertical line) are fundamentally united. This definition is a result of a systematic review of the ethical literature on *Ubuntu*. I justified the use of this methodological approach in that is likely to increase methodological transparency, reduce bias and ensure thoroughness.

Although the theoretical formulation which I highlighted in the fourth chapter is useful , it does not make specific reference to communicative ethics. In the first section of the fifth chapter, I therefore supplemented the theoretical formulation of this ethical theory by introducing a communicative system based on the Yoruba concept of *ootọ́*. A combination of this communicative ethics modelled around the Yoruba concept of *ootọ́* and the theoretical formulation of *Ubuntu*, properly constitute the African Ethics which I apply and defend in this dissertation.

By grounding the ultimate moral rule in what connects, rather than separates, individuals, I showed that this ethical theory is a better alternative guideline for justifying or addressing loss of values, such as the value of confidentiality in Case Two. Based on this ultimate moral principle, disclosure (of H’s serostatus) to W is mandated and justified, even if this might likely entail the violation of H’s right to confidentiality. Maintaining H’s right to confidentiality is not likely, or is less likely, to lead to a situation where H becomes a true object and subject of harmonious relationships, since others cannot appropriately care for him.

I acknowledge here that applying guidelines requires judgment. In the introductory case and Case One, I showed how ethical judgments, in dilemmas regarding information, can also incorporate the views and values of patients without revealing the truth of the information. Unlike previous suggestions for invoking therapeutic privilege or considering ethical dilemmas around non/disclosure which do not make any essential reference to how one can also incorporate the values of the patient, I introduced – based on the African ethics I defend – a communicative ethics for making decisions about non/disclosure in a way that does not rely only on the health professional’s discretion but also fosters the shared decision-making capacity of the patient.

This communicative ethics begins with engagement. The goal of engagement is to get a proper understanding of a patient’s values and views, as well as to include those views and values in the decision-making process. Sometimes disclosure may be mandated, following a patient’s responses in a friendly conversation, but at other times disclosure may be ill-advised. In these cases, I showed how a physician can avoid lying to a patient, in the event that non-disclosure is mandated, by focusing on the strategy of paltering. I defined paltering as a deliberate act of withholding the relevant truth by stating other truths. This, I noted, is my preferred non-disclosure strategy and is not inconsistent in itself with the value of honesty that is prized by the African ethics I apply and defend in this dissertation. This ethics eschews lying, since this is an inappropriate way of relating with others; it is not other-regarding; is a devaluation of oneself to the level of an *eranko* (animal); and finally, it entails a failure to exhibit the virtue of honesty. Paltering is a justifiable way of avoiding lies and deception, as well as preventing harm to a patient, especially when disclosure is medically contraindicated.

Although the African ethics I apply in this dissertation offers a compelling alternative to extant models of decision-making within the clinical context, the mere fact that patients, doctors, systems and communities have varying value systems reveals that no situation, such as the cases discussed in this dissertation, can ever be definitively addressed to the satisfaction of all concerned. In order for this to be possible, an over-arching value system is needed, which is currently not available; and given the overwhelming call for multiculturalism and theoretical diversity in clinical ethics support system, a monopoly by a single theory on normative guideline for ethical decision-making in clinical care is not desirable.

The African Ethics I defend in this dissertation possesses an under-emphasized value that can significantly contribute towards achieving theoretical diversity in clinical care. It also provides exposure to lesser known models of truth-telling from other regions of the world such as sub-Saharan societies. I recommend that future studies should focus on properly integrating this ethics into medical ethics curricula and codes. I am optimistic that if this alternative model is incorporated into current medical ethics codes and curricula, it will significantly enhance clinical decision-making, as well as health professional/patient communication. Although I have defended the view that the non-disclosure strategy I propose, paltering, may be justified following an African ethical framework, I encourage future studies to focus on developing other practical approaches – in addition to the one I propose in this dissertation – for employing paltering (and other non-disclosure strategies) in concrete contexts, so that it does not become a device for avoiding truth-telling merely because it is convenient to do so. Future studies should also focus on studying these and other ethical dilemmas using other ethical frameworks. I am optimistic that this would contribute to the theoretical diversity needed to address real ethical contexts where stakeholders are influenced by different beliefs and values.

APPENDIX ONE

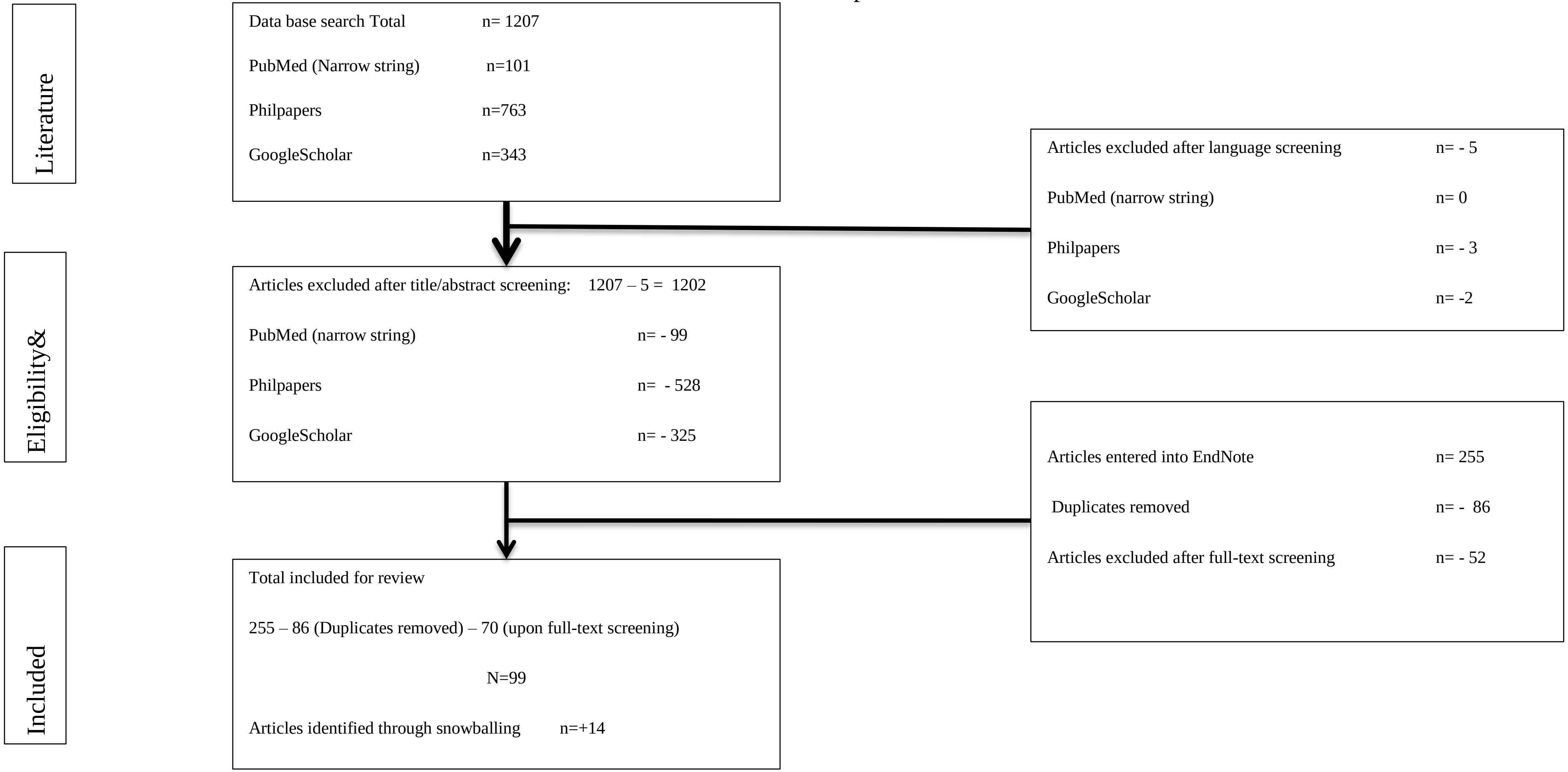
Table 1: Literature Search	
● Pubmed	☑ 1st Search
Search Date: 21 July 2017 Selected Restrictions: No restriction selected Search Mode: Default mode: sort by relevance Search String: ((("African Moral Theory" OR "African Ethics" OR "African Ethic" OR "African ethical theory" OR "African Moral Framework" OR "African philosophy" OR "Philosophy in Africa" OR "African tradition" OR "Humanistic Ethic" OR "African Morality")) AND (ubuntu OR "Ubuntu-oriented" OR "Ethics of Ubuntu" OR "African ethic of Ubuntu")) AND (philosophy OR philosophies OR philosophers OR philosopher) Hits:101	
Data base: Philpapers	Choose search number: Second Search
Search Date: 23 July 2017 Selected Restrictions: no restriction selected Search Mode: Default mode: sort by relevance Search String: ((ubuntu OR "Ubuntu-oriented" OR "Ethics of Ubuntu" OR "African ethic of Ubuntu") AND ("African Moral Theory" OR "African Ethics" OR "African Ethic" OR "African ethical theory" OR "African Moral Framework" OR "African philosophy" OR "Philosophy in Africa" OR "African tradition" OR "Humanistic Ethic" OR "African Morality")) Hits:763	
Data base: Google Scholar	Choose search number: Additional search
Search Date: 24 July 2017 Selected Restrictions:no restriction selected Search Mode: Default mode: sort by relevance Search String: "African Moral Theory" OR "African Ethics" OR "African Ethic" OR "African ethical theory" OR "African Moral Framework" OR "African philosophy" OR "Philosophy in Africa" OR "African tradition" OR "Humanistic Ethic" OR "African Morality" ubuntu OR OR OR "Ubuntu-oriented" OR "Ethics of Ubuntu" OR "African ethic	

of Ubuntu"

Hits: 343

APPENDIX TWO

Table 2: Article selection process



Data base search Total	n= 1207
PubMed (Narrow string)	n=101
Philpapers	n=763
GoogleScholar	n=343

Articles excluded after language screening	n= - 5
PubMed (narrow string)	n= 0
Philpapers	n= - 3
GoogleScholar	n= -2

Articles excluded after title/abstract screening:	1207 – 5 = 1202
PubMed (narrow string)	n= - 99
Philpapers	n= - 528
GoogleScholar	n= - 325

Articles entered into EndNote	n= 255
Duplicates removed	n= - 86
Articles excluded after full-text screening	n= - 52

Total included for review

255 – 86 (Duplicates removed) – 70 (upon full-text screening)

N=99

Articles identified through snowballing n=+14

APPENDIX THREE

	Author(s)	Year	Type of Study	Journal Name
1	Jaco S. Dreyer	2015	Journal Publication	IJPT
2	MICHAEL BATTLE	2000	Journal Publication	Interpretation
3	Munyaradzi Felix Murove	2014	Journal Publication	Diogenes
4	Anthony O Oyowe	2013	Journal Publication	African Human Rights Law journal
5	NIMI HOFFMANN and THADDEUS METZ	2017	Journal Publication	World Development
6	Joan M. Marston	2015	Journal Publication	Pain and Symptom Management Jour
7	John Hailey	2008	Journal Publication	Tutu Foundation publications
8	Johan Cilliers	2008	Journal Publication	Conference of Societas Homiletica,
9	David W. Lutz	2009	Journal Publication	Journal of Business Ethics
10	Andrew West	2014	Journal Publication	J Bus Ethics
11	Thaddeus Metz	2012	Journal Publication	Ethic Theory Moral Prac
12	Stacy Douglas	2015	Journal Publication	Law Critique
13	Birgit Brock-Utne	2016	Journal Publication	Int Rev Educ
14	Thaddeus Metz	2009	Journal Publication	Stud Philos Educ
15	ELZA VENTER	2004	Journal Publication	Studies in Philosophy and Education
16	Thaddeus Metz	2011	Journal Publication	AFRICAN HUMAN RIGHTS LAW JOURNAL
17	Barry Hallen	2015	Journal Publication	Thought and Practice: A Journal of the Philosophical Association of Kenya
18	Thaddeus Metz	2016	Journal Publication	Global Social Policy
19	Stephan F. de Beer	2015	Journal Publication	Verbum et Ecclesia
20	Angeline Masowa and Zvinashe Mamvura	2017	Journal Publication	International Journal of Arts and Humanities

21	Narnia Bohler-Muller	2007	Journal Publication	Stellenbosch Law Review
22	TARISAYI A. CHIMUKA	2001	Journal Publication	Zambezia
23	Maria Berghs	2017	Journal Publication	African Journal of Disability
24	Gert Breed and Kwena Semenya	2015	Journal Publication	HTS Teologiese Studies/Theological Studies
25	Elizabeth Chinomona and EugineTafadzwa Maziriri	2015	Journal Publication	International Journal of Research in Business Studies and Management
26	Thaddeus Metz	2016	Journal Publication	S Afr J Bioethics Law
27	Brad Breems	2016	Journal Publication	Journal of Sociology and Christianity
28	Thaddeus Metz	2012	Journal Publication	Phronimon Volume
29	Nonceba Nolundi Mabovula	2011	Journal Publication	Jnl Hum & Soc Sci
30	Thaddeus Metz	2013	Journal Publication	Journal of Global Ethics
31	Dion A. Forster	2010	Journal Publication	HTS Teologiese Studies/Theological Studies
32	Ramathate Dolamo	2013	Journal Publication	Scriptura
33	ED Prinsloo	2001	Journal Publication	Curationis
34	Bernard Matolino	2015	Journal Publication	South African Journal of Philosophy
35	Mark Tschaepe	2013	Journal Publication	Essays in the Philosophy of Humanism
36	Thaddeus Metz	2015	Journal Publication	Journal of Media Ethics
37	Douglas Farland	2007	Journal Publication	South African Journal of Philosophy
38	Leonhard Praeg	2008	Journal Publication	South African Journal of Philosophy
39	Thaddeus Metz	2017	Journal Publication	South African Journal of Political Studies
40	Wim van Binsbergen	2001	Journal Publication	Quest

41	Deane-Peter Baker	2016	Journal Publication	JOURNAL OF MILITARY ETHIC
42	Kevin G. Behrens	2017	Journal Publication	Developing World Bioeth
43	Daniel a. bell and Thaddeus metz	2011	Journal Publication	Journal of Chinese Philosophy
44	Matteo Migheli	2017	Journal Publication	Cambridge Journal of Economics
45	J.A.I. Bewaji & M.B. Ramose	2003	Journal Publication	South African Journal of Philosophy
46	J.W.F. Muwanga-Zake	2009	Journal Publication	Discourse: Studies in the Cultural Politics of Education
47	Berte van Wyk	2004	Journal Publication	Education As Change
48	Christian B.N. Gade	2011	Journal Publication	South African Journal of Philosophy
49	Sinenhlanhla Sithulisiwe Chisale	2016	Journal Publication	Gender & Behaviour
50	Sandy Haegert	2000	Journal Publication	Nursing Ethics
51	THADDEUS METZ	2010	Journal Publication	Journal of Human Rights
52	CHRISTINE WANJIRU GICHURE	2015	Book Chapter	
53	Jason van Niekerk	2007	Journal Publication	South African Journal of Philosophy
54	Mvuselelo Ngcoya	2015	Journal Publication	International Political Sociology
55	Mojalefa L. J. Koenane & Cyril-Mary Pius Olatunji	2017	Journal Publication	South African Journal of Philosophy
56	Thaddeus Metz	2007	Journal Publication	The Journal of Political Philosophy
57	Lesley Le Grange	2011	Journal Publication	Educational Philosophy and Theory
58	Thaddeus Metz	2014	Journal Publication	AFRICAN HUMAN RIGHTS LAW JOURNAL
59	Thaddeus Metz	2014	Journal Publication	South African Journal of Philosophy
60	ANA KOMPARIC	2015	Journal Publication	Bioethics

61	JY Mokgoro	1998	Journal Publication	Colloquium
62	Nyasha Mboti	2015	Journal Publication	Journal of Media Ethics
63	THADDEUS METZ	2009	Journal Publication	Journal of Philosophy of Education
64	THADDEUS METZ	2010	Journal Publication	Developing World Bioethics
65	THADDEUS METZ	2010	Journal Publication	Developing World Bioethics
66	Thaddeus Metz & Joseph B.R. Gaie	2010	Journal Publication	Journal of Moral Education
67	Thaddeus Metz	2017	Journal Publication	Theor Med Bioeth
68	Moeketsi Letseka	2012	Journal Publication	Studies in Philosophy and Education An International Journal
69	TIM MURITHI	2009	Journal Publication	International Review of Education
70	Ngwa, et al	2016	Journal Publication	Int J Radiation Oncol Biol Phys
71	Rebecca Bamford	2007	Journal Publication	South African Journal of Philosophy
72	Boissevain et al	2013	Journal Publication	Widening Partic Lifelong Learn
73	Moeketsi Letseka	2013	Journal Publication	Open Journal of Philosophy
74	Benjamin Piper	2016	Journal Publication	Int Rev Educ
75	GILLEAN McCLUSKEY and MIRRIAM LEPHALALA	2010	Journal Publication	Power and Education
76	Thaddeus Metz	2010	Journal Publication	Journal of Moral Education
77	Thaddeus Metz	2017	Journal Publication	Philosophical Papers
78	Christian B.N. Gade	2013	Journal Publication	South African Journal of Philosophy
79	RACHEL NDINELAO SHANYANANA and YUSEF WAGHID	2016	Journal Publication	Knowledge Cultures
80	Callum David Scott	2010	Journal Publication	Skills@work, Theory and Practice

81	Mary Kay Smith	2016	Journal Publication	Acad Psychiatry
82	Guma Prince Karakire	2012	Journal Publication	SSRN
83	Dalene M. Swanson	2007	Journal Publication	Journal of Contemporary Issues in Education
84	Patricia K. Kubow and Mina Min	2016	Journal Publication	Democracy & Education
85	Bernard Matolino and Wenceslaus Kwindingwi	2013	Journal Publication	South African Journal of Philosophy
86	Thaddeus Metz	2007	Journal Publication	South African Journal of Philosophy
87	Belinda du Plooy	2014	Journal Publication	South African Review of Sociology
88	Thaddeus Metz	2015	Journal Publication	South African Journal for ommunication Theory and Research
89	Thaddeus Metz	2007	Journal Publication	South African Journal of Philosophy
90	Edwin Etieyibo	2017	Journal Publication	Philosophical Papers
91	Colin Chasi and Ylva Rodny-Gumede	2016	Journal Publication	Critical Arts South-North Cultural and Media Studies
92	Lesley Le Grange	2012	Journal Publication	Journal of Moral Education
93	Yusef Waghid & Paul Smeyers	2012	Journal Publication	Educational Philosophy and Theory
94	Christopher Simon Wareham	2017	Journal Publication	Theor Med Bioeth
95	Michael Onyebuchi Eze	2008	Journal Publication	South African Journal of Philosophy
96	Christian B.N. Gade	2012	Journal Publication	S. Afr. J, Philos. 2012, 31(3)
97	Thaddeus Metz and Joseph B.R. Gaie	2010	Journal Publication	Journal of Moral Education
98	Thaddeus Metz	2017	Book Chapter	
99	Motsamai Molefe	2017	Journal Publication	South African Journal of Philosophy
100	THADDEUS METZ	2009	Book Chapter	

101	Thaddeus Metz	2014	Encyclopedia Entry	
102	Mluleki Mnyaka and Mokgethi Motlhabi	2005	Journal Publication	Black Theology: An International Journal
103	Y Mokgoro	1998	Journal Publication	PER/PELJ
104	Gessler Muxe Nkondo	2007	Journal Publication	International Journal of African Renaissance Studies - Multi-, Inter- and Transdisciplinarity
105	Barbara Nussbaum	2003	Journal Publication	REFLECTIONS
106	MOGOBE B.RAMOSE	2002	Book Chapter	
107	Thaddeus Metz	2015	Encyclopedia Entry	
108	Paula Horta	2017	Journal Publication	Coolabah
109	Blessing Radebe and Moses Phooko	2017	Journal Publication	South African Journal of Philosophy
110	Fainos Mangena	2016	Journal Publication	Journal of Pan African Studies
111	Devi Dee Mucina	2013	Journal Publication	Journal of Pan African Studies
112	Dirk Louw	2010	Conference paper	
113	Kevin G. Behrens	2013	Journal Publication	The South African Journal of Bioethics and Law

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