VIRTUE ETHICS AND THE DUTY OF VERACITY IN PHYSICIAN-PATIENT RELATIONSHIP

BY

Oluwaseun Adeola ADENUGBA
B.A. Philosophy (Ago-Iwoye), M.A. Philosophy (Ibadan),
EMMB (Erasmus Mundus Masters in Bioethics) (Leuven)
125824

Being a thesis submitted to the Department of Philosophy, Faculty of Arts, University of Ibadan in partial fulfillment for the requirements for the award for the degree of

DOCTOR OF PHILOSOPHY

of

The University Of Ibadan,
Ibadan, Nigeria.

October, 2014

ABSTRACT

The duty of veracity or truth-telling, a condition in medical practice which requires that patients be told the truth at all times about their medical diagnosis has generated ethical challenges in modern medical practice. Previous studies have examined the problem of veracity using principle-based ethical theories like deontologism and teleologism. These theories, however, failed to provide a basis for resolving the dilemma of truth-telling because of the conflicting nature of the principles they articulate and their disregard for the character of the moral agent, which, actually, provides the grounding for appropriate action. This study, therefore, proposed virtue ethics as an appropriate theory that provides the basis for mediating in the dilemma of veracity in physician-patient relationship, with a view to showing the crucial role that character plays in medical decision-making.

Aristotle's theory of phronesis, which emphasises the role of practical wisdom that derives from character in decision-making, was adopted as framework. Ten relevant texts in medical and applied ethics, particularly Beauchamp and Childress's *Principle of Biomedical Ethics* (PBE), Gorovitz's *Moral Problems in Medicine* (MPIM) and Drane's *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics* (BGD), and four in traditional ethics, particularly Aristotle's *Nicomachean Ethics* (NE) were purposively selected because they deal extensively with ethics and the issue of veracity in medical practice. Conceptual analysis was used to clarify key concepts like veracity, deontologism and teleologism, while critical method was adopted in examining earlier approaches to the issue of veracity and proposing virtue ethics as the basis for mediating the dilemma of truth-telling in physician-patient relationship.

Most texts on medical and applied ethics revealed a consequentialist position: that a physician has an overriding moral duty to prevent harm, which supercedes the weaker obligation to tell the truth at all times (MPIM and PBE). Texts on traditional ethics revealed that the major approaches to resolving the dilemma of veracity fall under two categories: deontologism which emphasises duty and teleologism which emphasises consequences. These approaches are inadequate because of the rigid and conflicting nature of the principles they advance, and their disregard for the character of the moral agent. Critical interrogation showed that character is essential in physician's relationship with patients as it aids the physician to apply practical wisdom when principles fail (NE and BGD). Consequently, the doctor is bound to higher ideals and virtues such as honesty, compassion, dignity and integrity, and is, therefore, able to go beyond the normal expectations of deontological and teleological principles in his relationship with patients (BGD). Virtue ethics helps in developing good character traits and habits which correspond to the higher ideals and virtues that a physician must necessarily cultivate in order to respond in a morally appropriate manner when faced with the dilemma of veracity or truth-telling.

Virtue ethics promotes good character traits in persons, providing grounds for morally appropriate actions when faced with the dilemma of veracity. Therefore, virtue ethics offers a more pragmatic ethical framework for resolving the dilemma of truth-telling in physician-patient relationship.

Key words: Physician-patient relationship, Principle-based ethical theories, Phronesis, Duty of Veracity, Virtue ethics.

Word count: 497

ACKNOWLEDGMENTS

The unfailing God has proved Himself great in my life. Lord, you have proved to me that with you all things are indeed possible. I thank you for making it possible to complete this programme and for making my dream come true. On numerous occasions I found it hard to move on; but your grace was always sufficient for me. I covet this grace the more in order to be able to render service to you continually.

I want to use this medium to appreciate my thesis Supervisor, Prof. Christopher Agulanna who has played a fatherly role to me throughout the duration of the programme. Prof. sir, you did not only opt to supervise my research, after mentoring me at the Master's degree level, you also introduced me to Prof. Clement Adebamowo of the West African Bioethics Training Programme – an encounter that resulted in my being sent to Europe to study. The encounter also led to my obtaining a Master's degree in Bioethics from three foremost Universities in Europe. Prof. Agulanna, sir, my prayer for you is that the Almighty God will reward you greatly for your good work and labour of love towards me and to many others. Thank you, sir, and God bless you!

I want to also appreciate, in a special way, my late father, Prince Samuel Adegbuyi Adenugba who laid the foundation of my intellectual pursuits and who believed so much in my academic dreams. Dad, I remember how you had to go through emotional trauma over how to raise the funds for this project. You stood behind me like a great pillar; both when it was rosy and when it was rough. Dad, many times I shed tears in my privacy but not everyone will understand why. You missed the interesting parts of my life – my marriage and academic achievements. I need to tell you this dad: though, you are no more, I eventually accomplished the dream. I still love you daddy.

My warm appreciation goes to my mother, who sat and watched my infant head. Mummy, thank you for your love and care towards me. Thank you also for taking care of EriOluwa in the course of this project. Thank you for keeping several vigils with me over IreOluwa. Thank you for your patience, endurance, prayers and sacrifices. 'Mummy mi', I love you so much. May God grant you more wonderful years in good health.

Prof Clement Adebamowo, I must say a very big 'Thank you' for granting me the rare privilege to undergo thorough training at the West Africa Centre for Bioethics at Basorun. You were the vessel God used for me to study at three consortium Universities in Europe in order to obtain a master degree in Bioethics. Thank you, sir.

I seize this opportunity to appreciate profoundly my lecturers at the University of Ibadan. I am grateful to Late Professors Olusegun Oladipo and Kolawole Owolabi – two wonderful human beings – heroes, who departed this world when the Ivory Tower needed them most. Your charisma, character and willingness to work have thus far kept people like me moving. May your gentle souls continue to rest in perfect peace. My gratitude goes to all the other lecturers in the Department of Philosophy, University of Ibadan such as Prof. Dipo Irele who availed me with some of his materials; Prof. Bola Ekanola, who always listened to me each time I needed him to; Dr. Adesina Afolayan who was always eager to help me and who read through the pages of this work; and Dr. Offor, who made great sacrifices for me. Dr. Offor, sir, I do not know how to thank you enough. You were God-sent, a man of honour and high integrity. May God reward your good works. My love goes to Dr. (Mrs) Lanre-Abbas for making me feel at home each time I came around. I say a big thank you to Dr. Ukpokolo for his kindness and love. You are loved, sir. A big 'Thank you' to Dr. Adegbindin, Mrs Ipadeola, Mr. Lawal and Mr. Layode for their kindness and love.

My journey as an academic started from Olabisi Onabanjo University where I was taught the foundation to Philosophy. To Profs. Ayo Fadahunsi, Ade Ali and Balogun, I say a big thank you to you all. Special appreciation goes to Prof. Balogun who kept asking me about the progress I was making in my research work. My love to Dr. Jide Dasaolu and Dr. Adefarasin: your support was great. Dr. Aina, you are awesome, Dr. Adegboyega, Dr. Onwuegbusi and Tolu Ajayi. Big thank you to Dr. Precious, Dele Idowu, Oyenuga, Surakat, Sammy and Funmi Ali.

A special column is intentionally reserved for you, mother, mentor, lecturer and friend, Prof. (Mrs.) Ebunoluwa Olufemi Oduwole. I call you *mother* because you are like, and even more than, a mother to me. You provided me with a good atmosphere to develop

in. You are my mentor because I followed your footstep. You are my friend because I could freely talk to you. This space is not enough to tell of your positive impacts and the roles you played in my life. I pray that the Great Rewarder will bless all that is yours. Prof. Mrs. Ebunoluwa Olufemi Oduwole, I love you dearly, ma.

My heart rejoices each time I reflect on the journey and the support received from my wonderful siblings. Late Adeshina Adebola Adenugba, it is so painful that you left so soon. Adebowale Adenugba, Adetola Adenugba, Adetokunbo Onilede, Ayodele Adenugba, Adeyemi Oluwafunmilayo Oyesile, thank you for everything. Sister Funmi, I cannot forget the sleepless night you did for me at OOU and my kid sister Tolulope Tanimowo. Tolu, thank you especially for the calls, encouragements, prayers and your time to keep EriOluwa for me when grandma was not around. I remembered the meals you rushed to prepare to ensure I travelled to UI with a flask of food. Also, worthy of appreciation are my in-laws and the entire Anifowoses, Oluwasanwo Ayokunle, Seun Tanimowo; you are all loved. Ademola Adenugba and Oluwatunmise Tanimowo, you are recognized. To all my friends and well-wishers, I say a big 'Thank you.'

Over the years, I have come to realize that God's ways are not our ways. Though, there might have been some delay, I can unapologetically affirm that God intentionally made it possible for me to be a complete and a fulfilled woman. With you 'Baby mi'; Oluwaseun Adeola Abiodun Anifowose on my side today, I am complete. With all sense of humility, I say 'thank you' to my soul mate, friend, father, mentor, editor, confidant, and, of course, my crowned husband for the patience. Many times we have had to keep vigils for proper editing and suggestions, especially those related to the medical aspect of this work. Thank you, my soul, for your efforts, endurance and understanding. I remember my husband will say, 'Do not worry about my food; just go and continue with your research.' I love you!

And finally to my God-given gifts, EriOluwa and IreOluwa, I say a big 'Thank you', with lots of wonderful hugs and kisses. EriOluwa, many times I had to take the risk of travelling with you when you were still small. And when you were one year old, I left you at home severally and returned late at night. Ireoluwa, yes you are God's goodness.

You came to the family and God's goodness came in with you. I love you two. May the Almighty God keep you both safe.

I am alive today because God made it possible. I return all glory to Him for keeping me to the end of this programme. On my knees to Jehovah Shiloh, singing:

Almighty Father, thank you
I have nothing to give you than to say, Thank you, Lord,
Almighty Father, thank you.

DEDICATION

This work is dedicated to the most high God, the giver and the owner of my soul who gave me the enablement to be what I am today.

It also dedicated to the memory of my late father Prince Samuel Adegbuyi Adenugba who waited patiently to see but could not see this glorious event of my life.

and

To my husband, Dr. Oluwaseun Adeola Anifowose and our daughters EriOluwa and IreOluwa Anifowose.

CERTIFICATION

This is to certify that this thesis, titled "Virtue Ethics and the Duty of Veracity in Physician-Patient Relationship" was carried out under my supervision by Oluwaseun Adeola, ADENUGBA.

…….. ……

Date Supervisor

Christopher O. Agulanna, PhD
Professor of Ethics and Social Philosophy
Department of Philosophy,
University of Ibadan,
Ibadan, Nigeria.

TABLE OF CONTENTS

CHAPTER THREE: PRINCIPLISM AND THE CHALLENGE OF VERACITY

CHAPTER FOUR: THE IDEA OF VIRTUE ETHICS

CHAPTER FIVE: VIRTUE ETHICS AND VERACITY IN HIV/ AIDS AND ONCOLOGY CASES

INTRODUCTION

The service of truth is the hardest service (F. Nietzsche)

There have been notable advancements and breath-taking innovations in the field of medicine and biotechnology in the last few decades. These advancements and innovations have continued to generate new ethical challenges in contemporary times. To a great extent, biotechnology has effectively addressed many issues relating to health and our environment such as the development of contraceptives, prenatal testing and reproductive technologies. It has also liberated human beings from many forms of ignorance. Although, it can be said that the unquantifiable advancement in Biotechnology and the knowledge of our medical situations have awakened and liberated us from the spirit of dogmatism, yet, we are confronted with new challenges which relates to the ethical concerns of these technologies. Ethical concerns in Reproductive technology, abortion, and currently, highly predictive prenatal tests that could reveal both the gender and other personal qualities of the unborn child are some of the front-burning issues in Bioethics today. These pressing issues call for increased need for ethics to help curb the excesses of scientific developments and specifically, those bordering on medical practice.

Furthermore, contemporary ethical thinking has moved beyond the question of right and wrong of everyday interpersonal relations to investigate professional conduct; including the field of medicine. Ethical theorizing in this area is called Bioethics. Bioethics seeks to elaborate strategies to check the poorly-regulated advancements in the field of medicine, and to safeguard medicine as a human enterprise. Bioethicists have continued to challenge issues that concern the value of human life, animals and the environment. Peter Singer is one of the scholars with a strong opinion that caution should be taken in dealing with issues that concern life and our immediate environment.[1]

The field of bioethics is very vital to every aspect of biotechnology as it deals with a wide range of issues such as veracity, informed consent, decision making in health care

practices, confidentiality, personhood and the problem of rationing in the Hospital. These problems constitute serious dilemmas to health care-givers. Of the issues mentioned above, the moral dilemma posed by truth-telling (veracity) in physician-patient relationship is one of the most crucial, and also a critical thrust of this study. It is important to state here that veracity and truth-telling would be used interchangeably in this study.

If indeed, the service of truth is the hardest service, let alone in the field of Clinical practice.

Our ordinary moral norms require that we are veracious in our dealings and relationship with people in all situations. Our failure to do this is seen as a vice. In medicine, the concept of veracity is a more complex one because it goes beyond the ordinary requirement of truth telling in the society. The question "should doctors tell the truth?" is one of the most difficult questions that confront the physician because truth telling is central to clinical practice and more specifically in physician-patient relationship. In daily clinical practice, the physician is expected to divulge the truth to the patient after medical investigation. It is also expected that the patient says the truth to the physician because acquisition of truth from the patient on the part of the physician assist in the process of diagnosis and for decision making on treatment options on the part of the patient. This has in turn led to a greater quest for trust between physicians and patient. One major problem however, with truth telling in clinical practice is how to divulge the truth in critical and terminal medical situations. Dilemma of truth-telling in clinical practice often hangs on the moral conflict between the patient's right to know the truth and the patient's welfare if the truth cannot be handled. Truth telling can be difficult in practice because of medical uncertainty and the concern that bad news might harm the patient. It can also be difficult when medical errors occur and when the patient's family or the patient in question is opposed to truth telling.

Previous studies have examined the problem of veracity using principle-based ethical theories like deontologism and teleologism. These theories however failed to provide a basis for resolving the dilemma of veracity because of the conflicting nature of the

principles they articulate and their disregard for the character of the moral agent. These existing approaches include biomedical principles (principlism) which include the principle of respect for autonomy, beneficence, non- maleficence and justice. There are many situation in which the principle of respect for autonomy conflict with the principle of beneficence, beneficence with non-maleficence and non-maleficence with justice. If this is the case, then the principle of biomedical ethics cannot therefore, be said to address the complex moral problem of truth telling in clinical practice since it is full of contradictions and generates more complex problems. Deontological ethical theory claims that one of our *prima facie* duties as moral agents is to tell the truth. Because of the emphasis on duty, it may be argued that we may not be able to solve complex problems such as truth telling in medical practice with such rigid principles. So also, is utilitarianism which emphasizes happiness for the greatest number of people. Departure from truth telling is seen as justified if there is the predominance of its good consequences over bad ones. This can be criticized on the ground that it does not put into consideration individual uniqueness. The limitation of the above mentioned earlier approaches to truth telling prompt us to look out for an alternative approach that can assist in addressing the problems of truth telling in clinical practice. This alternative approach is referred to as the virtue ethics based approach. It is a more flexible approach because it puts into consideration the following three parameters that this essay will adopt as an attempt to address the problems generated by truth telling. These parameters are: the moral agent, internal goal of medical practice and role of the community in ethical thinking. This essay is aware of some criticisms leveled against virtue ethics. One of such is that it is not helpful in complex situation where there are competing virtues, for example, when the virtue of compassion conflict with the virtue of truthfulness. Critique of virtue ethics has forgotten that virtue ethics recognizes the potentiality of such conflict. “Phronesis” is a way out of such, which is practical wisdom. Phronesis will be applied in situation of conflicting virtues. Virtue ethics is recognized as offering a coherent and plausible alternative to the mainstream approaches which are consequentialist (Utilitarian) and Kantian approaches (Deontology) and also principlism. Virtue ethics, this paper argues goes a long way in approaching truth in our clinical context (Nigeria).

The issue of truth telling is very important in bioethics particularly, in clinical practice, the same way informed consent and confidentiality are important to health care practice. Health care goes beyond treatment and care for the sick. It is entrusting a life in the hand of a care-giver. According to Roger Higgs, "if you trust someone to care for you; it implies you do not expect lies from someone you entrust your life with".[2]

Communication is vital in care-giving and receiving, and here is where truth telling plays an important role. Caring is not only by providing care to the care receiver but it also involves the act of information giving. By information we mean how and when to divulge the truth and present medical diagnosis and prognosis about the patient's health situation. Just as it is expected of a care giver to provide information on diagnosis and prognosis to the care receiver, it is also expected that the care receiver should provide the caregiver information that will help in the process of diagnosis. Though, care givers are motivated to help those in need but the vulnerability of the sick often makes him/her to be at the mercy of the care giver. Consequently, the care-giver develops a relationship with the care receiver by sympathizing with their condition. It is however, important not to confuse emotional attachment with caring because caring does not consist of emotions, to act based on emotions is not to act in caring manner.[3]Emotional attachment does not allow for objective judgment of specific situation. Often time, the judgment based on emotions is tinted with a biased mind because of some feelings which are not meant to be present in the analysis of medical situations.

Many health care givers acknowledge the need for truth telling yet deception still exists in daily clinical practices. The problem of truth telling revolves around the patient's right to information as against the physician's responsibility to protect the patient from potential harmful effects of receiving this information.[4]There is no doubt that the failure to divulge the truth leaves them in the dark and this necessarily forecloses the care-receiver the ability to make an informed decision about issues related to their health.[5]

Truth telling in clinical practice is important for the following reasons: it makes informed consent possible. While truth telling has to do with giving factual information to patient i.e. truth that is totally void of deception, informed consent on the other hand

has to do with giving information to enable the patient in question make an informed decision. The decision made in this kind of situation gives the opportunity to consent freely to one of various treatment options available. Moreover, the patient will be able to live with the awareness of the diagnosis, the possible treatment options and the possible outcomes.[6] Often time, patient acts in such a way that is harmful to their health just because they do not have accurate information related to their health that may assist in making practical and right decision health-wise.

Secondly, telling the truth will not only make informed decision possible but also make room for physician to respect the autonomy of patient. It allows the patient to obtain information that enables them to learn about their current health status, make informed consent and actively participate in the planning and execution of treatment .[7] This will also help to foster the acceptance of the reality of a patient's health situation not only by the patient in question but the patient`s relatives as well

Lastly, the patient has a right to know about their health and these rights are meant to be protected and respected. Telling the truth can defuse resentment on the part of the patient and reduce the risk of legal action.[8] It is evident that people sometimes sue physician out of a need for explanation to know how the injury happened and why.[9] Physician-patient relationship is a very sensitive aspect of health care practice because of the dilemma this area present to practitioners on everyday basis. Since it is rightly taken that there is a right to know and there is a duty not to inflict pain on patient by avoiding harming them, then what is the likely way out? The significance of truth telling discussed above is the reason why this research is out to look for an approach that will go a long way to resolving the dilemma around truth telling.

Generally, people seek for truth and hold the belief that one should tell the truth. Therefore, the need to divulge the truth should occupy the mind of care-giver at every point in time. On the part of the care giver, giving information is a duty s/he has towards the patient while it is the right of the patient to receive information on his/her health situation from the care-giver i.e. a right to know and be informed about his/ her medical situation. The extent to which the care giver should divulge the whole truth also

constitutes a disturbing problem in real clinical situation. One may be tempted to argue that in order to give proper health care service, untruth may be necessary. This is because of the belief that truth may at times endanger the life of the care-receiver. It is worth noting that physician/patient relationship has shifted radically from paternalism where the physician is said to know what is best for the patient without involving the patient in the process of decision making about his life to a more participatory model.

The problem with truth telling further strengthens the need to deal very carefully with issues of decision making about human being and their lives. Nevertheless, truth telling generates a lot of dilemmas in all areas of clinical practices with particular reference to the area in which the patient is more vulnerable like oncological clinical context (i.e. cancer-related issues) and the context in which truth telling conflicts with confidentiality such as the context of HIV. Most oncologists see truth telling as something that can shatter their patient's hope. In this case, it is believed that withholding the truth in cancer related cases is justifiable. This is because of the underlying assumption that cancer denotes death, therefore, patient should be protected from this despair.[10]Truth telling then constitutes an issue that attracts the attention of bioethicist because of the problems it generates in practice.

There is no way we can discuss truth telling without making mention of the role of confidentiality. The same way physician and patient are expected to tell the truth to help in diagnosis and decision making so is confidentiality vital. The issue of confidentiality then also presents serious problems to medical practices. Medical confidentiality is an important feature of doctor-patient relationship. In general term, medical confidentiality is non- disclosure of information given to the doctor by the patient that the patient does not wish to disclose to the third party without his consent or permission.[11] As the doctor respects confidential information given by the patient, autonomy/self determination is enhanced. Enhancing the individual autonomy is important to the lives of human beings. Here, two conflicting autonomy can be identified, autonomy of the physician and autonomy of the patient. The doctor as an autonomous person may not feel comfortable in the non-disclosure of such a vital information that is closely attached with life. Disclosure of such information may help in making a long lasting decision in

the case of HIV even while he knew the likely advantage the patient may benefit by not telling and respecting the autonomy of the patient in question.

The thesis states virtue ethics approach is more adequate because it overcome the contradictions in principlism and the problems confronted with the use of ethical theories such as deontology and utilitarianism. The presence of "*phronesis*" i.e. the use of practical wisdom in virtue ethics places virtue ethics above other principles. This evident contradiction in principles and limitation in ethical theories strengthen the need for virtue ethics approach. The principle based ethics and some ethical theories such as deontology and consequentialism cannot address the complex moral problems inherent in truth telling in clinical practice. Principle based ethics i.e. the principle of respect for autonomy, beneficence, non-maleficence and justice present a lot of contradictions. For example, autonomy conflict with beneficence, non-maleficence with autonomy, and autonomy in conflict with justice. Deontology as an ethical theory is said to be too rigid while utilitarianism does not acknowledge the uniqueness of an individual. This obvious fact presents the serious need for an approach that avoids the problems presented by existing approaches.

This study is directed to an evaluation of the duty of veracity in clinical practice. It intends to show the contributions of virtue ethics approach to truth telling in concrete clinical practice. The objective of this research is to examine the duty of veracity in clinical practice using the virtue ethics approach, to identify the typical ethical problems/dilemmas posed by the question of veracity in clinical practice and to highlight the contribution of the virtue ethics approach to the analysis and the solution of the above-mentioned problems/dilemmas (using the following parameters: attitudes of moral agent, internal goals of medical practice and role of the community)

Bioethics is a field that is of great significance to human life because it delves into the ethics of medical practices. Truth telling as an issue in clinical practice generates problems that require our immediate attention. This is of course the reason why this

research points out the problems inherent in truth telling and discusses the efforts made to address the complexities

This research work contributes to the on-going discussion on veracity in clinical practices specifically to veracity in dealing with HIV/ AIDs patient and cancer cases. How to divulge the truth in the HIV and oncological situations has been and still remain a difficult problem to approach in clinical practice. This research also helps to further strengthen the importance and values of truth telling in clinical practice. It endeavors to use a different approach by adopting the virtue ethics based approach. This approach captured the whole of virtue ethics because it examines the following parameters: attitudes of moral agent, internal goals of medical practice and role of the community).This is a challenging approach yet its contribution to truth telling is immeasurable. It also shows the limitation of principle based ethics and ethical theories in evaluating truth telling.

Chapter one of this work discuss the notion of veracity in clinical practice. Attempt is made at giving an explicit general perception of truth telling and the role of veracity in clinical practice. In our general overview of the notion of truth, emphasis will however not be placed on truth as an epistemic category; rather, the social dimension of truth is discussed from the various enlightened perspectives in the society such as the family, religion, workplace and finally in clinical practice. It is noteworthy that in this work, the notions of veracity are used interchangeably or as synonyms.

Following our critical exposition of the nature of veracity and its different facets as well as its complexities in clinical health care delivery in the preceding chapter, our discussion in chapter two is to examine the various ethical theories relevant in the analysis and understanding of veracity in clinical practices. In these wise, traditional ethical theories; such as consequentialism, deontology and situation ethics shall engage our attention in this chapter. Deontologism and consequentialism are held as opposing ethical standpoint as far as scholars have argued that the former crest moral rightness and wrongness of actions on the nature of duty, the latter on the consequences or outcome of actions. However, there have been sheaves of interpretations as to whether

the two theories are incompatible extremes that evaluate morality on the basis of distinction between agent-relative and agent-neutral based actions.

Further debates on this has led to other viewpoints that reduce one theory to other and led to diverse typification that seems to hold contrary to the general evaluation of morality (as given by the two theories). The attempt here is not to regurgitate the diverse stances regarding the two ethical theories, rather to basically engage the various shortcomings of these theories in addressing the dilemma around veracity in clinical practice and to also evaluate the extent of their tenacity.

Chapter three look at the four principles of biomedical practice as propounded by Beauchamp and Childress. These principles shall also be applied to the notion of veracity in clinical practice. This is important in order to reveal the inadequacies/ weaknesses of these theories. The focus of chapter four of this essay was a shift from this, to the mainstream of an alternative approach. Virtue ethics exhibits a unique approach. This chapter hence would be devoted to the justification of the uniqueness of Virtue Ethics, and this would be done by critically navigating through its definition, tenets/principles, criticisms and its suitability for contemporary existence.

This chapter is devoted to the justification of the uniqueness of Virtue Ethics, and this would be done by critically navigating through its definition, tenets/principles, criticisms and its suitability for contemporary existence. It shall discuss in an analytic manner the details of virtue ethics theory. It will state the contributions of virtue ethics to the analysis of truth telling and provide us with reasons why it is a better approach in the analysis of truth telling. This chapter will discuss the views of philosophers like Aristotle and delve into the work of Alasdair MacIntyre.

Chapter (five) is poised at an analysis and application of virtue ethics to an HIV and oncological cases. What should be done when an autonomous patient simply confides in a physician that he/she does not want the third party to know about his/her HIV status? Or he/she does not want to know when tested positive? One important duty to note in

clinical practices is the duty of confidentiality. To what extent should this be respected in situation like this? Should the physician respect the wish of the patient as indicated or keep confidential issues strictly confidential?

Questions such as this; shows that the problem with truth telling still remains a disturbing issue in clinical practices. It is not in my intention to solve the problem, but to contribute to the on-going discussion on truth telling and provide suitable approach to addressing the dilemma of truth telling in clinical practice. It is clear from the literature that most of the approaches to truth telling are principle based and these approaches could not properly handle the complex moral problems embedded in truth telling.

This is my motivation for proposing virtue ethics as a better approach to addressing this problem. I am very much aware that virtue ethics approach cannot solve all the problems associated with truth telling, but, it can give an important contribution to this moral difficulties posed by truth telling in physician-patient relationship.

END NOTES

[1]Singer, P. 1990. *Animal liberation*. New York: Random House. 62.

[2]Kuhse, H and Singer, P. 2001. *A companion to bioethics*. U.S.A: Blackwell Publishing Ltd. 11.

[3]Hooft, V. 1999. Acting from the virtue of caring. in *Nursing Ethics*, 6:192-193.

[4]Kelly, K. 1987. AIDS and ethics: an overview. *General Hospital Psychiatry*. 9: 331-340.

[5]Phillip, C. H. 1994. Truth telling in clinical practices. *Canadian Family Physician*. 40: 225-228.

[6]Marzanski, M. 2000. Would you like to know what is wrong with you? on telling the truth to patients with dementia. *Medical Ethics*. 26:108-113.

[7]Carlos, H. 2003. Not telling the truth in the patient-physician relationship, *Bioethics ISSN*. 17: 5-6.

[8]Ritchie, S. D. 1995. Professional negligence: a duty of candid disclosure?. *BMJ*. 310:888-9.

[9]Vincent, C., Young, M., and Phillips, A. 1992. Why do people sue doctors? a study of patient relationship. *JAMA*. 153:572-576.

[10]Asai, A. 1998. A patient with HIV. *Eubios Journal of Asian and International Bioethics*. 8: 15-18.

[11]Dunbar, S and Rehm, S. 1992. On visibility: AIDS, deception by patients, and the responsibility of the doctor, *Journal of Medical Ethics*. 18(4): 180-185.

CHAPTER ONE

THE DUTY OF VERACITY IN PHYSICIAN-PATIENT RELATIONSHIP

Introduction

The aim of this chapter is to discuss the notion of veracity in physician-patient relationship. Attempt is made at giving an explicit general perception of truth-telling and the role of veracity in clinical practice. In our general overview of the notion of truth, emphasis will however not be placed on truth as an epistemic category; rather, the social dimension of truth is discussed from the various enlightened perspectives in the society such as the family, religion, workplace and finally in clinical practice. It is noteworthy that in this work, the notions of veracity are used interchangeably or as synonyms with truth-telling.

On The Idea of Veracity

Veracity is defined as the unwillingness to tell lies or the quality of being true; that is, the habit of telling the truth.[1] It is a latent quality in human beings, that entails the habitual regard for speaking the truth irrespective of the circumstance that an individual finds him or herself. The human disposition of being characterized with truthfulness is core to the idea of veracity. Though, in reference to non- human norms, the word veracity is equally used to refer to correctness or accuracy, for instance, in the sense of scientific instrument or for something to be in accuracy with fact. However, our understanding of the word veracity in this work is in the sense of habitual human observance of truth, whether at the level of speech, statement, acts or relation towards others.

The idea of veracity, therefore, necessarily entails the notion of truthfulness. Despite the fact that, there is the tendency of reducing the whole discourse on veracity to that of truth; yet, caution need be taken to avoid some possible misconceptions. 'Truth' is a much debated concept in the history of philosophy, especially among epistemologists

and philosophers of language, who at various periods came up with different theories of truth: correspondence, coherence, pragmatic, semantic, among other.[2] Nevertheless, in the discussion of the idea of veracity, the focus is not so much about 'truth' as an epistemic category; rather, we are concerned with "truth" as essentially a moral category having much to do with the capacity, necessity and implications of 'truthfulness'. Whereas, the interest of epistemologists or philosophers of language interrogating the idea of "truth" revolves around fundamental questions such as: what does it mean to say that something is true?, the concern of the ethicist in this regard is to ask: do humans have duties and responsibility for acting truthfully, and telling the truth habitually?

At this point in the discussion, it is imperative to give a background idea on how people view truth telling in the society. Questions of truth pervade all human communication. They are questions that are raised in the family, religious settings, in our work places and of course, constitute an important question in doctor-patient relationship. We shall begin this discussion by looking at the idea of veracity from the family level as a unit of society since truth telling has to do with at least two or more persons.

In families, veracity is usually viewed as a good practice. Parents generally emphasize the importance of being veracious to their wards. They underscore this importance by rewarding truth-telling and reprimanding lies. They often encourage their children to keep away from others who are known to be deceitful and untruthful. Parents at times go to the extent of either reducing or even rescinding the prescribed punishment if truth has been told. Despite all efforts to encourage truth-telling in children, parents are often confronted with a dilemma on what to do about some situations in which truth-telling promises more ills than good. For example, when telling the truth will endanger a life. Therefore, some children from their formative years are inevitably trained to be careful about truth-telling.

These children grow into the wider world with a mind-set, often strengthened by the larger society on the need to be selective on truth-telling. The criterion for the selectivity is however to be determined by the individual based on his or her experience,

values, religious inclination and sometimes what immediately seems to appeal to the hearer's emotion. The attitude of non-willingness to tell the truth is a deep-seated mindset found in almost every individual in diverse sphere of human endeavour. While truth telling is generally perceived as a good virtue, it is usually well-known that truth-telling sometimes precipitates avoidable problems/ challenges.

There are also religious reasons for truth-telling. There are people who argue that truth is a moral/religion imperative. According to this line of argument, to withhold the truth is sinful as well as harmful and impractical.[3] The belief here is that truth helps an individual with his business before God and help him make peace with God. Refusal to speak the truth deprives an individual the avenue to make such peace with God. It is also believed that various religions promote virtue, which is often said to be pivotal to their beliefs and teachings. Christianity, for example, is believed to focus on its adherents and by all purpose and intent, all people irrespective of their faith should be truthful. Truth-telling, therefore, is supposed to be the hallmark of all who practice the religion. The Bible describes God as Truthful and his followers are encouraged to practice the act of truth-telling. Whether this encourages veracity at all times is subject to divergent views.

While some religious people believe that truth should be told at all times, others argue that telling the truth should only be for good purposes. In situation where truth-telling leads to hardship and pain, many people withhold the truth and lies are also avoided at the same time. They therefore canvass for silence to allow people make their assumptions. Among Muslims, the inclination to veracity is believed to be similar to that of Christians. When talking about African Religions, (Christianity, Islam, Traditional religions) care must be taken and ambiguity avoided as much as possible. This is because there are different kinds of religions and religious groups in Africa. Truth-telling is highly regarded among Africans as an attribute of good behaviour. Among the Yoruba people of Nigeria, truth-telling is regarded as the ultimate good and as a moral virtue.[4] It is highly encouraged and extolled among them. The following Yoruba proverbs are used to buttress this point.

1. Otito ni t’o ni l aye

   Meaning: Truth makes one live long. [5]

2 S’otito se rere

   S’otito se rere

   Eni s’otito n’imale gbe . [6]

   Meaning: Be fruitful, do good

   Be truthful, do good

   The divinity supports he who is truthful

The foregoing proverbs give credence to truth-telling because it shows that telling the truth attracts good.

It is however paradoxical to note that while majority of the Yorubas believe that being truthful should be encouraged; there are a number of Yoruba proverbs that suggests caution when dispensing the truth. Being veracious sometimes attract severe penalties such as physical injury or even death. The Yoruba proverbs below show some situations in which truth telling may not be encouraged or when it should be dispensed with great caution.

1. Aye k’ooto

Meaning: “The world rejects truth/ truth- telling”. [7]

2. Olooto kii leni.

Meaning: A truthful person doesn't have property. [8]

3. Olooto ilu osika ilu

Meaning: A truthful person is the enemy of the land. [9]

The above proverbs point to the fact that while truth may be good, it can also bring unpalatable outcomes, especially to the veracious person.

In work places and other human endeavour, truth-telling is an extolled virtue. This is because every employer knows that the success of his or her business, to a good degree, depends on loyalty of the employee and their willingness to always tell the truth. While truth-telling is seen as a virtue by many, others believe that the truth should not be told at all times and in all situations. A Jewish proverb says truth is heavy and only few men would carry it. Indeed, sometimes, telling the truth is believed to have caused more havoc in some situations than outright avoidance of truth or even telling lies. Among the self- employed and artisans, truth-telling is seen as a veritable criterion if one is to either engage them or not. The idea of truth-telling is of no less importance in clinical practice.

The Idea of Veracity in Physician-Patient Relationship

Having discussed the notion of veracity in the family, society, religious setting and in our work places, it is therefore important at this juncture to discuss the notion of veracity in clinical context which is the core of this chapter. For the purpose of this study, therefore, our searchlight is beamed on the concept of truth telling in clinical practice by proffering answers to these questions: Does a care-giver has a duty to tell the truth to the care receiver? Are there possible justifiable grounds in which the care – giver should be non - veracious to the care-receiver?

Issues of veracity in a doctor-patient relationship are not as simple as some think. It is an issue that poses a lot of dilemma most especially to the physician who is to tell the truth to the patient. A cursory review of literatures on this subject reveals that statement about veracity is not as clear cut as many would have it in the history of medical ethics. It is very clear from history that a physician should make efforts not to harm the patient. It can therefore be deduced that the core duty of the physician is to do no harm. However, within the scope of medical ethics, the subject of truth-telling to the patient has undergone some important changes in clinical practice. Issues such as the right to know the truth, informed consent, confidentiality and the likes in the field of medical ethics has contributed to the changes that have been experienced in health care services in general and in physician attitudes. This change has, however, been overshadowed by the problems encountered in the presentation of diagnosis to the patient.

In modern medicine, we discovered that patients do not really appreciate the old father to son relationship of the father claiming to know more than the son. Even with these changes, it is however still difficult to shift entirely from a paternalistic model of patient treatment to the now preferred participatory model. The reason is because some patients still see their physician as a semi-god who knows what is best for them. Development in medicine opens up a lot of ethical questions in a doctor- patient relationship which gave rise to the emphasis laid on honesty in the medical Ethics of the American Medical Association. The principle of Medical Ethics of the American Medical Association in 1980 state thus:

> A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.[10]

To a lay man, it will appear strange that telling the truth will constitute an important issue among physicians or even generate debate in medical circles. The reason is that physicians are usually seen as people of honour and nobility. Truth-telling among supposedly “noble” people is something usually taken for granted. In government or in the society as a whole, the doctor’s word is usually regarded as something credible or

reliable, such as certificate of medical fitness, excuse from duty, or medical report are usually honoured without much queries. Veracity is a given factor in social intercourse. Social intercourse and conversation become valueless when truth is not in place. By implication, physician-patient relationship is not complete without truth because deception makes it impossible for patient to have the truthful information about their health condition.

Developments in medical science and technology have made it possible for medical practitioners to accurately arrive at diagnose of ailment and diseases with the aid of more advanced equipment. With advances in medicine, came the ability by physicians to cure many seemly incurable diseases. Doctors are also able to eradicate or ameliorate their patients' sufferings. These advancements place the care-giver at the center of decision making whether to present the diagnosis of the patient before him or her even if the medical report is bad. The big question, then, is: should the physician always tell the truth to the patient no matter how bad the patient's condition is? Truth- telling is an important issue in bioethics particularly in clinical matters. Like informed consent and confidentiality, truth-telling is also important to health-care practice.

Modern Health care goes beyond treatment and care for the sick. It involves entrusting a life in the hand of a doctor. In the word of Roger Higgs, "if you trust someone to care for you; it implies you do not expect lies from someone you entrust your life with."[11] Truth-telling plays an important role in the process of care. Caring does not end when we give support to the care receiver. It involves as well, the giving of information. By information, we mean letting the patients know the true state of their health; presenting medical diagnosis and prognosis about their health situation. Just as the care-giver is expected to provide information on diagnosis and prognosis to the care receiver, it is also expected that the latter would provide the information that will help the doctor in the process of diagnosis.

This represents a very difficult task to care-givers. Care-givers are often motivated by the need to provide help. Sick people are no doubt, often vulnerable. This makes them to be at the mercy of care-givers. Consequently, the care-giver develops a relationship

with the care receiver and sympathizes with the condition. Emotional attachment should not be confused with caring, since to act with emotions may not constitute caring in the true sense of the word.[12] Many times, emotional attachment may not allow for objective judgment of specific situation. Similarly, judgments based on emotions may sometimes be tinted with bias thereby hindering one from arriving at the correct assessment of the situation.

Truth-telling in clinical practice is a two sided process that involves not only the doctor giving information to the patient, but also, the patient giving information to the doctor. Dissemination of truth to the patient is a basic premise of a therapeutic relationship in caregiving. This process can only be complete and useful when patients reciprocate by telling the truth to the doctor. Correct information on the part of the patients helps in the process of disease diagnosis while truth by the doctor helps to make reasoned decision about his or her health. From a bioethical perspective, the duty of veracity is understood as flowing from the obligation of fidelity and promise keeping. Once patient-physician relationship is initiated, the parties are believed to have entered a contract where the patient gains a right to the truth from the care-giver as regarding his or her diagnosis, prognosis, and procedures. For an effective management of the care-receiver, disclosure of information to the care-giver is also vital. This process does not go smoothly as it may seem; in that communication of patient' diagnosis to the patient may be essential to the process of therapy but sometimes, such information can be harmful.

When a physician fails to tell the patient the truth about his or her condition or the potential risks and benefits, the care-giver can be accused of making a unilateral decision about the patient's welfare. In other words, he denies the care-receiver the opportunity to exercise his or her autonomy. Controversies linger around the issue of veracity especially when we are presented with competing moral imperatives which leave us with the dilemma of what takes precedence over the other, for example, the duty to do good and to avoid harm. The question then: "should doctors always tell the truth" is one of the most difficult questions that confront the physician. There remains a lingering controversy as regards whether to habitually tell the truth as an ethically sound principle or not, with truth taken as sacrosanct or fundamental in any relationship and

more significantly in the management of a patient since human life is involved. Truth telling in clinical practice is important for the following reasons:

Firstly, truth-telling makes informed consent possible. While truth-telling has to do with giving factual information to patient that is information that is devoid of deception, informed consent on the other hand, has to do with giving correct information to patients to make an informed decision. The decision made in this kind of situation is well-informed and will help one choose between alternatives. Moreover, patients would live with the awareness of the diagnosis, the possible therapy options as well as new perspectives that the future presents.[13] Sometimes, patients act in ways that are harmful to their health because they do not have accurate information regarding their health that would have assisted them in making wise decision concerning their health.

Secondly, telling the truth will not only make informed decision possible, but also, make the physician to respect patients' autonomy. It allows the patient to obtain information that enables them to learn about their current health status.[14] Lying, on the other hand, will not allow for good decision about one's health. Non-disclosure of truth is a sign of disrespect for persons and their autonomy, violating implicit contracts and threatening relationships based on trust.[15] Not only does veracity foster trust; patients feel that trust is misplaced if they perceive lack of honesty by the physician. In the provision of truthful information or distortion of truth to care receiver, what is withheld or provided has a great effect on the wellbeing of the patient. Truth-telling goes a long way in assisting the care receiver in making a firm decision either negatively or positively. This will also foster the acceptance of the reality of a patient's health situation, if he or she survives would also learn to live by it. The importance of truth telling in the clinical situation is that it gives room for patients to participate not only in decision making process but also in the process of care. Lastly, patients have the right to know about their health, which should both be protected and respected. Telling the truth can defuse resentment on the part of the patient and reduce the risk of legal action.[16] It is evident that people sometimes sue physicians out of a need for explanation on how an injury happened and why.[17]

Advancement in medical practice has led to a shift from the question: "should doctors always tell the truth?" to the question: "how should the truth be told?" This is the case especially in critical medical situations. Major problem of truth-telling according to Friesen and Kelly is that it often hangs on the moral conflict between the patient's right to know the truth and the patient's welfare if the truth cannot be properly handled.[18] The moral conflict here is between the physician's duty to tell and consequences of such disclosure on the patient's welfare. Truth-telling can be difficult in practice because of medical uncertainty and the concern that bad news might harm the patient. It can also be difficult when medical error occurs and when the patient's family or the patient in question is opposed to this particular truth. What is in issue is the duty of beneficence versus non-maleficence. By this its meant that truth-telling may not always be beneficial to the welfare of the patient, as it and may sometimes lead to further harm to the patient.

Many health care-givers acknowledge the need for truth-telling, yet avoidance of truth still exists in daily clinical practice. The problem of truth telling revolves around the patient's right to information versus the physician's responsibility to protect the patient from potential harmful effects of receiving certain information.[19] Without doubt the failure to divulge the truth leaves patient in the dark and this necessarily forecloses the care-receiver's ability to make an informed decision about issues related to their health.[20] Physician-patient relationship is a very sensitive aspect of health care delivery because of the dilemma that this area presents to practitioners on every day basis. Since it is rightly taken that there is a right to know, there is a duty not to inflict pain on patient by avoiding harming them and also the right not to know. What then, is the likely way out? A clear- cut answer to this question would provide us with an approach to resolving the dilemma around truth telling.

Generally speaking, people seek for truth and expect that the truth should be told to them. Consequently, divulging the truth should be the concern of care-givers at all times. Care-givers owe it as a duty to patients to give them correct information while patients reserve the right to receive from care-givers on their medical situation. The extent to which the care giver should divulge the whole truth, however, constitutes a big

problem in the clinical situation. One may be tempted to argue that in order to render proper health care service, untruth may sometimes be necessary. The reason is due to the belief that truth may at times endanger the life of the care-receiver. It is worth noting here that physician/patient relationship has shifted radically from paternalism, a situation where the physician is believed to know what is in the patient's best interest which is a situation that unfortunately leaves out the patient in the decision- making process.

At this point in the discussion, it needs reiterating that truth-telling is a very difficult aspect of the physician-patient relationship. However, this difficulty is not a sufficient reason to jettison that which is ethically acceptable. For the purpose of emphasis, truth-telling is an obligation the physician owes the patient, while it is the right of the patient to know. Granted that there is merit in this argument, the question still remains: how much of truth do patients need to be told? One suggestion is to say that patients should be told all relevant facts concerning health situation, including the nature of the illness itself, expected outcomes, a reasonable range of treatment alternatives, risks and benefits of treatment, and other information deemed relevant to that patient's personal value and needs. Distinctively, facts that are not important should be withheld. This will take us back to the issue of paternalism in health care delivery. Who, for example, determines the type of information that is irrelevant for the patient? What are the criteria for determining how important the information is? Who says the patient would not find such withheld details useful?

Physicians withhold the truth from their patients for two major reasons. The most important is to give the patient hope. Some people argue that telling the truth in difficult situations may lead to a loss of hope, thereby negatively affecting treatment. Hope emerges from the desire to help make sense of life and to give it meaning. Health care professionals think of hope in terms of possibility of a physical cure.[21] This assumption is problematic because failure to tell the truth can even be more harmful than telling it. Of what use is false hope when the truth is available? The argument for nondisclosure of medical information based on hope retention is a way of undermining the need to

know the truth and a convenient means of justifying non-disclosure to patient. Hope should be viewed along with the reality and acceptance of one's new state of life. Certain facts about one's health have to be accepted and addressed in a more sensitive way. The havoc and pain caused by living in the dark is not a good experience and it leaves the patient in a devastating situation when he or she eventually knows.

The second reason is based on non-maleficence. This is the principle that emphasises the avoidance of harm on the patient. Some physicians believe that truth can bring or cause harm on the patient, and therefore should not be told all the time. Withholding medical information has implication on the decision making capacity. When information is withheld from a patient, it is an indirect way of saying the patient is not capable of handling the information. Competent individuals are judged capable of making decisions about their health, including on life and death matters, because they are assumed to possess the capacity to comprehend facts and choose between options. This however, is not possible when the patient is not given the opportunity to make informed choice. The danger here is that an uninformed person may unconsciously make decisions that are harmful to his or her health.

Some scholars believe that some truth is inhuman because it brings pain. Robert Weir argues for example, that, "giving the patient the truth and all the unadorned facts is erring against the ethos of medicine by which we try to help the patient."[22] Physicians generally believe they know more about what should be in the patient's best interest, needs and emotional stability than the patient. This explains why physicians withhold potentially damaging information to protect the patient from undergoing an emotional catastrophe. This, it is said, is in the patient's best interest. It is obvious from the discussion so far that opinions vary as to the issue of telling the truth. Tolstoy says that lying to dying patient is harmful. This he said in the Death of Ivan Illich that:

> This deception tortured him- their not wishing to admit what they all knew and what he knew, but wanting to lie to him concerning his terrible condition, and wishing and forcing him to participate in that lie. Those lies- lies enacted over him on the eve of his death and destined

> degrade this awful, solemn act to the level of their sturgeon for dinner—were a terrible agony for Ivan Illych.[23]

The view of Sigmund Freud does not contradict that of Tolstoy. In Sigmund Freud's view, lying can damage the doctor, the therapeutic relationship and the medical profession.

> Since we demand strict truthfulness from our patients, we jeopadise our own authority if we let ourselves be caught by them in a departure from the truth.[24]

In a study by Dennis Novack and his colleagues, we were told that physicians acknowledge that patients have a right to the truth, that this "right" is ignored when the physician judges that telling a particular patient the truth would do him/ her harm.[25] The physician sees himself possessing greater wisdom and power in that context to determine whether to tell the truth or not. But, it could be argued that physicians who make this decision is acting paternalistically. How can the physician or any other person claim to know that the truth will harm the patient? Knowing is an epistemic claim and has a deeper meaning. It is beyond mere assumption and feelings of something. Sometimes, the physician's claim to know may not amount to a knowledge claim. It is possible for the physician to think from experience that the patient may be harmed .It is not impossible that the patient may in fact not be harmed when told.

Kant in his own view argues for truth and strict rejection of lies. It is a duty to Kant to tell the truth and that lies are evil. To him, lies harm the dignity of human person.[26] The dilemma with the issue of veracity or truth - telling further strengthens the need to deal very carefully with issues of decision-making concerning human life. Moreover truth-telling generates a lot of dilemma in all areas of clinical practices, especially when the patient is vulnerable. For example, in oncological clinical context such as in cancer related issues and in the situations when telling the truth conflicts with confidentiality, such as in the context of HIV. Most oncologists see truth telling as something that can shatter their patient's hope. In this case, it is believed that withholding the truth in cancer related cases is justifiable. This is because of the underlying assumption that cancer denotes death, and therefore, patients should be protected from despair.[27] Truth-telling, then constitutes a big problem in bioethics.

Truth-telling is connected with the issue of confidentiality. The way physicians and patients are expected to tell the truth in care matters, the same way they are expected to deal with the issue of confidentiality. Like veracity, the issue of confidentiality also presents serious problems to the medical profession. Medical confidentiality is an important feature of doctor-patient relationship. In general term, medical confidentiality is non-disclosure of information given to the doctor by the patient, which the patient does not wish to disclose to a third party without his or her consent or permission.[28]

Autonomy/ self- determination is enhanced as the doctor respect confidential information given to him by the patient. Enhancing individual autonomy is important to human beings. Here, two conflicting type of autonomy can be identified, and these are autonomy of the physician and autonomy of the patient. The doctor as an autonomous person may not feel comfortable in the non-disclosure of a vital information that is closely attached with life. Disclosure of such information may help in making a long lasting decision for example in the case of HIV. Many times, the physician knows the likely benefit that the patient may derive by telling and respecting the autonomy of the patient that is willing to know.

The problem of truth-telling can be encased in these questions: What should a physician do when an autonomous patient confides in him saying "I do not want a third party to know about his/ her HIV status?" How do we tell the truth to a cancer patient, especially when prognosis is poor? This issue generates ethical questions in the light of confidentiality and patients' right to know or not to know about the state of their health. Another question is since confidentiality is crucial to daily clinical practices, how should we deal with the dilemma around truth-telling? To what extent should autonomy be respected, for instance in the HIV context? Should confidentiality be maintained at the expense of greater harm? Should we, for example, tell harmful truth to a cancer patient knowing fully well that the harm may increase with the information given? The problem discussed above point to the difficulties physicians encounter when it comes to divulging information to patients especially when to tell the truth-telling is in the context of clinical. Many scholars have reflected on this problem and came up with differing opinions on the matter.

Begley argues that withholding the truth in cancer related cases can be seen as morally acceptable because it gives and guarantees hope.[29] Many at times, physician chooses "not to tell" his patient in order to protect him from distress or pain. The patient trusts the care-giver over time and believes the information given him by his care-giver and may survive. On the other hand, by providing hope through deception, the care-giver loses his patient's trust and the physician patient relationship may also be affected. Where the patient fails to survive, the care-giver puts himself at risk of potential guilt.

Efharis rightly argues that concealing information in cancer patient is distressing. He arrived at this position following an experiment he carried out with the use of research participants. The experiment involves examining the emotional and psychological impact of disclosing versus concealing cancer diagnosis, anchored on the following three groups of concealment, disclosure and control group. Result shows that concealing of information is less distressing than revealing the truth.[30] So in order to avoid distress; truth should be concealed from the patient. In contrast to total concealment of truth from the patient as pointed out above, D. Kirklin identifies the potential role of metaphor in truth telling in clinical practices especially in cancer related issues. According to him, metaphor plays a significant role in truth-telling as a means of obscuring the truth.[31] This explains why Kirklin stresses that physician should be thoughtful with the kind of metaphor they use when divulging information to the patient in each clinical encounter.

Beauchamp and Childress propounded principlism, which offer some opinion on the notion of truth-telling in medical practice. The principle-based approach in bioethics consists of the principles of respect for autonomy, non-maleficence, beneficence and justice. These principles seem to be contradictory in nature. The principle used as argument for truth-telling can also be used to argue against truth telling. For example, the principle of autonomy conflict with beneficence and autonomy also conflict with non-maleficence. To buttress this point, we can simply acknowledge a situation where the autonomy of the patient to refuse a particular intervention conflicts with what benefits him or her medically. One can demand to know the information about his health based on his autonomy or right to know and can also claim that he does not want

to know because he has an autonomous right not to know. This is just one of the several crucial issues generated by this principle. Principlism would be discussed in details in Chapter Two of this work.

Conclusion

This chapter looked at the duty of veracity in its widest scope ranging from the smallest units of the society, which are the family and religion, to the society in the health care situation. The discussion in this chapter shows that veracity is a complex issue in clinical practice that yields a lot of dilemma on every day clinical encounter. In the next chapter, we shall examine ethical theories such as deontology, consequentialism and situationism. These theories shall be used to address the complex moral problem of veracity in clinical practice.

END NOTES

[1]Hornby, H.S. 2000. *Oxford advanced learner's dictionary of current english*. Oxford: Oxford University Press. 364.

[2] Fadahunsi, A. 1998. Truth as the central problem in epistemology. *Philosophy: an anthology*. Lagos: ARK Publishers. 32.

[3]Vaisrub, S. 1983. *Playing super God in moral problems in medicine*. New Jersey, Prentice Hall Inc. 199.

[4]Oduwole, E. 2011. *The concept of truth in an African language: An exercise in conceptual decolonization*. Germany: Lap Lambert Academic Publishing GmbH & Co. KG. 64.

[5] Oduwole. 86.

[6] Oduwole. 87.

[7] Oduwole. 89.

[8] Oduwole. 90.

[9] Oduwole. 90.

[10] The principle of medical ethics of the American, 1980.

[11]Higgs, R. 2001. Truth- telling. *A companion to bioethics*. Eds. Helga Kuhse and Peter Singer U.S.A: Blackwell Publishing Limited. 34.

[12]Hooft, V. 1999. Acting from the virtue of caring. *Nursing Ethics*. 6:192-193.

[13]Marzanski, M. 2000. Would you like to know what is wrong with you? On telling the truth to patients with dementia, *Medical Ethics*. 26:108-113.

[14]Carlos, H. etal. 2003. Not telling the truth in the Patient-physician relationship, *Bioethics ISSN*. 17: 5-6.

[15]Bok, S. 1978. *Lying: moral choice in public and private life*. New York: Vintage Books. xviii.

[16]Ritchie, S.D. 1995. Professional negligence: a duty of candid disclosure?. *BMJ*. 310:888- 9.

[17]Vincent, C., Young, M. and Phillips, A.1992. Why do people sue doctors? a study of patient relationship, *JAMA*. 153:572-576.

[18] Kelly, W. D. and Friesen, S.R. 1950. Do cancer patients want to be told? *Surgery*. 27: 322- 326.

[19]Kelly, K. 1987. AIDS and ethics: an overview. *General Hospital Psychiatry* 9: 331-340.

[20]Hebert, P.C. 1994. Truth telling in clinical practices. *Canadian Family Physician*. 40: 2105- 2113.

[21]Elaine, G., APN, BC-PCM; Cluxton, Douglas MA. 2004. Truth telling: ethical issues in clinical practices. *Journal of Hospice and Palliative Nursing*. 6(4): 232-240.

[22] Weir, R. 1983. *Truth telling in Medicine*, New Jersey Prentice Hall Inc. 202.

[23]Bok, S. *Lying: moral choice in public and private life*. op.cit., 220.

[24] Ibid.

[25]Novack, D.H. Plumer, R. Smith, R.L. e tal.1979. Changes in physician attitudes towards telling the cancer patient. *JAMA.* 241: 897- 900.

[27]Asai, A. 1998. A patient with HIV. *Eubios Journal of Asian and International Bioethics*. 8: 15-18.

[28]Dunbar, S. and Rehm, S. 1992. On visibility: AIDS, deception by patients, and the responsibility of the doctor. *Journal of Medical Ethics*. 18(4): 180-185.

[29]Begley, A. 2000. Truth telling versus hope: a dilemma in practice. *International Nursing Practice*. 6(1): 26-31.

[30]Panagoulou, Efharis e tal, 2008. Concealment of information in clinical practice: is lying less stressful than telling the truth?. *Journal of Clinical Oncology*. 7, (26): 75-77.

[31]Kirklin, D. 2007. Truth telling, autonomy and the role of metaphor, *Journal of Medical Ethics*. 33: 11-14.

CHAPTER TWO

TRADITIONAL ETHICAL THEORIES AND VERACITY

Introduction

Following our critical exposition of the nature of veracity and its different facets as well as its complexities in clinical health care delivery in the preceding chapter, our discussion in this chapter is to examine the various ethical theories relevant in the analysis and understanding of veracity in clinical practices. In these wise, traditional ethical theories; such as consequentialism, deontology and situation ethics shall engage our attention in this chapter.

Deontologism and consequentialism are held as opposing ethical standpoint as far as scholars have argued that the former crest moral rightness and wrongness of actions on the nature of duty, the latter on the consequences or outcome of actions. However, there have been sheaves of interpretations as to whether the two theories are incompatible extremes that evaluate morality on the basis of distinction between agent-relative and agent-neutral based actions. Further debates on this have led to other viewpoints that reduce one theory to other and led to diverse types that seem to hold contrary to the general evaluation of morality (as given by the two theories). The attempt here is not to regurgitate the diverse stances regarding the two ethical theories, rather it is to basically engage the various shortcomings of these theories in addressing the dilemma around veracity in clinical practice and to also evaluate the extent of their tenacity.

Consequentialism

Consequentialism is a type of teleological theory. Consequentialist theories in simple terms, state that moral value in terms of either moral rightness or wrongness of an act is basically a function of the consequence (s) of these acts. In the words of Walter Glannon, "consequentialism defines the rightness or wrongness of an action in terms of its consequences."[1] Advocates of this ethical orientation are called consequentialists. The theory suggests that an action is morally right either if it brings about the best

attainable consequences in the situation, or if the action is of a kind which would have the best attainable consequences if everyone did it in that sort of situation.

Consequentialism states that it is the goodness or badness of the consequences of actions alone that makes them right or wrong, rather than anything intrinsically good or bad about the actions themselves. Thus, on this view, there would be no universal moral prohibition against deliberately killing another human if so doing would produce a greater balance of good over evil than any other course of action at that time. Consequentialist ethical theories are of two basic types: ethical egoism or utilitarianism. Utilitarianism is the most familiar form of consequentialism which states that one should act to promote the greatest possible good for the greatest number.[2]

This theory is more concerned with the good of the majority than the interest of an individual. Utilitarianism is one of the major theories used in deciding whether an action is right or wrong, morally justified or otherwise in ethics. The origin is traced to the late 18th and early 19th centuries. The prominent figures in this theory are Jeremy Bentham and John Stuart Mill. Utilitarianism emphasizes that morality should minimize harms and maximize the welfare of people. Utilitarianism does not urge people to turn the other cheek and hope for justice in another life, nor does it exalt these virtues so cherished; the consequence from an action is what is of importance to Utilitarians.

There are different versions of utilitarianism, but they are all based on the utility principle. The principle of utilitarianism, according to Jeremy Bentham states that:

> By utility is meant the property in any object, whereby it tends to produce benefit, advantage, pleasure, good or happiness (all this is the present case comes to the same thing) or (what comes again to the same thing) to prevent the happening of mischief, pain, evil or unhappiness to the party whose interest is considered. If that party be the community in general, then the happiness of the community. If it is a particular individual, then the happiness is that of the individual[3]

Utilitarians believe that we are to determine what is right or wrong, morally justifiable or not based on what will have the best consequences for the welfare of human beings, that is, what will produce the greatest balance of good over evil in the world as a whole. The word 'utility' refers to the tendency of something to increase good and decrease evil. By good, it is meant that the total good and evil brought about right actions, which to the advocates of utilitarianism is the one that produces the best result. The principle of utility is the one and basic principle of ethics. Many utilitarians maintain that agent intrinsic good ought to be produced that is good such as freedom, happiness and so on. Bentham and Mill are hedonistic Utilitarians because they conceive utility entirely in terms of happiness or pleasure, two broad terms that they treat as synonymous.[4]

There are two forms of utilitarianism; act and rule utilitarianism. The act utilitarian theory holds that the principle of utility is to be applied to particular situations. We must find out for each alternative possible act in the situation what its net utility function is. The right act is defined as the one that has greater net utility than any other alternative. To do any of these other alternatives would be wrong because to do them would amount to not maximizing the balance of positive over negative value in the world, since one's duty is always to do that which has such maximization as its consequence. The principle of act utilitarianism may be stated thus:

> An action is morally right for an agent to do in a certain situation if and only if it will produce at least as great a balance of good over evil in the world as any other action open to him.[5]

Going by this line of argument, what makes an action morally right or wrong, is the amount of good over evil that the action brings. The means to the attainment of that good is not important.

For hedonistic Utilitarians, actions that produce pains are wrong while those that produce pleasure are right. What is most important in an individual's self-interest is to have pleasure (happiness) rather than pain (unhappiness). Bentham agrees that morality often requires people to pursue the common good rather than their own private good,

especially when there is conflict of interest. However, a major flaw of this assertion is to ask what constitutes common good itself. On common good, he writes:

> The community is a fictitious body, composed of the individual persons who are considered as constituting…its members. The interest of the community then is what? The sum of the interests of the several members who compose it.[6]

For Bentham, "a thing is said to promote the interest, or to be for the interest, of an individual, when it tends to add to the sum total of his pleasures: or, what comes to the same thing, to diminish the sum total of his pleasure." [7] A major teaching of this principle as it is expressed by Bentham is that it is wrong for people to do what will reduce the total happiness of the community. Let us take for example, Mr. Johnson who stays with four other neighbours in the same compound. Mr. Johnson does not enjoy music very well if it is not in a very high volume. Mr. Johnson's neighbours do not like to be disturbed with such loud music, yet, Mr Johnson prefers to satisfy himself and dissatisfy others. Obviously, the total happiness of the majority has been neglected. Going by this principle, Mr. Johnson's action would be considered wrong because it reduces the total happiness of the community.

The Rule utilitarianism was propounded by John Stuart Mill. He emphasizes the greatest number of happiness for the greatest number of people. He deviated a bit from the Act utilitarianism; which is concerned with a particular action. Rule utilitarianism is concerned with rules of actions. A rule utilitarian theory holds that we are generally, if not always, to tell what to do in particular situations by appeal to a rule, like telling the telling, rather than by asking what particular action will have the best consequences in a particular circumstance. These rules are to be determined by a retrospective calculation of which possible rules have the greatest net utility. Thus, it may be right to obey a rule like telling the truth because it is so useful to have the rule, even when in a few individual situations telling the truth may not in fact lead to the best consequences.

A rule utilitarian is prepared to revise his or her rules in the light of experiences, incorporating as exceptions those types of situation in which acting in accordance with the simple truth-telling rule leads regularly to worse consequences than not (e.g., a modification allowing "white lies"). Rule utilitarians reject the situation-by-situation calculations of act utilitarians because it doubts our ability to predict accurately, the consequences of our actions in an efficient and reliable manner. Rule utilitarians hold that experience may be most reliably and usefully encapsulated into general rules, and that a better long-run result will be achieved by following rules than by situational calculations. The only thing that is good and desirable is pleasure. Rather than looking at a particular action alone, one should ask if by acting this way, it will bring the happiness of the greatest number. If it would not, then, acting in such a way will be morally wrong, but if yes, in such instance, it will be morally right. Ultimately, the consequences of an action determine the rightness and wrongness of that action.

Ethical egoism is also a consequentialism ethical theory. It states that moral agent ought to do what is in their own self-interest while psychological egoism claims that people act in the interest of the self. Egoism elevate self-interest and the self to a status not granted to others but that one also should not sacrifice one's own interest to help others' interests so long as ones' own interest are substantially equivalent to the others' interests and well-being. While we agree that egoism, utilitarianism and altruism are all forms of consequentialism, it must be noted that egoism and altruism contrast with utilitarianism in that egoism and altruism are both agent focused but utilitarianism is agent neutral (objective) as it does not treat the subject's (the self) interest as being more or less important than the interests, desire or well-being of others.

Ethical egoism does not however require moral agents to harm the interests and well-being of others when making moral deliberation e.g. what is in an agent's self-interest may be detrimental, beneficial, or neutral in its effects on others. Ethical egoism endorses selfishness but does not endorse foolishness.[8] Many benefits of the utilitarian theory are matched with some serious flaws. Its basic tenet of "the greatest happiness" to "the greatest number" is faced with some difficulties. For instance, will utilitarianism

not be violating the traditional principle of the sanctity of life to save many people? Traditionally, it is believed that human life should be accorded certain right. Following this line of argument, the utilitarian principle will not see anything wrong in a person giving his life to save the life of four people as long as using an innocent healthy person will bring about the happiness for reasonable number of people, it will be morally permissible.

The second objection to utilitarianism is based on its violation of Fundamental Human Rights. Liberals believe that human beings have Fundamental Human Rights which are basic, self-evident and possessed by everyone: the right to free speech, right to freedom of religion, with the right to life being some of the most fundamental. Utilitarianism does not count on these rights but rather focuses on the principle of the greatest happiness even if it means violating these Human Rights. The conservatives believe that the amount of happiness derived from an action is irrelevant to the violation of human rights, that is, we cannot just violate human rights because it maximizes the greatest amount of happiness. They believe that human rights are the basis of morality. The reason above is why the conservatives objected to utilitarianism theory.

Thirdly, utilitarianism as an ethical theory does not preach equality. A physician is not expected to treat patient with equality but should focus on the greater number of people that may benefit. It also ignores intention and focuses on consequences; consequences are not all that matter. It is very possible for actions to have good consequences without good intention. Utilitarianism does not also account for justice or rights. It only states that an action is good if and only if it produces the greatest amount of happiness such that any action that brings about good consequences is right. For instance, some actions that may seem unjust may be permitted based on the consequences they yield.

Another difficulty with consequentialism is how to calculate consequences. Consequentialist theory requires that the consequences of acts or policies must be calculated. However, in many situations one cannot predict consequences with any certainty. Accordingly, consequentialism is mere probabilistic. It can be argued that one forecasts the consequences the best of one's ability. It is also important to note that any

ethics based on probability often yields futile predictions. The problems with the utilitarian theory highlighted above have necessitated the need to look elsewhere for other theories that are more theoretically sound and intellectually convincing.

One such theory is known as deontologism. What is this theory all about?

Deontology

The term Deontology is derived from the Greek word, *deon*, which means 'duty'. Deontology defines the rightness or wrongness of an action in terms of a duty or obligation to respect the right and values of persons.[9] Deontology and consequentialism purport to prescribe principles that tell us what we ought to do at any given time. Consequentialism lays emphasis on consequences resulting from an action, the other emphasises duty or respecting persons as an end in itself. The most well acclaimed deontologist is Immanuel Kant.

Deontological theory denies what utilitarians affirm. Kant's postulation is about the wrongness and rightness of an action based on duty and obligation. He was exclusive in his analysis of morality. He sees all actions that are opposed to duty as morally wrong even though they may be good for one thing or the other. He made a sharp distinction between acting for the sake of duty and acting according to duty.

Acting for the sake of duty is acting out of reference for the moral law without any desire or inclination while acting according to duty is acting because of a desire, feelings or consequence of an action. It is acting because one hopes to gain something from the act. In Kant's opinion, acting according to duty is not morally justified. He urges us to act for the sake of duty and contended that "any action promoted by self-interest is not morally good. It must be performed out of pure love of law from a sense of duty for duty sake.[10].

A will which act for the sake of duty is the goodwill.[11]An action done for the sake of duty has moral worth, while action done according to duty has no moral worth because the moral worth of an action does not lie in its effect. The thrust of Kantian morality is the categorical imperative. It sets the criteria for accepting an action as good and bad,

wrong and right. An imperative is a command which comes in form of 'do this' and 'do that'. There are two types of imperatives that is, the categorical and hypothetical imperative.

The hypothetical imperative takes the form of "if and then". For instance, "if you want to succeed, then, you have to work hard". Categorical imperative on the other hand has no "if… then…" The categorical imperative states "do this, do that" for example, 'tell the truth', 'do not lie'. Kant's interest is in the categorical imperative not in the hypothetical imperative because it depends a lot on the consequences if then. The categorical imperative states that act only the maxim act only on the maxim whereby there can at the same time will that it should become a universal law.[12] Kant is of the view that nothing can possibly be conceived in the world or even out which can be called the good without qualification except the goodwill. All other things can become bad when they are misused.

> Therefore, the only thing that is good not because of what it performs to effect, not by its aptness for the attainment of some proposed end, but simply by virtue of the volition, that is, it is good in itself and considered by itself as it is to be esteemed much higher than all that can be brought about by it in favour of any inclination even of the sum total of all inclinations.[13]

Fredrick Copleston shares the view of Kant on the concept of the goodwill. He asserts that:

> External possessions such as wealth can be misused as everybody knows. Hence, they are not good without qualification. And the same can be said about mental talents such as quickness of understanding. A criminal can possess and misuse mental talents of a high order. We can also say the same of natural traits of character, such as courage. They can be employed or manifested in pursuing an evil end. But goodwill in any circumstances is good without qualification. [14]

A Kantian would insist that our moral judgment should rest on reason. For instance, a mother wants to help her daughter by donating one of her organs out of compassion for her even when she is not fit to do so, her action would be lacking a moral worth. She

has to look beyond her compassion and look at the universality of that action. Kant argued that morality is ingrained in reason, not in tradition, intuition, conscience, emotion, or any attitude such as sympathy.[15] For Kant, one must act with a good motive. The intention behind any action determines the moral worthiness of that action. If one tells the truth because one is scared or because of the fear of disclosure by another person, then the action lacks the requisite goodwill. Actions that cannot pass the test of the categorical imperative are not morally good actions.

Consider as an illustration a man borrowed some money desperately, promising to refund it within a specific time even when he knows very well that he would not be able to pay. When we examine the action with Kant's maxim, the maxim of the man's action would go thus:

> When I am in need of money, I will borrow and promise to pay it back, although I know that I cannot do so.

This maxim above is not universalisable or passes the muster of what Kant calls the categorical imperative. The categorical imperative is captured as follows:

> I ought never to act except in such a way that I can also will that my maxim become a universal law; this one principle justifies all particular imperatives of obligations all right statements that morally obligate.[16]

Kant in his notion of autonomy contends that the principle of autonomy is "the sole principle of morals and autonomy alone gives people respect, value and proper motivation. A person's dignity- indeed, 'sublimity' comes from being morally autonomous."[17] Immanuel Kant and J.S Mill are two philosophers who have influenced contemporary interpretation of respect for autonomy. Kant was the first modern thinker to address autonomy. He saw freedom as a necessary condition for moral action.[18] He is of the view that an agent cannot act in a moral way unless he of she freely chooses to do what is right. Kant argues that "respect for autonomy flows from the recognition that all persons have unconditional worth, each having capacity to determine his or her moral destiny".[19] While Kant talks about treating persons as end in themselves, Mill talks about not interfering with and the recognition of autonomous person.

Kant, is without doubt, one of the most important, most widely read, and most relevant of modern moral philosophers. Central to Kant's moral theory is his conception that what matters morally speaking is our motive (our "maxim"). Motives, in the Kantian moral sense, are rationally, freely chosen reasons for actions. Therefore, it is that nature and fact of our being free, rational wills that characterizes the fundamental nature of morality. The heart of morality, thus, is to always act as a free, rational agent. That is, to truly be what we most ultimately really are: rational will.

Since what makes each of us a moral agent is our nature as rational beings, we are in that particular regard, thus, all alike. What is true for one of us-as a rational will-must likewise be true for each and every one. This is how Kant derives the first practical formulation of the moral law, the categorical imperative. Act only upon that maxim that you can will at the same that everyone act upon. In other words, if you are going to allow yourself to act out of a particular intent (maxim) then you must be willing that everyone do so as well. If you cannot rationally, without contradiction, so will; then you should not allow yourself to act upon that maxim.

Kant's second practical formulation of the moral law is the idea of ends: never treat another moral agent only as a means-to-an-end: but always treat other agents as ends-in-themselves. In other words, moral agents (persons) are by their nature self-governing. We decide for ourselves what we will (or will not) pursue, what we will seek to avoid, what we will admire and so on. For someone to forcibly impose these kinds of important choices upon us would be not to respect our autonomy. We wish for others to respect us as the rational decision makers, self-determining agents that we really are: likewise, we must respect the capacity for self-determination in others.

Kant's moral insights are certainly an important influence behind our modern commitment to political liberalism (the idea that individuals should be able to make their own individual choices about important life matters, even if their choices differ markedly from what we ourselves might choose in the same circumstances). And yet, there can be no doubt that the way Beauchamp and Childress (and nearly every other

contemporary bioethicist) use the term "autonomy" is a much thinner, less rich, less complex way than Kant uses the term.

Like Utilitarianism, there are two versions of deontological theory. They are "Act" and "Rule" deontological theories. Act deontologists hold that every judgment of moral obligation is completely particular. For example, "In this situation, I ought to tell the truth" and that general maxims or rules for example, "One ought always to tell the truth" are unavailable, useless, or at best, inductive generalizations from particular experiences. We must decide separately in each particular situation what is the right thing to do. Act deontologists differ over what they appeal to making such judgments, but rules are out looking at the consequences to see what will promote the greatest balance of good over evil for oneself. Act deontologists such as E.F. Carritt, H.A. Pritchard and Samuel Butler are intuitionists. They hold that to perceive what is the appropriate or fitting action to perform, to know what our duty is in the circumstance; we are enabled by a special faculty of moral intuition which is sometimes identified with conscience.

There is a religious version of act deontology as well. The divine command theory is a variant of deontological ethical theory. The divine command theory is a straight forward theory. It does not care about any means and does not give preference to end. The divine command theory says that an action is right or wrong if and only if it is commanded or forbidden by God. According to Emil Brunner, the will of God is the sources and standard of moral obligation and goodness.[20] The religious version of act deontology says, the source of our duty is the divine will, and what one ought to do in a given situation is what God wills for one to do in that situation, as given directly or through an inspired mediator. An example of this view might be found in the Biblical story of Abraham his son Isaac.[21] God is said to have commanded Abraham to sacrifice Isaac his son. He prepared to do the awful thing, but was stopped in the nick of time by a contravening command. Before the second order, he saw it as his duty to kill his son. Later, it became his duty not to kill his son.

One criticism against this version of act deontology is that it presents an obvious contradictory position. It could be quite confusing when you have two conflicting duties. Deontological theory does not foresee this kind of situation which may create a very big dilemma in concrete ethical decision making. Like any theory that falls under the umbrella of deontological theory, this theory that is the religious version of deontology focuses on the duty to obey what God commands. Not telling the truth contradicts the command of God about truth telling. The implication of this is that even if not telling the truth would bring about good outcome to the patient since it is not commanded by God, it would be considered as a morally wrong action.

AC. Ewing argued that "if right and good are defined in terms of the command of God, then if God rationally will that our whole duty should consist in cheating, torturing and killing, then it would be our duty to act accordingly".[22] The crucial point in this argument is that if the divine command theory is true, then if God commands lies, untruthfulness, dishonesty then it would be right to act in accordance to the command.

The second version is Rule deontology, which holds that there is a non-teleological standard of duty consisting in one or more rules; one's duty in any situation consists in acting so as not to violate any of those rules. Usually, rule deontologists have in mind a set of rather specific rules, such as the Biblical Ten Commandments, each commandment saying that we ought always to act in a certain way, in a certain context (a positive duty), or to refrain from acting in a certain way in a certain context (a negative duty).

The major difficulty with such multiplicity of obligations is that situations sometimes generate a conflict between the duties. When one's mother or father asks him to lie or to steal, or as when the physician chooses telling the truth and deceiving or telling lies in order to relieve suffering in a patient and where to do the latter, may endanger the hope of recovery of the patient. Some rule deontologists seek to avoid such conflicts by appealing to a single rule, such as the Golden Rule: "do unto others as you would have them do unto you." Such general maxims may fail in concrete situations to determine

our duties completely, and may not result in a rational agreement among all parties as to the morally correct course of action: such a result is often due to the ability of a situation to bear more than one description.

Our understanding of Kantian ethics shows that it will forbid action that is done because of the possibility of getting good consequences. For example, if there is a need to produce a stronger malaria drug to help address the attack of malaria by experimenting on human beings, this is likely to be supported by utilitarianism. But from Kantian perspective, it will amount to using human beings as a means to an end and not as an end itself; even if the action is in the pursuit of worthwhile goals. This does not matter to utilitarians, what matters is the best possible state of affair and good outcome.

Another criticism levelled against Kantian ethics is the problem of conflicting obligations. How would Kantian ethics resolve issues with conflicting obligations? For instance, if a man made a promised to care for his aged father and has also promised to satisfy his wife's request, the need to take care of his father may conflict with satisfying his wife. What should be done in this situation? Obviously, it is very clear that he cannot do the two at the same time since the two conflicting obligations require his presence and money. Kant seems to say that the two actions be carried out at the same time since to him moral rules are categorical.

Kant's ethical theory lays emphasis on the law and not on relationships. Our relationships with friends, families and children are rarely based on contract or law. Practically, the way we relate with friends, families and children is different from the way we relate with strangers. If Kant insists that our actions should be applicable to everyone, it will be better to say that his theory is better suited for relationships among strangers than among friends or intimates. For instance, parents do not carry out their duties to their children based on contracts or established rules. Deontologists are frequently, absolutist. It is interesting to know that some deontologists do not hold that what is morally right in a given situation may differ from what morally right in any

other given situation. Deontologists are united in their opposition to purely consequentialist moral thinking.

Situation Ethics

Situationism is a term coined by Joseph Fletcher in 1960, and at best referred to as a teleological or a consequential theory. It is a Christian ethical theory which sees love as the ultimate law. In situation ethics, it is permitted to put other laws aside as long as love is best served. Love, in the view of Fletcher, is the agape kind of love found in the teachings of Christianity. This love is also described as unconditional love. He does not believe in other laws because, in his view, other laws are laid down as guidelines in order to achieve this agape love.

Situation Ethics does not give a clear-cut definition of what makes an action right or wrong. Its emphasis is on treating cases with situation. The morality of an action is determined by the situation surrounding the action. The implication of this is that, what is sometimes called right is at other times wrong. Nevertheless, Situation ethics is flexible in its approach because it does not follow absolute rules like deontology.

According to Joseph Fletcher:

> The situationist enters into every decision making situation fully armed with the ethical maxims of his community and he treats them with respect as illuminators to his problem. Just the same, he is prepared in any situation to compromise them…if love seems better served by doing so.[23]

Situationism does not fall victim of being caught in the dilemma of what to do when duties conflicts. It places premium on the dictates of situation. A situationist may justify lying in a particular situation and reject it in another though lying is ordinarily not in the best interest of interpersonal communication and social integrity. There are four main

working presuppositions of situation ethics and six fundamental principles. The four working presuppositions are: pragmatism, relativism, positivism and personalism.

1. Pragmatism states that cases must be judged on the basis of what works.
2. Relativism: Relative in the sense that the way love is carried out would differ from situation to situation.
3. Positivism: actions must be carried out with a positive choice as the starting point
4. Personalism: laws are to benefit people. In order words, people should be put first because they are more important than rules. Man was not made for Sabbath rather Sabbath was made for man.

With the four presuppositions stated, it will be important to take a critical look at the six fundamental principles of situation ethics. The principles are stated thus:

First principle: One thing is intrinsically good, namely love: nothing else.[24]

Second principle: The ruling norm of Christian decision is love: nothing else.[25]

Third principle: Love and justice are the same, for justice is love distribution. Nothing else.[26] Justice is Christian love using its head, calculating its duties, obligations, opportunities, resources. Justice is love coping with situations where distribution be called for.[27]

Fourth principle: Love, wills the neighbours good, whether we like him or not. [28]

Fifth principle: Only the end justifies the means, nothing else. Actions only acquire moral status as a means to an end. For Fletcher, the end must be the most loving result. When measuring a situation one must consider the desired end, the means available, the motives for acting and the foreseeable consequences.[29]

Sixth principle: Love's decisions are made situationally not prescriptively.[30]

The strength of situation ethics is that it is sensitive to the peculiarities of circumstances unlike a duty based approach that gives no room for such flexibility. It is a consequential

(utilitarian) approach that relies on consequences of an action in a given situation and the idea that the end justifies the means. It is possible for same action to yield different consequences in different cases. While utilitarianism is concerned with the greatest amount of happiness, situation ethics is concerned with the greatest amount of love. One crucial criticism of this approach is that it may approve of certain evil acts as long as the action is considered good in that situation.

THE LIMITATIONS OF TRADITIONAL ETHICAL THEORIES IN APPROACHING TRUTH-TELLING DILEMMA

Having discussed the tenets of consequentialism, deontology and situation ethics, it is therefore important to highlight the limitations of the ethical theories discussed above in order to expose their limitations in approaching the complex moral problems inherent in truth telling in concrete clinical practice.

Consequentialism as earlier discussed in this chapter, based the rightness and wrongness of an action on the consequences it brings. In other words, right and wrong to consequentialism are purely a function of the consequences of actions or behaviour. They assess the rightness or wrongness of doing something by looking at the consequences caused by that act. So if avoiding or withholding the truth produces a better result than telling it, then not telling it would be a good thing to do. And if telling the truth produces a worse result than not telling it, telling it would be a bad thing to do. This has a certain common-sense appeal, but it is also quite impractical since it requires a person to work out in advance the likely good and bad consequences of the truth to be told and balance the good against the bad.

This is hard to do, because of the following reasons, consequences are hard to predict, and measuring good and bad is hard, how then should an action be judged good or bad? For whom is it good or bad? What system of measurement should be used? What consequences are relevant? How long a time-period should be used in assessing the consequences? Consequentialism, requires a person to value everyone involved equally and not to give extra value to their own wishes and also requires a person to consider

the consequences to the society in general of not telling the truth as well as the consequences for those actually involved.

There are two forms of utilitarianism and these two forms of Utilitarianism could lead to different results: An act-Utilitarian might say that not telling in a particular case did lead to the best results for everyone involved and for society as a whole, while a rule-Utilitarian might argue that since not telling made society a less happy place, it would be wrong not to tell, even in this particular case.

This theory implies that no action is intrinsically right or wrong but the consequence makes it right or wrong.[31] Consequentialism did not say that the truth should be told because it is the truth but the consequences of the truth to be told is all that matters and should be carefully considered before it is presented to the patient. It then boils down to the fact that the care receiver has to carefully analyze and reflect on the truth about the patient diagnosis, see if the truth may harm the patient and since he has a duty not to harm, then, the implication is that such truth should not be told.

Thorough reflection and the in-depth understanding of consequentialism further suggest that the caregiver knows the information that may cause harm on the care-receiver. This is a theory that says, consequences determine what is right and wrong and if this is taken to be true, then, the care-giver is assumed to know what telling the truth would bring. It may be argued that it may not always be true to say with all certainty that a certain result will come up after information is given. What the care-giver thinks may harm the patient may not. It is equally of great importance to note that taking decision on behalf of the patient under the umbrella of non-maleficence (consequentialism sees as action as wrong if it brings about bad consequences) is paternalistic in approach. It is worth noting that paternalism in health care delivery is very problematic. Health care delivery has moved beyond the level at which the decision about the patient lies solely on the health care-giver.

Presently, and to a very large extent patients are becoming aware of their role in issues concerning their health. It is important at this juncture, to state that truth telling to the

patient may help in assisting the patient to take a better decision and profiting outcome may therefore be realized. To discharge the duty of veracity according consequentialist, depends on the likely outcome of the information. We should be reminded that telling the patient the truth may help or assist the patient to take a better decision and positive outcome may equally be realized. Consequentialism as a theory can be seen as a theory that will not always give room for veracity to be upheld in health care delivery.

Truth telling in clinical practice is an issue for physician in their everyday practice. An application of Kantian viewpoint to veracity suggests that it will be right for a physician to disclose the truth about the diagnosis, prognosis and the nature of the illness to the patient if it is a duty. Kantian theory support truth telling and condemn lies.

This imperative (i.e. Kantian Moral Imperative) seems difficult in practice especially when applied to the issue in question. It does not care about the consequences of telling the truth, whether it may cause further harm on the patient is also not its concern. It should be immediately brought to light that non-maleficence is central to health care delivery. It is equally a core principle that the physician should adhere to because it is part of the Hippocratic Oath. If Kantian imperative implies that one should act duty for duty sake, then, it means the physician should divulge the truth by discharging his duty as a veracious physician. This invariably contradicts the Hippocratic Oath that says cause no harm. This results into conflict of duties. This is a conflict of the duty of veracity and "do no harm principle" in the Hippocratic Oath. How then do we manage this conflict being faced by the physician?

Deontology again fails to acknowledge the uniqueness of each case as it presents itself. There are many situations where rigid adherence to theory such as that of deontology may not help to resolve concrete ethical problems. Ethical problems are problems that truly require special and careful attention. Let us come down to more practical example of mother / son relationship. It is generally believed that a mother does the work of protecting, caring and attending to the needs of their kids. Let us assume a situation where the mother finds herself having to give a yes or no for an answer that determines

whether the son would be killed or not at the course of discharging a duty. If giving a yes for an answer is the right thing to be said despite the fact that it would affect her son; Kant says, the truth should be told. It appears to me that this theory only sounds good in theory but not in practice.

Kant's notion of acting duty for duty sake is also a strict approach to situation. In concrete clinical practice, physician are confronted with certain situations that require them have a rethink about certain decisions. In an attempt to help the patient in the way they consider better, they act against some of their dos and don'ts some of which yield very good results.

These various difficulties presented by Kant's approach to truth telling shows very clearly that deontological theory cannot address or handle the complex moral issues raised by truth telling in health care delivery. It must be quickly mentioned that issues such as that of truth telling cannot be handled with rigid theory like deontology. Situationism unlike deontology and consequentialism examined earlier, overcomes some of the challenges posed by the two approaches in their analysis of veracity in clinical practice. The determinant of the best kind of action in situationism is determined by situation and not rules. In relation to the issue of veracity in clinical practice, situationist explanation would be that if acting veraciously would not yield a good result in a particular situation then, the truth should be withheld.

In some other situation of veracity, acting veraciously might be justified. One may be tempted to argue that this approach is the best approach to the case of veracity because of its tenets and for the fact that it acknowledges the uniqueness of every given situation. In situation ethics, love is seen as the ultimate law which implies that acting in love is superior to acting according to what the law says. The implication of this is that a physician faced with the dilemma of truth telling should be motivated to take a decision that best represents love, which is the agape type of love found in Christianity. This approach did not take cognizance of the fact that the agape love cannot be found in every man.

Most other kinds of love are quite common and agape love is the least of the motivation of most men. How should the physician who does not possess the agape kind of love expect to know the best thing to be done in every given situation and case of veracity in clinical practice? This is a weakness on the part of situation ethics in approaching truth telling dilemma. The agape kind of love is a term in Christianity. And even in Christianity, we cannot pretend to take it for granted that not all Christians possess this kind of love. Otherwise, there would not be the type of teachings and sermons on the subject matter till date. It is pertinent to note that there are other religions and Christianity is hardly practised in some Countries.

In such regions of the world, a Christian-based ethical theory such as Situationism may not even be entertained. For example in Nigeria, the two popular religions are Christianity and Islamic religion. Islam-dominated northern part of Nigeria may not be even disposed to a Christian-based principle. Yet, there are so many other religions in other cultures. How then should a physician who is not a Christian act and take the best decision when faced with issues of veracity? Any approach that based its tenets on Christianity is a dogmatic approach as far as these people are concerned.

Situation ethics believes that the end justifies the means. This implies that a bad means can be justified if it brings about a good and desirable end. If telling lies to a patient, in a given situation, would bring about a good end then, lying is morally justified. It can be argued that this approach does not treat human being as end in itself. It must be clearly stated that as flexible as this approach may appear, its shortcomings in the analysis of veracity in clinical practice are quite daunting given its possible level of acceptability across religious boundaries. There is no doubt that situation ethics and virtue ethics shares flexibility in their approaches yet situation ethics lack some of the important tenets of virtue ethics.

Love does not think (or do) ill to is neighbour 1 Cor. 13:5.[32] In the case of a patient who wants to exercise his/ her autonomous right of not being given information, yet, the physician believes giving the information is the best and the only way to help the patient cope with his/ her illness. Giving the information to the patient is doing ill to him/ her,

the patient believes. Withholding same is doing ill to the patient, the Physician believes. Situationism does not help Physicians in these kinds of situation.

Firstly, situation ethics is not interested in character development and shaping of the acting agent. Virtuous character is what the virtue ethics holds as an ideal. This is of course central to virtue ethics. This aspect of virtue ethics is lacking in situationism. A physician who is not virtuous may not be motivated to act in the best interest of the patient.

Secondly, the idea of "Phronesis" (practical wisdom) is not present in situation ethics approach. The emphasis is love, faith, ends and this makes it lack practical wisdom. Whereas, the Virtue ethics theory, has Phronesis as a central theme. In virtue ethics, "Phronesis" is the way out of any dilemma even in cases where virtues conflict while love (agape) is the motivating factor in situation ethics.

Conclusion

This chapter has been able to highlight the various challenges faced with consequentialism, deontology and situation ethics in addressing the dilemma of veracity in clinical practice. The details discussion on the two theories exposes their shortcoming in truth telling analysis. Having argued beyond reasonable doubt that these theories cannot be considered adequate enough to address truth telling dilemma; it would be important to examine, in the next chapter, the four principles of Biomedical Ethics propounded by Beauchamp and Childress to reveal how much this could help.

END NOTES

[1] Glanon,W. 2005. *Biomedical ethics,* New York: Oxford University Press. 8.

[2] Ibid.,8.

[3] Bentham, J.1991. *An introduction to the principles of morals and legislation in the utilitarians*. New York: Doubleday. 18.

[4]Frankenna,W.K. and Granrose, J.T. 1974. *Introductory readings in ethics.* Eaglewood Cliffs: N.J. Prentice-Hall. 129.

[5] Bentham, *op.cit.* 12.

[6] Ibid.18.

[7]Ibid.18.

[8]James, K. 2008. Ethical egoism. *Reason and responsibility: readings in some basic problems of philosophy*. Eds. Feinberg and R. Shafer- Landau. California: Thomson Wardsworth. 534.

[10]Bittle ,C.N. 1950. *Man and moral: ethics,* USA: The Bruce Publishing Company. 338.

[11]Copleston, F. 1985. *A history of philosophy,* New York: Image Books. 315.

[12] Kant, I.1991. *Fundamental principles of the metaphysics of morals*. New York: Cambridge University Press. 117.

[13]Ibid.114.

[14]Copleston, 315.

[15]Beauchamp, T.L. and Childress, J. 2001. *Principle of biomedical ethics*, New York: Oxford University Press. 349.

[16]Kant, I. 1959. *Foundations of the metaphysics of morals,* trans. Lewis White Beck, Indianapolis, IN Bobbs - Merill Company. 37.

[17] ibid.

[18] Kant, *Foundations of the metaphysics of morals, op.cit.,* 127.

[19] ibid.

[20]Brunner, E. 1974. *Introductory reading in ethics*. Eaglewood Cliffs: N.J. Prentice-Hall. 67.

[21]Holy Bible, King James Version.

[22]Ewing, A.C. 1974. Discussions on the divine command theory. *Introductory readings in ethics*. Frankenna,W.K. and Granrose, J.T. 102.

[23]Fletcher, J. 1966. *Situation ethics: the new morality*. Philadelphia: West Minister Press. 56.

[24] Ibid., 59.

[25] Ibid., 87.

[26] Ibid.,95.

[27] Ibid., 103.

[28] Ibid., 120.

[29] Ibid., 134.

[30] Holy Bible, King James version

[31] Ewing, op. cit.102.

[32] Holy Bible, King James version.

CHAPTER THREE

PRINCIPLISM AND THE CHALLENGE OF VERACITY

Introduction

In chapter one of this study, the duty of veracity was discussed. The chapter started by looking at what veracity means by discussing it from the perspective of the family which is considered as the smallest unit of the society. It was established in the chapter that veracity is a duty of the health care-giver.

In chapter two, traditional ethical theories such as consequentialism and deontology were the selected ethical theories we discussed to avoid bringing in too many concepts. The chapter also discussed the limitations of these theories in details.

This chapter shall look at the four principles of biomedical practice as propounded by Beauchamp and Childress. These principles shall also be applied to the notion of veracity in clinical practice. This is important in order to reveal the inadequacies/ weaknesses of these theories.

The Principle of Respect for Autonomy

The principle of respect for autonomy is very important in biomedical ethics. Some bioethicists think that principle is capable of resolving the quality-of-care crisis in health care delivery. This principle evolved as a rejection of paternalistic ethics. Paternalism is the principle which allows a physician to act on proxy, which sometimes, is contrary to a patient's wishes and decision, on the basis of sufficient evidence that the patient in question cannot act in his or her own best interests.[1] The physician's decision is usually predicated on a supposed high level of expertise and informed knowledge over and above the patient's medical awareness. Paternalism's problem results from a confrontation with a patient's autonomous capacity to make decisions about his/her non-medical condition.

Autonomy is vital to the practice of medicine because our understanding of autonomy is important to how we treat people with respect and is therefore crucial to our understanding of moral judgments. The term Autonomy is derived from two Greek words *autos* (self) and *nomos* ("rule", "governance" or "law") which originally meant 'self-rule' or 'self-governance'.[2] Autonomy is extended to individual when we ascribe rights, privacy, liberty, choice to individual. Personal autonomy is therefore self-rule that is, being free from interference by others and from limitations such as inadequate understanding that prevents meaningful choice.[3] Autonomy is essentially a description of a capacity, to reflect, and decide for oneself. (Simon wood) A subject is competent to make a decision if he or she has the capacity to understand the relevant information, to make a judgment and to freely communicate his or her wish to caregivers or researchers(Beauchamp).In essence, the capacity for decision making and competence are tied with autonomy.

Since autonomy is conceived as self-rule or self-governance, we can therefore say that a person with diminished autonomy is not capable of acting on his or her desires, wish or choice. For instance, a Down syndrome child has a diminished autonomy and cannot be said to be in full control of his autonomy. Another good example is a prisoner. Imprisonment is a constraint on the exercise of autonomy. Mental incompetence is not the only constraint of autonomy because it is possible for someone to be mentally competent but not able to make a good decision because of circumstances.

Autonomy has a number of features such as capacity for self-governance, understanding, independent deliberation, and so on. Sometimes, autonomous persons fail to govern themselves in particular choices because of temporary illness/sickness or because of ignorance or other conditions that may stand as constraints to their options. For instance, it is not impossible for an autonomous person to sign a consent form for a medical intervention without reading through. Any decision without the knowledge of is really involved does not make a person autonomous.

The term "authority" presents some problems if we accept the view that autonomous persons must act on their own reasons and can never submit to an authority or choose to

be ruled by others without losing their autonomy. We may be tempted to argue that a person who adheres strictly to the rule of any authoritative institution such as church doctrine and medical authoritarian position loses his autonomy and deemed unworthy of respect. However, many obstacles hinder the full exercise of autonomy. We have noticed many patients who have failed to a medical counsel because it is against their faith and many others who have yielded to the view of the physician who acted paternalistically.

The concept of autonomy is one enmeshed in controversy because of what it emphasizes; respect and recognition of a person's autonomy. Must I respect a person's autonomy at all times? Can we set limit to the extent in which we should respect autonomy? At what point should we disregard autonomy? Take for instance; a child who prefers only carbohydrate meals as opposed to a meal with fruits, vegetables and protein. He severally resists taking meals that could assist in ensuring healthy growth. If the child is ignored and given what he wants, one would be doing him a wrong.

A good mother is duty bound to ensure that he has a good and well balanced diet. It is at the same time important to educate him on varied diet that will sustain him as an adult. Interference in such a case would be acceptable and can be said to be compatible in respecting the child because it is instrumental to the healthy development of that child. The worry with this scenario is that; would such interference be equally morally acceptable if my son were to be fourteen, seventeen or twenty year old? I might accordingly say as a mother, I should care for my child whether he be two or twenty years old. Though, thorough reflection would display very clearly that the justification I have for intervening in the life of a 2 year old child is different in degree from that of a twenty year old son of mine.

If I cannot care for my child just because he has autonomy to be respected, one should therefore worry about the goodness of the concept of autonomy. The question then is, is autonomy good in itself? What are we respecting when we respect a person's autonomy? To respect an autonomous agent is to acknowledge that person's right to make choices and to take actions based on personal values and beliefs.[4] Respecting the

autonomy of the other person requires non-interference in the person's personal affairs. Disrespect for autonomy therefore involves attitudes and actions that ignore, insult or demean others' right of autonomous action.[5]

Immanuel Kant and J.S Mill are two philosophers who have influenced contemporary interpretation of respect for autonomy. Kant was the first modern thinker to address autonomy. He saw freedom as a necessary condition for moral action.[6] He is of the view that an agent cannot act morally unless it was freely chosen to do what is right. Kant argues that "respect for autonomy flows from the recognition that all persons have unconditional worth, each having capacity to determine his or her moral destiny".[7] While Kant talks about treating persons as end in themselves, Mill talks about not interfering with a person and recognition of autonomous person.

Central to Kant's moral theory is his conception that what matters morally speaking is our motive. Motives, in the Kantian sense, are rational, freely chosen reasons for actions. Therefore, it is that nature and fact of our being free, rational wills that characterize the fundamental nature of morality. The heart of morality, thus, is to always act as a free, rational agent; that is, to truly be what we most ultimately really are: rational agent.

Since what makes each of us a moral agent is our nature as rational beings, we are in that particular regard, thus, all alike. What is true of one of us–as a rational agent–must likewise be true of each and everyone. This is how Kant derives the first practical formulation of the moral law, the categorical imperative. Act only upon that maxim that you can at the same will that it should become a universal law. In other words, if you are going to allow yourself to act out of a particular intent (maxim) then you must be willing that everyone do so as well. If you cannot rationally, without contradiction, so will, then you should not allow yourself to act upon that maxim.

Kant's second practical formulation of the moral law is the idea of ends: never treat another moral agent only as a means-to-an-end: but always treat other agents as ends-in-themselves. In other words, moral agents (persons) are by their nature self-governing.

We decide for ourselves what we will (or will not) pursue, what we will seek to avoid, what we will admire and so on. For someone to forcibly impose these kinds of important choice upon us would be not to respect our autonomy. We wish for others to respect us as the rational decision makers, self-determining agents that we really are; likewise, we must respect the capacity for self-determination in others.

Kant's moral insights are certainly an important influence behind our modern commitment to political liberalism (the idea that individuals should be able to make their own individual choices about important life matters, even if their choices differ markedly from what we ourselves might choose in the same circumstances). And yet, there can be no doubt that the way Beauchamp and Childress (and nearly every other contemporary bioethicist) use the term "autonomy" is a much thinner, less rich, less complex way than Kant uses the term. Understanding Kant means understanding that there are appropriate constraints upon free choice. For Kant, we are morally required to choose only maxims that can be universalized (via the categorical imperative). He urges that we should not act upon any maxim that we cannot universalize without rational contradiction.

What distinguishes Kant from Beauchamp and Childress is that Kant presents a very clear philosophical conception of what it means to be a person. It provides a philosophical foundation. Kant gives us room to morally condemn (and if appropriate, punish) agents who choose to act immorally. It is quite unclear if Beauchamp and Childress can make much sense of a particular agent making an autonomous but immoral choice.

Kant, then, offers an amazing view at what a moral philosopher can do: provide a vision of morality where all the pieces fall into place together like an elegant, intricate puzzle. It is also a very compelling view, and one that appeals deeply to the American sense of the importance of individual self-determination. In health care delivery, physicians are often confronted with some challenges of trying to foster patient dependency rather than to promote their autonomy. The principle of respect for autonomy can be stated as

negative and positive obligation. As a negative obligation, autonomous action should not encounter any constraints by another.

The principle of respect for autonomy presents some problems. We are worried about how we can adequately respect a patient autonomy without trapping on his/her autonomy indirectly, for instance, the right to information of the patient. Patients have a right to be informed about the diagnosis and prognosis of their illness. If providing information is a right, should we present information to the patient without equally caring to know if the patient wants such information? Should rights be forcefully imposed? The physician has a duty to provide medical information to the patient but the information is not meant to be forced on the patient. The autonomous patient has a right to either refuse to know or accept to receive such information. The physician does not have a forced duty to tell such information if it is not the wish of the patient.

Another problem with this principle is the question of whether people are acting autonomously in revoking their prior decisions. For instance, an autonomous person who previously refused blood transfusion because of his doctrine but later requested for transfusion when close to death, even so died later because it was too late. In revoking one's prior decision, can we still read autonomy in play?

The question of capacity for autonomous choice constitutes a serious problem to respecting autonomy. Minority groups, mentally retarded individuals, demented adults do not have the capacity for making an autonomy choice. Being an adult does not automatically guarantee competence. Competence as a concept is by nature a problematic concept. Who and what determines competency? How is the capacity for making decision determined? It is at this point vital to examine in details the features of competency and various forms of competency.

In health care delivery, the capacity for making a competent decision is important because it ensures that the patient understands and can solely decide without interference from other person. This is why in situations of incompetency; a surrogate decision maker is employed. At times, the court appoints a guardian to protect the

interest of the patient concerned. In talking about competence, we may also be interested in knowing what kind of competence we are referring to: psychological competence or legal competence? It is not enough to judge a patient competent or incompetent, additional effort may be necessary in order to know for certainty and have the ground to back up the argument that a person is incompetent.

Competence can be defined as the ability to perform a task.[8] If competence is defined in this way, then, we may begin to examine different tasks by which we can judge a person to be able or not able to perform. We can talk about the competence in decision about treatment, competence in deciding about financial issues, competency in decision about mental related issues etc. It is very possible for a person to be competent in making mental decisions but incompetent in making decision related to treatment. Competence features skill such as mental skills and cognitive skills. Medically, patients are considered competent if he or she can understand a therapeutic or reserved procedure, can deliberate as regards the tasks and benefits and can make decisions.[9] If this is impossible, then, the competency of such person is questionable.

S.P.K Welie highlighted four requirements that are needed for a competence judgment. These requirements include: (1) the ability to acquire and retain cognitive content (2) The ability to manipulative cognitive content critically (3) A freedom of will (4) the ability to express oneselves.[10]

One crucial problem impeding the idea of autonomy is identifying the ideal sense of autonomy. It usually assumed that the capacity to make decision, competence determines autonomy alone. A disturbed person or a person enduring severe pain is rational but that pain can influence the choice made. In this situation, a decision is autonomous in the ideal sense of the world because the decision made is not totally free. Freedom and autonomy in health care delivery has shown in many occasion that it is a constraint type of autonomy. It seems to me more theoretical than having the total autonomy to choose. Therefore, one is said to be theoretically free to choose but unable to enact the choice.

Another crucial problem that we do not really pay attention to is how chronic physical illness affects the decision capacity of an affected individual. Generally, the capacity to make decision is considered mental capacity. We therefore consider children, mentally ill, demented and mental disorder as those who cannot on their own make an autonomous decision. Physical factors too can influence the decision making capacity of an individual. For instance, the Parkiston's disease, advanced cancer, stroke etc.

Though, it is expected that they should be able to make decision of their own since their mental capacity is not tampered with. People in this category should ideally be said to be competent but they are seldom considered legally incompetent because they encounter problems in decision making that has to do with their medical treatment.

Chronic physical disorder can be incapacitating due to their nature, in terms of problems of cognition, reality disturbances, restrictions of movement, reduced levels of energy, not to mention the demands of treatment and a lack of necessary support to enable the individual to maximize his bodily functions.[11] The chronically ill find it difficult to adjust to their new self. They see their formal self-crumbling away. This constitutes a serious challenge to them and a fundamental form of suffering.

The notion of autonomy presupposes total independent; but experience in our daily life shows that even the mentally upright, the healthy individual are not free as we claim they are. By our very nature, all human beings are vulnerable though some set of people are more vulnerable than the other due to terminal illness and certain physical disability. To ascribe total autonomy to mankind seems to us an illusion. The paradigm of individual autonomy is critically scrutinized by a growing number of authors. Tronto, tried to criticize the one sidedness of the notion of man as a free, autonomous being.[12]According to her, human beings are not only free and autonomous but also vulnerable and dependent.

The Principle of Non-Maleficence

Relationships between two or more persons depict some sort of connection that is beyond mere exchange of pleasantries or show of civility. Rather, it indicates some sort

of intimacy that usually emanates from contact and communication. Relationships are freely developed amongst individuals such as the cultivation of friendships and acquaintances, while other relationships are not as freely cultivated. In contrast, they are determined, such as relationships between brothers and sisters, cousins and relatives in general.

Other kinds of relationships could be entered into as a result of the demands of professions and duties, as is the case with the physician-patient relationship. In the course of duty and relationship with patients, the physician must adhere to certain principles of medical ethics (autonomy, non-maleficence, beneficence and justice), rules (fidelity, confidentiality, privacy and veracity) and virtues (compassion, kindness, respect, etc). A physician may be sanctioned if he breaches the principles and rules of medical ethics, but he may not necessarily be liable or compelled to uphold the virtues entailed in his line of practice and duty. It is, however, morally upright (but not obligatory) for a good physician to be compassionate, kind and to show respect for his or her patients. Respect for patients and the wishes of patients are two different issues that must not be confused.

The principles and rules of medical ethics are derived from the Hippocratic oath and various declarations (Declaration of Geneva as amended in Sydney 1968, Declaration of Tokyo 1975, Declaration of Oslo 1970, Declaration of Helsinki 1975, etc.) regulating medical practice. Despite the Hippocratic Oath and various declarations, a certain aspect (non-maleficence) of the oath and declaration is sometimes breached in what seems to be in the "interest" of patients in circumstances that constitute moral dilemmas.

The Principle of Non-Maleficence Defined

The principle of non-maleficence revolves around the concept of harm. Harm brings about pain and pain brings about distress. Harm may be incidental, intended and

intrinsic.[13] According to Thomasma and Graber, incidental harm is brought about through carelessness and negligence, intended harm is calculated and inflicted pain, while intrinsic harm is such that harm is directly brought about. They explained further that to kill a person deliberately has the intrinsic effect of harming (the patient), thus it violates the negative duty not to harm. Physicians' obligation not to harm is reflected in various codes and declarations of medical ethics.

Non-maleficence in general, and medical non-maleficence in particular, recommends that one ought not to inflict evil or harm.[14] Albert Jonsen in his work *Do no Harm* itemised medical non-maleficence into four categories: physicians must (a) dedicate themselves to the well-being (not harm) of patients; (b) provide adequate care; (c) properly assess the situation, that is, risk/benefit analysis; and (d) make proper detriment benefit assessments.[15] The physician's provision of 'standard due care' is central to the avoidance of harm. According to the American Law Reports, elements inherent in due care may be said to be violated and harm inflicted when and if the: (1) professional (physician) has a duty towards the affected party (patient); (2) professional (physician) breached that duty; (3) the affected party (patient) must experience a harm; and (4) this harm must be caused by the breach of duty.[16]

Based on these elements, the obligation of medical non-maleficence could be defined as not imposing risks of harm as well as not inflicting actual harm.[17] Veatch explains further that it is the responsibility and duty of physicians (and based on the fiduciary relationship between physician and patient) to keep patients away from harm.[18] Mason and McCall Smith also indicated, in line with Veatch, that based on their ability and knowledge, physicians must not engage in medical procedures that may be harmful to their patients.[19]

This is because, and based on, the obligation of non-maleficence, the responsibility of physicians is to maximize health and not to inflict harm. In real life situations physicians do inflict harm on patients but generally for the purpose of achieving some kind of good. According to Beauchamp and Childress, a harm inflict such as a surgical wound may be negligible or trivial yet necessary to prevent a major harm such as

death.[20] Infliction of harm (that is, negligible harm) purposed at arresting harm for the purpose of realising good does not constitute a moral dilemma. This is because negligible harm is usually inflicted by physicians based on detriment-benefit analysis in favour of patients.

However, infliction of harm is not always negligible. Sometimes, and increasingly regularly, physicians inflict fatal harm with the use of double effect medications in what seems to be in the patient's interest as well as to his/her benefit. The moral dilemma here is this: could the infliction of fatal harm that breaches the obligation of non-maleficence ever be in the interest and benefit of patients? Non-maleficence is a principle that presents an obligation not to harm the others. In medical ethics, it has been clearly associated with the maxim premium non nocere: Above all (or first) "do no harm". [21] By implication this principle will not give room for a medical student to treat patient by practicing on them. In the process of practicing, there is the likelihood of harming the patient. Patients are meant to be helped; they are not to help students in learning.

The principle of non-maleficence reflects in the work of William Frankena. He divided the principle of beneficence into four obligations. The principle he highlighted goes thus:

(1) One ought not to inflict evil or harm;

(2) One ought to prevent evil or harm

(3) One ought to remove evil or harm

(4) One ought to do or promote good.[22]

The first principle reflects the principle of non- maleficence while the three others reflect the principle of beneficence.

Non-maleficence is not only an obligation not to inflict harm on the other but it also includes an obligation not to impose risks of harm. Imposition of risks is sometimes

unintentional. There is harm done to others even while it is known. For example, a care-giver who consciously told information that he knows will harm the patient after series of objections to such information. The Hippocratic Oath expresses an obligation of non-maleficence and an obligation of beneficence: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."[23]Non-maleficence requires that one intentionally refrains from actions that cause harm. Obligation of non-maleficence goes beyond infliction of pain, it extends to imposition of risks of harm.

Harm could come in two (2) ways; it could be caused directly or indirectly. It is direct when one intentionally allows the patient to be harmed. And it is indirect if intentionality is not present. Certain unpredictable consequence/ outcome are likely to occur which are harmful to the employers which an employee did not intentionally or knowingly cause the harm. Direct and indirect causes of harm could be equated to negligence which is categorized into two types: intentionally imposing of risk or harm and secondly; unintentionally imposing of risk/ harm. A person is said to intentional impose risk or harm when e.g. a nurse uses already used syringes on another patient; when one unintentionally imposes risk; when one discloses information that may be harmful to the patient as a result of negligence of duty.

Physicians are expected to take very seriously their responsibility and to observe the standards of their profession. The failure to comply strictly leads to negligence on their side. The physician must give detailed explanation of the nature of the treatment. The below quotation better explains this:

> When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have implied by contract that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient so that a

> cure may follow such care and skill, and this degree of care and skill is required of him, not only in performing an operation or administering first treatment, but he is held to the like degree of care and skill in the necessary subsequent treatments unless he is excused from further serviced by the patient himself, or the physician or surgeon upon due notice refuses to further treat the case.[24]

This shows that there should be no room for negligence but the physician should be diligent in the treatment of patient.

The principle of non-maleficence presents many problems. It is possible not to harm but difficult to satisfy this principle in totality. Not harming can give room for paternalism in health care delivery. For example, a physician can decide not to tell a patient of his diagnosis because he felt the information could harm. We are therefore cut in the dilemma of how to handle situation especially when the care-giver and the patient do not share the same position.

Secondly, if the principle is insisting on "do no harm", what should be done in situations of serious dilemma? For instance, a patient has been sick and live on life sustaining treatment. He has not given any written document as to whether treatment should be withdrawn from him when he is in this situation. The physicians in charge presented the situation before the wife and family and they agreed that the treatment be withdrawn from him by applying the principle of non-maleficence that says do no harm. Would withdrawing life sustaining treatment amount to acting non- maleficently? Is it not more harmful to allow the patient to continue to remain in pains till death? Obviously, it is really a serious dilemma that bioethicists are still battling with because there are conflicting or contrasting views as to allowing, killing by withdrawing treatment from a patient.

The right to know of the patient is meant to be respected if the principle of respect for autonomy is to be recognized. And of course, there is the obligation not to inflict harm. In concrete medical situation, cases such as this are very difficult to address except

when the care-givers wants to assume or pretend as if there is no rule guiding such action.

Another crucial question that needs to be attended to while reflecting on the principle of non-maleficence is this: could a physician be held morally, if not legally, liable when in course of duty he breaches the obligation of non-maleficence? This kind of situation presents lots of dilemma as a physician would naturally want to give the best to his patient in the process of treatment. We should be reminded that some harms are unforeseen, how do we classify harm done in this kind of situation?

The Principle of Beneficence

This principle requires something more than the principle of non-maleficence that says we should not harm the other person. It requires that we take additional step to help others. Beneficent according to the *Oxford Advanced Learners Dictionary* means giving help; showing of kindness.[25] The act of beneficence is highly important to the produce of medicine. The principle of beneficence is to medicine what the principle of freedom is to journalism.[26] Beneficence is the guiding principle of medical professional which first and above all the doctor must strive to fulfil.

Beneficence understood that 'doing good to others' is clearly tied to the Judeo-Christian and Muslim virtue of compassion and helping others.[27] The principle of beneficence is more than not harming; it takes a step further by insisting that we contribute to the welfare of others. It is possible for a person to be left alone in a terrible situation without being touched at all under the pretence that I do not want to harm the person in question. Beneficence as principle says certain measure should be taken to ensure that patients benefit from treatment.

Broadly speaking, beneficence can be said to include all sort of actions intended to benefit others. The principle of beneficence refers to a moral obligation to act for the benefit of other.[28] Act of beneficence is different from the principle of beneficence. The principle of beneficence involves obligation towards others while it is not the case that all beneficence act are obligatory. There are two principles of beneficence: positive

beneficence and utility. Positive beneficence requires benefits from the agent and utility talks about benefit with best overall results.

The principles of beneficence and non-maleficence have certain sharp distinction. Generally, one cannot act beneficently towards all persons but it is very possible to act non-maleficently toward all persons at all times. The failure to act in accordance with this two does not have the same consequences. For example, the failure to act beneficently is often not immoral but the failure to act non-maleficently toward a party is immoral. Strict adherence to the principle of beneficence and autonomy sometimes conflict with each other like some other theories. Consider a case of a psychologically derailed person; being given a sedative in other to calm the person down, should his right still be respected or should the person be injected with sedative for his own good?

Beneficence is the ethical principle referring to good acts that are peculiar to the produce of medicine while benevolence is the virtue or the character traits which disposes the doctor to act beneficently when a doctor is approached for help, the virtue of benevolence disposes the doctor to provide such help. The principle of beneficence refers to a statement of obligation to act for the benefit of others.[29] Beauchamp and Childress distinguish between general and specific beneficence. While specific beneficence is directed at parties such as children, friend, and patient, general beneficence is beyond these special relationships to all persons.[30]

In a way, we are all obliged to act beneficently to the other. The obligation of general beneficence as suggested by W.D. Ross rests on the mere good that there are other beings in the world whose condition we can make better".[31] By way of interpretation, Ross is saying that we do not really need to have a relationship with the person we are helping. The existence of other people in the world necessarily calls for our attention to give them a helping hand. The problem with this statement is whether helping the other in the world is an obligation we have to fulfil?

Ross's position can be criticized on the ground that what kind of obligation we do have towards the other?. We must have overlooked the disadvantage of such an obligation. The disadvantage of this is that if we have obligation towards the others to the extent

that we must endeavour to make their condition better, than we may unconsciously neglect those we are indebted to. At the end, we may not meet with our primary responsibilities. Asides the fact of not meeting with our primary responsibilities, there is a need to take note that an obligation that exposes you to risk should be properly handled and addressed. For instance, let's assume Ross was right that we have the obligation to better the condition of the others in the world, if this is rightly taken to be true, what am I supposed to do when in an attempt to make other people's condition better, it endangers my life?

Quality health care delivery is very important to our daily survival and could also be seen as the source of our survival. Health care professionals are trained to promote the welfare of patients. The practice of medicine goes beyond merely avoiding harm but extends promotion of the welfare of patients. This is reflected in various attempts made at elevating the life of the public though social action of beneficence that includes programs on health education and administration of vaccination to the targeted public.

Thorough scrutiny of the principle of beneficence shows that the principle encourages paternalism. If a physician acts beneficently with the intention of acting in the best interest of the patients, paternalism is enhanced. For example, a caregiver who fails to tell the patient of the diagnosis of cancer with the intention of enhancing the coping mechanism of the concerned patient, acts paternalistically and fails to recognize the autonomy of such person.

Principle of Justice

The evident inequality in health care and increase in the cost of health care calls for serious discussion of justice and how justice can be ensured in medical community. Injustice pervades our health care system because there is no sufficient facility to meet up with the medical needs of patient. Since this is a problem, physicians are therefore caught in the dilemma of how to distribute limited available resources' amongst the many patients that needs them. The question of equality in health care has given rise to a lot of issues. There is the notion that equal opportunity be given to patient by physician. Considering the fact of inequalities in health care combined with the cost of

health care, the issue becomes more difficult. Can there really be equality? Is justice attainable in health care?

Justice means treating similar kinds of people in a similar way. For a physician to be just, he must treat patient based on equality; not giving special treatment to one and treating the other like a slave or no man. Justice could be given a political and social interpretation. However, justice in the most normal sense requires physicians to treat patient impartially, without bias on account of gender, race, sexuality or wealth. "Even in such a minimal sense, justices required a high standard of behaviour among physicists" The term fairness, desert (what is deserved), and entitlement have been used by various philosophers in an attempts to explicate justice.[32]

There is the formal principle of justice which requires that equals should be treated equally and unequal be treated unequally. This principle fails to provide the criteria by which we can determine whether persons are equal. It is also said to lack substance. Despite the fact that we are aware of equal political rights, equal treatment etc. Material principle of justice made a specification of relevant characteristics for equal treatment. It emphasizes that the distribution of resources is based on need. To say a person needs something means that if the need is not met, the person will be affected. Some needs that are not met are detrimental to the person in need e.g. a person who needs food may definitely suffer malnutrition.

Health care system no doubt, is of great importance to us not only to medical practitioners but also all individuals in the society. The dilemmas in health care system keep extending on daily basis. This is as a result of the development in the area of medicine and also the awareness of individual as autonomous being which fostered a radical shift in the medical tradition from the paternalistic approach to more participatory model.

The problem of how to determine choices in each specific health issue represents a very difficult task for medical practitioners. How these choices are made also raises a lot of ethical questions. These ethical questions have emerged in relation to the contemporary cost of health care. The conscious intensified effort made by both the media and the

public for the situations in the domain of health, attracts the attention of politicians/policy makers. The policy makers are in charge of fund allocation; they had to reform the health care system in order to meet with medical possibilities and patient's demands.

The major question relevant for this discussion is how justice can be attained in the face of cost effects of these resources. How can we distribute limited resources with fairness? Should they be distributed based on need? The following theories of justice shall be considered after which we shall determine if they have really provided us with an adequate instrument for making choices in health care especially in relation to enduring justice.

For the purpose of clarity and elucidation, I will discuss these theories one after the other. Libertarianism is a theory that emphasizes the principle of private property. An individual has the right to own a private property and this right must be protected in the society.[33] This theory strongly believes that transfer of property through sales, gift etc., must be a voluntary act which should not be performed under coercion. Any attempt to acquire any property through forcing someone to contribute to the wellbeing of others without being voluntarily done is not justified and considered as a violation of the right to property. This theory does not frown against helping others but any act of charity must be a voluntary act, otherwise. Libertarians acknowledged the difference between charity and justice.

Libertarians hold that there is no moral claim to health care therefore; the individual must be left alone. [34] This theory does not deny that there are basic needs but these needs are not the obligation of the society. Individuals operate in a free market system where everyone is responsible for themselves. It is strictly the view that your ability to pay determines your access to health care. It is a care free theory which consequently increases and intensifies the gap between the rich and the poor.

The utilitarian theory of justice is about the greatest number of happiness to the greatest number of people. For them, a just health care system should provide the greatest amount of health to the greatest number of people. This is a form of consequentialism.

There are two forms of utilitarianism; act and rule utilitarianism. The act utilitarianism says an act is right when it maximises utility while rule utilitarianism say an act is right if it complies with rules when such a rule(s) is obeyed, the utility will be maximised. Here, the moral significance of health care is the ability to maximise utility.

This theory would exclude certain person from having an entitlement to health care if it maximizes utility, regardless of the value of health care for this particular individual.[35] It does not take into account the values of individual being but of greatest number. Secondly, it does not mind if sacrificing a life will help to save several others. As long as utility is attained, the means to attaining the end is not important. There is no doubt that this theory cannot provide us with the solution to the problem of justice.

Egalitarianism is the principle based on equality. This theory holds that everyone must have equal access to health care services and nobody should be prevented from getting health care. This has a link with John Rawls theory of justice. He emphasized equality for all in terms of basic liberties and social and economic inequality which must be attached to offices with equal opportunity for all and including the least advantaged. The right to health care here is irrespective of the status of that individual person. In contrast to utilitarian theory, egalitarian theory does not just see an individual as a means but also as end. Egalitarian principle of justice is problematic since it does not provide us with proper method to know how resources should be justly distributed with fairness.

Communitarianism is another principle of justice. Communitarianism involves a shared value of group. The principle frowns at individualism because it fails to acknowledge the communal value embedded in the community. Individuals are members of the community and must not be left alone as it is in libertarian approach. The standards of rightness and wrongness in principle of justice evolve in the society not outside the society.[36] Communitarian principle in health care implies that the need of the individual should be determined within the community; therefore the need in health care cannot be determined independently of the ethical community.

The four theories of justice mentioned above do not really provide us with an adequate instrument for making choices in health care because of the limitations embedded in each of these theories. The problem of choice is still not being solved because none of these four approaches could capture our world's dilemmas.

It is worth noting at this juncture that there is no health care system that strictly uses only one of these principles. For instance, the United States of America was formerly libertarian. Currently, it is mixed or two-tied system. This is obvious in the fact that they now provide care and treatment to vulnerable group e.g. aged, poor and disable. This is also the case in United Kingdom which moved from egalitarian to mixed-tied system. Now, the free market has been incorporated. Health is made available for all and additional treatment can be obtained through free market system.

The dilemma on health care cannot be addressed strictly by using one of these theories. The dilemmas differ in status. While some countries are talking about rationing; others do not even have resources to ration. The research carried out by Prof Reithel et al using four countries UK, Norway, Switzerland and Italy reflects rationing by age and cost. It sounds unethical to say a person is being turned down just because he or she is old and when these are people who have contributed in a big measure to the society through taxes and etcetera.

There is no reason for doing this other than the scarcity and cost effects of these resources. When this is compared to the problem in developing countries it becomes clear that there is a more severe sense of rationing. Bed and drugs are being rationed, and some patients are even rejected because there is no bed space to accommodate them in the hospital. We cannot really have an adequate way of making choice in health care without being unfair to some. The dynamics of human life and challenges in health care are so complex that any attempt made to act fairly, conflict with some other fundamental principles and right. Certain fundamental values of man i.e. the human person must be put into serious consideration when choices have to be made to a reasonable extent.

The most important of which is the right to live. All human beings have a right to live with the foreknowledge that we all have a right to live. How can we then be just if all human beings have a right to live with the facts of limited resources in health care? Where is the place of fairness in the allocation of resources? How can we avoid injustice?

Principle of Beneficence and Veracity in Clinical Practice

Beneficence as discussed in chapter two of this thesis is a principle that emphasizes acting in a way that benefits the other. Any action that does not consider this is outside this principle. The implication of this principle is that before any decision could be taken or any action could be done, the benefit to be derived from such act must be put into consideration i.e. placed at the centre of treatment. Just like the other principles of biomedical ethics, the principle of beneficence also generates a lot of moral problems and questions. One of the questions raised with the application of the principle of beneficence to veracity in clinical practice is the question of how a care-giver knows with all certainty the kind of veracious information that benefits the care-receiver, how he knows truth that will not harm and at the same time remove harm from the care receiver.

Proponent of this principle may argue that the care-giver has a therapeutic privilege over the patient and should be able to know when to tell or not to tell the patient when truth may not bring about any form of benefit most especially when the interaction with the patient over time suggests the patient may not be able to handle the truth when told which may eventually results in harm.

Therapeutic privilege therefore refers to the withholding of information by the clinician during the consent process in the belief that disclosure of this information would lead to the harm or suffering of the patient[37] It is however doubtful whether a care-giver is justified in making a value judgment about what is best for a competent patient. A cogent reason for this is that a patient who has the knowledge of her medical situation would be able to avoid activities that could jeopardize her health.

There are patients who prefer to know the truth and often times, the inability to diagnose a patient condition often result in traumatizing situation. Many patients' relatives become worried when they cannot name the disease of their relative. Knowing bring about a certain amount of peace to the care receiver and her relative. Another good reason why it may be unacceptable for physician to withhold truth from the patient is that when a patient is not aware, it becomes difficult to consider alternative form of treatment or even consent to treatment. Telling makes informed decision to be possible and give room for patient to participate in the process of care for her health.

There is an evident contradiction in the principle of biomedical ethics. If the principle of beneficence says good should be promoted, harm avoided and removed; how do we account for the harm done to patient by not knowing? Lying or deceiving the patient breach the autonomy of the individual and interferes with the doctrine of informed consent which is equally important to health care delivery. It is after being notified that the patient can be said to have been informed and can consent.

Withholding of information from the patient impairs their decision making capacity. In conditions where there are limited options, telling allow patient to prepare for what lies ahead instead of being overtaken by events. In essence, if care-givers are meant to act to benefits others specifically the patient, how would they handle this issue? It is pertinent to examine situations where the patient do not want to know the truth about her health. Should care giver impose the truth on such patient as against her wish if he perceives the truth would benefits? Are we saying by implication that the autonomy of the patient should not count if the truth would benefit the patient? There seems to be a conflict with the principle of autonomy and beneficence in this context.

The principle of beneficence promotes paternalism in health care delivery. It is claimed that many health care-giver revert to non-disclosure and non-discussion in the face of uncertainty about patients' prognosis and the best course of treatment thereby forecloses opportunities for shared decision making. [38] However, uncertainty cannot justify non-disclosure.

In situation of uncertainty about the patient prognosis, it is vital for care giver to be extra vigilant to ensure that patients are given the information they need in order to participate in joint decision making about their care. Adequate and effective disclosure protects trust and assists the patient to manage information about uncertainties.

Principle of Non-Maleficence and Veracity

The principle of non-maleficence is the "do no harm" principle. This principle runs through the Hippocratic Oath. The principle stresses that actions that harm the patient should be avoided because harm brings about pain. Harm according to Thomas and Grabe may be incidental, intended and intrinsic. According to them, incidental harm is brought about through carelessness and negligence, intended harm is calculated and inflicted pain while intrinsic harm is that harm that is directly brought about. The obligation not to harm is a key principle in health care delivery. Its application to veracity in clinical practice becomes vital here. The health care provider is to care for the patient, provide treatment without causing harm to the patient. The process of treatment sometimes involves inflicting pain because treatment procedure such as giving of injections and passing IV Lines in patients are sometimes painful. This obvious truth about harm and pain that is resulted from treatment is one of the reasons some health care giver gives for equally withholding certain truth from their patients because they perceive it will cause further harm on the health of their patients.

There are situations where mere telling a patient the truth in a particular medical procedure caused High Blood Pressure (BP). Non-maleficence by implication would support withholding the truth from the patient if the effect will cause harm. On the other hand, we must acknowledge the fact that patient at times demands that they should be told. Is it also expected that the physician withheld such truth even if the care-receiver requested for the truth? Do care-giver has an obligation to also withhold the truth if he feels otherwise about the patients' request?

Health care-delivery is surrounded by very many difficult cases. For example: how to handle the case of an HIV patient who would not like to know when tested positive is a

crucial issue. We acknowledge the fact that autonomy is vital but the question is what other obligation do we have towards the larger society, who may be affected by non-disclosure of such information on request of the patient? "Do no harm", harm to whom? Is it the psychological harm or the discriminatory tendency the concerned patient may suffer? What about those who may be affected by non-disclosure e.g. the husband? HIV is transmittable from one person to the other.

In dealing with a case that involved married people, it may then be important to inform the patient who had earlier requested that he/she may not like to know so that the partner is told. This will help them to work out a good strategy for sex making if they have the knowledge of their status [39]. If we then insist on the psychological harm the patient may suffer when told then can non-maleficence as a principle help in addressing the problem of truth telling in clinical practice since by its understanding it also raises controversial issues and questions?

Very importantly, we are also confronted with the question of how we know or recognize truth that may harm. Often times, physician claims to know or have a clue, because of the epistemic privilege they claim to have over the patient. At times, mere asking of questions and observations of the reactions of the patient could immediately reveal that the patient may not be capable of handling the truth about the diagnosis.

We can at the same time argue that it may not be true to say categorically that the truth will harm the patient. There are so many situations in which the truth helps the patient to make better decision concerning health issues especially when the prognosis and diagnosis is known. Knowing gives room for better planning. A patient who does not know may do a thing that further endangers his/her health because he/she has no knowledge of what to avoid. In order words, not telling could produce or result in more harmful events in some given situation. It is crystal clear that relying on the principles of non-maleficence presents its own problems most especially on how we know and determine that this particular truth will harm the patient.

The issue of conflicting obligation also arises in this principle. The physician has a duty to tell the patient the truth especially to those capable of consenting to treatment.[40] Here comes the dilemma in non-maleficence and truth telling. We are left with the dilemma in non-maleficence and truth telling. We are left with the dilemma of whether it can be justified to withhold truth from patient because the care-giver has a therapeutic privilege that the truth may harm the patient.

> Therapeutic privilege refers to the withholding of information by the clinician during the consent process in the belief that disclosure of this information would lead to the harm of suffering of the patient (Etchells:) Although, it is thought that the failure to tell the truth in the content of the doctor- patient relationship, is an essential part of treatment (Johnson).[41]

It appears doubtful whether the care-giver is proficient or justified in making a value judgment about what is best for a competent patient. Additionally, the therapeutic privilege permits physician to tailor (and even withhold) information when, but only when disclosure would so upset a patient that he/she could not rationally engage in a conservation about therapeutic options and consequences.[42]

It can further be argued that there is evidence to support the notion that informing patients truthfully about life threatening diseases does not result in a greater incident of anxiety, despairs, depression, insomnia or fear.[43] The truth that the patient has towards the physician is eroded if truth is withheld from them. Therapeutic privileged therefore tramples on the autonomy of the patient. Gold, Cobbs write that:

> A medical doctor being the expert appreciates the risks inherent in the procedure he is prescribing; the risk of a decision not to undergo the treatment. Once this information has been disclosed, that aspect of the doctor expect function has been performed. The weighing this risk against the individual subjective fears and hope of the patient is not an expert skill. Such evaluation and decision is a non-medical judgment reserved to the patient alone. A patient should be denied the opportunity to weigh the decision is a non-medical judgment reserved to the patient alone. For example, where there is an emergency or the patient is a child or incompetent.[44]

To sum up, the arguments for the veracity of the care-givers truth does the following:

- Provide respect for the person's dignity
- Provide mental ease
- Provide emotional handle in the struggle to
- Accept reality crew death
- Assists two persons to maintain control
- It recognizes the autonomy of the persons and the right to informed consent.

In other words, not telling violates autonomy and some leads to hopelessness because the patient and even the family are ignorant. There is no doubt that a patient's knowledge of diagnosis and prognosis is not all-or-nothing. It exists on a continuum, anchored at one end by the purely theoretical 'absolute ignorance' and at the other end, the unattainable 'total enlightenment'.

Actual patients are to be found along this continuum that vary in response to external factors (verbal information, non-verbal clues, etc.) as well as internal dynamics such as denials.[45] (Freedman, of offering Truth).

Principle of Autonomy and Veracity

Autonomy is central in the four principles of biomedical ethics. It emphasizes the right and respect for individuals. Autonomy is violated when:

- we are coerced or threatened
- our choices are based on misinformation supplied by others
- our competence to make sound judgments is impaired.

We value our autonomy, so actions by others which violate it are (usually) morally objectionable. Failure to respect the patients' wish to know or not to know violates the individual right to information. Just as we found the earlier discussed traditional ethical theories with some inherent flaws so also is the principle of respect for autonomy. Before now, our health care system most especially in the African context was basically paternalistic where the care-giver decides the fate of the health care-receivers. Presently,

to some certain degree, we found care-receivers willing to participate in the process of care delivery. Though, this so-called participation cannot be likened to the practice in European context.

The principle of autonomy by implication means that the autonomy of the patient should be central in any decision related to the care giving of the patient in question. In contrary to this, it could be argued that medical ethics since the time of Hippocratic, has required doctors to do the best for their patients. The Hippocratic Oath requires that "I will follow that system or regimen which, according to my ability and judgment I consider for the benefit of my patients."[46] It says nothing about doing what patients say they want, not deceiving them, consulting them about their wishes, explaining likely consequences, good or bad, or describing alternative courses of action. If this is taken to be true, it then means autonomy could be suppressed for the care giver to do what he considers to be at the benefit of his patients.

Put in real life circumstances, however, when a care-giver is dealing with patients terrified by their diseases, maybe suffering great pain and other highly unpleasant symptoms, it becomes far more plausible to think, especially if one is that patient's doctor, relative, or friend, that the last thing one should do is to add to the misery and worry by passing on the results of the biopsy, the risks of treatment, the unsatisfactory options, or whatever other nasty bits of information the doctor has up his sleeve in the name of respecting the patient's autonomy.

There are problems with this principle and the following questions are important. How do we manage a case of veracity where the autonomous patient insists on not wanting to know? Should the physician withhold the truth or impose the truth about the patient health on the patient who earlier said he/she does not want to know? How do you decide when and where not to attend to the wish/request of a patient who is autonomous especially when the physician perceives the truth may harm? Should all autonomous patients' request be granted as requested? How do you know with all certainty that the

patient is truly and genuinely autonomous? How do we resolve the conflict between paternalism and autonomy?

Attributing autonomy to an individual requires having some basic things in place. In respecting autonomy, the issue of ability to consent must be settled. It sounds irrational to talk autonomy when the ability for consent giving is absent in the individual involved e.g. imbecile. Autonomous patient must be competent to understand what they are told about their condition and capable of exercising judgment; be provided with relevant information about their illness and the proposed treatment in an understandable form and allowed the opportunity to ask questions; given information about alternative treatments, including no treatment at all; allowed the freedom to make a decision about their treatment without coercion. A patient that cannot understand treatment options cannot be said to be autonomous. In order words, decisions cannot be left with such individual.

The principle of autonomy presupposes that a patient may decide to exercise her right not to know. In other words, if you do not know, you do not know also you have the right not to know and if you know, the right not to know becomes useless. The right to know goes hand in hand with the right not to know (paragraph 67 of the explanatory memorandum of the European Convention on Biomedicine and Human Rights-ECBHR-).[47]. These two rights can be exercised by an autonomous patient.

In fact, the reference to a right not to know obliges us to reconsider the goals which makes compulsory to inform a person before his/her consent is requested for a medical intervention. If we believe that the concept of autonomy is pre-eminent because a person has some right to decide on his/her medical treatment, we may understand the right to know as an application of the principle of autonomy. Because I have to decide for myself, I may wish that in some circumstances I will not look at the information that derived from the medical investigations. There are different reasons that can be given as explanations as to why patient may make this choice. One good reason is to avoid psychological trauma that may resulted from being told about a person's health in

situation where there is presently no available cure or treatment for the disease. The right not to know in this case may be a way of protecting the patient from useless anxiety and also a way of safeguarding his social life and family.

It is also important to know that there are situations when patient's autonomy may not be respected even on request that he would not want to know. This shall be supported with Article 9 of the ECBHR, the French Patients' Act of 4 March 2002 which explicitly states (Art L1111-2 PHC paragraph 4) [48] that a person's will, not to be informed of a diagnosis or a prognostic, shall be respected except when third parties are exposed to a risk of transmission. Having this in mind, physician should then be conscious of the fact that the right not to know should be used as a way to lose consciousness of our responsibilities towards the family, close friends and community.

Another reason why a patient may want to exercise her right not to know is to prevent insurance company from knowing so that the knowledge about her health may not be used to exclude or deny the patient the opportunity to benefit from the contract. It must be made clear at this juncture that discharging the duty of veracity is not an easy task on the part of the care-giver. It is not a responsibility that can be taken to be acted upon dogmatically.

The Principle of Justice and Veracity

This principle emphasizes fairness to all in terms of access to health care. In order words, inequality must be greatly discouraged in dealing with patients that needs medical attention. It denounces discrimination in the delivery of health care. One may be bothered about how this can be made available to all without being biased? How can health care be fair at the same time treat health care receiver equally when veracity is involved? Considering the peculiarities of each patient, it is possible or feasible to handle truth same way to all patients. There are situations where truth telling may be withheld from a patient if perceived that the truth may harm such patient. Would such action amount to injustice in health care delivery?

As much as justice is important in health care sector basically to ensure that all persons regardless of race, culture, and or background are given fair treatment not only in terms of the care given to them but also in terms of the information given to them. We should also bear in mind that it is easier said than done to say or assume that respecting the principle of justice in health care delivery is an easy task. When a physician refuses to tell and withhold the truth from a patient, it does not necessarily mean that the physician intends to act unjustly but it may be that he sees the patient as not competent enough to handle the truth. He may present same truth to another patient in similar situation and refuse the other.

One may want to argue further if there can be reasonable ground to support the view that treatment of patient can be equal in truth telling. Is the earlier position justifiable i.e. the position that some patient may be told and another may not even in the same circumstances? If we say yes based on the peculiarity of an individual and the ability to handle truth; where then is justice? Is it indeed attainable in discharging the duty of veracity? The questions raised above also suggest to us that the principle of justice cannot be used to address the problem of veracity in clinical practice.

Conclusion

This chapter has successfully delved into detailed discussion of principlism in contemporary bioethical discourse. It has also presented and highlighted the major flaws of the principles. Following Beauchamp and Childress's exposition of principlism, it is evident that they tried to put this forward as a general moral principle with which we all readily agree without bringing in a lot of subterranean philosophical architecture.

Unfortunately, dispensing with the philosophical architecture altogether brings its own difficulties, as I suspect we are beginning to notice. Recall how Beauchamp and Childress have some difficulties explaining what to do when any of the four principles directly conflict with the other: For example, should autonomy take place over beneficence? Should justice overrule individual autonomy? Without some deeper, more

fundamental understanding of ethics, how are we to resolve such conflicts? What should we say to health professionals who might prefer to emphasize beneficence over respect for autonomy? Also, what should we say about other cultures that perhaps place much less importance upon individual autonomy? Should the principle of justice take precedence over that of autonomy, beneficence or non-maleficence?

END NOTES

[1]Beauchamp, T.L. and Childress, J. 2001. *Principles of biomedical ethics*. New York: Oxford University Press. 56.

[2]ibid. 57.

[3] Berlin, I.1969. Two concepts of liberty. *Four essays on liberty*. Oxford: Oxford University Press. 118.

[4] Beachamp and Childress, *Op.cit.* 63.

[5] *Ibid.* 103.

[6] Kant, *Op.cit*. 1786.

[7]*Ibid.* 127.

[8]Culver, C.M. and Bernard, G. 1988. *Philosophy in medicine*. New York: Oxford University Press. 34: 123-126.

[9] Beachamp and Childress, *op.cit.* 114.

[10]Welie, SPK. Criteria for patient decision making (in) competence: a reviewing and commentary on some empirical approaches. *Medicine, Health Care and Philosophy*. 4:139-151.

[11]Rolland, J.S. 1983. A Conceptual model of chronic and life threatening illness and its impacts on families. *chronic illness and disability*. Eds. C.S Chilman, C.S. Nunnally, E.W. and F.W. Cox, F.W. Newbury Park: Sage Publications.

[12]Tronto, J. 1993. *Moral boundaries: A political arguments for an ethics of care*. London: Routledge.

[13]Thomasma, D. and Graber, G.1990. *Euthanasia: towards an ethical policy.* New York: Continuum Publishers. 292.

[14]Beachamp and Childress, *Op.cit*. 122.

[15]Jonsen, A. 1989. Do no harm. *Principles of biomedical ethics.* Eds. Beauchamp, T and Childress, J. Oxford: Oxford University Press. 126.

[16]*American law report*, 1997. 1084.

[17]Beachamp, T.L and Childress, J. *Op.cit.* 125.

[18]Veatch, R. 1977. *Case studies in medical ethics.* Massachusetts: Havard University Press. 357-358.

[19] Mason, J.K and Smith, M.1983. *Law and medical ethics.* London: Butterworths Publishers. 257.

[20]Beachamp and Childress, *op.cit.* 122.

[21]*ibid*.

[22]Frankena,W. *op.cit.*

[23]Holder, A.R. 1975. *Medical malpractice law*. New York: John Wiley and Sons. 42.

[24]Pence, G. 2004. *Classics works in medical ethics: account of cases that home shaped medical ethics*, New York: McGraw Hill. 78.

[25] Hornby, H.S. 2000. Oxford advance learner's dictionary of current english. Oxford University Press.

[26]Drane, J.F. 1988. *Becoming a good doctor: the place of virtue and character in medical Ethics*. Pennsylvania: Rowman & Littlefield.

[27]Pence, op.cit. 22.

[28]Beachamp and Childress, *op.cit.* 16.

[29]Ibid., 197.

[30]Ibid.,199.

[31]Ross,W.D.1930. *The right and the good*. Oxford: Clariondon. 21.

[32]Maclntyre, A.1988. *Whose justice, which rationality?*. Notre Dame, IN: University of Notre Dame Press. 57.

[33]Yvonne, D and Meulenbergs, T. 2002. Health Care Needs and Distributive Justice. Philosophical remarks on the organization of health care systems. *European perspective on health care ethics*. Eds. Schotmans P, Reidar, L, Hansen, B and Meulenbergs, T. Leuven: Peeters. 265- 297.

[34] Ibid.

[35]Buchanan, A. 1997. Philosophic perspective on access to health care: distributive justice in health care. *Mount Sinai Journal of Medicine* 64/2. 91-92.

[36]Dennier and Meulenbergs, *Op.cit.*

[37]Etchella, E., Sharpe G., Burgess M., Singer, P. 1996. *Bioethics for clinicians: 2 disclosure*. CMAJ. 155: 387-389.

[38]Parascandola, M., Hawkins, J., Danis, M. 2002. Patient autonomy and the challenge of clinical uncertainty. *Kennedy Inst. Ethics.* 12 (3): 245 - 264.

[39]Johnson, C., Holt, G. 2006. The legal and ethical implications of therapeutic privilege – is it ever justified to withhold treatment information from a competent patient? *Clinical Ethics*. 1:146-151.

[40] Cote, 119- 216.

[41]Etchella, E., Sharpe G., Burgess M. M., Singer P. A. Op.cit. 387-389.

[42] Meisel, 2521 -2526.

[43]Gold, M. 2004. Is Honesty always the best policy? ethical aspects of truth telling. *Intern Med J*. 34: 578 -580.

[44] Ibid.

[45]Freedom, B. 1993. Offering truth. *Achievers of Intern Medicine*.153 (3) 572-576.

[46]British Medical Association. *The handbook of medical ethics*. London: BMA, 1984:69-70.

[47]Paragraph 67 of the explanatory memorandum of the European convention on biomedicine and human rights-ECBHR-).

[48]Article 9 of the ECBHR , The French patients' act of 4 March 2002 which explicitly states (art L1111-2 PHC paragraph 4)

CHAPTER FOUR
THE IDEA OF VIRTUE ETHICS

Introduction

The philosophical enterprise has continually been spurred by critical hindsight, which most scholars unassailably agree is the hallmark of its nature and as such it has become a base for diverse intellectual perspectives, often times not short of theoretical preferences or biases, which lead to curious questioning. The critical mind becomes uneasy in its search for truth; inquiring and investigating the justification of any proposed alternative to the search for truth; what is knowledge? Is God an idea or a divine arrangement? Is good and bad a matter of motive or consequences? These questions among several others are the preoccupation of the entire enterprise of philosophy, which the diverse branches of epistemology, metaphysics, logic, and ethics attempt to address.

But of significance in this chapter is to argue that the ethicists or philosophers of morality have risen up to the challenge of what is a good action, attitude or person from a bad one. Quite a number of moral theories, mainly deontological and consequentialist inclinations have been proposed over time. However, the focus here would be a shift from this, to the mainstream of an alternative approach. Virtue ethics exhibits a unique approach. This chapter hence would be devoted to the justification of the uniqueness of Virtue Ethics, and this would be done by critically navigating through its definition, tenets/principles, criticisms and its suitability for contemporary existence.

Virtue Ethics: Definitions and Issues.

Before digging into the development of virtue ethics, it is important to note that it arose out of the drive for an alternative approach to ethics. Raising objections to other normative theories (specifically those of deontological and consequentialist strand) and defining itself in opposition to the claims of others, was the first stage in the

development of virtue ethics. It initially emerged as a rival account to deontology and consequentialism, developing from the dissatisfaction with the notions of actions as duty and obligation and their central roles in understanding morality.

It also emerged out of objections to the emphasis on rigid moral rules and principles and their application to diverse and different moral situations. Importantly, virtue ethics lay claim to the role of virtue and character in its understanding of moral life and uses it to answer the questions "How should I live? What kind of person should I be?" Unlike consequentialist theories that are outcome-based and deontological theories that are agent-based, virtue ethics is character-based. Rather than just criticizing consequentialism and deontology, virtue ethicists took up the challenge of developing full-fledged accounts of virtue that could stand on their own merits.

The propagation of this could be traced to the ancient thinkers like Socrates, Plato, and Aristotle down to Aquinas, Augustine, Hume, Elizabeth Anscombe, Alasdair Macintyre, Bernard Williams, Michael Slote among others. The conception of virtue ethics as pointed out by Pellegrino and David C. Thomasma, has its root in the classical, medieval, and in the present period when it was resuscitated.[1] Virtues are character traits, they are not innate in us but they are cultivated. A virtuous person is seen as a morally good person. I may consider something morally good and another person may say it is bad.

The search for the good life occupies the mind of individual in the society. Everyone wants what is good for himself but this search for good life sometimes conflict with some other interest of people in the society such that some interest are being infringed upon. The pursuit of the good life is well encapsulated by P. Philippa Foot. She believes that " Men and women need to be industrious and tenacious of purpose not only so as to be able to house, clothe and feed themselves, but also to pursue human ends having to do with love and friendship. They also need the ability to form family ties, friendships and special relations with neighbours. They also need codes of conduct. And how could they have all these things without virtues such as loyalty, fairness, kindness and in

certain circumstances obedience?"[2] The above assertion by Foot shows how much humans are pursuing the good life for themselves by forming friendship and relational ties. All these to her cannot be attained without virtues.

Following from this brief introduction to virtue ethics, it is cogent to examine considerably in detail the ideas of the chief inspiration of this theoretical alternative, that is, Aristotle; so as to have an in-depth understanding of the take-off point of subsequent virtue ethicists, the issues raised and the concerns generated from the debate.

Aristotelian Conceptions of Virtue

As noted earlier, virtue ethics was presented as an alternative normative approach to the debate of good and bad, wrong and right actions on the basis of character or traits considered virtuous. Following the path of Aristotle, it is preliminary to examine what 'virtues' are in virtue ethics. What are virtues? Are virtues pre-determined by exemplars or internally cultivated? Is there a nexus between virtues, rules, duties, obligations and human actions? Aristotle's notion of good is a head start to his exposition of virtue.

Aristotle's conception of virtue begins with the understanding that things, inquiry, beings are created for certain purpose(s); the human person is no exemption here. His conception of the human person is as a being unto function (*ergon*) and this function as implied by Aristotle is basically the good. The opening remarks in Book I of the *Nicomachean Ethics* reveal that "every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim".

Of importance is Aristotles' acknowledgement of the centrality of reason in the human person. Aristotle's intention is not one that sets out to deny that man shares appetitive and emotional (passion) instincts with others (animals), but one that emphasizes that there is a unique feature in the human person that distinguishes it from others and it is this aspect of the human person that enhances the possibility of the effectiveness of the

human function. This feature is the possession of internal states; which is referred to as reason by Aristotle.

However, the possession of this faculty is not just for the sake of it; it must correspond with the function in the pursuit of happiness/flourishing, which he tagged as '*eudaimonia*'. *Eudaimonia* became the prized vocabulary of Aristotle's ethics, the highest good of the human person. According to him, there is an epistemic basis to the conception of virtue ethics and this aids clarity for the understanding of virtue ethics as a practical approach. Aristotle's belief here is that the study of Ethics is shaped by the framework of theoretical (episteme/sophia) and practical knowledge. It is within this framework that the dimension of intellectual and moral virtues comes to light in virtue ethics. Though in his analysis of virtues, Aristotle focused on the moral virtues but his point that human persons are meant to be morally virtuous by being practically wise through the practical application of theoretical knowledge (*phroenesis*), has been made.

This suggestion is central to Aristotle's argument that virtues are internal states cultivated through training (from the stages of childhood) and habits that are meant to be developed towards the goal of *eudaimonia* or happiness. Even though Aristotle does not deny the aspect of irrationality, emotion or passion in man, his notion of happiness is not a reference to a fixed state of pleasure. Happiness is a pursuit, an activity for Aristotle (to attain a well lived life).

It is pertinent to ask then; what is virtue in Aristotle's worldview? In Book II (*Nicomachean Ethics*), Aristotle seems to imply that virtue is a normative concern. He equates virtue to excellence (*arête*). Virtue as it appears in Aristotle's account is not only normative, but also reductive. Its reductionism is not far-fetched as Aristotle argues that 'this kind of excellence makes us to do what is best in matters of pleasure and pain.[3] He observes that moral virtues/excellence is closely concerned with pleasure and pain, the former moving one towards what is noble (*kalon*), beautiful and advantageous, the latter moving one away, towards that which is ugly and shameful (*aischron*). Aristotle holds that these motivations determine the choice(s) of man. It

should be noted here that Aristotle does not seem to say that virtue is pleasure (in the way we conceive of pleasure) and that in his explanation of what virtue is, he had an idea of vice as all that is contrary to virtue. This point would later become obvious.

However, what determines a man's choice is the primal factor of whom a person is; Aristotle shows that men become just and temperate only by doing what is just and temperate and it may be said that if their acts are just and temperate, they themselves are already just and temperate, as they are grammarians and musicians if they do what is grammatical and musical. Justifying this basis of virtue, Aristotle notes that it must correspond with the fulfilment of the conditions of certain states of mind (internal states).

It must correspond with doing what a person knows is 'good' (proper by his/her function), a subject of choice (reason), from a certain disposition of a formed and stable character.[4] Aristotle attempts to get rid of the ambiguities about virtue by responding to the contemplation of whether virtue was just a mere habit or an emotion or mutual inclination. He defines virtue as "the habit of trained faculty that makes a man good and makes him perform his function well".[5] His understanding is that the proper excellence of virtue in man lies in 'goodness' or performance of his functions appropriately in accordance with reason in the pursuit of happiness.

Aristotle's further analysis of what virtue is led him to the analysis of virtue as the intermediate or moderate mean. He clarifies that this mean is not an absolute one but relative in persons and that it does not imply the mean in arithmetic terms; Aristotle's mean denotes the extremes of excess and deficiency and these extremes prevail on actions in virtuous and vicious ways, implying that virtue/excellence is destroyed by excess or deficiency but secured by observing the mean.[6] Simply stated, a virtue in Aristotle's opinion is a mean, having a due amount of feelings, pleasure and pain, not (too) much, not (too) little. It has to do with feeling fear, confidence, desire, anger and so on (pleasantly and painfully) neither too much nor little but to be affected at the right time, on the right occasions, towards the right person in the right fashion; either excess

or deficiency in acts, wrong and undesirable. Aristotle illustrates his analysis of virtue by presenting a list of virtues: courage, temperance, liberality, magnificence, magnanimity, proper ambition, truthfulness, patience, wittiness, friendliness, modesty and righteous indignation. He gives the instance of courage as the mean between rashness and cowardice. Excess and deficiency, for Aristotle, are characteristics of vice, while virtue is a moderate between the two extremes; a mean. Little wonder then that often times Aristotle's ethics is regarded as ethics of moderation.

While this account carries an implicit explanation about whom a virtuous person is, Aristotle finds it crucial to distinguish 'continent and incontinent persons' from virtuous persons. The continent persons (*enkrates*) do what virtuous persons do. They are capable of suppressing certain internal pressures spurred by emotion, pleasure, anger and so on; yet they are not virtuous persons because their actions are not under the influence or control of reason. The incontinent (*akrates*) persons disregard ethical virtuous acts and, for Aristotle, this is *kakos phalous*, which means evil since they are driven by the desires for domination and luxury, seeing no value in virtues like temperance, justice and so forth. They are single-minded, dissatisfied, and full of hatred and the desire to accumulate more (*phronexia*) in the pursuit of their goals; subsequently what is 'good'.[7]

On another level, Aristotle does not generalize that all actions/acts are within the category of virtue. He makes it clear that certain actions/passions are bad in themselves and hence cannot be an exercise of mean. Such acts include adultery, stealing (theft), murder and so on. These acts are not even dependent on the occasion, manner, measures or appropriate persons; they are merely bad and wrong.

As far as Aristotle is concerned, these acts are to be removed from the moral plane (ethics), but the impressions this creates is that they be subjected to rules or legal framework or not has continuously remained a controversy which has resulted in so many questions directed at Aristotle. The discussion of this however, is beyond the scope of this section. It is worthwhile to state here that Aristotle's ethics/virtue ethics

was mainly a response to the claim that no ethical theory can offer a decision procedure (from an objective stance). His attempt was to suggest an alternative to other normative theories and focus on the virtuous agent as the way out of moral dilemma.

It would not be out of place to state that Aristotle's virtue ethics as it has been analysed, holds on to certain presuppositions for the sake of virtue (morality or the good). Virtue ethics presupposes that moral actions are by choice but one that must be in accord with internal character traits in harmony with practical reason. This character trait/virtue must be inculcated for practice not for purely theoretical or intellectual wisdom alone. This draws reference to the epistemic backdrop of Aristotle's ethics. Virtues are mean, not in the sense of average/medium proportion but a due amount of doing that which is appropriate and regarded virtuous in a given situation.

Virtues presupposes two extremes (vices); excess and deficiency and may also presuppose a unity of extreme virtues in the sense that it may set off the perceived corresponding vice inherent in virtues in the process of making choice of actions in situations. The discourse of virtue ethics however has been subjected to diverse interpretations after Aristotle and this would be the point of our concern in the next section.

Some Post Aristotelian Conceptions of Virtue

The conception of virtue ethics has been modified after Aristotle even though the discourse of virtue ethics still retains some of its fundamental Aristotelian version in recent times. With the emergence of Christian/Renaissance thinkers, attempts have been made to define virtue ethics by what it is not. For instance scholars like Aquinas and Hobbes expand the categories of virtues to correct what has been termed the elitist paradigm of virtues as proposed by Aristotle. Aristotle's ethical writing said to be meant for the aristocratic male class of the Greek society (to the exclusion of women and slaves).

Thus, it was not surprising that right from the theological era, virtue ethics has been broadened to include the categories of faith, charity, hope, humility, forgiveness, social harmony and so on. Regarding this springboard of post-Aristotelian conception, Cooper notes that "however when a language of moral philosophy in recent decades is considered, a substantial break is evident in the long and lively intellectual history of virtue."[8]

In recent times, virtue ethics has been subjected to theoretical exploration and ethicists in turn have the responsibility to get acquainted with diverse accounts to unravel the point of contentions raised in the discourse of virtue ethics. Micheal Slote, a formidable pro-virtue ethicist, presents an agent-based virtue ethics version, following Aristotle. Slote's ethics advances a theory of good on the basis of the moral agents. He advocates that human acts must be in accordance with practical reason. Virtue ethics in his opinion is in three theoretical variants: agent-focused, agent-prior, and agent-based. Agent-focused virtue ethics centres on the virtuous individuals and inner traits in them rather than rules/principles; agent-prior concerns the evaluations of actions. The agent-based virtue ethics treats the moral status of acts as being totally derived from independent/fundamental claims about the motives, dispositions of the inner life of moral individuals.

He further argues that Aristotle's account instigates the evaluation of moral actions in non-altruistic and other regarding motivation terms like the health of one's soul, compassion, benevolence and so forth. This assertion is not just for the sake of itself; in his view, it was to signify propagation of an agent-based virtue ethics that would expound the notion of 'balance-caring'. Slote explained that this notion reinforces the argument that virtue ethics is an expression of morality in non-altruistic and 'motivation' terms. 'Balance-caring' connotes that morality or evaluation of moral actions should not be on the basis of a slavish attention to aggregate well-being or strict egalitarianism (acting for the sake of altruism; the good of others alone).[9] The assumption here is that the principle of 'balance-care' would make room for the pursuit of good we have for ourselves, our intimates and humanity in general. It is not difficult

to see that the analysis of 'balance-caring' is similar to the Aristotelian mean that emphasizes moderation of motives in appropriate proportion but this takes another direction in Slote's view.

Rosalind Hursthouse argues that the assessment of moral actions are not merely reducible to the assessment of agents but rather to something other than the assessments of agents namely; the judgment of human flourishing. Her attempt is to show that virtue ethics is not incapable of assuring action guidance as some of its critics would make us believe. She admits the role of motivation/rationality in human flourishing as Aristotle has argued. However, contrary to the claim that virtue ethics does not provide rules, Hursthouse argues that this is advantageous as virtue ethics, is meant to inform actions, not provide rules for actions. This is to inform moral agents to act in assertive ways like "act courageously", "act justly", "act honestly", et cetera. Thus the impression that it does not provide single/uniform rules and principles applicable for all actions after all may not be out of place.

For Hursthouse, people's response to happenings in different situations is what exhibits the virtue or vices in actions. It becomes legitimate therefore, to hold that there are cases of irreconcilable moral happen-stance not one of vice though, but situation in which two virtuous persons come to different conclusions about the ways to act but yet each recognizes that the other also acts rightly.[10] In a similar way, Phillipa Foot agrees with Slote and Hursthouse that an account of moral judgment lies in a conception of morality that is in accordance with practical rationality. This must be met by practical reasons that guide or determine moral judgment. For Foot, all practical judgment must have connection with the human-will; they are within the category we associate with voluntariness, and hence with responsibility.[11]

Stohr and Wellman observe that this claim presupposes Foot's virtue ethics and it also seems to have spurred Foot's argument that virtues must cohere with the life form of a human person, as a member of the human species. Virtue thus becomes a necessity for man to fulfil the life form of a human person. In the manner that a dandelion that has a

strong root system would be accorded as a 'good-dandelion', so also is a person virtuous, who can act in accordance with the natural facts of being human; functioning in consonance with practical reason.

Though Foot's interpretation seems to be filled with the emphasis on practical reason, it has been argued that it differs from the Kantian ethical interpretation of practical reason;

> I want to say that there is no criterion of practical rationality that is not derived from that of the goodness of the will…. Kant was perfectly right in saying that moral goodness was goodness of the will; the idea of practical rationality is throughout a concept of this kind. He seems to have gone wrong however, in thinking that an abstract idea of practical reason applicable to rational being as such could take us all the way to anything like moral code. For the evaluation of human action depends also on essential features of a specifically human life.[12]

Foot's assertion is that practical reason is specific to human life, but not in the abstract sense as Kant holds. A thorough examination of this is a later concern of the chapter as this has generated contentions about the scope of virtue ethics; whether there are elements of virtue-claims in other normative ethical theories such as Kant's. Elizabeth Anscombe, William Bernard and Alasdair Macintyre are familiar figures in the project of virtue ethics after Aristotle. Elizabeth Anscombe posited that the rigid law conception of ethics must be jettisoned.

She encourages getting acquainted with the Aristotelian alternative of virtue, hence moving ethics into the site of character and traits rather than principles or rules that guide action. Virtue, in her view, should be the central to our understanding of morality. The extent of her zeal for the project of virtue ethics is well contained in her book, *Modern Moral Philosophy* (1958), where she exposed the bane of normative ethical theories of Mill and Kant. Bernard on his own part pursued his argument through the presentation of the differences between morality and ethics. He holds that most other normative theories are concerned with obligation (morality); these concerns are

restricted and confined to the discourse of morality alone, that do not grant that human actions could be influenced by forces beyond its control.

Contrarily, he notes that virtue ethics pinpoints the ample benefit of the broad horizon of ethics over morality as it does not ignore the view that the determinants of good acts could be the influence of factors/forces beyond human control. For instance, virtue ethics reckons with the wider significance of forming character/trait which may be informed by friends, family, and upbringing or the society at large.

This idea goes back to Aristotle's and Plato's emphasis on the essence of training, but with thinkers like Bernard, the interpretation of virtue as excellence in accord with human function and reason (internal states) which are cultivated as Aristotle had claimed became re-interpreted to accommodate the idea of 'moral exemplars'. Moral exemplars are other moral persons (external in a sense) whose essences (lifestyle) are emblems of virtues or virtuous action, which are worthwhile of emulation for potential virtuous persons.

Alasdair Macintyre's virtue ethics takes a new dimension. Taking cognizance of the diverse accounts of virtue ethics, he holds that virtue ethics must be in congruence with prior moral and social features in practice. For him, the diverse accounts are as a result of different practices and hence would generate different conceptions of virtue. This implies that virtues are exercised within practices that are coherent, social forms of activity that seek the goods internal to the activity more than that which is external. It further implies that virtue ethics bears a *telos* or consequence (flourishing) for the good of the human person and society at large. The virtue of integrity and constancy as far as Macintyre is concerned must not be found wanting in any sort of experience.[13] In as much as we have several post-Aristotelian ethicists, there would be degrees of variation in the conception of virtue ethics.

However, of utmost importance in this section is to outline those basic principles or tenets that are evident for the contemporary understanding of virtue ethics that these

scholars have presented. This would aid a common assumption of virtue ethics and the points of the contention in the debate of virtue ethics in present times. Fundamentally, and crucial to virtue ethics, is the principle of *functional interpretation* of a moral person. The theme of function here is not an instrumental one of means to an end but rather of an intrinsic value which most virtue ethicists even after Aristotle have signified must be the pursuit of the good life, though this notion of 'good' differs from one thinker to another. For Slote, it is 'balance-caring', for Hursthouse it is 'judgment of human flourishing' while for Foot, life form.

It is needless to say that virtue ethics as shown in the works of its proponents is also a pursuit of the goal of 'the good' (happiness) even though it is 'person-routed'. It is likely that it is in this sense that virtue ethics shares an affinity with other theories, though it has been argued that it takes a different line. An equally important tenet of virtue ethics is that it is an expression of the concern for the '*self and other*'. Though, this kind of claim sounds existentialist, virtue ethics is not far from it. These principles are reflected in the virtue ethicists' narrative of the necessity for moderation (following Aristotle) and the recognition that the pursuit of good must be in terms of a common concern for others or humanity. In fact, the implication of 'moral exemplars' suggested by Bernard is a clear indication of this and Slote's notion of 'balance-care' also shows the intricacy of this principle/tenet as central to virtue ethics.

The need for *character development* is central to the framework of virtue ethics. This is glaring in both Aristotelian and post-Aristotelian accounts and it carries the intimation that any theory that must be counted worthy as virtue ethics must be agent-centric by laying emphasis on the importance on the character of the agent. Beyond this analysis, there is the need to merge theory with practice (particulars) as Aristotle had challenged[14]. It is not enough to deliver the theoretical exploration of virtue ethics after Aristotle, it is also necessary to situate the principles/tenets of virtue ethics within the realm of lived-experience. Despite the claim by ethicists that virtue ethics is predominant in the various spheres of life, there is the shared sentiment that it is more

peculiar to the profession and practice of medicine; it is therefore pertinent to briefly consider the viability of virtue ethics in the medical profession.

Virtue Ethics and the Medical Practice

The activities of medical practitioners, their roles as professionals in relationship with the patients have often been subjected to ethical discussion. In this section, we interrogate the possibility of integrating virtue ethics into societal relevance.

According to Gardiner,

> Virtue ethics account of motivation surely sits well with human society in which we develop special bonds and alliances that encourages us to behave well out of friendship, love and loyalty. It is these elements that bind communities together and that it is the weakening of such commitments that are seen when communities begin to fragment.[15]

Gardiner supports the given assertion that doctors are provided with ethical guidelines for the practice of their profession. However, it is expected that a doctor should also possess good training and sound moral character and judgment in the performance of their duties. This is illustrative in Gardiner's account of two cases of moral dilemmas; the Standard Jehovah-witness case and the case of selling kidneys for transplantation.[16]

Through these cases, Gardiner proposed that the four principles; that is; the principles of non-maleficence, beneficence, respect for autonomy and justice, should be entrenched as a foundation for virtue ethical approach in medical practice. The assumption is that since the medical practice is propelled by the roles of the doctors in relationship with the patients, then only an agent-based ethics that emphasizes virtuous acts can lead to the appropriate medical practices. Besides this, there is the claim that since the 4th century to modern times, the various codes of conduct and oath of practice sworn by doctors (Hippocratic Oath, Nuremberg Code, Declaration of Helsinki, and Belmont Reports among others) had suggested a commitment to virtuous behaviours.

This is to state that despite the fact that the doctors are the directors of the theatre, the assumption in contemporary times is that the doctors are expected to partner with their patients by informing, guiding, advising and aiding them to make appropriate choice of action as to the nature of the patient's illness and treatments accordingly. However, this is to be done with respect for the professional integrity of medical practice and the consideration of socio-cultural or health beliefs of the patients involved.

It is however probable that the two conditions conflict. This kind of situation poses challenge to medical practice, which may be minimal or intense. Even though the doctor is enlightened professionally, it is not certain that either respecting the situation/conditional beliefs of the patient or following professional guidelines would rescue the doctor out of this moral dilemma. The doctor is likely to find him/herself at a cross road. As Gardiner would have us believe, responses or choice of action in such cases is dependent on the motivation behind the medical practitioner's decision.

This could also be stimulated by the contemplation of either deviating obeying the professional guidelines, succumbing to/or not to the patient's choice of treatment or vice versa as the case may be. The result of this play of choice bears consequences, the death of the patient(s) or compromises in the professional guidelines of the medical practice. It seems there is no middle ground. It is either the doctor allows himself to be swayed by the professional integrity of the medical practice or the patient's interest.

In practice, virtue ethicists propose that the doctor slip off the deontic/consequentialist drive to act, and act by virtues in terms of compassion, trustworthiness, discernment or regret. Gardiner makes it clear that each of this virtue would lead the doctor in respecting the patient's choice of treatment but operates on different disposition as the case demands in accordance with the doctor's practical wisdom. That is, the doctor would either be motivated to make a choice of action by compassion (for the patient, in the case of euthanasia), discernment and trustworthiness (moral judgment in compliance with patient's confidence in the doctor) or regret. It is not impossible that these virtues conflict but the confidence of virtue ethicists is that it would not constitute hindrance

the way deontological or consequentialist theories do. It would rather render the practice of medical professional flexible, given the claim that it would provide alternative range of choices of virtuous actions and decisions in correlation with the states or conditions of the patient.

By the terms of virtue ethics, stipulating ideal rules for all situations is monistic and risky for the medical practice; the assumption is that the efficient medical practice can be encouraged through the medical assessment of patient's situation individually. The claim is that via a virtue ethical approach, the medical enterprise in the society can alleviate from the constraints and banes of deontological and consequentialist interpretation of medical practice.

The idea that virtue seeks to entrench is that ethics is also a framework of welfare that goes beyond the moral obligations/duties of doctors. This re-emphasizes that efficient medical practice could be fostered through the cultivation of virtues like compassion, discernment, balance of justice and fairness in the medical profession (doctor-patient relation). Subsequently, when the viability of virtue ethics is justified in medical practice, it would not be out of place to suggest that it should be adopted as a practical approach in all spheres of life.

It is not out of place to highlight and demonstrate how virtue ethics could assist the physician in overcoming truth telling dilemma. The three parameters that will be discussed below pinpoint the important themes in virtue ethics.

Virtue Ethics as a Model that Focuses On Moral Agent

Virtue ethics, unlike other theories in ethics, that focuses on rules and set rules that helps an individual in deciding the rightness and wrongness of an action; focuses on how to help the moral agent itself to develop a good character such as kindness, truthfulness, honesty, compassion etc. This virtue becomes part of the moral agent by habitual practice. Virtues are not innate; they are cultivated and developed. This

character trait that virtue ethics helps one to develop can be very useful in helping an individual to make a right decision in specific cases. This is also reflected in the famous work of Aristotle who says that acquisition of good habit of character helps an individual to regulate emotions and reason.[17]Same applies to A. MacIntyre who so much believes that one's notions of right and wrong is being determined by the type of person one is. By implication, it takes a person with good character and right virtue to be able to act in a virtuous manner and having this trait will make one to have the ideal knowledge of what is good and bad. It is also seen as a trait of character, manifested in habitual action, which is good for a person to have. Virtue places an individual over the others because of the ability possessed by a virtuous person of being able to act with practical reason in place.

The physician in practice can be referred to as the moral agent who is expected to act virtuously. The physician can act in a virtuous manner if virtue is cultivated as a habit and made a daily practice so that acting virtuously becomes his daily routine and way of living. The focus on the moral agent is not to tell the care-giver what is obligatory, what is right and what is ethically unacceptable but to enrich the virtuous traits which has been cultivated and internalised by the agent in order to guide the physician virtuously.

Virtue Ethics as a Model that Focuses on the Internal Goals of a Specific Medical Practice

Virtue ethics does not only focus on the moral agent itself (virtuous physician) but also focuses on the internal goals of practice (medical practice). This is evident in the work of A. MacIntyre. He is interested in practices rather than profession especially in dealing with group engaged in common practices. MacIntyre says that we all engage in a lot of different practices. Practices are activities which contain a particular idea of good within them. When we look at good in the game of cricket, we obviously know that the good in cricket will be different from good in childcare, but both are practices. Hitting a ball hard and straight is good for a cricketer, but hitting a baby hard and straight is bad for a father. Architect is a practice but bricklaying is not. The range of

practice is very wide which is inclusive of arts, games, politics etc.[18] There are two types of practice; they are internal goods of a practice and external good of a practice but our focus is internal practice.

MacIntyre defines practice as "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence, which are appropriate to and partially definitive of that form of activity with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended."[19] Three key important criteria can be deduced from Macintyre's definition of practice; it requires that the practice has to be complex; it must have an internal good and must have the power to achieve excellence. These three criteria are present in the game of chess. To further elaborate this, a child first learns to play chess with certain motivation from the tutor without the knowledge of the internal good attached to it.

The child is being motivated by certain gift given him or her before he plays. At a point he begins to appreciate the game itself even without having any motivation in form of gift to play it. The gift he gets at the initial stage is external good of the game which is being overtaken by his interest in the game itself; this is the internal good of the game of chess. Medicine is a practice. The stage at which physician sees their practice beyond duty and perceive virtue attributed to their practice as a necessary condition for practice shows they have been able to internalised virtue and recognise the goods internal to the practice of their medical profession.

Virtue Ethics and the Importance of the Community

The value of the community is very much reflected in the works of Aristotle. Every state to Aristotle is a part of the community and every community is formed with the view to doing well. Health care system, which is of vital importance here, is also for the good. Every man's daily activities are to achieve the good for oneself and for all. The

means of achieving the good may differ but the intention is to have a good life. Aristotle spoke about the necessity of man and woman living together; in this condition human life can flourish.

Man and woman then constitute a household in which the eldest in the family is the head of the household which is comprises of several slaves living with them for security reasons. The development of several households, bring about several cities and more needs that are beyond the needs for daily survival. The community which is being developed is concerned about the good life of the people in there. Man is conceived as a political animal which strikes for the good of itself. The major distinction between man and animal is the perception of right and wrong that man has and the ability to express them in speech. Though, animals also express themselves through foones but this is used to express pain not right and wrong. Animals are by nature citiless. Each individual in Aristotelian thought is not self-sufficient when he is separated from the whole.[20] In line with the view of Aristotle, Agulanna also agrees that the individual needs the support of other human beings to weather the storms of life.[21]

The three parameters presented above shows the advantages of how virtue could help in truth telling because it considers all the things that are necessary for care-giver to act virtuously. They include (a) the development of moral character, (b) the internal goal of their practice which is the therapeutic covenant and (c) the importance of the community. It must be noted at every point in time that Man is not just an individual, an island, left to himself and sufficient to himself, on his own, man is essentially community. No one ever came to beng as a bolt from the blues, like an oil bean seed falling from the sky.... [22]. Decisions concerning them have to consider the community in which they reside in. This is a way of respecting them not only as individuals but respecting the holistic aspect of them. In this tradition, truth telling is used for maintaining the political aim of the community.

Contentions in Virtue Ethics

Over time, the theoretical framework of virtue ethics has been held in doubt, as a result its practical import in real life has come under suspicion. These contentions cannot be side tracked and it is the onus of this discourse to pay attention to accounts of contentions ranging from the debates as regards the relationship of virtue ethics with other normative theories (Kantian and consequentialist ethics in particular) to the arguments for and against the tenacity of the alternative approach.

In the case of virtue ethics, certain debates have emerged in its relationship with other normative ethical theories, its point of differences and convergence. Are there virtue claims noticeable in any deontological ethical theory for instance in Kant's deontology? If the consequentialist or deontological theories are capable of being interpreted from a virtue ethics perspective, what happens to the claim that virtue ethics constitute an alternative approach? These and other questions are the focus of thinkers like Martha Nussbaum, Cafaro, Stohr and Wellman among others.

Cafaro criticizes virtue ethics. His observation is that the 'eudaimonist' approach in the Greek periods was a combination of intellectual, moral and physical excellence, where excellence connotes "the good life". It makes reference to the human and non-human excellence; the excellence of human beings and their creations and achievements.[23] The impression here is that it is an aberration to present as virtue ethics a deontological account (like Kant's) that surmises virtues as stable dispositions to act according to duty.

Such theories, Cafaro argues, are not concerned with human excellence and good life, rather, they are concerned with human dutifulness, which does not constitute a true virtue or eudamonist ethics which is holistic. It goes beyond human dutifulness even though this is a necessary component of a good life. This implies that virtue ethics takes note of motivation, emotion, a wonderful variety of character traits, wisdom, moral education and special obligations to certain persons. This is to argue that virtue ethics,

in contrast to other normative ethics, is a pluralistic framework of values, a richer conception of happiness or the good.[24]

There is also the argument that virtue ethics, unlike the other normative theories, is not trapped in the sort of incompatible or complex moral dilemmas that emerge as a result of dichotomy rules that are inflexible. It is supposed that virtue ethics, more than the other normative ethics, is flexible in dealing with the complexity of life, appealing to virtues instead of rules. This reinforces Aristotle's argument that possession of virtue is not enough but the appropriate application of it. Virtue ethicists, in this context, doubt the viability of other normative theories to capture and deal appropriately with the complexity of moral scenarios in this way.

On the other hand, Martha Nussbaum rejects the logic behind proposing virtue ethics as an alternative normative approach, noting clearly that the other normative theories already contain a trace of virtue ethics. According to her, there is no need for virtue ethics as an alternative normative approach to ethics as its protagonists have suggested. She argues that "it is perfectly reasonable to pursue this interest (those of virtue ethics) while remaining squarely within either the Kantian or utilitarian camp".[25]

Nussbaum's argument is corroborated by Robert Louden and Christopher Cordner. Louden distinguishes virtue ethics from other normative ethics but does not disqualify Kant's ethics as a virtue ethics. He said that virtue exhibits agent-ethics while the deontological and consequentialist theories emphasize act-ethics. He contends that this is what discerns virtue ethics as concerned with "being" rather than with "doing". Also, even when both allude to practical reason, the former downplays atomic acts and devise situations in decision procedures that rely on character while the latter is derivative and interested in formulating decision procedures (rules and principles) for making choices of action.[26] Louden explains that Kant's ethics unlike virtue ethics proper, disregards the motives of natural inclination (once it is at discord with the moral law).

This is to state that the Kantian notion of goodwill is a virtue. However, humans, being what they are, are swayed by natural inclinations and hence act or display duties that are contrary to the moral law. Despite this, Louden grants the interpretation that Kant's goodwill is not of act but of agents; it is the highest good or stage of human morality. Virtue then; is an approximation of the goodwill in Kant's ethical perspective, though it is subject of basic conflicts or tension in human will.

Thus, like Stohr and Wellman, Louden agrees that recent virtue ethicists' attempt (Hursthouse's, for example) was to bridge the gap between Kant's ethics and virtue ethics.[27] While in another of her work, she explains that the contentions of Anscombe and Foot was not to create alternatives to other normative theories; she argues that their attempt was to set in the right priority the domains of ethics which should begin from "what and how I ought to be" (that is, agent-based) to the question of "how do I act?" (from motives or consequences of action?).

In Defence of Virtue Ethics

Despite the various criticisms levelled against virtue ethics, there is no doubt it is still an important, and remains a better approach, in addressing the dilemma of veracity in clinical practice. Its major strength lies in its basic tenets such as character and "Phronesis". It has been mentioned earlier that virtue ethics' central focus is on 'who we are' (our character traits/ personality) and what we would become (as a moral agent caught in a web of choices of how we want to perceive ourselves and how we want others to perceive us). It is never based on rules or utility of Kant and Utilitarians respectively.

Virtue ethics on how people can develop their moral character traits such as kindness, caring, generosity and so on. It is about how we can be better made. In order words, when we make our decisions on everyday basis to be kind, caring etc., we will be made into becoming better. As we continue to act virtuously, our bad habit would be gradually broken down and with time we lose the bad habits. It is more about being or

becoming not really so much about doing like other principles. This character is said to develop over time through training.

Virtue ethics stands out when compared to other ethical theories such as utilitarianism and deontology because character traits are stable, fixed and reliable. A virtuous person who has a good moral character of kindness for example, will always be kind at all times, in all situations and over a long period of time. This is because characters are built over time. The stability of character in virtue ethics is another edge it has over other theories. It covers all aspects of personality which includes the practical skills, qualities of character and intelligence. This holistic nature of virtue ethics gives it an edge over other principles.

However, it is not enough to indulge in a theoretical exhortation of the points of virtue ethics; most important is to couple the potentials of virtue ethics with practices that are healthy for contemporary existence of the well-being of humans in general. The development of virtuous characteristics through certain habitual practices would enhance human nature in becoming an embodiment of values which in turn would ensure human flourishing. These practices have their bases in values, the list of which are endless. Such values include sincerity, humaneness, perseverance, objectivity among others which cultivate virtuous practices like confidence/courage (when you are sincere or truthful), compassion (when you are humane), hope (when you persevere) and so on. It is in this sense that virtue ethics is worthy for contemporary existence (as it provides imperatives for acting in such ways).

Virtue ethics allows us to think and maintain integrity. It encourages us to be true to our values unlike consequentialism that justifies bad actions in as much as its brings about good consequences and deontology an absolutist theory that requires us to hold to principles even if the actions would cause harm.

It provides moral education. A person with good character influences the student under him/her and the character of the student changes over time. It must be understood that

virtue in itself is not a habit but when the agent can develop it by acting it over time, it becomes a habit and this aid the development of virtue. It is forced on an agent so the agent has to consciously choose to be virtuous. This is only possible when the agent recognizes the value of virtue.

The element of practical wisdom in the appropriation of these virtuous practices is useful in our daily affairs. 'Phronesis' in virtue ethics is to be used at the right time, in the right way with the right intensity to the right person and for a right reason. Mere relying on rules would not give room for so much reflective because there are already laid down rules guiding our actions which must be strictly followed without leaving anything untouched.

Though there is the fear that practical wisdom would engender diverse motivations in people and several explanations for why several people are the way they are or do what they do. We should be careful not to miss the point; which is that, given practical wisdom engender diverse motivations, however within the domains of virtue ethics, it suggests that people and their actions would be guided by a level or sense of moderation that would be conducive for positive living/flourishing.

Virtue ethics has the ability to include the strength of utilitarianism and deontology and avoid their weakness. This is possible because of its flexible nature. For instance, utilitarianism as a theory is interested in bringing out the best consequences in all situations even though the means to bringing out the best is bad. Virtue ethics can also achieve this but it will ensure that it brings out the best only if the means to the attainment of the best or good is good. It is also ensure that the action is done at the right time, in the right way, with the right intensity, to the right person for the right reason.

It avoids the weakness of deontology, when with the use of practical wisdom it discerns and recognizes the need to treat persons with respect. Virtue physician knows when and how to ignore an action that does not promote virtue or not virtuous. For instance,

respect for person is a virtue. But in a situation where the person is to be respected requested for something that may bring about a vice, practical wisdom suggests that such action should not be done.

The flexibility of virtue ethics is a good justification for this approach. Though, some have argued that virtue ethics is too flexible on the contrary this is where the strength of virtue ethics lies because concrete ethical problems especially in health care delivery need not be a rigid principle but a flexible one. It is flexible enough to deal with the complexities of moral life because its emphasis is on virtue instead of rules. The focus on character of the agent, the place of reason in virtue, the importance of the community and the presence of the use of practical wisdom; present us with an edge over other ethical principles when considering how to act. Its ability to recognise emotions, its flexibility as against the rigidity of deontology and principles, it avoidance of consequentialist approach to situations places virtue ahead of other theories.[28]

This can be buttressed by saying that virtue has nothing to do with the strict way of referring to these actions as morally wrong and those actions as morally right actions, instead it focuses on agent attitudes toward an action and helps the moral agent to build and mould its moral character in a way that becomes an attitude of that person. Its ability to do this shows an additional advantage over the use of strict principles that distinguishes between right and wrong actions.

The arguments provided above is convincing enough to accept that virtue ethics give a plausible account of how best to find a way around any moral dilemma presented to us especially with the dilemma of truth telling. The last chapter of this study is an attempt to practically show how virtue ethics can succeed in addressing the moral dilemma inherent in truth telling analysis.

Conclusion

This chapter has been able to discuss in details, the fundamental tenets of virtue ethics by stating its definitions and issues. It also discussed Aristotelian and some post

Aristotelian conceptions of virtue. It highlighted the fundamental parameters in virtue ethics by looking at virtue ethics as a focus on the following: the moral agent, the internal goal of medical practice, and the importance of community in virtue ethics. It equally recognised some of the various contentions in virtue ethics and attempted to provide a good ground for virtue ethics in the analysis of veracity in physician-patient relationship.

END NOTE

[1]Pellegrino, E.D. and Thomasma, D.C. 1993.*The virtue in medical practice*. New York: Oxford University Press. 21.

[2]Foot, P. 2001.*Natural Goodness*. Oxford University Press. 38.

[3]See L. Mastin, "Introduction in the basics of philosophy". 2008. *Internet Encyclopedia of Philosophy*. Retrieved 8/8/2012 from http://google/branch/doctrine-basics of phil//.com

[4]*Ibid*.

[5]*Ibid*. See also E. Slingerland 2011. The situationist critique and early confucian virtue ethics. *Chicago Journals.* 121:2: 390-419.

[6]Solomon, R.C. and Greene, J.K. 1999. *Morality and the good life: an introduction to ethics through classical sources*. USA: McGraw-Hill Companies Inc. 86.

[7]*Ibid*. 87.

[8]See Aristotle, *Nicomachean ethics I*, transl. W.D Ross. Retrieved 10/8/2012 from *http://classics.mit.edu//Aristotle/nicomachaen.html*.

[9]Solomon,R.C. and Greene, J.K. *op cit*., 1999. 89.

[10]See "Aristotle's Ethics" available in *Stanford Encyclopedia of Philosophy*. Retrieved 12/8/2012.

[11]Cooper, T.L. 1987. Hierarchy, virtue and the practice of public administration: a perspective for normative ethics. *Introduction into Bio-Ethics*. Ed.W. Dekker. 58

[12]Stohr, K. and Wellman, C.H. Recent work on virtue ethics. *American Philosophical Quarterly*, 39:1-30.

[13]Ibid.55.

[14]Ibid. 62.

[15]Ibid.

[14]Anscombe, G.E.M. 1958, Modern moral philosophy, *Philosophy* 33. See also A. Macintyre 1985, *After virtue*, London; Duckworth, See also B. Williams 1985. *Ethics and the limits of philosophy* London; Fontana.

[15]Aristotle had implied in his ethics that universals must merge with particulars. He incorporated this when he also presented the twelve instances (as listed) of virtuous particulars or practices, which he conceived as intermediate means that moderate actions.

[15]Gardiner, P. 2003. A virtue ethics approach to moral dilemmas in medicine. *Journal of Medical Ethics.* 29. 291-316.

[16] Ibid.

[17]Aristotle: *The Nicomachean ethics*, W.D. Ross, Trans, Oxford: Oxford University Press. 101.

[18] MacIntyre, A. 1984. *After virtue*. U.S.A: University of Notre Dame Press. 45.

[19]bid., 187.

[20]Simpson, P. 1998. *A philosophical commentary on the politics of Aristotle.* Chapel Hill: University of North Carolina Press.32.

[21]Agulanna, C.O. 2010. Community and human well-being in an African culture, *TRAMES.* 14 (64/59) 3: 282-298.

[22] Ibid., 291.

[23]Cafaro, P. 2012. Virtue ethics (Not too simplified), *IIAIAEIA*, available on http://www.jstor.com. Retrieved 15/8/2012.

[24]See 'why virtue ethics is better than consequentialism and deontology, confession of a handful Of dirt'. *Philosophus Autodidactus*. Retrieved 15/112010 from http://jadedreprobate.wordpress.com

[25]Nussbaum , M.C.1999. Is virtue ethics a misleading category. *The Journal of Ethics.* 3. 168-171.

[26]Louden, R. 1986. Kant's virtue ethics. *Philosophy.* 61:238. 475.

[27]Stohr, K. and Wellman, C.H.*op cit.*56.

[28]Gardiner, P. 2003. A virtue approach to moral dilemmas in medicine. *Journal of Medical Ethics*. 29: 297-302.

CHAPTER FIVE

VIRTUE ETHICS AND VERACITY IN HIV/AIDS AND ONCOLOGY CASES

Introduction

Chapter one of this essay was devoted to the understanding of truth-telling in clinical practice. It examined truth-telling from the general viewpoint ranging from the family, the society, with the discussion situated within the clinical context. Chapter two discussed extensively ethical theories such as deontology, utilitarianism and situation ethics. It states very clearly their strength and shortcomings in approaching the dilemma of truth-telling in clinical practice. Chapter three attempted a detailed discussion of the four principles of biomedical ethics which includes the principle of autonomy, principle of beneficence, principle of non-maleficence and justice with the intention of revealing the weaknesses. Chapter four proposed an alternative approach to truth-telling. The alternative approach proposed is virtue ethics. Virtue ethics in this chapter was pictured as a better approach to truth-telling. Though, it also tries to mention some of its weaknesses.

The objective of this chapter (five) is poised at an analysis and application of virtue ethics to an HIV and oncological cases. The first part of this study is an application of virtue ethics to a concrete case of HIV and the second part is an application of virtue ethics to an oncological case. What should be done when an autonomous patient simply confides in a physician that he/she does not want the third party to know about his/her HIV status? Or he/she does not want to know when tested positive? One important duty to note in clinical practices is the duty of confidentiality. To what extent should this be respected in situation like this? Should we respect the wish of the patient as indicated or keep confidential issues strictly confidential?

Questions such as this; show that the problem with truth-telling still remains a disturbing issue in clinical practices. It is not my intention to solve the problem, but to contribute to the on-going discussion on truth-telling and provide a suitable approach to addressing the dilemma of truth telling in clinical practice. It is clear from the literature that most of the approaches to truth telling are principle based and these approaches could not properly handle the complex moral problems embedded in truth telling.

This is my motivation for proposing virtue ethics as a better approach to addressing this problem. I am very much aware that virtue ethics approach cannot solve all the problems associated with truth-telling, but, it can give an important contribution to this moral difficulties posed by truth telling in clinical practices.

Case 1: A Case from HIV Clinical Context

Mrs. A., a twenty-eight-year-old lady, came from the Northern part of Nigeria. She is married, a housewife but does not have any child. She presented to the outpatient department with chronic cough and weight loss and was then diagnosed to have pulmonary tuberculosis. She was soon commenced with anti TB medications. She has also been offered a voluntary counselling and testing for HIV. She consented to have the HIV test under certain condition. She said: "I am not willing to have an HIV test but if you insist, I can only agree on the condition that I do not want to know about my status either positive or negative nor will I like anyone to know too". She was at the end tested and the result turned out to be reactive implying she is HIV infected. The counsellor was afterward faced with the problem of divulging this information to the patient since she has made her fear known prior to submitting herself for the test. She was quite aware of the perception of HIV in her environment and the stigmatisation associated with people living with HIV which may eventually result in isolation from the community. The risk associated with the failure to disclose the result to her and her husband was discussed over several counselling sessions in the coming weeks but she still declined disclosing her status to anyone. The physician and the counsellor were concerned about the consequence of the failure to notify her husband who is at risk but

at the same time notifying the husband could mean breaching patient's autonomy and confidentiality.

CASE 2: A CASE OF CANCER

Mr. Fuji a 69-year-old man was brought to the emergency room of a Medical Centre after coughing up blood. He presents with severe coughing, fatigue, chest pain, shortness of breath, and headaches. After stabilizing him, the emergency room team admits him to the hospital, where he was given (over the course of some few days) a thorough workup, including chest x-rays, CT scans, mediastinascopy, and a PET scan. The diagnosis shown that he has an extensive small cell lung cancer. After almost three days in the hospital, the results of the various scans are in; and the attending physician, find it almost difficult to present the diagnosis and prognosis before the patient. Though, there are basically "two possible treatments" available for this cancer: chemotherapy and radiation, the physician strongly prefers beginning with the first (chemotherapy). Given the apparently advanced stage of the disease, even chemotherapy would be very unlikely to provide a complete cure, but it could provide some relief and lengthen the remainder of his life. The patient had earlier displayed attitude that suggested he would make a difficult patient. The attending physician is aware that this information need to be disclose to the patient but afraid that the patient may not cooperate since the available treatment would not bring about any cure and the family wants the physician to do everything possible to prolong the life of their father for additional years with the best option of treatment. The physician has in mind the need to treat the patient to the best of his knowledge at the same time acts non-maleficently.

Understanding HIV and Its Context from Case 1

The reality of HIV in our societies has raised a number of ethical dilemmas associated with disclosure especially when we consider the possibility of stigmatization associated with the infection. Stigma can therefore be seen as a feature of HIV and many people who are HIV positive report that their lives are affected by the fear of discrimination,

depression, abandonment by spouse, loneliness and other consequences that may result from disclosure of such infection.

This is the reason why disclosure demands careful consideration because of the attendant potential adverse social consequences which may accompany such disclosure such as physical assault.[1] HIV infections/AIDS is a disease with the dimension of public attention because it a disease affecting people in many developing countries especially in sub-Sahara Africa. Although, there is presently no permanent cure, drugs that suppress the multiplication/replication of the virus exist. There are researches going on in order to help address and interrupt with the continuous danger of HIV on life and health of the people. Its existence poses more threat to human life and this has devastating effects on the society as a whole because of the tendency to spread to other people through several media.

HIV is known to target the T-cells of the immune system. It also affects the brain system; nervous system as a whole and it can affect other parts of the human body. The danger with HIV is that it reproduces itself by manifesting itself in new T-cells and attacking other functioning of the human system. HIV renders the immune system redundant which naturally helps in fighting organisms in the body. Once the immune system has been weakened; several diseases penetrate the body. AIDS creeps in when the immune system has gone down. HIV is not equivalent to AIDS and it does not instantly lead to AIDS; this is the reason why an HIV tested positive person can live several healthy years without developing AIDS.

HIV is a disease that can be transmitted in so many ways; one major way of contracting HIV is through unprotected sex. Other ways includes using the injection used by an infected person, use of sharp object which has been used by carrier of HIV, infected blood transfusion, and receiving an organ from an infected donor. Physicians are overwhelmed by the social and ethical question generated by HIV/AIDS epidemics. This has great effects on the best methods or standard of communicating the disease to their patient. It is also worth noting at this point that the gravity of the disease should

not be an excuse not to communicate the test result to those who are affected. The most obvious ethical dilemma in dealing with HIV disclosure is the conflict between societal interest and individual rights, including rights to freedom of movement, privacy and access to goods and facilities.[2]

Just as we can justify the reason for non-disclosure of HIV result: there are also good reasons to disclose. One of the most important reasons is that HIV infection is a chronic disease that calls for urgent attention and the need to know. This need to know could help in planning the follow up of the patient and how to handle the sexual dealing with a partner without causing more problems.

There is no doubt that the case presented above is a sympathetic one. The lady in question is unemployed and she depends so much on her husband for daily survival. Telling the truth by disclosing her status to her husband might result in potential disharmony and divorce. In addition she might experience stigmatization, discrimination and possibly isolation in the community she resides. If we look at the context in which she is coming from (Northern part of Nigeria) she stands to experience several difficulties in facing the reality of this problem. The questions associated with truth telling and disclosure then include:

(a) How do we balance the Hippocratic Oath and up-to-date professional codes of medical practice that physician should maintain the patient's confidentiality?
(b) How do we maintain the patient-physician relationship of trust that a patient has for the physician?
(c) What do we do and or how do we handle the consequences of disclosure for others who might want to be tested?
(d) Can we respect the patient's autonomy here at the expense of non-maleficence and the benefit of the other?
(e) Are physicians obliged to tell the truth?

There is no doubt that less number of individuals would turn out for HIV testing because of the fear of disclosure of their status without their consent. This will have an

adverse effect on the public health goal of reducing transmission. The increasing number of people with HIV is a global problem which confirms the need for addressing the problem of truth telling and disclosure to infected persons. One of the things that could help decrease this spread of this infectious and terminal disease is disclosure/truth telling. As long as HIV status is strictly hidden especially from the partner then the problem continues to multiply.

In view of this, disclosure of serostatus remains an important tool for the prevention of further infection.[3] Many people want to protect the patient from emotional trauma, pains and shock yet some are still in favour of disclosure in HIV case because they felt knowledge of HIV status would benefit the patient.[4]Attitude towards HIV disclosure differ from cancer and other terminal illnesses because HIV is deadly and could continue to spread if not properly addressed.

Truth-Telling in HIV and Virtue Ethics

Truth-telling in the case of Mrs A is a very difficult issue. This young lady feels reluctant to have the HIV test because of her basic understanding of HIV and immediate perception of it in the community she belongs. The question then is do we tell her about her HIV status despite her wish not to know? On what basis should we withhold medical information? Should the result be kept to the physician? What happens to her husband? Are we also responsible for the consequences of our failure not to tell the husband? What are the duties of care-giver? What are the needs and importance of truth in this scenario? These and many more questions arise from the case at hand.

In addressing the above raised questions, there is a need for carefulness in order not to confuse and miss out some important facts related to this. The notion of autonomy is of significant concern and it is associated with many ethical questions. We can simply say that this lady is autonomous and conclude that her wish be respected. This conclusion will definitely appear unwelcome. Decision making goes beyond autonomy especially when we recognise an individual as part of the immediate society and community.

Ordinarily, the use of practical wisdom reveals that confidentiality will be of less importance when it evidently constitutes a danger to the health of the generality of people. In medical practices, confidentiality is vital. However, the obligation of confidentiality is not an absolute one. It is mediated by greater interests for instance, where public interest in disclosure outweighs the desire to ensure confidentiality, health professionals are permitted though normally not obliged to breach confidentiality.[5]

Close examination of the concept of truth-telling from a deontological perspective, presents it as a duty of the care-giver. Truth-telling from a deontological perspective is a duty of a care-giver to the patient. There is no doubt that duty related issues have great significance in health care giving. These duties are not without their problems because of the conflict they present. There is a duty to tell the truth by the care-giver and a right not to know on the part of the patient. The identification of the problems inherent in strict duty based approach will lead us to the main concern of this paper which is virtue based.

Truth-telling is not a mere concept that should be neglected. It is a concept that has to be taken with all sense of seriousness though executing it has several moral questions. It is worth noting also that moral problems are not problems we address using a no and yes responses. They are problems that need in-depth understanding of situation alongside thorough examination and needs to be carefully scrutinised. There is a serious need for virtue in analysing situations that goes with character. Since this study focuses on a virtue ethics approach; it will be of vital importance here to analyse this case using the three parameters highlighted in Chapter Four of this study which includes the focus on the attitude of the moral agent, internal goal of medical practice, and focus on community.

Proposed Solution to the HIV Case on the Basis of Virtue Ethics:

Case 1

Virtue ethics from our first parameter is focused on the attitude of the moral agent. Here, the care-givers who have cultivated virtuous character identify the various virtues peculiar to practice and uphold this character to the maximum. They identify virtues such as honesty, truthfulness, patience, wisdom and etc. With the acts he has cultivated he is moved to act in a way that goes along with his practice no matter what the case may present. A virtuous physician who embraces virtuous acts is necessarily motivated with the need to execute virtuous acts necessary for his practice. He is moved by the act of honesty and truthfulness. He knows the right medium and means of communicating facts and truthful information to his patient in a manner that best suits the specific situations.

The major problem with truth-telling in the case in question is the conflict between autonomy and beneficence or non-maleficence. This is evidently the medical ethical problem generated by truth-telling. Medical ethical problems are characterised by conflict of principles.[6] In this case, we could say that the virtue of benevolence should motivate the decision of the physician because of the good that telling may bring in this particular case. This is also necessary because of the medical oath of do no harm made by the physician. Doing good is not just for the individual alone but also for others.

If the physician wants to work along the line of benevolence; and by the virtuous character he possesses, he would recognise the fact that telling Mrs A of her situation would help her in decision making as regards her health. On the other hand, disclosure of such are uniquely associated with protecting others from possible exposure to HIV, suggesting that this disclosure can be focused more on others than on oneself.[7] It is also good and necessary for the health of her husband.

Virtue ethics from the second parameter focuses on the internal goal of the practice. The internal goal of medical practice is the therapeutic convention of medical practice. No doubt, beneficence and non-maleficence are also important to the physician in discharging his/her duty to the patient. The decision that better promotes the internal goal of medical practice should be favoured over every other decision. Truth-telling obviously is a necessary condition of medical practices but could at times be withheld in order to avoid another vital interest that may help in promoting the healing process which the intervention hopes to achieve. Also important to this case is the woman's autonomy. However, respecting the autonomy here may be contrary to the internal good of medical practices of 'doing no harm'. Harm will be done to the husband of this young woman and the failure not to tell may also endanger the life and the future of others.

Virtue ethics from the third parameter focuses on the need to be concerned about community in decision making. It is always very easy to take a decision when the decision to be made does not have a negative effect on others. As pointed out earlier individuals are in relation to other beings in the society. According to P. Ricoeur, other beings are present in the world and this call for mutual respect for each other. Respecting autonomy also includes non-infringement on the autonomy of the others in the world. Despite the strong wish of this woman (Mrs A) not to know, the physician takes into consideration, the effects on the larger society which is at stake here (face of the other).[8]

The relationship between a doctor and patient is a sensitive aspect of care-giving. Dealing with medical related problems is a difficult thing to do by mere emphasis on duties. From this perceptive, there are good reasons to say that the doctor-patient relationship goes beyond normal daily practice. It goes beyond duty based practice, moral obligations, respect for the others etc. Drane writes that, the doctor is bound to higher ideals and higher virtue because of the nature of the medical relationship.[9] Care-givers often find themselves in situations where their knowledge of objectivity cannot

address such controversial and sometimes confusing issues they encounter on daily practices.

Background Information of Lung Cell Cancer

Cancer is a form of tumour. Tumour simply refers to any kind of swelling. Swelling could be from various causes such as inflammation, infection and Neoplasia. However, neoplasm is the umbrella word for all forms of abnormal growth in the body. It can thus be defined as an abnormal mass of tissue, the growth of which is virtually independent and exceeds that of normal tissues.[10] Unlike other form of swellings which are non-neoplastic, the growth of a neoplasm persists after cessation of the stimuli that initiated the change. Neoplasia is classified into two broad categories: benign and malignant. It is the malignant form of Neoplasia that is usually referred to as CANCER.

Cancer can be classified based on the cellular component from which they arise. Hence, we have: a. Carcinomas: those arising from epithelial cells (covering of cavities, tissue and organ). b. Sarcomas: which are those arising from mesenchymal tissues (musculo-skeletal components of cells/ tissue).[11] The nomenclatures of specific types of carcinomas / sarcoma depend on their appearance and presumed cell of origin. Cancers exist for virtually every part of human body. Organs as small as ovary measuring only about 3.0 x 1.5 x 1.0 cm to big human components like the liver, all have their various forms of cancers. Some human cancers include Breast cancer, Lung cancer, Colorectal (large bowel) cancer, Prostate cancer, Non- Hodgkin lymphoma (white blood cancer), Gastric (stomach) cancer, Oesophageal cancer, Melanoma (cancer of the skin), Pancreatic cancer, Ovarian cancer, Renal cell (Kidney) cancer, Endometrial (uterine) cancer, Invasive Meningioma (Brain covering cancer), Cervical cancer, Hepatic (Liver) cancer and Seminoma (Testicular cancer).[12]

However, incidence of cancer in any population varies depending on factors such as Age, sex and geographical location. Some cancers are common among the elderly and

almost never occur in the children. An example is Prostate cancer in men, while some are almost exclusively seen in very young population. A good example of this is Wilms tumour which is usually diagnosed between the ages of 2 and 5 years. In the same vein, there are cancers that are only found in women. This kind of cancer is called cervical cancer and those found in men are called Prostate cancer. In Asia, more than any other part of the world, Nasopharyngeal and oesophageal cancers are common. In Africa, Cervical cancer remains a scourge partly due to underdevelopment, while the incidence of Lung cancer is highest in Europe and North America.

It is often said that cancers have no cause except risk factors but recent studies have gathered overwhelming evidence in the causative mechanisms of cancer. A good example of this is cigarette smoking, a cause of lung cancer. [13] Though, cigarette smoking does not cause lung cancer in every smoker, it depends on the genetic predisposition of the smoker to induce the changes necessary for the emergence of cancer in the lung.[14] Hence, like most other forms of illness, cancers come about by interaction between nature (gene) and nurture (environment and lifestyle). Other risk factors for cancer are Anticancer drugs, Infections like Schistosomiasis, Aniline dye, Asbestosis, Aflatoxin, Ultraviolet light and abnormal genes (such as BRCA1 and BRCA2).[15]

Clinical presentation of cancers depends on the primary organ/system involved as well as the secondary ones affected. Its effect could be due to sheer size leading to compression of the surrounding structures and distortion of normal anatomy. It could also be due to overproduction or underproduction of normal body chemicals with consequent change in body functions.[16] Depending on the organ / system involved and stage of the cancer, patient's complain could range from simple cough, sweating, headache and weight loss to more disturbing one like noise in the ear, chest pain, dizziness, generalised body weakness, Bone pains, Drowsiness and possible loss of consciousness (coma).

Investigating what is wrong with a patient or which cancer he suffers from depends on the clinical presentation of the patient, available diagnostic technology especially in resource-poor environments like most parts of Africa and unfortunately affordability by the patient. Medical interventions also depend on the clinical presentation, cancer type, and level of expertise of the managing physician, established protocol for managing the illness and available technology in the centre where patient is being managed. Treatment could be purely medical, that is, involving the use of only drugs; mixed, which is combination of drugs and surgery with or without radiation (radiotherapy). The latter is usually preferred because combination of methods usually leads to increased response by the cancer.

Prognosis (outlook) of a cancer describes the likely outcome of a patient diagnosed with a cancer. It is often expressed in percentages of those likely to be alive after a period of time say 2 to 5 years with or without intervention. It depends majorly on the type of cancer, when the cancer was diagnosed whether early or late as well as management instituted. While most cancers are theoretically avoidable, the only way to avoid cancer is never to be born.

Small cell lung cancer

This is a variant of lung cancer. It is the most malignant of all lung cancers. Statistically, there is an equivocal link between the frequency of lung cancer and the number of cigarette smoking (pack-years). Like other types of lung cancers, small cell carcinoma of the lung is strongly associated with cigarette smoking. It is called small cell lung cancer because of the microscopic appearance of the tumour cells where it looks like small, oat-like cells. [1]

Cough is the most common presentation of lung cancers in hospitals. It is often dry but may contain pus if there is associated (secondary) infection.[18] Other common problems that patient with small cell lung cancer may present include weight loss, chest pain, difficulty in breathing (dyspnoea) and coughing up blood (haemoptysis). However, patient may present with uncommon symptoms because the cancer has either spread

beyond the lungs to parts of the body (metastasis) or because the cancer has grown so big as to disturb the normal function of contiguous structures. Some of these uncommon presentations include Epileptic seizures, Personality change, jaundice, bone pain, Anorexia, lassitude and skin nodules. Whichever way small cell lung cancer presents itself the attending physician who has obtained a history of cigarette smoking for a substantial period of time would be looking out carefully for it.

Whenever a presumptive diagnosis of lung cancer is made some investigations would have to be done to confirm the diagnosis, establish the cell type and define the extent of the disease. Some of these investigations include chest x-ray, Bronchoscopy (direct visualisation of the bronchial airway), Computerised tomography (CT) or Ultrasound guided biopsy, CT scan of the chest, Thoracotomy (opening of the chest), Bone scan and Liver Ultrasound. Though, various methods exist for the management of lung cancer but the fact that Small cell carcinoma has almost always spread to other parts of the body by the time of diagnosis makes it unfit for surgical intervention. The goal of treatment is to reduce tumour size, kill as many tumour cells as possible, prolong survival, enable good quality of life, prevent or minimise complications, and relieve symptoms of the disease as well as side-effects of the anticancer drugs.

To achieve these in small cell cancer, other forms of treatment apart from surgery are employed. These include Chemotherapy (use of anticancer drugs) and Radiotherapy (use of radiation materials to kill cancer cells). Small cell cancer is particularly responsive to chemotherapy but ultimately recurs.[19] The overall prognosis in Bronchial carcinoma is about 6% with around 80% of patients dying within a year of diagnosis. The best outcomes are obtained when lung cancer is managed in specialist centre where it is possible to have multidisciplinary teams including Oncologists, Thoracic surgeons, respiratory physicians and specialist nurses. Lung cancer can cause depression and anxiety. Hence, family support is very crucial for these patients.[20]

Analysis of a Case of Cancer from Case II

It is important to provide some basis relevant to the case of cancer as presented in case 2. Careful scrutiny of the case of the 69 year old man Mr Fuji suggests that truth telling is a difficult task for any physician confronted with this case. The first thing to note is the fact that the patient in question is a difficult patient. Secondly, the family wants him alive and thirdly, the physician is in a dilemma whether to present to him and the family the various options available to the patient. It must be quickly noted that presenting the various available options means he has to be informed that he has an extensive small cell cancer of the lungs. We have a case of veracity immediately evident in this case.

It is crystal clear that a 69 year old person is an autonomous adult and at the same time, an autonomous human being. Going by this case, there is no doubt in mind that he can be considered to be autonomous in the sense that he has the capacity to make a decision for himself since the case did not suggest to us that he was at any time unconscious.

For emphasis purpose, the case in question is a case in African context specifically from Nigerian context where family plays an important role in taking care of their sick relatives. This is a communalistic setting, therefore, decisions on the sick are not solely of the wife or husband of the patient. In fact, the wife or the husband gets the other family members involved in cases that seem impossible or terminal to avoid being blamed for anything negative that may happen to the patient. Often time, the wife or husband is being invited alongside any elder in the family to disclose prognosis and diagnosis of treatment.

The case of this man is difficult because the family (with the wife inclusive) wants the truth withheld from the patient in order to attain reasonable success in the course of treatment. The physician, also autonomous in his capacity, saw the need to disclose the truth to the patient in order to get him involved and also to discharge his duty as a veracious physician. This case presents to us some ethical dilemma and questions that need to be addressed so that we can decide on how best to treat and care for the patient

putting the context and other issues of autonomy, non -maleficence and physician's conviction into consideration.

The autonomy of the patient here is in conflict with the physician intension of not wanting to cause further harm. Another ethical problem here is how best to deal with the issue of relatives who requested that the truth be kept away from patients so as to avoid harm. This case obviously cannot be addressed using principles that would give a Yes or No answer. It requires a theory that would put into consideration the relational and other aspects of the patient.

Proposed Solutions to the Case of Cancer On The Basis Of Virtue Ethics: Case II

Virtue ethics as noted many times in this study is not focused on rules or set of rules that help an individual in deciding the rightness and wrongness of an action but focuses on how to help the moral agent itself to develop a good character. The virtuous act cultivated by the physician over time helps the physician to make a decision in specific cases. A physician who has developed and cultivated the virtuous acts and character knows how best to address any given case. This is what virtue ethics focuses on (the shaping of character).

The physician addressing the case of Mr Fuji having internalised the internal goal of medical practice which is the therapeutic convention of medicine (do no harm) first think about how best to realise this goal in the course of discharging his duty as a virtuous physician. In Mr Fuji' case, withholding the truth from him would promote the therapeutic convention of whom he was called to discharge at duty.

The last step is to put into cognisance the role of the community as reflected in the works of Aristotle. In Aristotle's view, every state is a part of the community and every community is formed with a view to do well. Every man's daily activities are to achieve

the good for oneself and the good for all. Aristotle spoke of the necessity of man and woman living together and in this condition can human life flourish.

He says that each individual is not self-sufficient when separated from the whole. The implication of this school of thought is that dealing with patient requires that you put people (family) around the patient into consideration. The family of Mr. Fuji going by the case at hand did not display in any way that they were already frustrated instead they demanded for more care which shows that they still want to participate in the care of their relative. Just like the physician, the family believes that he should not be told.

So the question that bothers us as bioethicists is whether non-maleficence should override the patient's autonomy. However, Virtue ethics would not immediately support this position. It would rather prefer to see if the character of the moral agent has been shaped, the internal good of medical practice has been internalised and the importance of the immediate community (family) has been taken care of. Only in this condition would virtue ethics suggest whether or not the truth should be told. Using Phronesis (practical wisdom) to analyse the case of Mr Fuji having taken care of other conditions, virtue ethics would suggest that the truth be withheld from Mr Fuji.

Conclusion

This chapter has attempted to do a detailed analysis of truth telling in HIV and Lungs Cell Cancer scenario using a virtue ethics based approach. It tries to explore some of the medical ethical problems posed by truth telling. It discussed the need for virtue in analysing and approaching ethical problems in medical practices viewing it from three parameters: moral agent, internal goals of health care practice and the role of the community. There is no doubt that virtue to a certain extent has been able to address the dilemmas posed by these issues without falling victim of conflict between principles. Amongst the strength of virtue is its' ability to take practical steps in the analysis of practical issues.

The use of practical wisdom in virtue approach shows that complex issues do not appeal to principle because if we stick to rigid principles we may not be able to approach issues in the right and ethical manner. Virtue is important for truth telling scenario and is a good way of approaching truth telling in clinical practices.

Having seen the importance of presenting issues related to the care-receiver‘s health situation in a way that reveals the reality i.e the truth of the patients’ health; one should be careful in order to ensure it is done in a productive manner. However, it is important for practitioners to take note of how to approach practical and ethical dilemmas in long time care. Even when it is beyond reasonable doubt that truth is important for informed decision making; one should also note that truth has the tendency of bringing about confusion especially on how best it should be divulged.

Truth is to be sought after in everyday activities but it must be highly noted that it involves a lot of sacrifices and it is the greatest service. For care givers to serve humanity better; they need the act of truth telling and they must be passionate about the need to tell the truth. There are few and concrete things that make the communication of this such as in the case of Mrs A and Mr Fuji to be possible and easy to communicate.

One of which is the recognition of the need to prevent further harm on people. There is no doubt that there is a duty and need to ensure confidentiality and enhance patient’s autonomy but when confidentiality and autonomy is extended to other people’s autonomy and this is capable of having negative and devastating effects in their lives then such autonomy is meant not to be disrespected but to be given less recognition. But for Mr Fuji, autonomy and non-maleficence is the ethical problem identified. Autonomy may be undermined in this too since it is to prevent harm.

My analysis of virtue approach to truth telling in relation to the case of Mrs A. demonstrated very clearly that Mrs A should be informed of her HIV status. Telling her as I have earlier mentioned, will afford her the knowledge of her health status, give her

the opportunity to make an informed decision, allow her to plan her future and face the reality of living with HIV. It takes virtuous physician whose moral character has been shaped by virtue (first parameter), who have internalised virtue related to its practice (second parameter) and who recognises the importance of the community (third parameter) to do this.

These three parameters if present in practice could help physicians to disclose the HIV result to the young lady in question. The virtuous physician therefore, presents the situation to her compassionately and tells her the need to get the husband informed. This could be done by getting her counselled and if she finds it difficult to tell it herself; the physician or counsellor could come to her aid by inviting the husband and present the diagnosis to him.

In the case of Mr Fuji, the truth may be withheld for the following reasons, Mr Fuji attitude suggests he would not cooperate with treatment and this will make the care for his health to be difficult. Secondly, the physician perceived telling him may cause harm and he is not in any way convinced that he should disclose the truth to him and lastly, going by the third parameter that points to the fact that we are not alone in the society, there is a need to equally consider the view of the people that surround Mr Fuji and the fear of losing him. Practical wisdom ("Phronesis") obviously suggests he should not be told.

END NOTES

[1]Kalichman, S.C., DiMarco, M. et al., 2003. Stress, social support, and HIV-status disclosure to family and friends among HIV-positive Men and Women, *Journal of Behavioural Medicine*, 26. 4.

[2]Kelly, K.1987. AIDS and ethics: an overview: *General Hospital Psychiatry* 9, 331-340.

[3]Ndiaye, C. 2009. Gender related factors influencing HIV serostatus disclosure in patient receiving HAART in West Africa, *World Health and Population*. 10 (3): 43-54.

[4]Seki, Y. 2009. Should we tell the truth? Why families in Japan chose to tell their loved ones: they were victims of iatrogenic HIV infection. *Qualitative Health Research.* 19 (6): 723-733.

[5]Montgomery, J: 1997.

[6]Beauchamp, T.L. and Childress, J.K. 1994. *Principles of biomedical ethics*. 4th edition. Oxford University Press. 23.

[7]Schnell, D., Higgins, D., et al., 1992. Men's disclosure of HIV test results to male primary sex partner. *Am.J. Pub. Health.* 82: 1675- 1676.

[8]Reagan, C.H. and Ricour, P. 1996. *His life and his work*, Chicago. University of Chicago Press. 34.

[9]Drane, J. 1998. *Becoming a good doctor: the place of virtue in character in medical ethics*, U.S.A: Sheed and Ward. 18.

[10]Robbins, S.L., Cotran, R.S. Kumar ,V. and Collins,T. 1991. .*Pathologic basis of disease. 6th Edition*, Oxford: Saunders. 261.

[11]Ibid., 261.

[12]Boon, M.A. Colledge, N.R. and Walker, B.R. 2006. .*Davidson's principles and practice of medicine* 20th Edition. New York: Churchhill Livingstone Elsevier. 254.

[13]Robbins. 741.

[14]Boon. Op. cit. 256.

[15]Boon. 255.

[16] Robbins, op. cit., 319.

[17] Ibid. 744.

[18] Boon, 706.

[19] Ibid

[20] Ibid

SUMMARY AND CONCLUSION

The study was devoted to the analysis of the duty of veracity and virtue ethics in physician-patient relationship. The first chapter of this study was a discussion of the idea of veracity in clinical practice. In the chapter, veracity was described as the unwillingness to tell lies or quality of being true. Veracity was explained from the smallest societal groupings such as family level, work places and of course in the clinical context, being the primary focus of this work. We elaborated that truth is emphasized in the family. While some parents encouraged their children to say the truth, some encourages lies and others advised their children to keep mote about some things even if they know it to be true by adopting the Yoruba adage that says " ti oju ba ri, enu a da ke" meaning The mouth should be quiet of what the eyes sees. This shows that as much as truth is good, it is not without its inherent problems. This chapter was able to give a picture of how veracity present ethical dilemma in doctor-patient relationship. One of the reasons why attending physician find it uneasy to tell the truth about his/her medical investigation is when the diagnosis and prognosis is very poor and the physician perceive that the patient in question may not be able to handle the truth when told. Another reason is to retain hope in patient. Withholding the truth sometimes serves a therapeutic measure for the patient. Be that as it may truth telling is an important aspect in clinical practice specifically in physician-patient relationship. In this chapter, we discussed extensively the importance of veracity in physician-patient relationship by stating that truth telling makes informed consent possible, give the patient the opportunity to make an informed decision and give the opportunity to participate in the process of care.

The second chapter discussed the traditional ethical theories such as consequentialism, deontology and situation ethics. The basic tenets of the theories were clearly discussed and their general weaknesses outlined. It was argued in this chapter that consequentialism, and situationism could not properly handle the complex moral dilemma of veracity in physician-patient relationship. Looking at consequentialism vis a vis veracity in physician-patient relationship, a consequentialist approach would approve of truth telling as long as it yield good consequences and disapproves if it yield

bad consequences. This theory was criticised on the following grounds: it has a common sense appeal also quite impractical since it require a person to work out in advance the likely good and bad consequences of the truth to be told. There is no doubt that consequences are hard to predict. This theory further suggest that the care-giver kmows the truth that may harm the care-receiver. This theory has a paternalistic tendency because it portray the physician has having an epistemic privilege over the patient. It is not always true to say with all certainty that a certain result will follow preceding from the information provided. It was equality argued that deontologism cannot address the complex moral problems of truth telling because it is too rigid reason because it places too much emphasis on duty. It must be noted that issues such as that of truth telling need more that duty, It need a subtle theory because they dilemma of truth telling rest on a relationship. This chapter also did an application of situationism to veracity in physician-patient relationship. After the application, one may be tempted to say that situationism better address the dilemma in question but we argued in this chapter that it is not because what determines the rightness and wrongness of an action rest on situation. It obviously lacks the fundamental tenets of virtue ethics (character and practical wisdom). In situationism, the end justifies the means. This implies that a bad means can be justified if it brings about a good end. It therefore means that of lying would bring about a good end then lying is justifiable. The submission of this chapter was that these theories cannot properly handle the complex moral problem of truth telling in clinical practice because of their disregard for the character of the moral agent.

Having argued in chapter two that consequentialism. Deontologism and situationism cannot be considered adequate to address the moral dilemma inherent in truth telling in physician-patient relationship, the third chapter focused on an examination of principlism. Principlism was a theory propounded by Beauchamp and Childress. The principles include the principle of respect for autonomy, principle of non- maleficence, principle of beneficence and principle of justice. The principle of respect for autonomy evolved as a rejection of paternalism (the father to son relationship) which allows a physician to act on proxy which sometimes, is contrary to patient's wishes and decision. The principle of autonomy emaphazies treating people with respect. By implication it

means that the autonomy of the patient should be central in any decision related to the care-giving of the patient. The problem with the principle of autonomy is that the autonomy of the patient sometimes clashes with the duty to do no harm. This in turn leaves the physician in dilemma of wether to act non-maleficently and ingnore the autonomy of the patient or respect the patients' autonomy and act maleficently. The same contradiction applies to the principle of beneficence, non-maleficence and justice. It was pointed out with concrete examples how and why these principles conflict with one another. From the analysis, we concluded that principlism present lots of contradictions. The shortcomings of these principles show that it cannot be considered adequate to address truth telling dilemma in Clinical practice hence the need for a plausible approach to the dilemma of veracity in physician-patient relationship.

In chapter four, an alternative approach (virtue ethics) was proposed because of the inadequacies of the earlier examined theories in chapter two and three. In this chapter, we argued that unlike consequentialism, deontologism and situationsim, virtue ethics has nothing to do with the strict way of referring to these actions as morally wrong and those actions as morally right actions, instead it focuses on agent attitudes toward an action and helps the moral agent to build and mould its moral character in a way that becomes an attitude of that person. Its ability to do this shows an additional advantage over the use of strict principles that distinguishes between right and wrong actions. It avoids the weakness of deontology, when with the use of practical wisdom it discerns and recognizes the need to treat persons with respect. Virtue physician knows when and how to ignore an action that does not promote virtue or not virtuous. Phronesis that is, practical wisdom in the appropriation of these virtuous practices is useful in our daily affairs. 'Phronesis' in virtue ethics is to be used at the right time, in the right way with the right intensity to the right person and for a right reason. Mere relying on rules would not give room for so much reflective because there are already laid down rules guiding our actions which must be strictly followed without leaving anything untouched. Virtue ethics was considered an adequate approach because it offered a plausible solution to truth-telling dilemma in Clinical practice.

Chapter five was able to show how virtue ethics that was proposed in chapter four better address the dilemma of truth telling in physician-patient relationship. In this chapter, cases of HIV/ AIDS and Oncology were examined. Virtue ethics was used to analyse these cases. The first case (HIV case), we argued that Mrs A should be informed of her HIV status. Telling her as I have earlier mentioned, will afford her the knowledge of her health status, give her the opportunity to make an informed decision, allow her to plan her future and face the reality of living with HIV. We added that it takes a virtuous physician whose moral character has been shaped by virtue (first parameter), who have internalised virtue related to his/her practice (second parameter) and who recognises the importance of the community (third parameter) to do this. In the second case (Oncological case), the truth may be withheld for the following reasons, Mr Fuji attitude suggests he would not cooperate with treatment and this will make the care for his health to be difficult. Secondly, the physician perceived telling him may cause harm and he is not in any way convinced that he should disclose the truth to him and lastly, going by the third parameter that points to the fact that we are not alone in the society, there is a need to equally consider the view of the people that surround Mr Fuji and the fear of losing him. Practical wisdom "Phronesis" obviously suggests he should not be told. These analyses show the contributions of virtue ethics approach in addressing the dilemma of truth telling in physician-patient relationship.

Conclusively, our discussion in chapters two of this work, shows that ethical theories such as deontology, consequentialism and situation ethics failed in their various attempt to address the dilemma of veracity in physician-patient relationship. The four principles of biomedical ethics which includes the principle of respect for autonomy, principle of non-maleficence, principle of beneficence and justice could not also handle this problem.

These approaches are considered inadequate because of the rigid and conflicting nature of the principles they advance, and their disregard for the character of the moral agent. This was the basis for proposing the virtue ethics. The dilemma revolving around veracity in physician-patient relationship goes beyond principles that give a yes or no

for an answer. There is the need for character and this as stated earlier in this work is not innate in man but cultivated over time. The submission of this work is that the proposed virtue ethics theory is better able to address the dilemma of veracity in Clinical physician-patient relationship.

This is because virtue ethics promotes good character traits in persons, providing grounds for morally appropriate actions when faced with the dilemma of veracity and it is better able to mediate in the dilemma of veracity in physician-patient relationship. Therefore, virtue ethics offers a more pragmatic ethical framework for resolving the dilemma of truth-telling in physician-patient relationship.

REFERENCES

Agulanna, C.O. 2010. Community and human well-being in an African culture, *TRAMES.* 14 (64/59) 3: 282-298.

Aristotle, 1925. *The nicomachean ethics.* Ross, W.D. Trans, Oxford: Oxford University Press.

Athanassoulis, N. 2000. A response to Harman: virtue ethics and character traits. *Proceedings of the Aristotelian Society,* New Series 100. 215-221.

Atsushi, A. 1998. A patient with HIV. *Eubios Journal of Asian and International Bioethics*. 15-18.

Audisio, R. A. et.al. 2007. Surgical management of oncogeriatric patients. *Journal of Clinical Oncology* 25. 1924-1927.

Audrey, S. et.al. 2008. What oncologists tell patients about survival benefits of palliative chemotherapy and implications for informed consent. *BMJ.* 6: 337-339

Baile, W.F. et.al. 2000. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist.* 5: 302-311

Baron, J. 2006. *Against bioethics,* London, The MIT Press.

Beauchamp, T.L and Childress, J. 2001. *Principles of biomedical ethics 5th Edition*, Oxford University Press.

Begley, A. 2000. Truth telling versus hope: a dilemma in practice, *International Nursing Practice*. 6: 26-31

Bentham, J. 1991. *An introduction to the principles of morals and legislation in the utilitarians,* New York: Doubleday.

Berlin, I. 1969. Two concepts of liberty. *Four essays on liberty*, Oxford: Oxford University Press.

Blackhall, L.J. et.al. 1995. Ethnicity and attitudes toward patient autonomy. *JAMA.* 275 (10): 820-825.

Bok, S.1978. *Lying: moral choice in public and private life*. New York: Vintage Books.

Boon, M.A. Colledge, N.R., and Walker, B.R. 2006. *Davidson's principles and*

practice of medicine 20th Edition. New York: Churchhill Livingstone Elsevier.

Brewin, T.1991. Three ways of giving bad news. *Lancet*. 10: 1207-1209

Buchanan, 1997. A philosophic perspective on access to health care: distributive justice in health care. *Mount Sinai Journal of Medicine.* 64 (2): 91-92.

Buckman, R. 1992. *How to break bad news*. Baltimore: Johns Hopkins University Press.

Cabot, R.C. 1903.The use of truth and falsehood in medicine: an experimental study. *Am Med* 5: 344-349.

Cafaro, P.2012. Virtue ethics (Not too simplified).*IIAIAEIA.* available on http:// www.jstor.com. Retrieved 6/8/2012.

Cassel, C. 1996. The patient-physician covenant: an affirmation of Asklepios. *Ann Intern Med* 124: 604-606.

Campbell, A.V. and Higgs. R. 1982. *In that case: medical ethics in everyday practice*. London: Darton Longman and Todd.

Carlos, H. et.al, 2003. Not telling the truth in the patient-physician relationship. *Bioethics.* 17: 5-6.

Chattopadhyay, S. and Simon, A. 2008. East meet west: cross- cultural perspective in the end of life decision making from Indian and German viewpoint. *Med Health and Philos*. 11 (2): 165-174.

Chaturvedi, S.K., Chandra, P.S., Simha, S. 1998. Dealing with difficult situations. in Chandra, PS, Chaturvedi, S. K, eds. *Psycho Oncology: Current issues.* NIMHANS: Bangalore. (41): 500-504

----------. 2008. *Communication skills in palliative care.* New Delhi: Voluntary Health Association of India.

Chilman, C. S., Nunnally, E. W., and Cox, F.W. 1983. *Chronic illness and disability*, Newbury Park: Sage Publications.

Christy, S. 2004. When hope makes us vulnerable: A discussion of patient healthcare provider interactions in the context of hope, Bioethics ISSN. 18 (5): 428-447.

Cordner, C. 1994. Aristotle's virtue and its limitations, *Philosophy*. 69: 291- 316.
Cooper, T. L. 1987. Hierarchy, virtue and the practice of public administration: a

perspective for normative ethics in W. Dekker (Course Collection) *Introduction into Bio-Ethics*.

Crisp, R. and Slote, M. 1997. *Virtue ethics*. Oxford: Oxford University Press.

Culver, C.M., and Bernard G. 1988.*Philosophy in medicine*. New York: Oxford University Press. 123-126.

Davies, R.S. 1995. Professional negligence: a duty of candid disclosure? *BMJ* 310: 888-889.

Drane, J.F. 1988.*Becoming a good doctor: the place of virtue and character in medical ethics*. Rowman and Littlefield.

Driver, J. Monkeying with motives: agent- basing virtue ethics, *Utilitas*, 7, 281-8.

Dunbar, S. and Susan, R. 1992. On visibility: AIDS, deception by patients, and the responsibility of the doctor. *Journal of Medical Ethics*. 180-185.

Elaine, G., APN, BC-PCM; Cluxton, Douglas, M.A. 2004. Truth telling: ethical issues in clinical practices; *Journal of Hospice and Palliative Nursing*. Vol. 6 (4). 232-242.

Elian, M. and Dean, G. 1985. To tell or not to tell the diagnosis of multiple sclerosis. *Lancet.* 12: 27-28

Egbert, L., Battit, G., Welch, C., and Bartlett, M. 1964. Reduction of postoperative pain by encouragement and instruction of patients. *N Engl J Med.* 825-827.

Entman, S.S, Glass, C.A, Hickson, G.B, Githens, P.B, Whetten-Goldstein K. and Sloan F.A. 1994. The relationship between malpractice claims history and subsequent obstetric care. *JAMA* . 272:1588-1591.

Etchella, E., Sharpe, G., Burgess, M. M., Singer, P. A. 1996. Bioethics for clinicians: 2 Disclosure. CMAJ. 155:387-391.

Eraker, S, Kirscht J, Becker M. 1984. Understanding and improving patient compliance. *Ann Intern Med.* 100:258-268.

Erde, E., Nadal, E., and Scholl, T. 1988. On truth telling and the diagnosis of Alzheimer's disease. *J Fam Pract.* 121: 401-406.

Evans, K. 1995. Report of general counsel. *Canadian Medical Protective Association Annual Report*. Ottawa. 23.

Fadahunsi, A. 1998. Truth as the central problem in epistemology. *Philosophy: an anthology*. Lagos: ARK Publishers.

Faulkner, A. and Maguire, P. 1994. *Talking to cancer patients and their relatives.* Oxford University Press.

Foot, P. 1978. *Virtues and vices. Berkeley*: University of California Press.

Freedman, B. 1993. Offering truth: one ethical approach to the uninformed cancer patient. *Arch Intern Med*. 153: 572-576.

Gardiner, P. 2003. A virtue ethics approach to moral dilemmas in medicine. *Journal of Medical Ethics.* 29. 297-302.

Galletly. C.L. 2008. HIV positive persons' awareness and understanding of their states criminal HIV disclosure law. *Springer Science*. 6: 262-269.

Glass, Elaine et.al. 2004. Truth telling: ethical issues in clinical practice, *Journal of Hospice and Palliative Nursing*. 6 (4). 232-240.

Giovanni, Reale. 1987. *A history of ancient philosophy.* Trans by John R. Catan, Albany: State University of New York Press.

Glanon,W. 2005. *Biomedical ethics*, New York: Oxford University Press.

Gold, M. 2004. Is honesty always the best policy? ethical aspects of truth telling. Intern med J. 34. 578-580.

Good, M., Good, B., Schaffer, C., and Lind, S. 1990. American oncology and the discourse on hope. *Cult Med Psychiatry*. 14(1): 59-79.

Hauerwas, S. 1995. Virtue and character. *Encyclopedia of Bioethics, 2nd Edition*. Reich, W. New York: Macmillan. 5.

Hebert, P. C. 1994. Truth telling in clinical practices. *Canadian Family Physician*. 40: 2105-2113.

Hickson, G.B., Clayton, E.W., Entman, S.S., Miller, C.S, Githens, P.B, Whetten-Goldstein K. et. al. 1994. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA*. 272:1583-7.

Higgs, R. 1982. Truth at the last-a case of obstructed death? *Journal of Medical Ethics*. 8: 152- 156.

…… 1985. *On telling patient the truth in lockwood, moral dilemmas in*

modern medicine, Oxford University Press.

Hodkinson, K. 2008. How should a nurse approach truth telling? a virtue ethics perspective. *Nursing Philosophy*. 9(4): 248-256.

Holder, A. R. 1975. *Medical malpractice law*. New York: John Wiley and Sons.

Hooft, V. 1999. Acting from the virtue of caring. *Nursing Ethics*. 6: 192-193.

Hurka, T. 1992. Virtue as loving the good. *The good Life and the human good*. Paul, E.F. Miller, F.D. and Paul, J. Cambridge: Cambridge University Press.

Hursthouse, R. 1987. *Beginning lives*. Oxford: Blackwell.

----------.1991.Virtue theory and abortion", *Philosophy and Public Affairs*.

----------.1995. Applying virtue ethics in *virtue and reasons: Philippa Foot and Moral theory: essays in honour of Phillipa Foot*. R. Hursthouse, G. Lawrence and W. Quinn. Oxford: Clarendon Press.

----------.1996. *Normative virtue ethics in crisp, how should one live? essays on the virtues*. Oxford: Clarendon Press.

Hushe, H. and Singer, P. 1998. *A companion to bioethics*, Oxford: Blackwell Publisher.

Jackson, J. 1991. Telling the truth. *Journal of Medical Ethics*. 17: 5-9.

Johnson, C. and Holt, G. 2006. The legal and ethical implications of therapeutic privilege – is it ever justified to withhold treatment information from a competent patient? *Clinical Ethics*. 1: 146-151.

Jonsen, A., Siegler, M., and Winslade, W. 1992. *Clinical ethics*. 3rd ed. New York: McGraw-Hill.

Kalichman, S.C., DiMarco, M., et al. 2003. Stress, social support, and HIV-status disclosure to family and friends among HIV-positive men and women. *Journal of Behavioral Medicine*. 26 (4): 54-58.

Kaye, P.1995. *Breaking bad news*, Northampton, UK: EPL Publications.

Kaplan, S., Greenfield, S., Gandek, B., Rogers, W., Ware, J. 1996. Characteristics of physicians with participatory decision-making styles. *Ann Intern Med*. 124 (5): 511- 513.

Kelly, W.D. and Friesen, S.R. 1950. Do cancer patients want to be told? *Surgery*. 27: 322-326.

Kelly, K. 1987. AIDS and ethics: an overview. *General Hospital Psychiatry*. 9: 331-340.

Kirklin, D. 2007. Truth telling, autonomy and the role of metaphor, *Journal of Medical Ethics*. (33): 11-14.

Kruschwitz, R. and Roberts, R.C. 1987. *The virtue: contemporary essays on moral character*, Belmont: Wadsworth.

Logan, R. and Scott, P. 1996. Uncertainty in clinical practice: implications for quality and costs of health care. *Lancet*. 1595- 1598.

Louden, R. 1984. On some vices of virtue ethics, *American Philosophical Quarterly*. 21:238- 475.

MacIntyre, A. 1984. *After virtue*. U.S.A: University of Notre Dame Press.

----------.1988. *Whose justice, which rationality*? Notre Dame, IN: University of Notre Dame Press.

Maguire, P. 1998. *Communicating with cancer patients.* Manchester: CRC Cancer Research Campaign, Psychological Medicine Group.

Martins, R. 1978. Some ethical issues in disclosure of progressive distress of the nervous System. *South Med*.

Marzanski, M. 2000. Would you like to know what is wrong with you? On telling the truth to patients with dementia. *Medical Ethics*. 108-113.

Mastin, L. 2008. Introduction in the basics of philosophy. *Internet Encyclopedia of Philosophy*. Retrieved 8/8/2012 from http://google/branch/doctrine-basics of phil//.com.

Mason, J.K. and Smith, M.1983. *Law and medical ethics.* London: Butterworths Publishers.

Mayaert, P. L. 1996. On neighborly love: the relation to the thing in the other who is my neighbour. *A Journal of the History of Philosophy*. 1. (4): 12-15.

Narayan, R. K. 2006. The doctor's word.in Malgudi days. *Penguin Twentieth Century Classics. Paperback.*

Ndiaye, C. et al. 2009. Gender related factors influencing HIV serostatus disclosure in patient receiving HAART in West Africa, *World Health and Population*. 10 (3): 43-54.

Nodding, N. 1984. Caring: a feminine approach to ethics a moral education, Berkeley and Los Angeles: University of California Press.

Nolin, C. 1995. Malpractice claims, patient communication, and critical paths: a lawyer's perspective. *Qual Manage Health Care.* 3:65-70.

Novack, D., Plumer, R., Smith, R., Ochtill, H., Morrow, G., and Bennett, J. 1979. Changes in physicians' attitudes toward telling the cancer patient. *JAM*.241: 897- 900.

Numico, G., Anfossi, M., Bertelli, G., Russi, E., Cento, G., etal. 2009. The process of truth disclosure: an assessment of the results of information during the diagnostic phase in patients with cancer. *Ann Oncol*. 20 (5): 941- 945.

Nussbaum, M. C. 1999. Is virtue ethics a misleading category, *The Journal of Ethics. (*3). 168-171.

Nyberg, D. 1993. *The varnished Truth: truth telling and deceiving in ordinary life*. Chicago: University of Chicago Press.

Oakley, J. 1996.*Varieties of virtue ethics*, Ratio.

Oduwole, E.O. 2011.*The concept of truth in an African language: an exercise in conceptual decolonization*. Germany, Lap Lambert Academic Publishing GmbH & Co. KG.

Oken, D. 1961. What to tell cancer patients: a study of medical attitudes. *JAMA*. 175 (3): 1120- 1128.

Oliffe, J., Thorne, S. etal. 2007. Truth telling and cultural assumption in an era of informed consent. *Fam Community Health*. 30 (1): 5-15.

Panagoulou, Efharis etal. 2008. Concealment of information in clinical practice: is lying less stressful than telling the truth? *Journal of Clinical Oncology*. 7 (26): 75-77.

Parascandola, M., Hawkins, J., and Danis, M. 2002. Patient autonomy and the challenge of clinical uncertainty. *Kennedy Inst. Ethics J*. 12 (3): 245-264.

Pellegrino, E. D. and Thomasma, D.C. 1993. *The virtue in medical practice*. New York: Oxford University Press.

Pence, G. 1984. Recent work on the virtues. *American Philosophical Quarterly* 21: 32-35.

…….. 1991. Virtue theory. *A companion to ethics*. Singer, P. Ed. Oxford: Blackwell.

……., 2004. *Classics works in medical ethics: account of cases that home shaped medical ethics,* New York: McGraw Hill.

Pincoff, E. 1986. *Quandaries and virtues*. Lawrence: University Press of Kansas.

Phillip C. Hebert. 1994. Truth telling in clinical practices. *Canadian Family Physician*. 40: 225-228.

Philip, C. etal. 1997. Bioethics for clinicians: truth telling. *Canadian Medical Association*.152 (2): 131-137.

Picard, E. 1984. *Legal liability of doctors and hospitals in Canada*. 2nd ed. Toronto: Carswell Legal Publications.

Pittman Estate v. Bain. 1994. 112 DLR (4th) 257 (Ont Gen Div) Cited in Mitchell SG. Diseases contracted during pregnancy: reviewing a physician's duty to disclose the risks faced by the fetus. *Ont Med Rev*. 61(7): 53-57.

Reagan, C. H.1996. *Paul Ricour: his life and his work*. Chicago, University of Chicago Press.

Ritchie J, Davies S. 1995. Professional negligence: a duty of candid disclosure? *BMJ*. 888-889

Robin N. F. 2008. Ethics, "Culture and clinical practice", *Northeast Florida Medicine Supplement*. 56-59.

Robbins, R.L., Cotran, R.S., Kumar ,V., and Collins, T. 1991. *Pathologic basis of disease 6th Edition*, Oxford: Saunders.

Rosenstand. 1994. *The moral of the Story: an introduction to questions of ethics.* Mayfield Publication.

Ross, W.D. 1930. *The right and the good*, Oxford: Clariondon.

Seki, Y. 2009. Should we tell the truth? why families in Japan chose to tell their loved ones they were victims of iatrogenic HIV infection. *Qualitative Health Research.* 19 (6): 723-731.

Sahakian, W.S. 1974. *Ethics: an introduction to theories and problems*. New York: Barnes and Noble Books.

Samp, R. Curreri, A. 1957. Questionnaire survey on public cancer education obtained from cancer patients and their families. *Cancer*. 10: 282- 384.

Schnell, D., Higgins, D., et.al. 1992. Men's disclosure of HIV test results to male primary sex partner. *Am. J.Pub. Health* 82. 1675-1676.

Schotmans, P., Reidar L, Bart H, Meulenbergs, T. 2002. *European perspective on health care ethics*, Leuven, Peeters. 122-124

Scott, D. and Susan, R. 1992. On visibility: AIDS, deception by patients, and the responsibility of the doctor. *Journal of Medical Ethics*. 18 (4): 180-185

Selgelid, M.J. and Christian, E. 2008. Infectious diseases, security and ethics: the case of HIV/AIDS. *Bioethics ISSN*. 22 (9): 457-465.

Shamasundar, C. 2008. Telling the truth to patients and relatives. *Indian J Psychiatry.* 50 (3): 219- 220.

Shelton, D.L. 2006. There are consequences, legal and moral for withholding HIV status in sex relation. *HIV article*. 10-12.

Shelp, E. 1985. *Virtue and medicine*, Dordrecht: Reidel.

Silverstein, M., Stocking, C., Antel, J., Beckwith, J., and Siegler, M. 1991. ALS and life-sustaining therapy: patients' desires for information, participation in decision-making, and life-sustaining therapy. *Mayo Clin Prac.* 66(9): 906-913.

Slingerland, E. 2011. The situationist critique and early confucian virtue ethics. *Chicago Journals.* 12 (2). *Retrieved Jan 12.*

Slote, M. 1992. *From morality to virtue*. New York: Oxford University Press.

----------., 1995. Agent- basing virtue ethics. *Midwest Studies in Philosophy*.Eds.

French, P., Uehling, T.E. and Wettstein, H.K. Notre Dame, IN: University of Notre Dame Press.

Statman, D. 1997.*Virtue ethics*, Edinburgh: Edinburgh University Press.

Stewart, M. A. 1995. Effective physician–patient communication and health

outcomes: a review. *Can Med Assoc J.* 152(9): 1423- 1433.

Stohr, K., and Wellman, C. H., "Recent work on virtue ethics", *American Philosophical Quarterly.* 39:1-50

Sugarman, J. 2001.*Methods in medical ethics*. Georgetown University Press.

Surbone, A. 1992. Letter from Italy: truth telling to the patient. *JAMA.* 1470-2045.

Surbone, A. 2006. Truth telling to patient with cancer: what is the truth? *The Lancet Oncology*.7 (11): 34-36.

Swaminath, G. 2008. The doctor's dilemma: truth telling. *Indian Journal of Psychiatry*. 50(2): 83-84.

Tate, P. 1995. *The doctor's communication handbook*. Oxford: Radcliffe Medical Press.

Terzis, G.N. 1994. Human flourishing: a psychological critique of virtue ethics. *American Philosophical Quarterly*. 31(4): 45-48.

Ten Have, H.A.M.J and Janssens, M. 2001. *Bioethics in a European perspective.* Dordrecht: Kluwer. 234-241

Thomas, G.Gutheil etal, 2003. "The whole truth" versus "The admissible truth": an ethics dilemma for expert witnesses, *The Journal of American Academy of Psychiatry and the Law*. 31: 422-427

Thomasma, D., and Graber, G. 1990. *Euthanasia: towards an ethical policy*. New York: Continuum Publishers.

Thomsen, O., Wulff, H., Martin A., Singer, P.A. 1993. What do gastroenterologists in Europe tell cancer patients? *Lancet.* 341(8843): 473-476.

Thushan, I.de Silva etal. HIV-2 The forgotten AIDS virus, *http-www.sciencedirect.com*.

Tronto, 1993. *Moral boundaries: a political arguments for an ethic of care*, London: Routledge.

Tuckett, Antshony G. 2004. Truth telling in clinical practice and the arguments for and against: a review of the literature, *Nursing Ethics*. 500.

Vaisrub, S. 1983. *Playing super God in moral problems in medicine*, New Jersey, Prentice Hall Inc.

Varga, Andrew C. 1985. *Main issue in bioethics*, New York: Paulist Press.

Veatch, R. 1977. *Case studies in medical ethics.* Massachusetts: Harvard University Press. 357-358.

----------.1988. The danger of virtue, *Journal of Medicine and Philosophy*. 13.

Vincent, C., Young, M., Phillips, A. 1994. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet*.57: 572-576.

Williams, B. 2002. *Truth and truthfulness*. New Jersey: Princeton University Press.

Quill, T.E and Townsend, P. 1991. Bad news: delivery, dialogue and dilemmas, *Archives of Internal Medicine*. 151.

Welie, S.P.K. Criteria for patient decision making (in) competence: a reviewing and commentary on some empirical approaches. *Medicine, Health Care and Philosophy*. 4: 139-151.

Weir, R. 1983.*Truth telling in medicine*, New Jersey Prentice Hall Inc.