Chapter 2
Historical Context of the Western Bioethics Approach to Autonomy

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

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

2.1 History and Origin of Informed Consent

There is some argument as to when critical discussion of informed consent began (Faden et al. 1986). However, there is a consensus that informed consent became an issue in the American medical practice in the late 1950s and early 1960s (Faden et al. 1986). It was at about this time that the expression "informed consent" became more widely use (Beauchamp 2010b; Faden et al. 1986; Jonsen 1998; Menikoff 2001; Dennis 1999). In their study of the history of informed consent in the USA, Ruth R. Faden, Tom L. Beauchamp, and Nancy M. P. King used the following criteria to determine whether or not informed consent existed in a particular era:

P. Ikechukwu Osuji, *African Traditional Medicine: Autonomy and Informed Consent,* Advancing Global Bioethics 3, DOI 10.1007/978-3-319-05891-7_2,

(a) a patient or a subject must agree to an intervention based on an understanding of (usually) disclosed relevant information, (b) consent must "not be controlled" by influences that would engineer the outcome, and (c) the consent must involve the intentional granting of permission for an intervention (Faden et al. 1986). For Faden, Beauchamp, and King, the three conditions combined specify what they called "informed consent" as they examined historical evidence for the practice, policy, and theory of every era. If any of the three criteria was lacking in a particular situation, depending on the circumstance, Faden, Beauchamp, and King considered such a practice or policy an example of consent or refusal of disclosure, but not informed consent (Faden et al. 1986).

The three conditions are reminiscent of Beauchamp and Childress' elements of informed consent: competence, disclosure, understanding, voluntariness, and acceptance (Beauchamp and Childress 2009; Beauchamp 2010a). While Faden, Beauchamp, and King adduced three conditions or criteria for informed consent, Beauchamp and Childress set out five. Faden, Beauchamp, and King were constrained by their bid not to employ over demanding criteria in identifying informed consent in their interpretation of historical writings and practices. Thus, they limited the criteria to three. They argue that employing over demanding criteria "would render it impossible to find any theory or practice of informed consent at any time" (Faden et al. 1986, p. 54). Moreover, Faden, Beauchamp, and King are open to more criteria or elements of informed consent. They considered the three points necessary for informed consent but they do not commit to their sufficiency. A closer look at the wordings of the three criteria reveals a much closer similarity to the Faden, Beauchamp, and King's. One can deduce the following criteria from Faden, Beauchamp and King's three elements: understanding, voluntariness, intentional or acceptance, disclosure and permission. For instance, their first criterion reads thus, "the patient or subject agreeing …based on understanding of (usually disclosed relevant information) …." (Faden et al. 1986, p. 54). It embodies acceptance, understanding and disclosure of information. Then the second element would be voluntariness etc. What appears to be missing in their criteria is "competence."

Bernard Gert, Charles Culver, and K. Danner Clouser like Faden, Beauchamp and King, discussed three conditions or criteria of informed consent in their book. These are adequate disclosure of information, competence and absence of coercion. They do not disagree that understanding the information is necessary to informed consent even though it is not a heading or sub-title in their book. However, Faden, Beauchamp, and King emphasize the degree of autonomy, understanding, coercion etc. more than Bernard Gert, Charles Culver, and K. Danner Clouser (Gert et al. 2006; Faden et al. 1986).

In their project, Faden, Beauchamp, and King discovered that from 1930–1956 there were only nine articles published on the issue of consent in the American medical literature (Faden et al. 1986). They drew the following conclusions: first, that informed consent did not become an issue in American medicine until the twentieth century; and second, that, even though in the nineteenth century there was some evidence of seeking consent as well as respect for a patient's refusal, prior to the mid-twentieth century, the beneficence model trumped other principles (Faden et al.

1986). Thus, before the widespread adoption of informed consent, the principle of paternalism was dominant. The principle of paternalism presupposed that, because of experience and expertise, the physician knew best what the patient needed (Lidz et al. 1982; Steinberg 2003). However, Jessica W. Berg, Paul S. Appelbaum, Charles W. Lidz, and Lisa S. Parker found two medical instances where consent and disclosure of information regarding the risks and benefits of the treatment or trial were operative. The first was in Prussia in the 1890s, after public outcry about trials on unsuspecting patients inoculated with the spirochete which causes syphilis. As a result, the government of Prussia required consent for further experimentation involving human subjects (Berg et al. 2001). The second was in Cuba where Walter Reed carried out a research on yellow fever. He devised a contract similar to the modern consent form for the volunteers to sign. In addition to the contractual form, there was a discussion, about the risks and benefits to volunteers. However, public outcry in Germany led to development of guidelines requiring "clear explanations of innovative treatment." (Berg et al. 2001, p. 250). Albert Jonsen appears to support Faden, Beauchamp, and King's view. Jonsen noted that it was only in 1957 that informed consent, emphasizing the relevance of information to consent, was given "judicial blessing." (Jonsen 1998, p. 355). It has both legal and bioethical origins. Its emergence was, in part, a reaction to paternalism.

2.1.1 Legal Origin

Based on the above, it is evident that informed consent was solicited long before it was legally required in the physician-patient relationship. The legal origin of informed consent was precipitated by various litigations and court decisions over the years. Although there are some early court cases dealing with consent and privacy, these cases were not strictly about informed consent. Nevertheless, they helped in its development. Such cases include the 1767 English decision, Slater v. Baker and Stapleton (Faden et al. 1986, p. 116), Mohr v. Williams 95 Minn. 261.104 N.W. 12 (1905), and Pratt v. Davis 1905/1906. The cases of Mohr v. Williams and Pratt v. Davis are not only intertwined in reasoning and in chronology, but they are also memorable for other reasons as Faden, Beauchamp, and King have shown. According to them, Mohr v. Williams, and Pratt v. Davis are significant because they required "physicians to obtain consent to particular procedures." These cases are also important for restricting "implied consent" to "limited exceptional circumstances" such as emergencies (Faden et al. 1986, p. 122). Finally, they are memorable for their strong language about "the nature and importance of self-determination." (Faden et al. 1986, p. 122).

The first legal cases which not only involved informed consent *per se* but which directly impacted and further advanced the development of informed consent are those of Schloendorff v. Society of New York, Salgo v. Leland Stanford Jr. University Board of Trustees (1957), and Canterbury v. Spencer a Washington, D.C. These

three cases will be discussed in detail because of their direct impact on the development and advancement of informed consent.

Schloendorff v. Society of New York In the case of Schloendorff v. Society of New York (1914, and Mary E. Schloendorff, Appellant, v. The Society of the New York Hospital 1914), Mrs. Mary E. Schloendorff consulted a physician in a New York hospital in January, 1908 for some stomach disorder. After some weeks of treatment, the house physician, Dr. Bartlett, found a lump which proved to be a fibroid tumor. Dr. Bartlett consulted Dr. Stimson, the visiting surgeon, who advised surgery. According to Mrs. Schoendorff's testimony, the physicians informed her that the character of the lump could not be determined without examination under ether. She consented to such an examination, but notified Dr. Bartlett that she did not want surgery. However, on the following day she was anesthetized, and the tumor was removed. Following surgery she developed gangrene in her left arm, and some of her fingers had to be amputated. She suffered intensely. She sued the hospital for the wrong. She testified that the surgery was done with neither her consent nor her knowledge. She was contradicted by Dr. Stimson, Dr. Bartlett, as well as by many of the attendant nurses. Justice Cardozo stated that even if her narrative is improbable, it has to be taken as true because the verdict issued in her favor, concluded that the complaint was not merely negligence, but trespass. Justice Cardozo ruled that every adult human being with sound mind has a right to determine what shall be done with his or her own body. If a surgeon performs an operation without the consent of the patient, the surgeon commits an assault, for which the surgeon is liable in damages (Schloendorff v. Society of New York 1914).

The consent requirement here is justified on the grounds of the right of self-determination. The right is the equivalent of the moral principle of respect for autonomy (Faden et al. 1986). The case focused on the liability of the New York hospital as defendant for torts committed by surgeons using its facilities. Consequently, the court did not find that there was a violation of informed consent or that the hospital intentionally withheld information that the patient might need to exercise the right of self-determination. However, the opinion of Justice Cardozo is considered as a "classic statement" of the right of self-determination of a patient (Faden et al. 1986). It draws great attention to the fact that patients have "the right to protect the inviolability of their persons" by deciding and dictating their medical treatment. Any interference with this right may be considered unauthorized bodily invasion or battery, notwithstanding both the skill with which the treatment was administered and the ultimate benefits of the intervention (Faden et al. 1986, p. 123). The court also held that it is the responsibility of the patient to solicit information relevant to consent. It meant that a physician is negligent only when he performs a procedure against the express wishes of the patient. The physician was not under obligation to communicate all the risks and benefits in advance (Bennett 2000).[1] Most legal cases hinged on this landmark case, Schloendorff v. Society of New York. However,

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the judicial "blessing" began with the California Supreme Court ruling in Salgo v. Leland Stanford Jr. University Board of Trustees (1957).

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

Three years later, the Kansas Supreme Court, in Nattanson v. Kline, 186 Kan 392, 350 P 2d 1093 (1960), weaved a new concept of informed consent into the legal framework, namely, the negligence theory instead of the battery theory (Jonsen 1998). The battery theory or a tort is the unlawful touching of another person, unconsented physical contact even if the contact is nonviolent. It had been the legal basis for enforcing informed consent requirements until the case of Nattanson v. Kline. The decision in this case also impacted on informed consent theory by establishing that true informed consent required a "thorough-going self-determination" (Dworkin 1988, p. 101) instead of a reasonable physician standard that had been in use. The reasonable physician standard was defined by the court at Schloendorff v. Society of New York, as noted above (Bennett 2000). The first expanded description of the new legal requirement of informed consent was not to come till 1972 in the case of Canterbury v. Spencer a Washington, D.C. 464 F 2d 772 (DC Cir 1972) (Cf. Jonsen 1998).

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

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each (Cf. Jonsen 1998, p. 355).

The court argued that, because the typical patient has little or no comprehension of the science and art medicine, one ordinarily has only one's physician to consult for information and explanation which will assist in making an intelligent decision. In light of this, the patient's dependency on the physician for enlightenment, the court concluded that this compels the physician to make reasonable divulgence of risks to a patient in order to arrive at as informed a decision as possible (Cf. Jonsen 1998).

What this ruling recognized is that the amount of information to be disclosed is established not by medical practice or standards but by the patient's need to know.

Supporting this point of view, Jerry Menikoff argues that the patient's right of self-decision should shape the boundaries of the duty to reveal. The scope of the physician's communications to the patient must be measured by the patient's need. That need is the information material to the decision. It means then that the test for determining whether a particular danger should be disclosed or not is its materiality to the patient's decision rather than standard care. All risks that potentially affect the decision must be divulged. The law must itself set the standard for adequate disclosure in order to protect the patient's interest, instead of leaving it to the practice of medical community (Menikoff 2001).

Menikoff further observes that the Canterbury v. Spencer case in addition to establishing adequate information as per the need of the patient, demonstrates how physicians or professionals can define for themselves the standard of care. The court, by basing the standard of disclosure of information required by the patient on the standard of care, or on good medical practice, or what a reasonable physician will do, was leaving it to the physicians or professionals to define for themselves the standard of care. Menikoff suggests that, rather, the scope of the standard should not be subjective as to either the physician or the patient; it should remain objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation (Menikoff 2001).

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

Patient's Bill of Rights In 1973, the American Hospital Association was instrumental in publishing a patient's Bill of Rights which was adopted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Commenting on the American Hospital Bill of Rights, Faden, Beauchamp, and King noted that it "was one of the earliest signals of the place of an autonomy model in medical practices." (Faden et al. 1986, p. 94). This Bill of Rights introduced the language of "rights" into the discourse and practice of patient autonomy. It became the most influential of several patients' rights statements to appear in the 1970s (Faden et al. 1986). The Patient's Bill of Rights incorporated and strengthened some of the fruits of previous legal wrangling. For example, it endorsed the patients' rights to obtain from their physicians information necessary to give informed consent before any procedure or treatment (Hospital 1973). It also recognized the individual patient's right to refuse medical treatment to the

> extent permitted by law and to be informed of the medical consequence of his action. … The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. (American Hospital Association 1973).

Prior to the adoption of Patient's Bill of Rights, medical codes and didactic writings had traditionally emphasized the physician's obligations or virtues. Trust rather than commerce was the theme of the doctor-patient relationship. As a result, the language of rights suddenly shifted the focus in a different direction (Faden et al. 1986). Right, for example, is about entitlement, that is, a demand made by someone regarding the conduct of others. When rights are turned in the direction of medical decision-making, they literally invite or, at least, encourage the replacement of the beneficence model with the autonomy model (Faden et al. 1986).

2.1.2 Bioethical Origin

While the legal formulations were in process, the importance of informed consent was also being critically examined and discussed from a moral perspective in the area of medical experiments and research (Jonsen 1998). There were, for instance, events at Nuremberg, Helsinki, the National Institutes of Health (NIH), and the Federal Drug Administration (now known as Food and Drug Administration) that began to have a cumulative ground-breaking effect on medicine, especially on research ethics. According to Faden, Beauchamp, and King, these events, more than anything drew and directed the attention of scholars in law, theology, history, and biomedical and behavioral sciences to the subject matter of informed consent (Faden et al. 1986).

The Nuremberg code of 1947 declared consent "absolutely essential." It insists that the patient or the subject who is giving consent must not only possess sufficient knowledge of the intervention but must also sufficiently comprehend the information in order for that patient or subject to make an "enlightened decision." (Beauchamp and Walters 2003, p. 354; Jonsen 1998, p. 356). In view of this insistence, Jonsen surmised that consent was required to go beyond mere permission. In 1972, the year several courts in USA included informed consent in medical practice, the Tuskegee syphilis study scandal occurred. Shockingly, it was discovered that the subjects of the Tuskegee syphilis study were not fairly consulted, not given information regarding the study, nor were they asked to give consent to the study. For example, they were not furnished with the reason why the government doctors were collecting their blood samples. Dr. Jay Katz, a member of the Tuskegee panel, noted that "the most fundamental reason for condemning the Tuskegee Study … [is that the subjects] were never fairly consulted about the research project, its consequences for them and the alternatives available to them." (Katz 1973, p. 320; Jonsen 1998, p. 356). Bioethicists of the time held that consent to therapy or experimentation "is the external manifestation of the moral values of freedom and loyalty" that makes the relationship between doctors and patients (and or subjects) a moral one

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

Finally, there was the study of informed consent to experimentation initiated by the National Commission for the Protection of Human Subjects. The study led to the production of the Belmont Report which classified informed consent under the general topic of "Respect for Persons." (Jonsen 1998, p. 357). One of the contributing essays to this project was from Robert Veatch. His article, "Three Theories of Informed Consent: Philosophical Foundations and Policy Implications," set the path for an in-depth exploration of informed consent. He posited three possible philosophical grounds for informed consent: one, that the beneficent duty of physicians requires them to warn patients of possible harm associated with treatment; second, that "the utilitarian principle recommends consent as a means of maintaining the general trust between the scientific profession and society;" third and last, that possible philosophical grounds for informed consent is the right to self-determination. Veatch was critical of the first two although he approved the third. In defense of the right to self-determination, Veatch argued that an informed consent that is grounded in the right to self-determination means a standard of disclosure that is centered on the need of a reasonable person for information to make a decision and is not based on professional judgment (Veatch 1978; Jonsen 1998). Veatch's exposé shaped the Belmont's commission Report on informed consent.

Later, in November 1978, the Congress in the USA asked the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to examine the issue of informed consent. As a result, in 1980, the Commission was convened and informed consent was its agenda (Faden et al. 1986). In its study, the commission chose to go beyond the legalistic scope of informed consent in order to consider how to nurture a relationship between patients and medical personnel "characterized by mutual participation and respect and by sharing decision-making." (Jonsen 1998, p. 357). The Commission published its study as: *Making Health Care Decisions: the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship and Deciding to Forego Life-Sustaining Treatment*. Its appendices contain two volumes of documents, scholarly papers, and empirical research (Faden et al. 1986).

In the Report, the Commission observed that, in spite of the fact that the concept of informed consent is a product of legal history; the requirements are not legally-oriented. Rather, they are basically "moral and policy-oriented." Emphasizing self-determination, the Commission (President's Commission 1982; Faden et al. 1986) further noted that informed consent is ultimately founded on the principle that competent adults are entitled to make their own decisions in keeping with their own values and goals; that the context of informed consent and any claim of valid consent must derive from active, shared decision-making. The report supported its statements with "a philosophical argument based on the principle of autonomy…" that is, that persons have an intrinsic right to direct their lives; and on the principle of beneficence, that is, that care is improved when patients collaborate in their care President's Commission 1982, Rept. 36; Jonsen 1998, p. 357). Although the

primary goal of health care, in general, is the maximization of each patient's well-being, to act simply in a patient's best interest without recognizing the individual as the essential decision-maker would fail to respect each person's interest in self-determination." (President's Commission 1983, p. 44; Faden et al. 1986, p. 98).

In its later report, the Commission concludes that "the right to autonomous choice" implies the choice to forego life-sustaining treatment. This conclusion contradicts the usual "presumption in favor of sustaining life," (President's Commission 1983, chs 1–2; Faden et al. 1986, p. 97) and the Commission recognized that this fact could have "a pervasive and unsettling effect" on medical facilities, where such practices are generally looked at "as suspect and disruptive." According to the Commission, such a view undermines patient self-determination. (President's Commission 1983, chs 1–2; Faden et al. 1986, p. 97). These public discussions about the moral and legal obligation to obtain consent for therapeutic interventions have shaped the private discourse that is supposed to take place between physicians and patients. What should be an improvised interaction tailored to suit each situation and the personalities involved has been usurped by legal and moral obligations. Moral and legal obligations require a conversation about certain elements prescribed that have been dictated by the public discourse which took place in commissions and in courts (Jonsen 1998). All these bioethical and legal insights, especially those regarding self-determination directly helped the development of the informed consent theory and indirectly raised awareness and re-evaluation of paternalism in the physician-patient relationship.

2.1.3 Reaction Against Paternalism

Finally, informed consent emerged, in part, because of a reaction against paternalism. Paternalism is the intentional overriding of an individual's known wishes and choices or actions by another person. The one overriding justifies the action by arguing that it is to benefit or to prevent harm to the one whose preferences or actions are overruled (Beauchamp and Childress 2009). In healthcare, paternalism was based on the view that, because a health professional has superior training, knowledge, and insights, that authoritative position is used to determine what is in the patient's best interests. Throughout the history of medical ethics, both principles of beneficence and nonmaleficence have produced a basis for paternalistic actions towards patients. Joel Feinberg distinguishes between weak (soft) and strong (hard) paternalism. In weak paternalism, an agent intervenes on grounds of beneficence only to prevent substantially nonvoluntary conduct, that is, to protect a person against his or her own substantially nonautonomous action (s). Substantially nonvoluntary or nonautonomous actions include cases of consent or refusal that are not adequately informed, severe depressions that preclude rational deliberation, and addictions that prevent free choices and actions. In weak paternalism a person's ability is compromised in some way (Beauchamp and Childress 2009).

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

In fact, in ancient Greece, a patient's participation in medical or treatment decision-making was seen as undesirable. It was accepted practice not to disclose possible risks or difficulties of treatment or procedure to the patient because such disclosure was believed to erode patient trust. Physicians were required to stimulate and foster patient confidence in the treatment (Murray 1990). According to Albert Jonsen, Plato noted that, when a free physician attended to patients who are free citizens, the physician conversed with them and attempted to understand their problems. Then, having gained their confidence, he went on to administer the prescription or the treatment. On the other hand, when treating slaves, the physicians dispensed with the conversation and went directly to prescription, giving orders like tyrants (Plato, and Cf. Jonsen 1998). The distinction between the treatment method for slaves and that for free citizens melted into Hippocratic aphorism: if a patient is under orders, that patient will not stray; whereas, if the patient is left to his or her own discretion, that patient will give up the struggle and die. Hippocrates advised, therefore, that the physician should take the patient in hand. They (physicians) should "assume authority," "give orders firmly," "urge obedience" and reproach the "delinquent." (Hippocrates, and Cf. Jonsen 1998, p. 354). For example, Hippocratic ethics required physicians not to reveal anything of the patient's future or current condition. The reason was that, on learning the prognosis, patients would take a turn for the worst (Hippocrates, and Cf. Jonsen 1998). These practices of the beneficence model of Hippocratic medicine encouraged and fostered beneficence and paternalism. Consequently, by following this beneficence model of Hippocratic medicine, physicians traditionally took the general view that disclosing certain forms of information can cause harm to patients under their care and that medical ethics obligates them not to cause such harm. The principle of autonomy is more a product of the traditions of Kant and the Liberal political philosophy than of the Hippocratic tradition (Veatch 2003).

According to Peter Murray, in medieval times physicians were encouraged to utilize their conversations with the patients to foster "comfort and hope while emphasizing the need for the doctor to be manipulative and deceitful." (Murray 1990, p. 104; Faden et al. 1986, p. 63).In Medieval Europe, Henri de Mondeville (1260–1325), a French surgeon and teacher of anatomy, upheld the Hippocratic beneficence model of medicine and ethics. In truth-telling, for example, beneficence was the criterion. He encouraged physicians to promise a cure to all patients and to tell patient's relatives or friends if there is any risk (Faden et al. 1986). The prevailing view of medical moralists supported that sort of therapeutic privilege, namely, paternalism, which is an offshoot of beneficence. Physicians and medical professionals directed the conversation and sanctioned what today would consider to be ethically suspect, such as the withholding and distortion of truth.

http://www.springer.com/978-3-319-05890-0

African Traditional Medicine: Autonomy and Informed Consent

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2014, XVII, 206 p. 1 illus., Hardcover
ISBN: 978-3-319-05890-0