

FOUR ETHICAL PRINCIPLES

The four-principles or principlism approach to Bioethics developed by Beauchamp and Childress in *Principles of Biomedical Ethics* (5th ed., 2001) is arguably the most known and influential examples of principle-based approaches. This approach recognizes four key principles (autonomy, beneficence, nonmaleficence and justice) arising from reflections on common morality and many centuries of medical tradition. Altogether, these principles provide general guidelines and individually they each highlight certain obligations. In instances where the principles come into conflict with each other require balancing. There is no predetermined order of preference; each is essentially of equal importance. In different situations, a particular principle may assume a greater or lesser priority.

1. AUTONOMY

Autonomous choices of persons have to be respected. This is a principle that runs deep in common morality. However, people do not agree totally regarding the nature of autonomy. However, there is a need to analyze and to realize the principle of autonomy especially as this relates to specific interventions in health care.

The meaning and extent of Autonomy

The word autonomy is derived from the Greek words 'auto' meaning 'self' and 'nomos' meaning 'rule'. Thus, autonomy means self-law or law to oneself. The original usage then of autonomy is to mean 'self-rule' or 'self-governance' of independent city-states. Autonomy has since then been extended to individuals and has acquired meanings and derivatives such as, self-governance, liberty rights, privacy, individual choice, informed consent, causing one's own behavior and being one's own person (Beauchamp and Childress, 2001). Broadly, it can be defined as the capacity to think, decide and act on the basis of such thought and decision freely independently and without hindrance (Gillon, 1985).

The problem that comes next is; are their justifications that are needed in order to exercise autonomy? Would it be correct to say that a person can exercise one's own autonomy regardless of age, status, creed, and race have autonomy? This inquiry can be answered affirmatively, if we regard autonomy as a human feature. However, autonomy can be studied into different aspects, for example, some theories on autonomy have featured the traits of an autonomous person. An autonomous person must have the capacity for self-governance. To govern one's self, one must have the capacities: **to understand** (*moral reflection*) the issue and what the situation is all about and to reason out and give one's own opinion; **to deliberate** (*effective deliberation*) by weighing the pros and cons of the issue, and then eventually **to make an independent** choice (*free choice*) and basic to making an independent choice is one's capacity to make decisions.

Beauchamp and Childress believed and agreed that even autonomous persons with self-governing capacities often fail to govern themselves in the choice because of temporary constraints that restricts their options due to illnesses, extreme fatigue, depression, or perhaps ignorance, coercion. Beauchamp and Childress state that an autonomous person who signs a consent form without reading or understanding the form had failed to act autonomously because of the failure to read and understand what the consent demanded. On the contrary, some can still make an autonomous choice though not generally an autonomous one. Consider the example, some patients who are confined in mental institutions may be unable to make autonomous decisions such as stating preferences for delicacies, refusing some medications and interventions or making/choosing to talk to certain relatives or friends or perhaps to an acquaintances.

Some writers maintain that autonomy is a matter of having the capacity to reflectively control and identify with one's own basic or so-called first-order desires or preferences through higher level desires or preferences (Dworkin, 1988). To make the matter clear, let us take an example of an alcoholic person who may intentionally desire to discontinue drinking and a smoker who in similar manner wanted to do as well. An autonomous person in the situation cited is one who has the capacity to rationally identify with, accept, or repudiate a basic order desire or preference. In away by which it is independent of the manifestation of the desires. The intentional acceptance or repudiation of the lower level in favor of the higher level, through which it demonstrates the individual's capacity to change one's own preference, constitute autonomy.

In the Filipino culture it seems that the practice of autonomy is affected by Filipino family affinities. Filipinos generally has the tendency to proceed towards a hierarchical approach in whatever decisions they may have, even decisions for oneself, many of it are decisions that was influenced if not affected by Filipino's high regard to authority.

In the practice of medicine, autonomy of the patient/client must be respected because this is the person's right to exercise freedom of decision and choices. As a nurse, there is a need for each to keep this in mind so that the client cared for, is assured of his/her practice of autonomy. The health professional can concretize the practice of autonomy by being first a role model in his/her freedom to decide what is best for himself/herself. This is demonstrated by respecting one's decision, not being influenced by others' opinion.

"The fundamental principle of nursing practice is respect for the inherent dignity and worth of every client. Nurses are morally obligated to respect human existence and the individuality of all persons who are the recipient of nursing actions.... Truth telling and the process of reaching informed consent should be as fully as possible in the planning and implementation of their own health care" (American Nursing Association, 1985). This fundamental principle of nursing then sets a moral limit on the professional's actions in pursuit of their goal (see the discussion on beneficence for clarification).

Practical implication of respect for Autonomy in medical practice

1. Right of the patient, that is, right to self-determination which is guaranteed by the patient's bill of rights
2. Informed consent
3. Actual directive
4. Advance directive/Living Will
5. Refusal of Treatment

Informed Consent

Informed consent is also known as enlightened consent, to mean, any prior substantial or therapeutic treatment and research participation, patient must have a full information of what the procedure is all about, objective, need and advantage. It is also a form of invitation to a patient to participate in his health care decisions.

Informed consent is not a sole prerogative of the patient and it is not just a matter of reciting the contents of a form and getting a signature; not a ritual to be equated with over viewing the contents of a form that details the risks. Rather, it is a process of 'shared decision-making' (because it is founded in autonomy, that is, the right of the patient and beneficence, the duty of the health care provider to benefit the patient) based on mutual respect and participation. Thus, informed consent is a patient's right and a health care provider's duty.

Informed consent maybe be expressed into two setting

1. Therapeutic setting
2. Research setting

Elements of informed consent: Threshold elements

1. Disclosure/Information
2. Competence/comprehension
3. Voluntariness

Disclosure/information, the extent of information given to the patient by the physician/nurse relating to the medical procedure, or whatever medicine is to be given to the patient, must be to such extent, or intelligently and naturally give consent. It must of such sufficient amount of information, not so little so that it deceives the patient into readily giving in into procedure thinking that all would be well throughout the procedure. It must not be so much also that fear instilled in the patient's mind that he becomes reluctant to give his consent when in fact the procedure is well within control and possibility of any untoward incident is almost nil. The expenses to be incurred, likewise is decisive whether or not consent is to be given by the patient for medical procedure.

Competence/comprehension, along with the competence is also understanding of the patient. The level of understanding of the patient must be likewise explored. The patient's level of education greatly affects one's own decision and the level of emotion to the extent relevantly possible. The health care provider can appropriately assess the accessibility of the language that will be understood by the patient. Since, often times consent to be considered naught is due to the language barrier. Perhaps the better way to make the patient comprehend and understand, thus, make the patient competent is by presenting or showing a visual presentation, like, audiovisuals in a form of a anatomic or medical charts/sketches. Some may opt to use videos of actual procedures taken from previous patients. Any schematic presentation or strategy is possible just to ensure that at the end of the day, the

patient can finally render an intelligent decision whether or not proceed to procedures. Thus, patient becomes competent.

Voluntariness, this element of informed consent is customarily understood as free and willfully given by the patient. But how free is free, how willful is willful? It is often described as, 'the patient signed the consent without someone telling him to do or not to do so'. However, there are more to this what is actually happening in the hospital. Given all the necessary information, and the procedure described the way it should be, was the patient given ample time to decide? Such as consulting the family or some elders as it is seen in the Filipino culture of hierarchical order. The issue at hand is that the patient must be given sufficient time and ample space to consider every information that is given to him in order for him to make an intelligent decision that is free of constraints or external force. Often the usual pressure that a doctor would say, 'I must do the procedure right away, otherwise, your condition might get worse and that you might even die before you reach home', or to say, 'you should decide right now otherwise I'll be attending the need of other patients first and that in turn you may be considered last'. It is to this opinion that the element of voluntariness is vitiated in these instances, it is vivid to say that the patient in the first place does not make a consent at all.

The two functions of informed consent

1. Protective (to safeguard against the tension of integrity)
2. Participative (to be involved in the health care decision-making)

Two basic ways of obtaining consent

1. Written consent (it is often use upon admission of the patient into the hospital, another used it maybe deem necessary for other procedure likely surgery)
2. Verbal consent (it usually comes in the form of an implied consent like when a patient seeks consultation with his physician)

Exceptions of informed consent

1. The patient must be incapable of giving consent and no lawful surrogate (proxy) is available upon arrival to give consent (this presume that the wishes of the patients are not known, otherwise one is not dealing with narrowly defined emergency)
2. There is danger to life or danger of a serious impairment of health.
3. Immediate treatment is necessary to avert those dangers that may lead toward the cessation of life.

Significance and justification of informed consent

1. Patient has an opportunity to be an informed participant in health decision.
2. It is also a legal document and as a form of an assurance of safety for the patient and for healthcare professionals (example: invasive procedure such as: surgery, anesthesia and others).
3. A form of a protocol of the research process because most researches involve patient's lives.
4. It emphasizes *honesty* trait of the professional to carry in their very selves an honest character when asking patient to sign informed or enlightened consent.
5. It reduces risks and avoids unfair treatment and exploitation by the professionals and it is also regulatory and institutional control.
6. It also protects the autonomous choice, by which the claim of patient's right to autonomy was promoted.

Barriers to informed consent vis-à-vis nursing intervention

1. Language: the nurse can use intermediary such as a translator to translate information to language that can be understood by the patient.
2. Cultural Differences: the nurse can use intermediary or let patient meet other persons who underwent the same medical procedure or treatment of the same culture background as the patient.
3. Physical Impairment/illiteracy: the nurse can show pictures, videos, literature and other related teaching aid.
4. Incompetence: the nurse should help to ensure that the decision made by the person responsible for the patient is for latter's benefit and well being.

Generally, it is ethical as well as legal responsibility of the nurse to overcome these barriers and do everything in her capacity to ensure that the patient sufficiently gets all the needed information to make an informed decision. This responsibility arises from the nurse role as a patient's advocate.

Actual Directive and Advance Directive

The right to self-determination originated from the principle of autonomy which entails every individual to informed consent including the right of a person of legal age and sound mind to voluntarily refuse a diagnosis and treatment procedures after he is informed of the medical consequences of his refusal will not jeopardize public health and safety. It's an issue which is advance based from the principle of autonomy and the right to self-determination. Since, it is the concern of many to possibly extend their right of control over themselves and their lives to the future time when in turn they become severely sick and incapable to take any decisions. By performing an actual or advance directive people would be able to determine the treatment that they should and should not be subjected to medical intervention.

Actual directive is an instruction that was given on the very moment that it is being done by any person with a normal condition and in turn satisfies the elements of informed consent though the patient is under certain circumstance of sickness but is still capable of making it.

Advance directive, on the other hand, is an issue given in anticipation of what a person might think would happen relative to his/her health condition. It expresses what the patient would want doctors to do. It can also designate an individual to make decision about the treatment for the patient. This second thought of advance directive takes a form of surrogate decision-maker (proxy). In case of this, the following (proxy) maybe consider in decision-making:

- a. Biological parents of the patient
- b. The oldest child of the patient if of legal age
- c. Legally adapting parents of the patient
- d. Nearest kin
- e. Municipal health officer of the place where the hospital is located/medical director

Two forms of advance directive

1. Living Will (instructional directive). A will by which any competent adult give direction and instruction for future care in the event that the patient involve can no longer make due to terminal or severe illness or an impending death.
2. Medical Power of Attorney (Health care proxy). A probable patient can name a person trusted so as to act in their behalf as an agent/proxy in making health care decisions in an event of incapacity.

The best way to protect and ensure the practice of autonomy in an end-of-life decision-making is done through written Advance Directive (Dunlap, 1997). By providing such AD the family as a whole can reduce stress and patient may attain peaceful death. This is so because of our Filipino values and character that if the AD was not executed then family members may experience great dilemma and great deal of responsibility at a time when they are already under too much stress and anxiety. By that, we asked the question, what are the roles of the nurse in advance directive issue?

Refusal of therapy/treatment

Patient has the right to refuse any form of medical treatment/intervention. It is the right of the patient to refuse any medical intervention, this right is explicit in the 'Patient's Bill of Right'. The patient has the right to refuse treatment to the extent permitted by the law and to be informed of the medical consequences of his action.

This expression of right to refuse for medical treatment was apparently in a statement by the AMA in 1973 that in turn affirmed the right of the patient (right to self-determination as this right is his expression of autonomy) and the family to decide about 'the cessation of extra-ordinary means to prolong the life of the body when there is irrefutable evidence that biological death is immanent (See different forms of refusal to medical treatment: DNR, actual directive and advance directive in autonomy, withholding treatment and withdrawing treatment in nonmaleficence discussion).

Practical implication/issues of limiting Autonomy

1. Paternalism (Parentalism)

The conflict between respect for autonomy and the desire to help the patient (beneficence) brings the problem into forefront of paternalism. Paternalism comes from the Latin word 'pater' to mean father. The Oxford English Dictionary dates the term paternalism from the 1880s (date after Kant and Mill) that describe paternalism

as, 'the principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way a father does those of the children. This analogy opens two important features of paternalism: that the father acts beneficently, namely, in accordance with the conception of the interest of his children and he makes all or at least some of the decisions relating to his children's welfare, rather than letting them make those decision (Beauchamp and Childress, 2001). In health care relationship, the analogy extends further: a professional has a superior training, knowledge, and insight and is thus in an authoritative position to determine the patient's best interest. In this view, the health professional therefore is seen as like of a loving parent of dependent and often ignorant and fearful children. Paternalistic act typically involved forms of *force, coercion, deception, lying, manipulation of information, or even nondisclosure of information to others.*

For example, if a man ignorant of his fragile, life-threatening condition and sick with raging fever attempts to leave hospital, it would ideally be appropriated to paternalistically detain him, even though the patient may attempt to leave did not derived from a substantial autonomous choice. So, paternalistic actions then necessarily place a limit on autonomous choice. Paternalism therefore is the intentional overriding of one's person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the parson whose preferences or actions are overridden.

In medicine, paternalism is applied when health care givers such as doctor, nurses and the like, assumed the authority to make decision for and in behalf of the patient without their consent or knowledge. For example, an unconscious patient was brought to the emergency room that received medical treatment without him being made to sign consent for medical treatment first.

Paternalism can be possibly seen with the therapeutic use of placebo that typically involves intentional deception/incomplete disclosure to the patient. A placebo is a substance/intervention that the health care professional believes to be pharmacologically or biomedically inert for the condition being treated. Studies indicates that placebos relieve some symptoms in approximately 35% of patients who suffer from conditions such as angina pectoris, cough, depression, hypertension, headache, and the common cold (Howard Brody, 1980 and Herbert Benson and Mark Epstein, 1975). Evidence also suggests that the placebo effect~an improvement in the patient after use of placebo~can sometimes be produced without nondisclosure, incomplete disclosure or deception. Health professionals believed that placebo appears to work because of the 'healing context' which includes the professional's *care, compassion and skills in fostering hope and trust*, thus act paternalistically. Nevertheless, a placebo is less likely to be effective if used with the knowledge of the patient so that patient can exercise their autonomy. By this, it raises now a question of whether nondisclosure used of placebo is morally permissible. It is not only placebo that is considered where paternalism can be applied. Instead, there are many examples that can be demonstrated with the use of paternalism.

2. Resuscitation

Resuscitation can be defined as a form of medical intervention done in a series of steps directed to sustain adequate circulation of oxygenated blood to vital organs while an effective heartbeat was restored. Many patients who require and request resuscitation are very ill and may have underlying medical condition, that if taken for granted may lead towards death.

Though sometimes resuscitation may have a very poor outcome, still resuscitation is considered as the *standard of care* for patients. In general, such as in an emergency situation, patient is presumed to give consent to medical standard care unless they have previously stated any form of objection. To sum, resuscitation therefore is a unique form of therapy applied to patients without their consent, and only withheld upon their request or direction. It is therefore a successful outcome of any attempt to resuscitate.

A request to forego resuscitation maneuvers is therefore term as Do not Attempt Resuscitate (DNAR) or commonly known as Do not Resuscitate (DNR). The right of the patient/proxy/surrogate to request DNAR/DNR status is based on the patient's right to autonomy/self-determination (with an assumption that the patient is competent). This right takes precedence over other considerations such as the potential success, other family member's desire or perhaps the physician/nurse preferences. Many hospital institutions have various policies with regard to DNR order. However, it is a general policy that physician/nurse have the responsibility based on the principle of beneficence and justice to discuss the DNR issue. Beneficence would hold that it is in the patient's best interest to have an opportunity to make their own wishes known and justice would hold that since some patients have the opportunity to hear concerning the use of DNR, will be given the chance to decide with regard to their medical condition. Thus, justice and beneficence also would support a patient's right to refuse a DNR status and thus have an access to therapy that might be considered ineffective and costly regardless of their ability to pay the

costs. The DNR orders includes only resuscitative measures and should not influence/interfere with other palliative treatment that maybe appropriate for the patient.

This DNR order is not and should not be viewed as a form of abandonment of the patient. DNR is a re-direction of care towards alleviating suffering and ensuring maintenance of personal hygiene and dignity. Ordinary supportive measures, palliative care including food and water, should be given. Creating a prayerful atmosphere may be encouraged at all times especially when a patient appears to be dying already.

When the patient was rendered competent, the DNR decision should be taken or be made by the patient himself/herself, on the other hand, if rendered incompetent, the following must be observe:

1. If an advance directive is made available by the competent patient prior to their condition, and after consultation to the family members, it should usually be respected.
2. If no AD is available, the patient's family member can take the decision, provided that it satisfies what the rule of law set (look for the criteria on who is permitted by the law in advance directive discussion).
3. If the patient was abandoned by any of those set by the law, then, decision must be referred to proper medical authorities.

Indications for DNR orders

1. When the patient condition is terminal and death is immanent so that life support only prolongs the dying process.
2. When the patient is irreversibly comatose or in persistent vegetative state and there is no hope of improvement.
3. When the burden of treatment far outweigh the benefit (adapted from Southeast Asia Center for Bioethics).
4. The following are reasons for DNR order, these were taken from different sources gathered: *no medical benefit, poor quality of life after CPR (cardiopulmonary resuscitation), poor quality of life before CPR, poor prognosis, severe brain damage, extreme suffering or disability in a chronically or terminally ill patient, request by the a patient or family member, enormous cost and personnel commitment* as opposed to the low probability of patient recovery, by not administering any cardiopulmonary in the event of cardiac arrest, we are actually letting the person go in peace and in dignity.

2. BENEFICENCE

Our common morality dictates that it is not enough to promote and respect autonomy but also contribute to their welfare. In the discussion of beneficence it will highlights altogether the significance of beneficence in our dealings with ourselves and with our fellowmen especially those who seek care. And that our dealing with ourselves and with others does not only involved the principle of beneficence but also our very traits/virtues are to promote beneficence as well.

Case Study

Peter, a 65-year-old, has one leg in sling and the other on a pillow. It is mid-morning and the staff nurse, Patrice, rushes in. she is in a hurry because the ward is short-staffed. She quickly gives Paul a cup of tea without giving him any time to say anything or checking that he can manage. As Peter tries to drink the tea it spills and burns one of his hands badly. What is Patrice's responsibility for this accident, bearing in mind that when the ward was adequately staffed more time would have been spent ensuring that Peter could cope safely with drinking the tea? How responsible is Patrice for Paul's accident?

The Meaning of Beneficence

Beneficence, etymologically, comes from two Latin words, '*bonus*' where *bene* was taken to mean 'good' and *fic* where *fiche* was taken to mean 'to act or do.' So, beneficence refers to 'action done for the good of others. In the language of medicine, this principle highlights the duty of health provider to do good and take positive steps, such as prevention, removal of harm to the patient. Beauchamp and Childress and Pesche believed that beneficence could be seen through the associated acts of *kindness, charity, humanity, altruism and love*. Beneficence then was often thought to broadly include all forms of actions (e.g., benevolence and provenance) intended to benefit other persons. So, beneficence refers to an *action* done to benefit others; benevolence refers to the character trait/virtue of being disposed to act for the benefit of others; and the principle of beneficence refers to a moral obligation to act for the benefit of others. So, beneficence goes hand in hand with benevolence and

provenance. Benevolence is goodness in each personhood, while, provenance is the attentiveness dictated by kindness to anticipate what one needs since each one of us, has that inner goodness that pushes us to alleviate the pain and discomfort of others.

Obligatory and Ideal Beneficence

Some ethical theories like utilitarianism are based on the principle of beneficence. This means that goodness and kind-deeds form the substratum of the utilitarian theory (recall your discussion on utilitarianism).

Recent thought of beneficence touches on the idea of an obligatory beneficence and ideal beneficence. Different philosophers like J. Bentham and W.D. Ross differ in the meaning of beneficence yet they employed the term beneficence as a positive obligation, to other, though some critics (W.D. Ross) denied this kind of beneficence for he holds that beneficence is a virtuous ideal/acts of charity, thus any person therefore is not morally deficient if he/she failed to act beneficently.

An example is presented by Beauchamp and Childress that was found in the bible about the good Samaritan which illustrates several problems in interpreting beneficence. In the said parable, a man traveling from Jerusalem to Jericho was beaten by a robber that left him 'half-dead'. After two travelers passed by, the injured man without rendering help, a Samaritan who saw him was touched by his compassion and went to him and bound up his wounds... brought him to an inn and asked the inn keeper to care for the man and that by his return he will pay the expenses of the man. In having compassion and showing mercy, the good Samaritan expressed an attitude of caring for the injured man and also took care of him. In this case, both the actions and the motives of the Samaritan are beneficent actions. So this parable suggests that positive beneficence is more ideal than an obligation because the Samaritan's act serves to exceed ordinary morality.

Beneficence then is sometimes an admirable ideal of action that exceeds obligations. Others and Beauchamp and Childress asks, are we obligated to act beneficently? Does moral obligation stems from one's feeling and duties to do good to one's own neighbor? These queries can be address by saying that acts of beneficence has an indispensable role in the moral life of the person quite apart from the principle of obligatory beneficence. Such as nobody denies that beneficent acts, such donating one's own kidney to a stranger is morally meritorious and therefore morally praiseworthy away from a personal obligation.

Virtually everyone perhaps agrees that common morality does not contain a principle of beneficence that requires severe sacrifice and extreme altruism in behalf of the moral life of others. For only ideal beneficence incorporate such extreme generosity. So also we are not morally required to give benefits to persons in all occasions, even if we are in a position to do so. Say for instance, we are not morally required as morality dictates to perform all possible acts of generosity or charity that will benefit others. By this, ideal beneficence means going out of one's way in order to do good to others, while, beneficence is merely goodness to others without going out of one's way.

To sum up, ideal beneficence, is benevolent act that involves going out of one's way to do good to others as that of good Samaritan. To concretize, a nurse who is riding on a bus, suddenly, one of the passengers fainted because of hypoglycemia and fatigue. The nurse brings her to the nearest hospital, stays with her, until she regained her consciousness. Furthermore, the nurse accompanied the woman in going home. This act done by the nurse is ideal and also meritorious that not all will do the same thing. It was the nurse's extreme moral obligation that prodded her to act and this act of beneficence makes is ideal one.

Obligatory beneficence is a mandatory act to do good and to give aid to those who are in need. To perform one's duty in emergency situation by which no one should not be denied of urgent care; to offer a glass of clean water when someone is thirsty, to give shelter to those were homeless, feed the hungry, give love and care to the orphan, these were some but not limited to it so that exercise of beneficence becomes obligatory.

Nonetheless, the principle of obligatory beneficence in turn forms an important part in morality.

Most act of beneficence is not obligatory, but there are instances when one is obliged to do emergency care to one who is hovering between life and death. The following are practical applications of the principle of beneficence to keep in mind by the health practitioners, although, it was not been referred to as rules. The following were adapted from Beauchamp and Childress:

- Protect and defend the right of others
(Example: on the surgery case, the nurse must explain to the patient who will undergo surgery that he/she has the right to know what the surgery is all about, what benefits versus risks the surgery will bring, and that he/she has the right to know the alternative management aside from surgical intervention)
- Prevent harm from occurring to others

(Example: putting up the side rails of the bed of a restless patient is an example of preventing the occurrences of harm to others. Another example is using double gloves when doing an intervention with an AIDS patient in order to prevent harm from occurring to self and others. In academic setting, tutoring a failing student will help him/her to pass the course)

- Remove conditions that will cause harm to others
(Example: when caring for the patients that are not mentally sound the following like pills, sharp objects, hazardous materials be kept away. Another example is avoiding talking about topics that will depress or provoke patients to violence)
- Help persons with disabilities
(Example: guiding and holding the hand of the blind or deaf individual while crossing the street, reading a newspaper or book to someone who has defective eyesight, etc)
- Rescue persons in danger
(Example: throwing a lifesaving device to someone who is drowning, cheering up someone who is depressed and suicidal incident, etc)

Let us see how this principle of beneficence can be applied to emergency situation. One clear example exists in health care where the principle of beneficence is given a priority over the principle of respect for patient's autonomy, when the patient is brought to the hospital via emergency room due to severe accident or illness that makes the patient incapacitated and become unconscious due to great damaged, the health care provider such as the nurse then presumed that the reasonable person would want to be treated *aggressively* and thus the health care provider may perform immediate medical intervention according to medical best standard procedure. So, the health care provider then provides by stemming the bleeding, mending the broken part or suturing the wounded.

Beneficence therefore implies that nurses must promote the positive benefits and is obligated to seek all involve, the alleviation of disease and injury, if there is a reasonable hope of cure. The harm to be prevented, removed or minimized the pain, suffering, disability of injury of the disease. These duties are viewed as self-evident and are widely accepted as the proper/primary goals of medicine and nursing and these goals are applied to individual patients and also to the good of the society as a whole. In addition, nurses are enjoined from doing harm if intervention inflicts unnecessary pain and suffering of patients.

The principle of beneficence is already been practice by Filipinos by showing one's goodness such as, delicate and generous hospitality and this is shown in different situations like, sharing of goods, lending of money, materials, equipment, and even human resources, like, *bayanihan*.

Case Analysis of Patrice's responsibility to Peter

(Refer to the case issue/scenario presented above)

The main issue in this case study is the effect of staff shortages. Although it focuses on fair routine quasi-domestic aspects of Patrice's job. The ethical and legal issues it raises are identical to those would apply whatever the nature of the task she was performing. The relevant ethical principle involved is beneficence. For it imposed a duty on Patrice to safeguard and promote Peter's well-being and to eventually not harming the patient at the end. In practical terms, this means that she has at the very least a professional responsibility to ensure that Peter can cope with, and Patrice is personally accountable for Peter's burn. Has she, in other words, failed to reach a professional standard of care, bearing in mind the pressures under which she was working?

However, other factors are relevant here. Was the ward so short-staffed, for example, that even when priorities were set it would have been impossible for another member of staff to help Patrice? Was such an accident reasonably foreseeable, so that additional precautions should have been taken, or was it an inevitable accident and therefore unavoidable? Perhaps it would have been safer to postpone giving Paul his tea? According to Dimond (1995), these are the kinds of question that should be asked.

And if the conclusion is that the accident was avoidable and that another nurse should have been assigned to help Patrice, then this will not automatically relieve Patrice of her responsibility, especially if she was in charge of the ward. If so, then unless it was the first time that staff shortages had compromised standards of care, it would be important to know whether Patrice, in addition to reporting her concerns, had suggested some kind of remedial action, such as employing agency management role. As Dimond notes, failure to take such action—if Patrice had a management role—would mean that she would have share some responsibility for Paul's burn.

Now, assuming that Patrice had made her concerns but still no extra staff was provided, what then? Is it a defense to say to Peter: "sorry you spilled the tea but I was very busy yesterday because we were so short-staffed

that I did not have time to check that you could cope.” The answer here is a big NO. Patient’s are still entitled to the approved standard of care. In this regard the hospital could be liable to Peter for his injuries in failing to provide a safe system of institutional treatment and aftercare. Patrice, too, however, might have share responsibility if it was decided that in the circumstances she had failed to reach the legal standard of care. Her legal and moral duty is towards Peter and she has to act in his best interests without reference to the interests of other patients and potential patients (Jones, 1996).

3. NONMALEFICENCE

One’s own obligation to do good in the practice of medicine is also limited by one’s own obligation to avoid evil/harm. One’s avoidance of harm on others is embedded into what we call, the principle of nonmaleficence. In medical ethics it has been closely associated with the maxim, *primum non nocere*, which means, above all (or first) do no harm (Beauchamp and Childress, 2001). This maxim expresses an obligation of nonmaleficence in the Hippocratic tradition, ‘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’.

This principle helps in decision-making about issues that may alter one’s own life, such as on killing and letting go, withholding and withdrawing treatment, use of extraordinary and ordinary means/procedures and other issues.

Case Study

Staff nurse Ayeesha is concerned about the drug dosage written on the medicine chart. She is sure the dosage is too high but, mindful that John, the doctor who prescribed the drug, has a formidable temper and is known to make life very difficult for anyone who challenges him, Ayeesha remains uncertain to what to do?

Should Ayeesha obeys John instruction? What if she does and the patient is harmed?

The meaning of nonmaleficence

Nonmaleficence comes from a Latin words: ‘non’ to mean ‘not’; ‘malos’ from which ‘male’ is taken to mean ‘bad/evil’ and ‘faceo’ from which ‘fic’ comes which means ‘do/make’. Thus the term nonmaleficence means not to make or to do bad or to make evil things intentionally. So, in medicine, nonmaleficence means not to inflict harm which is not different from ‘not doing evil or bad things’. This principle requires a health care provider to prevent or refrain from any sort of actions that eventually causes harm to patient and more importantly when the action is never been justified.

Distinction between nonmaleficence and beneficence

Generally an obligation of nonmaleficence is more stringent than obligations of beneficence and in some cases, nonmaleficence perhaps may override beneficence. Beauchamp and Childress suggested the following schema to distinguish the principle of nonmaleficence and beneficence. But the said authors do not propose a hierarchical order.

Instructive Principle	Bioethical Principle
One ought not to inflict evil or harm	Nonmaleficence
One ought to prevent evil or harm	Beneficence
One ought to remove evil or harm	Beneficence
One ought to do or promote good	Beneficence

In the graph we see that beneficence and nonmaleficence focuses on doing good to others. Both were attune to altruism, that is, to do acts of kindness and goodness to oneself and to others. The difference lies in the nature of execution: beneficence, starts with preventing harm from happening to anyone and beneficence sees to it that any individual will not be harmed physically, emotionally, psychologically and spiritually. On the other hand, nonmaleficence focuses mainly on the subject of not inflicting harm intentionally. By way of immediate glance, we see that this principle have more similarities than differences, simply to say, what is due is doing good deeds to others at all times.

Because there are many types of harm the principle of nonmaleficence supports many specific moral rules. In 1988, Gert, a bioethicist working in moral-oriented disciplines gave the following typical examples of nonmaleficence.

1. Do not kill
2. Do not cause pain or suffering to others
3. Do not cause offense to others
4. Do not incapacitate others
5. Do not deprive others of the goods of life

The principle of nonmaleficence can be applied in one's own common language, that it is often called 'negligence', that is, if one imposes harm or become careless and produces unreasonable risk of harm upon another. So to provide a proper standard of care that avoids or minimizes the risk of harm is supported not only of common conviction of morality but also of laws of the society as well. In view of professional model of care one may be morally and legally blameworthy if one fails to meet the best medical standard of due care to the patient. This implies corresponding consequence to one's own action, and this is term as 'negligence'. There are criteria on determining negligence:

1. The professional must have the duty to the affected party
2. The professional must breach that duty
3. The affected party must experience a harm
4. The harm must be caused by the breach of duty

This principle of nonmaleficence affirms the need for medical competence. It is clear that medical mistakes occur, however, this principle articulates a fundamental commitment ethically and legally on the part of the health care professionals to protect their patients from harm. For example, in a case of *Adkin V. Ropp*, the supreme Court of Indiana considered a patient's claim that a physician had been negligent in removing foreign matter from the patient's eye: here is the judgment of the court that favors the claim of the patient,

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 contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skills, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure and negligence cannot be imputed because a cure is not effected, but he does not impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient so that 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 treatments, but he is held to the like degree of care and skill in the necessary subsequent treatment unless he is excused from further service by the patient himself, or physician or surgeon upon refuses to further treat the case (Beauchamp and Childress, 2001).

This principle of nonmaleficence is also a part of Filipino character through avoidance of confrontational dialogue that will eventually cause harm to others. For example,

Many Jose knows that his neighbor has a terrific armpit odor. But because Mang Jose wants to be good and does not want to hurt the feeling of his neighbor he then prefers to keep it for himself. Thought he knew that it would be charitable to tell it to others by frankly letting them knew it.

Confrontational attitude was avoided because we Filipinos do not want to cause harm to others and it was embedded in the guise of being good and not hurting the feelings of others.

Case Analysis of Ayeesha's Dosage Dilemma

(Refer to the case issue/scenario presented above)

The core issue here is obeying instruction. The principle of non-maleficence imposes an obligation on the nurses not to harm patients. In this situation it must at the very least mean that Ayeesha should not just blindly

follow orders but should act as an autonomous practitioner. To do otherwise, i.e., not to seek some kind of confirmation that the drug is the correct one, would constitute a breach of the principle of non-maleficence.

This means that the nurse, is expected not just to scrutinize carefully the prescription and the dosage but also to question the doctor as appropriate and where necessary, to refuse to administer. Ayeesha therefore has a professional obligation to question John. Note too that she should make sure that she keeps an accurate record of the problems that have arisen. This is very important since any document that records any aspect of the care of the patient can be required as evidence before the court of law. Ayeesha in this case has the moral responsibility not to administer a drug about which she has such doubts, given its potential harmful effects. If Ayeesha fails to take these measures, gives the drug and the patient is harmed there is little doubt that she is morally and professionally accountable for her actions. It seems then that when administering any drug is it the nurse's personal and moral responsibility to ensure that is the right drug, at the right time, in the right place, at the right dosage, in the right route, to the right patient (Dimond, 1995). This means that the nurse should challenge any order which seems to be wrong.

So whatever concerns Ayeesha has should be dealt with by first taking appropriate action. Otherwise she should be liable legally and morally thus guilty of negligence for failing to follow the reasonable standard of care expected of a nurse. Finally it is worth repeating that, even after confirmation has been sought and has been obtained, nurses should still refuse to administer any order that is manifestly wrong.

Practical application/implication of the principle of Non-maleficence

Withholding Treatment and Withdrawing Treatment

Many health care professionals and the family feel guilty when treatment is withdrawn (stopped) and withheld (not started). Both withholding/withdrawing treatment are bioethical issues which can be acted upon or justified by the following conditions:

1. When the case is irreversible any form of treatment will not benefit the patient
2. When death is imminent or when patient is already dead

When the condition is such that any intervention will not benefit the patient, then treatment is not obligatory. Thus, we have to respect the patient's call for a dignified death. On the other hand, **caring** must surround the person until the time of death. For example,

An elderly man suffered from several major medical problems, including cancer, with no reasonable chance of recovery. Comatose and unable to communicate, he was being kept alive by antibiotics to fight infection and by intravenous (IV) line to provide nutrition and hydration. No evidence indicated that he had expressed his wishes about life-sustaining treatment while competent, and he had no family members to serve as surrogate decision-maker. The staff quickly agreed on a 'no code' or 'do not resuscitate' order, a signed order not to attempt cardiopulmonary resuscitation if a cardiac or respiratory arrest occurred. In the event of such an arrest, the patient would be allowed to die. The staff was comfortable with the decision because of the patient's overall condition and prognosis and because not resuscitating the patient could be viewed as withholding rather withdrawing treatment.

Ordinary and Extra-ordinary Treatments

As the tradition suggests the term 'ordinary' was interpreted as 'usual' or 'customary' and 'extraordinary' was interpreted as 'unusual' or 'uncustomary'. So, according to this interpretation, treatments are extraordinary if the treatment is unusual or uncustomary. As the time goes by, the meaning of 'extraordinary' had gained a new meaning that was referred to particular technologies and alterable standards of practice (Beauchamp and Childress, 2001).

So, ordinary treatment comprises of the provision of necessities of life that usually pertain to *food, normal respiration and elimination process*. Hence like *intravenous fluids, nasogastric tube feedings, indwelling catheters*, are some among the many considered ordinary and necessary measure of treatment and may be sustained even if the case is irreversible. Thus, all measures considered to be ordinary may be sustained until the time of death.

On the other hand, extra ordinary treatment comprises of the use of *aggressive modalities* vis-à-vis the capacities of the family or maybe some family who can very well afford it, continue to give extra ordinary measure. But this means do not necessarily offer any benefit to the patient. This is also a way of artificially prolonging the life

of the patient. Obviously, this extra ordinary measure loads the patient with more burden and fatigue and are in fact a hindrance to letting the patient go in peace and dignity.

Traditionally, the rule on extraordinary treatment can be legitimately be forgone, whereas, ordinary treatment cannot be legitimately be forgone. This may also lead towards accounting whether death was letting die or perhaps killing.

As a nurse, what you can do is to enlighten the families or any surrogate on the futility of the actions and those resources can be better use in other channels resulting in more benefit to others. (Example: subjecting the patient to chemotherapy and hemodialysis when they are on the verge of death may become disproportionately extra ordinary because of the burden on the patient who has already a weak body vis-à-vis the intervention will offer no benefit to the patient).

Unfortunately, the distinction between ordinary and extraordinary treatment is often vague and morally misleading because patient may very well refuse ordinary treatment. The case will show on how this can be accounted, and make your response with regard to the issue.

A 76-year-old widow was admitted to a nursing home for several years already. In the past she had experienced repeated transient ischemic attacks, caused by reduction or stoppage of blood flow to the brain. Because of the progressive organic brain syndrome, she had lost most of her mental abilities and had become disoriented. She had also thrombophlebitis (inflammation of a vein associated with clothing) and congestive heart failure. Her daughter and grandchildren visited her frequently and loved her deeply. One day, she suffered a massive stroke. She made no recovery and remained nonverbal, but she continued to manifest a withdrawal reaction to painful stimuli and exhibited some purposeful behaviors. She strongly resisted a nasogastric tube being placed into her stomach to introduce nutritional formulas and water. At each attempt, she thrashed about violently and pushed the tube away. When the tube was finally placed, she managed to remove it. After several days, the staff could not find new sites for inserting IV lines and debated whether to take further 'extraordinary' measures to maintain fluid and nutritional intake for this elderly patient who had failed to improve and was largely unaware and unresponsive. After lengthy discussions with nurses on the floor and with the patient's family, the physician in charge reached the conclusion that they should not provide further tube feeding. The patient had minimal oral intake and died quietly the following week.

Killing and Letting Die

According to the common sense 'all the difference in the world' view, deliberately killing people is obviously evil. In a medical environment it conjures up images of healthcare workers secretly and possibly involuntarily killing their patients, of handicapped infants and elderly people in an institution being quietly snuffed out of wicked experimental programs. Letting the people die, suggests the much acceptable practice of 'letting nature take its course', facing up to the limitations of medicine and the fact of impending death, and avoiding heroic measures such as aggressive surgery, drug therapies or intrusive devices. In the end it is not the responsibility of the health care provider to keep everyone alive, nor could the health care provider tried. And it is a good thing to be allowed to die in peace.

In ordinary language 'killing' is a causal action that deliberately brings about another's death. For example, in automobile accidents, one driver killed another even when no awareness, intent, or negligence was present. Whereas, letting die is the intentional avoidance of causal intervention so that disease, system failure causes death, as to the case of Karen Ann Quinlan (Beauchamp and Childress, 2001).

'Letting die' is 'prima facie' acceptable in medicine under two conditions:

1) a medical technology is *useless* (medically futile) and 2) patients (or valid surrogate/proxy) have validly refused a medical technology, that is, letting a patient die is acceptable if and only if satisfies the condition of futility or the condition of a valid refusal treatment (note, honoring one's own valid refusal or a useful treatment is here as Beauchamp and Childress contend is letting die and not killing, this may be debated). So, it implies now that once the criteria of letting die was not satisfied, then letting the patient die involves negligence (see how negligence is committed) and may perhaps constitute a form of killing.

'Killing' has been conceptually and morally connected in medicine to *unacceptable* acts (Beauchamp and Childress, 2001). See, the 2nd condition for 'letting die'. Generally, act of killing is not regarded as absolutely wrong, e.g., in self-defense, call of duty as police officer etc.

In short, whether 'killing' and 'letting die' is justified or unjustified are matters in need of analysis and argument and not matters that medical tradition and legal prohibition have adequately resolved.

4. JUSTICE

Etymologically, justice comes from the Latin word 'jus' to mean 'right'. The etymological meaning of the word 'justice' that connotes 'right' is somewhat a bit different from the word 'justice'. What then is justice? The terms *fairness*, *desert* (what is deserved) and *entitlement* are used by various philosophers in an attempt to explicate justice. This account interprets justice as fair, equitable, and appropriate treatment in the light of what due or owe to others.

The writer of the Hippocratic Oath insists that it is a part of the doctor's duty to keep his patients free from injustice they can do themselves, Justice is generally thought to be giving *others* their due. This idea may be taken into different senses, most narrowly as fulfilling responsibilities prior to any undertakings, more widely, as being fair perhaps to others, quite generally, as acting uprightly in any way of actions bearing on others, biblically, the scripture would say that justice may mean goodness and holiness in general. However, most philosophers use the term justice in a more specific sense that was referred to as 'rightness in people's interactions and interrelations'. Thus, it is rightfully correct to say that sometimes the word 'justice' overlap with the word 'right'.

Formal Principle of Justice

Formally speaking, as Aristotle in Nicomachean Ethics would say that justice refers to 'equals must be treated equally' and 'unequals must be treated unequally'. This is the formal principle of justice, it is 'formal' because it identifies no particular respects in which equals ought to be treated equally and thus provide no criteria for determining whether two or more individuals are in fact equal (Beauchamp and Childress, 2001).

Material Principle of Justice

Principles that specify the relevant characteristics for equal treatment are called 'material' because they identify the substantive properties for distribution. Philosophers like Engelhardt, Keusch, Wildes and others have suggested the following material principles of justice:

1. **To each person an equal share.** [example: all members of the society are given equal services such as the free immunization to all children below seven years old]
2. **To each person according to need.** [example: when there is a shortage of ex. Hepatitis B vaccine, it is provided only to the high risks groups. Likewise, only health care workers assigned in the high risks areas are provided with free health check-ups, medication, including treatments and vaccinations to protect them]
3. **To each person according to contribution.** [example: only people who are members of the Philippine Health can avail of its medical services and privileged]
4. **To each person according to free-market exchanges.** [example: the service is provided only to those who can afford it such as cosmetic surgery]
5. **To each person according to merit.** [example: this principle involves that implementation of set of rules/criteria that must be met before a privileged can be granted. Example: Philippine Charity Sweepstakes service of providing free health care assistance only to those who meets the required criteria and that is having no financial capacity to provide it for themselves and to their family]
6. **To each person according to effort.** [example: this refers to the patient's efforts to comply or not to comply with the medical advice. A diabetic client has the choice to comply or not to comply with his medication and diet regimen]

Types of justice

1. **Distributive justice.** It refers to fair, equitable, and appropriate distribution or responsibilities or share or rights and roles, resources and privileges
2. **Criminal justice.** Refers to the infliction of punishment or penalty proportionate to the crime committed. In other words, no exemption in the merited penalty.
3. **Rectificatory justice.** Refers to just compensation for transactional problems such as breaches of contract and practice based on civil law. Rectify the person who did not observe hi/her word of honor.

The discussion of justice will only be limited to distributive justice for it's too complex to handle it here. Theories of distributive justice have been developed to specify and unite one's diverse principles, rules and judgment. Theory attempts to connect the characteristics of persons with morally justifiable distribution of benefits and burdens. Nonetheless, systematic theories of justice have been proposed to determine how social burdens, including health

care goods and services should be distributed or redistributed. Some influential theories that go with the discussion of justice are the following:

The Paradigm Approach to Justice

Utilitarian: *Justice as whatever brings about the greatest good of the greatest number (John Stuart Mill)*

For a utilitarian, justice is not an independent moral principle. Rather it is a principle dependent on, governed by, that sole principle of morality, the principle of utility. It names the most paramount and stringent form of obligation created by the principle of utility. Utilitarian therefore work out all the predictable benefits and all the predictable losses of some proposed change or *state of affairs*, calculate the net sum (or utility) of the proposed changes and choose that *state of affairs* which will bring about the greatest good for the greatest number, which will in turn maximize utility. Justice in this instance then is the distributed result of that calculation. Thus, any form of state of affairs is considered just if it represents the greatest good for the greatest number and unjust to the extent that it does not affect that result.

As it is applied in health care, utilitarian used two principal criteria for working out one's utility: *quality of life measures and social contribution measures*. It is a fact that some utilitarian may have various emphases yet they tend to favor the following principles in medicine: a) prevention is to be preferred to cure and cheaper (less expensive) therapies are to be preferred to a more expensive ones, b) expensive or scarce therapies are only available to the young and those who likely to lead long productive lives, c) preference should be given to those likely to receive the greatest benefit in terms of improved length and quality of life and to those likely to make the greatest future social contribution, d) short-term services are to be preferred to long-term care and institutional care is eliminated as much as possible and e) healthcare for the terminally ill, dying, elderly, chronically sick or incapacitated, severely handicapped and permanently unconscious is to be given the lowest priority (Anthony Fisher).

Egalitarian: *Justice as the equal distribution of good and services (John Rawls).*

Egalitarian argued that justice means is essentially considered what is due is what is fair, equal, or perhaps fairness. John Rawls principle of justice is derived from what people would choose if they were forced to be impartial, if they had to choose principles on which to base a social structure that will satisfy them whenever they turn out to be located in it. John Rawls continue to say that each person will choose two principles that will lead towards the exercise of fairness, namely, a) each person should have the most extensive system of basic liberties compatible with similar liberties for all and b) social and economic inequalities should be arranged so that they are to the greatest benefit of the least advantaged and are open to all under conditions of fair equality of opportunity. Simply to say, justice for Rawls therefore consists in fair equality of opportunity.

John Rawls himself never applied justice to the distribution of health care. However, most readers (Daniels, Norman) of John Rawls believed that his theory inspired approaches to health care distribution by insisting that each person irrespective of social condition such as poor and the wealthy should be provided with equal fair opportunity to health.

Distribution Rawls believed must be on the basis of need which is understood as what is necessary for equality of opportunity. For example, better services, such as luxury hospital rooms and expensive but optional dental work, should be available for purchase at personal expense by those who are able and wish to do so. On the other hand, everyone's basic need of health service should be met at an adequate level. By this, it ensures decent minimum of health care and equal opportunity.

Libertarian: *Justice as the lack of restraints on individual liberty (Robert Nozick).*

Contemporary libertarian like Robert Nozick believed that it is not the role of the state to impose any pattern of distribution of benefits and burdens on its members since that will violate the rights of individuals. Nozick believed that individual have rights, such as right to liberty, life, property and others, which those individual are entitled to enjoy and to exercise so long as it does not interfere into the rights of others. Nozick therefore believed that the affair of the state is to protect citizens against any unjust interference such as, theft, fraud, violence and others and it is not the business of the state to distribute benefits and burdens such as health care since that will turn violate the rights of individuals.

So, as the libertarian suggests, the only just system of allocation of health care is the operation of the free-market. It is up to people individually to choose what health care or service, and from whom, for which they wish to spend their own resources. It is up to the health professional as well to decide how, when, for whom, with whom and for how much they wish to work. Libertarian therefore treats autonomy, both the health care professional and the patient as a central notion of health care and allocating resources. Individual then must be encouraged to take responsibility for their own health (Ronald Dworkin, 1981).

Applying Nozick's libertarianism to health care, health care professionals are obliged to provide care only that health care in keeping with their own prior undertakings or present choices. Thus, they may legitimately decide for themselves what distribution standards to apply to their own practices. Furthermore, libertarian, supports generally a health care system, the state or any instituted state that does not coerce in taking one's own personal property rights, physician have liberty, nurses too, and society is not morally obligated to provide health care if it is done through coercion.

Communitarian: *Justice is what is due to individuals or groups depend on the community-derived standards (Alasdair MacIntyre).*

Communitarian regards justice as pluralistic (Beauchamp and Childress, 2001). That means it derives justice from as many as different conceptions of the good as there are diverse moral and cultural communities. Communitarian then placed the community as the core of a value system than prioritizing an individual as libertarian proposed. The value of any public goods are rooted from a communal practices. Communitarian believed that human life will go better if collective and public values guide people's lives. They have a commitment to facilitate and practice designed to help members of the community develop their common and henceforth personal lives (Honderich, 1995).

Modern communitarian writers disagree on the application of these theories to health care access. Some proposes a federation of interlinking community health programs that are democratically administered by the citizen-members. In this approach to communitarian, each individual program would determined which benefits to provide, which care is most important, whether expensive service will be included or excluded (Beauchamp and Childress, 2001).

The following table shows a summary of the different approaches to justice:

Approaches to justice	Proponent	Principle	Description of Justice
utilitarianism	Mill	Justice as whatever brings about the greatest good of the greatest number	Equality of all persons and impartiality between persons
Egalitarian	John Rawls	Justice as the equal distribution of (at least some) goods or services	Emphasized on what is owe (as a matter of fairness) by the rest of us to the poorest and most vulnerable members of the community
Libertarian	Robert Nozick	Justice as the lack of restraints on individual liberty	Recognizes the centrality of individual's autonomy
Communitarian	Alasdair MacIntyre	Justice is what is due to individuals or groups depend on the community-derived standards	Consist in favoring and fostering the common good of one's communities. It emphasizes on solidarity with every human being/person

Justice underlies the nurse commitment to provide services with respect for human dignity and render nursing care to the best of their ability to every patient regardless of religion, sex, race, economic status and beliefs.

Allocation of Scarce and Resource (Triage)

The basic ethical question to allocation of scarce and resources is not whether there is a need to rationing or prioritization but how it should do so, given the case that it is inevitable. Unless there is a systematic ethical examination and criticism of health care distribution, there are likely to be inconsistencies, abuses in the way the goods of the state is allocated.

The first issue on allocation of scarce resources is on the 'macro' level is: how much should be spent on healthcare? The second would be on meso-allocation which is: how many healthcare resources should go to what kind of services? And finally, on the microallocation: who should get what share of the healthcare resources?

The problem of health care distribution does not only arise when being addressed directly. Time and again it rears its head when treating other bioethical questions such as the appropriate treatment of newborns, the infertile, the chronically sick and the terminally ill and the permanently unconscious.

To allocate is to distribute by allotment as Beauchamp and Childress would argued. And such distribution does not presuppose either a person or a system that rations/prioritize resources. A criterion of one's ability to pay in a competitive-market for instance is a form of an example of allocation.

'Macroallocation' decisions determine the funds to be expended and the goods to be made available, as well as the method of distribution. This emphasize that a macroallocation deals with how much of the society's resources will be used for various needs, including health-related expenditures. A certain state therefore decides how much of the national budget goes to the health care program and what proportion of available health goes to which program.

On the other hand, 'Microallocation' decisions determine who will receive the particular scarce resources. This distinction that were mentioned are useful, but the line between them are not clear and oftentimes interact.

One's own moral intuition often drives each one into two conflicting directions: either to allocate more to treatment or to allocate more to prevention and education. Now, determining who among the given options will receive priority varies due to different philosophies one is adhering. So, the only recourse perhaps is to give what is due to ones own.

Case Study Format

- I. Introduction
 - Give an overview of the case or the problem
- II. Facts of the case
 - Personae (persons involved in the case)
 1. Patients
 - ✓ Identify the patient
 - ✓ Present the pertinent information regarding the patient such as age, sex, condition or sickness, decision and competence of the patient.
 2. Relatives
 - ✓ Identify the family members, husband, wife, parents, or the surrogate
 - ✓ Discuss briefly their participation in the case, the decision they have regarding the ethical issue.
 3. Health Care Provider
 - ✓ Identify the Doctor or the Nurse
 - ✓ Tell something about their background and their participation in the case.
 - ✓ What are the options?
 - Setting
 - ✓ Determine the context of the case if it happened in a local or foreign setting.
 - ✓ If the particular place is given, specify it.
 - Summary
 - ✓ Summarize the scenario of the case.
 - Definition of terms
 - ✓ Define medical terms or concepts used in the case
- III. Ethical Issue
 - What is the dilemma in the case? Or what is the problem?
- IV. Analysis
 - Consider the ethical issue and establish the options.
 - What are the analyses considering the pros and cons / advantage and disadvantages of certain alternative courses of action?
- V. Resolution
 - After analyzing, come up with the decision regarding the ethical issue
- VI. Substantiation
 - This covers the discussion of the resolution or decision made. This highlights the different ethical theories/concepts/principles that support the established decision regarding the case. Theories and principles should be discussed in accordance to the case or as it supports the decision made.
- VII. Appendix
- VIII. References

Sample Case

Mark is 28 years old and newly wed. He is processing his papers for his new job and he is required to submit a medical certificate. The Doctor who consulted him happened to be his close friend. After the laboratory tests conducted, it appeared that Mark is diagnosed positive with HIV. He asked his friend to make this issue be kept confidential and assured his willingness to undergo whatever treatment.

Case Presentation

I. Introduction

One of the important principles in the physician/provider-patient relationship is confidentiality. This establishes the trust between the physician /provider and the patient. Although confidentiality is ideal, it may not be absolute. Under what conditions can we say that it is right for us to accept confidentiality? And, under what

conditions can we be justified to breach confidentiality? This is a concern in the hospital setting that doctor or nurses would end up experiencing the ethical dilemma.

The case of Mark exemplifies the problem concerning confidentiality. What is the right decision to be counted? This ethical dilemma will be discussed, analyzed and resolved in this case study.

II. Facts of the Case

a. Personae

1. Patient

Mark - 28 years old and newly wed. He is suffering from HIV positivity and is requesting that his condition be confidential.

2. Relative

Wife (give information about the wife and her participation or decision)

3. Health Care Provider

Doctor – a close friend of Mark

b. Setting

The case happened in a hospital setting.

c. Summary

Mark is 28 years old and newly wed. He is processing his papers for his new job and he is required to submit a medical certificate. The Doctor who consulted him happened to be his close friend. After the laboratory tests conducted, it appeared that Mark is diagnosed positive with HIV. He asked his friend to make this issue be kept confidential and assured his willingness to undergo whatever treatment.

d. Definition of terms

Note: enumerate and define the terms in the case

1. HIV+

III. Ethical Issue

Whether to respect the decision of the patient and not to inform about his condition or to disregard it?

IV. Analysis

Option A: Respecting the decision of the patient

- We respect the autonomy of the patient to decide concerning his condition
- We respect the concept of confidentiality and assure that the reputation of the patient is secured.
- Veracity is violated
- (you can analyze further and discuss the advantages and disadvantages of the option.)

Option B: Disregarding the decision of the patient

- We respect the right of the people concerned, particularly the wife to know the truth.
- The principle of non-maleficence is recognized as we avoid further harm that is possibly given to the wife.
- Veracity is established
- (You can analyze further and discuss the advantages and disadvantages of the option.)

V. Resolution

After considering and weighing the possible alternative courses of action, I/ we have decided as a group to disregard the decision of the patient. (note: just clearly state your decision and no need to explain further. Justification or explanation is given emphasis in the Substantiation)

VI. Substantiation

The patient's decision concerns the principle of confidentiality is this important in the physician/provider-patient relationship. Respecting the autonomy of the patient is in a way beneficial

for the patient. However, autonomy is neither something absolute nor confidentiality given that there are substantial justifications for it. Confidentiality is indeed ideal but not absolute. One of the conditions that strongly justify us in violating confidentiality is the nature of the condition and the substantial harm that goes along with it. In the decision of the patient, though it may be beneficial for him not to let others know about his case, non-maleficence and paternalism would justify us with our intention to avoid the probable harm, particularly the wife. It is the right of the wife to know and veracity tells us to do so. Harm given to the wife can be avoided or further harm can be address if given that the wife is already affected with the disease. Disregarding the decision of the patient does not imply that we have to divulge the information to all people but only those concerned and those possibly affected by it, such as the wife.

Note: Use the principles that will justify your decision as shown above.

VII. Appendix

Note: Include here the additional research you have gathered regarding the case. This may include the articles or discussions taken from the books, journals, downloaded files in the internet and other references. This can be used as a reference during the deliberation and discussion which can just be simply cited if needed.

VIII. Bibliography

Note: Cite the references used in the case study.

ETHICAL CASE STUIDES

1. Ethics Case Study –Emotional Intelligence

Mukul was a hard working policeman. He married a beautiful girl from his village. Both of them stayed in a house at police quarters.

Mukul's boss, Sub-Inspector Sandeep was an arrogant and flirtatious officer. He did not treat his subordinates well. He had an eye on Mukul's wife ever since he first saw her on the day of Mukul's wedding. His house was in the neighborhood of Mukul's. Unlike other superior officers, Sandeep often invited Mukul to visit his home with his wife for dinner and to other get together parties. Mukul had noticed that Sandeep was trying to get closer to his wife by making jokes and giving unsolicited advises.

Sandeep denied Mukul any holidays. Mukul was tired of asking for leave so many times and had even mildly protested once. Sandeep wanted Mukul and his wife to stay at the quarters all the time.

Once Mukul wanted a fifteen days of leave to arrange and look after his only sister's wedding. He had to go to his native with his family for fifteen days. Mukul officially kept asking for leave two months well before the wedding date itself. But as expected Sandeep kept refusing him any leave. Just before the scheduled day Mukul had to leave for his native, he once again finally asked Sandeep to grant him leave. Sandeep said that he would grant him leave provided he went alone to the marriage leaving behind his wife in the quarters. Mukul, agitated, took his loaded rifle and shot the inspector dead. He then surrendered to the police. Emotional intelligence is must for police officers to work in a stressful and provocative environment.

2. Ethics Case Study:

You are travelling in a train in sleeper class at night. You have not slept properly for three days because of some hectic tiresome personal work. You are desperately in need of some good sleep.

At around 10 pm an old woman and a small girl child with lots of luggage gets into the car you are in. They have general ticket but don't possess reserved tickets. Someone had advised them that if any seats are vacant, Ticket Examiner(TTE) would accommodate them. Unfortunately no seat is vacant. You are falling asleep and the old woman and child are standing next to your cabin awaiting anxiously the arrival of TTE. It appears that the old

woman is sick and they are traveling to some distant place on an urgent notice. This TTE is not a kind man and as soon as he comes to know that these two are travelling without a valid ticket, he starts abusing them badly. He asks the woman and child to pay hefty fine and sleep on the floor near toilet or wait near the door till next station arrived which is two hours away and get into general car — which is far away from the sleeper class for these two to run and get into. Their ardent requests are met with constant abuses. TTE even doesn't care when the small girl starts crying as she is very sleepy. TTE states clearly that he is not willing to accommodate them with anyone in the sleeper class as it's against rules.

You lost your sleep and heard the diatribe of TTE against these hapless woman and child. Inside the train it's very cold. As a responsible citizen with empathy towards others, what would you do to help the old woman and child? How will you resolve the issue?

3. Ethics Case Study –: Moral Dilemma, Ethics in Private and Public Relationships

You are having lunch with your close friend Naveen. You both are friends since childhood and your families are also close to each other, it's like one family. Naveen recently got appointed as Assistant Director in Social Welfare Department.

During conversation, Naveen tells you that he is enjoying his work because it's giving him an opportunity to help the poor. He also says that he is not asking anyone for bribes but people themselves pay him money because they are happy with his speedy service. He says that he initially did not receive any money but when more and more people insisted, he started taking bribes. He also says that just before he arrived for lunch he was given a good amount of money by a happy beneficiary in his office.

You are a Deputy Superintendent of Police and you are on duty. Naveen knows this, but he is sharing his experiences as he does with any one of his family members. He did not, even for a moment, think that you were a cop on duty.

As a responsible officer who is on duty, and who's duty is to enforce law, what will you do to your friend?

4. Ethics Case Study-: Ethics in Private Relationships; Moral Dilemma

Raghu and Ragini loved each other a lot. When everything seemed fine, Ragini was forcefully married off to a wealthy guy by her parents and sent to a distant country thanks to Raghu's lower caste. Raghu was heartbroken and slipped into depression. He swore that he would either marry Ragini or die of hunger. However, luckily for him, he found a new friend in Rashmi. She was his classmate in his college days and had loved him secretly, but never expressed it to him. Rashmi with her presence and constant support made Raghu to forget the past. Raghu's friends convinced him to marry Rashmi. He married her. Though he didn't love Rashmi, nevertheless he was happy to get a companion and liked Rashmi very much.

Meanwhile, Ragini never loved her wealthy husband. Every day she was craving for Raghu, with whom she was not in contact for many months now. Unfortunately her both parents got killed in a road accident. She came back to India, but never returned to her husband. Now Ragini was alone with no one around her for her support. She was the only child of her parents. She inquired about Raghu. Came to know about his whereabouts and present condition. Still she contacted him and both met secretly. She narrated how she loved him all these days and expressed her desire to get married to him despite knowing he was already married. Though, Raghu was pushed into chronic depression indirectly by Ragini, he never hated her. In fact he still had soft corner for her. Now she had come for him leaving everything behind.

What should Raghu do now?

5. Ethics Case Study:

Rajendra is a reputed structural engineer and is working for a major metro rail project. He is in charge of design, construction and positioning of pillars of metro flyover.

A junior engineer in his team tells him that there is a major flaw in two erected pillars supporting a section of the flyover and they should be replaced/readjusted at any cost. These two pillars supported a flyover curve and if collapsed, it would cause a major accident and put many lives into danger. Moreover, in few days it is to be inaugurated for trial runs. Rajendra brushes aside the apprehension and warning by his junior. But later in the evening, on second thought, he once again scrutinizes his plans and drawings, and finds that his junior was indeed right.

Accepting his mistake would tarnish his reputation for Rajendra. If any accident happens, which is certain to happen at certain point of time in future, it would affect the reputation of the company that constructed it. It will embarrass the government too.

Also, replacing the pillars would inflate the cost for the company and would further delay the project.

In this situation:

- 1) What should Rajendra ideally do?
- 2) What would be the legal and ethical consequences of Rajendra's continued silence?
- 3) What are the qualities that are tested in this case study? Examine.

6. Ethics Case Study

Sampath is working in a Software company. His salary is not good. He is a divorcee and has ailing parents to look after. He is living with them in a small rented house. His father, whom he respects and loves a lot, is diagnosed with cancer and is on chemotherapy. Sampath's monthly salary is almost spent for medicine purpose. He also has large debt. His mother, who was healthy till recently, is also sick most of the times. Sampath is the only son to his parents. As an obedient and loving son, he is taking care of his parents in spite of large difficulties he is facing financially.

His hard work was recognized by the company where he worked and now he is offered a high paying job in USA at the company headquarters. All along it was his dream too. He has to leave for USA in few days. He convinces his parents that he would send them money as soon as he reaches there and asks his mother to look after his father. He also promises them that if all goes well, he would take them to USA to live with him.

On the day of departure to USA, half an hour before his boarding time, Sampath receives a call from his mother. Sobbing, she tells him that his father's health has deteriorated and he is on the verge of death. She requests him to do something. Sampath is not sure if his father would live or die even if he is taken to the hospital right away.

If Sampath misses the plane, he may never get an opportunity like this. He has huge debt which can not be repaid with his meager salary for many more years, and if he goes to USA, he will earn five times more than his present earnings.

What should Sampath do now? What characters are being tested here? Justify your answer.

7. Ethics Case Study

A former employee who was fired due to poor quality work, absences, and lateness related to her drinking problem, informs you that she has applied for a position at another company and has already given your name as a reference. She desperately needs a job (she is a single parent with three children), and she asks you to give her a good recommendation and not mention her drinking, which she assures you is now under control.

She also asks you to say that she voluntarily left the company to address a family medical crisis, and that the company was pleased with her work. You like this person and believe she is a good worker when she is not drinking. You doubt that she really has overcome her drinking problem, however, and you would not recommend your own company hire her back.

- What do you say to this woman?
- What do you say to an employer who calls you for a reference?
- What if the prospective employer was a friend?
- Suppose the problem was a theft?
- Suppose she had asked you to be a reference prior to supplying your name to her prospective employer?

What values are at stake? Do some of the values conflict with one another?

8. Ethics Case Study

You are posted as Superintendent of Police to a District. The stenographer, a beautiful young lady who is smart and hard working, grows close to you. You take her assistance in many office tasks. In the office and beyond a rumour spreads that you are having an affair with her. To make things worse the stenographer has confessed to her friends in office that she loves you. You are affectionate towards her but you are faithful to your wife. You do not worry about rumours and carry on with your work meanwhile growing more close to stenographer. Your wife comes to know about these rumours. A point is reached where the stenographer becomes powerful in the office thanks to your close association. Your continued association is straining your relationship with your wife and is also affecting your public image.

What will you do in these circumstances? Which values would you uphold most in such a scenario and explain why.

9. Ethics Case Study

As a senior officer in the Ministry of Public Works Department you have access to important policy decisions and upcoming big announcements such as road construction projects before they are notified in the public. Your son is a land dealer and realtor. The Ministry is about to announce a mega road project. Once its is announced, the land price in the vicinity would see a steep hike. You have access to maps and know the dimensions of land to be acquired. Your son wants to know the complete details and he is insisting you about this. He wants to buy the land at present rates which is very cheap in and around the soon to be announced project. He is trying to convince you by saying that he would purchase land confidentially and there would be no problem in future for you. You are aware that the Minister has already shared this information with his children who are also into the land business. In fact, the minister has asked you to do the same so that your son also makes huge profits. He has tried to convince you by saying that his and your children are buying land legally and there is no harm in it.

In this situation, what will you do? Critically examine various conflicts of interests at play in this case study and explain what are your responsibilities as a public servant.

10. Ethics Case Study

You are travelling in a government bus to attend a very important job interview. In one hour you should be present at the interview venue. The bus is very congested. Luckily you are seated. From your seat you observe that a middle aged man standing next to a girl is touching and trying to molest her. The girl is silently resisting and trying to move away from him. But the man is continuing his actions. As the bus is congested, nobody is noticing this except you.

- 1) In this situation, what will you do? Explain. 2) If you do not do anything, which values will you be compromising? Explain their importance.

11. Ethics Case Study

Case Study: You are walking home from your work. There is a railway track nearby, which bifurcates some distance away from your home. While on your way you notice that four women have been tied to the tracks. A goods train is approaching fast. Some distance away you notice that your daughter is walking on the other track which is actually a bridge below which a deep gorge is located. There is an option to save all five women by changing the route of the train to other track. If you do so, you will kill your daughter. Your daughter has no escape option. She is unaware of any of these developments as she is walking blissfully listening to her favourite songs from iPod from her headphones. That track on the bridge is not used by trains owing to some reasons.

You can not run and untie all five women as it's impossible to do so without risking your life. If you do so, you will also get killed along with the five women.

In this situation, what will you do? And explain why.

12. Ethics Case Study

You are working as an employee in a private company. One afternoon in the office you get a frantic call from your wife that your two year old daughter is very ill and her condition is critical. Unfortunately nobody is there around to help your wife in any way. Your car is the only option to take your daughter to the hospital, you have to rush to help your daughter as soon as possible.

You soon leave the office. On your way back home you hit an old woman and she is critically injured and before you notice she dies. Nobody has noticed the accident as it has taken place on a stretch of road that's always free of traffic and people. Your wife is calling you frantically for the help. Any delay would cost your daughter's life.

In this scenario what will you do? And why?

13. Ethics Case Study

You are a boss of a small private organization. You are about to meet important clients who will be visiting your office shortly. But you get a call from your wife that your son who is suffering from autism is performing dance in his school, which is first for you both and a very happy occasion. The meeting which was scheduled can not be postponed, moreover if the meeting is successful, your company benefits enormously in terms of new contracts. As you deem son's performance is more important than the business deal, you ask your personal assistant to call the clients and tell them that you are unwell and the meeting can be held tomorrow.

Identify different personal and professional ethical issues present and examine if any values have been compromised in the above case study?

14. Ethics Case Study

Your father is persuading your sister to study medicine after her 12th Class results. Your sister wants to study engineering in a famous college. Because of her good ranks in entrance exams she can get admission for both engineering and medicine in top colleges. Your father tells her that he has invested lots of money and time for her education, moreover he and his wife are getting old and are tired of frequent bouts of illness. He tells her that if she becomes doctor she can look after him and your mother when they get old. Your sister, despite your father's persuasion, decides to go for engineering course. Your father is shocked by her decision and has fallen sick, but your sister doesn't want to change her decision.

In the above case study, was your father right in persuading your sister against her will? Substantiate. Do you support your sister's decision? Explain why.

15. Ethics Case Study "Pornography"

Sexual ethics is a study of a person's sexuality and the manner by which human sexual conduct must be exercised. There are many instances where sexual behavior must be observed in order to properly nurture good interpersonal relationships. Thus, sexual ethics becomes a vital subject that must be studied by everyone. On particular topic being discussed within sexual ethics is the issue of pornography. Pornography is the explicit manifestation of sexual matters presented in different forms of media. Pornography normally shows different illustrations of nudity and sexual acts in print, videos, and social media outfits. Some people view pornography as immoral, citing how it treats persons as mere sexual objects for pleasure. Some people, on the other hand, view pornography as a personal way of displaying one's freedom of expression, which must be respected by everyone. What is your view on this?

Perhaps, virtue ethics, as a framework for moral valuation, can be utilized in assessing one's sexual behavior specifically with regard to the person's fondness for pornography. If virtue ethics aims for the development of the person's good character, does watching pornographic materials reflect of such a character? Is there a virtue that is produced by the behavior of patronizing pornography? What do you think will happen with regard to the character of a person if one habituates the act of watching pornography? Virtue ethics challenges the person to look at one's habits concerning sexual behavior. What would possibly be affected by such behavior is the person's appreciation and valuation of human relationships.

1. Discuss the possible implications (positive or negative) of the patronage of pornography to the development of one's character.
2. Discuss a different topic within the scope of sexual ethics and explain how this might affect the development of one's virtuous character.

16. Ethics Case Study "Letting Be"

Jason is 71 and adamant about not being resuscitated. "When my time comes, let it come! His wife tells all of you that she wants everything done for my husband." There have been a team conferences and sensitive counseling. Still each of them is firm and the nurses are concerned over what is right to do if Jason has a cardiopulmonary arrest. His doctor refuses to write a "do not resuscitate" order.

17. Ethics Case Study "I Want It"

Colleen's cancer is out of control." There is nothing more we can do, " she was gently told. She wants her doctor to start total parenteral nutrition (TPN) by intravenous route so she can try one more round of the research protocol of medication

and make it to his son's graduation. Her son is five and is a kindergarten. Her doctor agrees the TPN will offer her nutritional support and energy, but the side effects of the treatment are unduly burdensome and could cost her life. Should the treatment be started because she wants it though the doctor disagrees?

18. Ethics Case Study "Refusing Treatment"

Scott is a ventilator dependent. He suffered a total transection of spine at C4. He is only 17. Scott pleads with his caregivers to be taken off the ventilator. "I have the right to refuse treatment! I don't want to be trapped in this body!" Does he have the right to refuse treatment though he is not terminally ill or immediately dying?

19. Ethics Case Study "Lessening Pain"

Marilyn is suffering from inoperable cancer. When alert, her pain is intense she cries and draws herself into a fetal position. Her family is distraught the doctor has ordered continuous intravenous morphine sulfate at an accepted rate. Her family wants you to increase the rate so that Marilyn is kept under and completely oblivious to her condition.

20. Ethics Case Study "Dying Peacefully"

Angela is 96 years old. Both her hands and feet are severely handicapped with rheumatoid arthritis. She is admitted to the hospital with a bowel obstruction and several rectal hemorrhages. She is confused and is babbling incoherently. Her daughter wants her mother to have immediate surgery and other aggressive treatments. Her granddaughter says she has spoken often with Angela about her death. She says her grandmother just wants to die peacefully. There is no living will.

21. Ethics Case Study "Down syndrome"

Don and Elaine had been married for nearly twenty years. They had two daughters- one nearly 17 and the other 14. Don was 42 and Elaine was 39 on her last birthday. Yesterday, Elaine's doctor confirmed that she is pregnant for two months. Elaine had mixed feelings because she will have a new baby but disturbed having the prospect that she might have a baby with birth defect or genetic abnormality. She has read in an article that Down syndrome occurred with high frequency among the children of older women just like her case. She knew about Down syndrome because the Johnsons, their neighbor, who were on their forties had a son with that condition and knew the challenges they had. She wasn't sure that they could cope with similar situation.

Elaine learned that one method of prenatal diagnosis of genetic conditions is amniocentesis. If the fetus were shown to have a genetic condition, the parents will have the problem to entertain abortion if they don't want the baby.

22. Ethics Case Study "Barney Says No"

Almeda was an eighty-four-year-old woman who lived a retiring life with no family and few friends. She suffered from a disabling stroke three years ago and has been confined to bed in a nursing home. Almeda has lost decisional capacity and left no advanced directives. Barney, her long time friend, has been her unofficial substitute decision maker. Almeda has developed a stage IV sacral decubitus, now colonized with multiple resistant staphylococcus aureus and pneumonia with heart failure. Now she is in the intensive care unit.

For two weeks, Almeda has been on the ventilator and fed with a gastric feeding tube. During this time, she has been treated with high dose cardiovascular drugs and Vancomycin antibiotic. There has been no progress in the heart failure or pneumonia. Although stoic, Almeda shows clear signs of pain when moved about for care.

The nurses and attending physicians have approached Barney on the numerous occasions to raise the question about stopping aggressive curative treatment and moving toward palliative care. Barney has always insisted that he sees more potential in Almeda's condition. When asked what the right goal for Almeda ought to be, he answered, "it would be good if she could sit up and watch a little television." Almeda's renal function has now become seriously impaired and requires renal dialysis. With the prospect of dialysis, the nursing staff asked for a meeting with the attending physician and Barney to discuss treatment redirection from curative to palliative care.

23. Ethics Case Study "Truth Telling"

Jenny is 37 years old, a recent widow and pregnant. She and her husband had wanted a child, but it seemed as if that possibility was unlikely. Now, after the recent death of her husband, she finds herself pregnant. Fearing the birth of a Down's child, she had amniocentesis and fetal chromosomal studies run and await the results of the tests. Dr. Harold, a genetic counselor, studies the results of a Karyotype run on the fetal cells obtained from Jenny's fetus. He determined that Jenny is carrying a female who does not have Down's syndrome but a Turner's syndrome child. Turner's children are short females with

nearly normal IQ, broad shield-like chest, and no functional ovaries. Most often they are spontaneously aborted. However, in Jenny's case, there appears to be a high probability she will carry the fetus to terms. However, the stress of telling Jenny about the Turner's fetus might induce abortion. Dr. Harold looks up from the papers in front of him and wonders, "What ought I tell Jenny?"

24. Ethics Case Study "Confidentiality in a Rural Setting: There Are No Strangers Here"

The following case presents a typical ethical dilemma in a rural community where public and personal lives are closely interwoven and health care clinics, doctors, and hospitals are few and far between.

Mrs. Sheila Murphy lives in a small town in the foothills of Rocky Mountain West. Her roots in this town are deep. Sheila's grandparents were ranchers and her aunts, uncles and cousins still alive in the area. Ever since she had her husband announced her pregnancy there has been much enthusiasm and support. Sheila considers herself lucky because she had her family known and trust Dr. Hughes a family physician who serves the small community. There is however a problem. During Sheila's last visit, Dr. Hughes discovered an open lesion and diagnosed it as a genital herpes lesion. Dr. Hughes explained that if Sheila has open lesion at the time of delivery, a C-section will have to be performed to prevent the child from becoming infected. Sheila is very upset. She says her husband knows about the problem and they do not want the information entered into her medical record. Sheila doesn't want Dr. Hughes to talk to anybody about her problem. She scheduled an appointment believing she could rely on the "confidentiality" that has come always surrounded their relationship. Dr. Hughes understands Sheila's concern; the receptionist in Dr. Hughes' office is Sheila's sister-in-law. Since the receptionist also types the patient's records, she will see any information if Dr. Hughes places in Sheila's chart. Sheila knows many of the nurse and aides who work in the hospital several of them are also members of her church.

25. Ethics Case Study "Do Everything"

Mr. M, a 67 year old chronic asthmatic with frequent acute exacerbations. For the last 4 years he has progressively deteriorated. Twenty (20) minutes after a cardio-respiratory arrest he is resuscitated and connected to a mechanical ventilator. After 1 week he remains unconscious with decerebrate posturing and with no sign of improvement.

Diagnosis- Chronic bronchial asthma with exacerbation/hypoxic Encephalopathy/Status post cardiac resuscitation. The neurologist claims that Mr. M. is brain dead. There is no reasonable possibility of Mr. M. emerging from his comatose condition to a "cognitive sapient stage".

In the past Mr. M has expressed desire not to become a burden to his family. His family though unable to pay for the expense ask that "everything be done"

26. Ethics Case Study "Drugs Cost Money"

AJ, a 67 year old retired independent schoolteacher who has occasional tolerable dizzy attacks is found to have diabetes and osteoporosis. She is advised diet, exercise and medications amounting to approximately P150/day.

He is informed that without proper control the diabetes can lead to blindness, renal failure and heart disease and the osteoporosis can lead to broken bones. AJ has a monthly income of P15,000/month as a schoolteacher. He lives in a rented comfortable middle class one-room apartment and has one live-in maid (Kasambahay). In order to pay for the recommended medicines he will have to radically change his life style-maybe move to a cheaper apartment and spend less for food, transportation and social obligations. She might also have to ask for financial support from her son. AJ ponders on what to do.