TRUTH TELLING BEYOND BORDERS: AN AFRICAN PERSPECTIVE

A Dissertation
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for the degree of Doctor of Philosophy

By

John Twinomujuni

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ABSTRACT

TRUTH TELLING BEYOND BORDERS: AN AFRICAN PERSPECTIVE

By

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May 2017

Dissertation supervised by Henk ten Have, PhD, MD

The dissertation will focus on answering the question of how can patient’s autonomy, privacy and liberty be safeguarded especially within cultures that do not regard them as primordial principles? In some communities, truth-telling is one of the moral principles unquestioningly inherited from the West. The dissertation will try to compare African and Western perspectives. The African perspective has been chosen to explore through this search hoping that such venture would help in showing how the issue of truth-telling may be approached from such perspective. For instance in the African communalism based on the cardinal point that “I am because we are; and since we are therefore I am.” This point presumes prior recognition of the individuality of those making the “we.” The dissertation hopes that the solution of the above problem can be achieved by applying the gradation approach whereby the physician fulfills the duty of revealing the patient’s health information gradually in accordance
with the patient’s ability to cope with such information and also recognizing the time left for the patient to deal with such knowledge. This approach will be great contribution in bioethics in terms of enabling physicians to gradually bridge the gap between patients’ knowledge and understanding of modern medicine and their cultural beliefs and interpretations of disease. The gradation approach will help in striking a balance between these differences and bring about some complementarity in the field of health care.
DEDICATION

To my parents, my mother Verena Kagashanga and my late dad Luciano Matsiko who succumbed to lung cancer the sickness that inspired me to the field of Health Care Ethics study.

To other cultures in our world that are faced and challenged by truth telling issues today.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Dedication</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter One: Introduction: Revisiting, truth telling</td>
<td>1</td>
</tr>
<tr>
<td>1. Outline of the Dissertation</td>
<td>3</td>
</tr>
<tr>
<td>a. Chapter 1: Exploring the Norm of Truth Telling</td>
<td>4</td>
</tr>
<tr>
<td>b. Chapter 2: Focusing on the Ethical Issues and</td>
<td>7</td>
</tr>
<tr>
<td>Problems Connected with Truth Telling</td>
<td></td>
</tr>
<tr>
<td>c. Chapter 3: Approaching Truth Telling From A Pluralistic Health Care Environment</td>
<td>10</td>
</tr>
<tr>
<td>d. Chapter 4: Developing the Gradation Approach</td>
<td>12</td>
</tr>
<tr>
<td>e. Chapter 5:Presenting the Sub-Saharan African Ethical Perspective</td>
<td>15</td>
</tr>
<tr>
<td>f. Chapter 6: The Application of the Gradation Approach</td>
<td>18</td>
</tr>
<tr>
<td>Chapter Two: Explore the Norm of Truth-Telling</td>
<td>28</td>
</tr>
<tr>
<td>a. The Notion and Implications of Disclosure in Physician-Patient Relationship</td>
<td>28</td>
</tr>
<tr>
<td>b. The Seven Elements of Informed Consent with Emphasis on Disclosure</td>
<td>36</td>
</tr>
<tr>
<td>c. The Nature of Information Needed by Patients</td>
<td>53</td>
</tr>
<tr>
<td>d. The Development Regarding Truth Telling</td>
<td>60</td>
</tr>
<tr>
<td>e. Other Values Connected with Disclosure</td>
<td>68</td>
</tr>
<tr>
<td>Conclusion</td>
<td>75</td>
</tr>
<tr>
<td>Chapter Three: Focusing on the Ethical Issues and Problems Connected with Truth-Telling</td>
<td>88</td>
</tr>
<tr>
<td>a. Cultural Diversity</td>
<td>88</td>
</tr>
</tbody>
</table>
b. Meaning of Autonomy ........................................................................ 97

c. Health Literacy ................................................................................... 108

d. The Effects of Medical Tourism on Truth Telling............................ 121

Conclusion ................................................................................................. 133

Chapter Four: Approaching Truth-Telling from a Pluralistic Health Care Environment …… 147

a. The Relationship between Different Services Rendered a Patient in a Health Care Organization ........................................................................ 147

b. Analyzing on Confidentiality ................................................................... 156

c. The Role of Organizations in Protecting Patient’s Information by Introducing the Culture of Transparency ........................................................................ 176

Conclusion ................................................................................................. 196

Chapter Five: Developing the Graduation Approach ............................... 206

a. Analysis on Disclosure as a Process ......................................................... 206

b. Revisiting the Notion of Compassion in the Effort to Improve on Physician-Patient Communication ........................................................................ 220

Conclusion ................................................................................................. 253

Chapter Six: Presenting the Sub-Saharan African Ethical Perspective .......... 264

a. Focusing on the African Concept of the Person ....................................... 264

b. Different Concepts of Individual .............................................................. 270

c. Implication for Health as well as Disease .............................................. 275

d. Implication for Death and Suffering ..................................................... 281
e. Implication for Truth Telling ................................................................. 287

Conclusion ........................................................................................................ 290

Chapter Seven: Application of the Gradation Approach .................................. 299

a. Elaboration on the Gradation Approach ...................................................... 299
b. Improving the Art of Medical Dialogue Needed by Health Care Personnel ... 301
c. The Role of Ethics Committees in helping Physicians to Facilitate Truth-Telling ................................................................. 308
d. The Role of the Governments towards Improving on Health Care ............ 312

Conclusion ........................................................................................................ 317

Chapter Eight: Conclusion .................................................................................. 324

Bibliography ....................................................................................................... 334
Chapter One

Introduction: Revisiting Truth Telling

How can patient’s autonomy, privacy and liberty be safeguarded especially within cultures that do not regard them as primordial principles? In some communities, truth-telling is one of the moral principles unquestioningly inherited from the West. The significance of truth-telling as an ethical component of Western medicine presents a challenge for practitioners among some of the communities that are well known for their social inter-connectedness and the way they value their extended family relations. As many people migrate to Europe and North America and enter the health care systems of the west, it is important that health care providers understand their cultural perspective to health care. Such ambivalent situations therefore call upon health care providers to be sensitive and respectful of the varied perspectives and valuations patients bring to the clinical encounter.

The dissertation will try to compare African and Western perspectives. The African perspective has been mostly influenced by her communalism based on the cardinal point that “I am because we are; and since we are therefore I am.” This point presumes prior recognition of the individuality of those making the “we.” The implication here would be that the involvement of family members in treatment decisions may serve to respect patients’ and families’ autonomy while at the same time benefiting the individual patient. This may sound opposite to the Western principle of individual autonomy in which the patient is responsible for making decisions regarding his/her health and especially in the US where truth telling has become part of an accepted dogma. For instance, in the American cultural context is essential to obtain individual consent for the treatment, to challenge the disease, and to be in control of the situation. So being aware of one’s condition affords autonomy and the ability to make decisions and to master one’s
fate. While it may be taken true that truthfulness can do harm but an important consideration should be given to the manner in which the truth is conveyed to a patient. Therefore, several factors should be considered. Among those factors: the time of giving the information, especially bad news, the environment in which the information is given, the manner in which the information is given, the words chosen to convey the information and most importantly the attitude of the person bringing the news.

According to some Sub-Saharan African cultures illness is not addressed directly. Therefore, patients from such backgrounds necessitate the health care providers to begin by talking about things unrelated to illness and gradually move the conversation towards the patient’s diagnosis. The process may involve more than one session in order to give patients the opportunity to digest the information as their understanding of what is coming evolves too. However this procedure underscores the dominant mode of interpersonal discourse in some African cultures that includes extended greetings and indirect discussions of personal matters or problems before private or painful topics can be broached. This may also be another reason for approaching truth-telling from the African perspective in the sense that gradually, these physicians may move their conversation with the patient towards the issue at hand. However, such indirect approach should be more sensitive to the desire and readiness of patients to be informed or to remain ignorant of their diagnoses and prognoses while fulfilling the physician’s fundamental responsibility of respecting the patient’s autonomy. This approach will be a great contribution in bioethics in terms of enabling physicians to gradually bridge the gap between patients’ knowledge and understanding of modern medicine and their cultural beliefs and interpretations of disease. The gradation approach will help in striking a balance between these differences and bring about some complementarity in the field of health care.
Truth telling forms part of the contemporary debate in clinical bioethics and centers on the right to receive information concerning his/her medical condition/illness and the duty of the doctor to give this information to the patient. The emphasis on truth telling is associated with the leading principle in bioethics emphasizing on patient's autonomy, grounded in a strong tradition of privacy rights and personal liberty, whereby the sick person has a right to self-governance and to the information needed to become an active partner in health care. However, autonomy, privacy and liberty are not primordial principles in other cultures. The basic challenge for global bioethics is the empirical variation based on different ethical principles or at least a different balance between various principles. This is why in Africa where people have different ethical perspectives, truth telling does not have a high priority. For instance, within most African cultures, the person is viewed as a relational self where by social relationships and inter-dependence rather than individualism provide the basis for moral decisions.

Exploring some of the moral worldviews of the Sub Sahara Africa indicates that different cultures give different significances to truth telling. This implies that an acceptable truth telling framework should be sensitive to the cultural realities of the people where it is employed and contextual in its application. This can be achieved by applying a gradation approach whereby the physician fulfills the duty of revealing the patient’s health information gradually in accordance with the patient’s ability to cope with such information and also recognizing the time left for the patient to deal with such knowledge. This approach will enable physicians to treat people from different cultural backgrounds while respecting their rights as well as autonomy. The dissertation hopes to answer the question of how truth telling may be possible to apply in other cultures where this principle has seemed impossible to practice.
1. **Outline of the dissertation**

The chapter will elaborate the outline of this dissertation by briefly introducing on each and every one of the six chapters that will be used in this work. Each chapter is divided in different sections whose numbers vary according to the size of the issue to be addressed. The next first division will explore the norm of truth telling.

**a. Chapter 1: Exploring the Norm of Truth Telling**

In this chapter the thesis will explore the norm of truth telling that forms part of the contemporary debate in clinical bioethics which centers on the right to receive information concerning his/her medical condition/illness and the duty of the physician to give this information to the patient.

The first section will explain the notion and implications of disclosure as an important component of physician-patient relationship. The medical profession has undergone a great change especially on the attitude of informing patient’s illness and treatment. Therefore, physicians are supposed to truthfully communicate to their patients so as to help them maintain their autonomy. Differently, in the 1960s the physicians in US were not disclosing diagnosis of cancer to patients with the pretext of not wanting to destroy the patient’s hope. Later on the physician attitude changed by stressing the patient’s right to full disclosure of diagnosis and prognosis. Similarly, the legal doctrine of consent at first did not address physician’s commitment to patients’ decision making needs until the late 1950’s when physicians were asked to acquaint patients with both risks and alternatives to any proposed procedure. Since a patient is part of the treating team he/she needs to be kept regularly within the information loop and denying such information would be for a patient both like an insult and paternalistic. However,
a patient is also supposed to give as much information to the physician which may also be
disclosed to other professionals in the interest of that particular patient. 5 The responsible
physician should not persist in concealing the truth from the patient so that his or her working
team may discharge their functions responsibly to the patient. 6 Physicians therefore, do not treat
disease but a patient who has disease. 7 This is why communication has become among six listed
components that might form the ideal physician-patient relationship. 8

The second section will discuss the seven elements of informed consent with emphasis on
disclosure that is considered to be number three. The obligation of disclosing information to
patients is taken as the only major condition of informed consent especially in the United States
where disclosure plays a pivotal role for patients to use as basis towards decision making. 9 The
implication being that the patient provided with all the necessary information would be able to
make a prudent treatment choice on his or her own behalf. 10

The third section will address the nature of information needed by patients. A patient needs to
know what kind of information would be relevant and beneficial for his/ her decision making.
This requires physicians to disclose information according to their professional knowledge and
criteria. Then patients can use this information to determine what meets their needs and
expectations. 11 In order for patients to be adequately informed and understand the disclosed
information, the professionals will have to use their imaginative, empathic and professional
skills. 12 Therefore, a patient is not required to be on the same understanding level with his or her
physician so as to make an informed choice. Instead the patient will be able to understand the
information through the explanation given by the physician about the likely effects of the
medical condition and possible treatments. 13 Therefore, a patient needs adequate information
from the physician. 14
The fourth section will address the development regarding truth telling. Today, the ethical question regarding truth telling is changing from the question whether physicians should tell the patient how the information should be shared with him or her. Therefore, telling the truth should be regarded as one of life’s basic rules although doctors in the past seemed to treat truth like medicine especially when difficult news was to be given to a patient. The ordinary politeness also requires little white lies whereby a person tells the other person only what he or she would only want to hear even if that is not exactly the truth. Different social settings may change and make it very hard to strike the balance in the areas of human behavior. However, physicians should not use it as an excuse to avoid the issues or not wanting to add stress to the patient. The purpose of disclosing alternatives, costs and benefits in medical diagnosis and treatment is not to relieve the physician of the onus of decision or displace it on the patient. Rather, it is to permit the physician to function as the technical expert and adviser while allowing a patient consideration of his or her personal values.

The fifth section will talk about other values connected with disclosure. Truth telling, therefore, is not only a requirement for doctors in respecting the patient’s autonomy but is also part of the ethics of medicine in the aspect of showing respect for the patient. This requirement allows doctors to accept a patient’s refusal of what the physician takes to be the second best treatment option as long as the choice has been made by a competent patient. The implication here is that respect for patient’s autonomy has to be incorporated into the professional commitments of the physician in order to maintain trust as truthfulness is a form of trustworthiness. The reasons for telling the truth have a basis in all human relationships where truth must be told as a right, a utility and kindness. Telling lies, therefore, distorts the duty we owe to other human beings of taking each human being as an end in itself but not as means towards the end. This dissertation
proposes a gradational principle where by the physician would fulfill the duty of revealing the patient’s health information gradually in accordance with the patient’s ability to cope with such information and also recognizing the time left for the patient to deal with such knowledge.

b. Chapter 2: Focusing on the Ethical Issues and Problems Connected with Truth Telling

The chief ethical principle underlying the idea that patients should be offered the truth is consistent with the leading principle in bioethics emphasizing on patient's autonomy. However, autonomy is not a primordial principle in other cultures. The chapter will then elaborate the thesis in the following paragraphs. 1. Cultural diversity. 2. Meaning of autonomy. 3. Health literacy. 4. Medical tourism.

The first section will address the problem of cultural diversity. Culture is a complex whole which summates the most fundamental beliefs in art, language, literature, custom and law. The culture in which one is born and raised has some long lasting effect. In some cultures, individual autonomy is not recognized and a patient prefers making decisions together with the family. This necessitates physicians to carry out an informed consent discussion in a manner that is appropriate to the patient’s beliefs and understanding. For instance, among Ethiopians where the family’s importance dominates over individual members, any information, including diagnostic facts, belongs to the family. The family will then use such information at its discretion to benefit the patient. Interviews conducted in Tanzania indicate that some physicians believe in telling the terminal diagnosis to the relatives of elderly cancer patients and the family can decide on whether or not to tell the patient based upon their knowledge of his/her temperament.
and mental state. However, some interviews conducted in the US among people who are seriously ill or with dying patients reveal that they would want such information delivered but not in an abrupt and brutal manner. In some cultures the family excludes a patient from the process of information exchange in an effort to protect him/her from despair and a feeling of hopelessness. Therefore, the physician-patient relationship becomes a triangle consisting of the physician, the patient and the family with each part supporting the other two. Generally, the need for family involvement in health care decisions is obvious for people from all cultural backgrounds although to some this involvement might be somewhat different. However, the moral right to truthful disclosure should not be waived by a majority vote even if it can be shown that the patient comes from a culture that generally follow a pattern of nondisclosure as there may be patients with a different view about involving the family in their health care choices.

The second section will analyze the meaning of autonomy. This principle is grounded in respect for persons and the acknowledgment that as rational beings we have unique capabilities to make these personal choices. The majority of patients in the United States would demand and are given information that enables them to make decisions either autonomously or with the physician’s advice about their health care. Whereas the Italian patients believe that no patient can acquire enough knowledge to fully participate in health care without the physician’s knowledge that is assumed incommunicable. The perspectives held by Native Americans, African Americans and many immigrant groups may conflict with Anglo-American values especially when it comes to clinical decisions. However, the therapeutic privilege supports physicians in North America to withdraw information from the patient if such would lead to causing harm like social damage or suicide. Similarly, during emergencies when the time taken to obtain informed consent might irreversibly harm the patient, a physician is justified to go ahead with the
treatment. 36 Therefore, the patient’s autonomy is neither the primary nor the sole consideration but the personal good has to reflect the good from the society as well. 37 Respect for autonomy requires sometimes moral situations that do not maximize the patient’s well-being. For instance the condition of doubt may cause delay in delivering the “reasonably meaningful” information required for a patient to make autonomous choices about the treatment options. 38

The third section will address health literacy. Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. 39 Such situation entails training health care providers to identify very early and interact with a low health literacy patient in an appropriate way so that a patient can comprehend his/her situation. This might require changing the process of informed consent whereby talking has to replace reading. 40 The purpose of informed consent is to provide the patient with all the information necessary to allow a patient to make a prudent choice for his/her treatment freely. 41 Autonomy may possibly be promoted by attempting to impose unwelcome information in case a patient has some false beliefs on medicine. 42 However, even in an era of patient autonomy, a patient still wants to have caring and respectful relationship with his/her physician and not all issues will only be communicated directly during office visits. 43 The importance of linguistic concordance to patient-provider has been emphasized as a means to create an accurate medical and social history and assessment of the patient’s cultural health beliefs. 44 However, quality of patient care depends directly on the quality of patient’s education and responsibility. 45

The fourth section will analyze the effects of medical tourism on truth telling. Over recent decades there has been a rise of international travel for the purposes of medical treatment that is commonly known as medical tourism. An overarching concern is how the growth of medical
tourism contributes towards individual health being further commercialized and commodified. Under pressures of commercialization and commodification, relationships become shaped by the less elevated values of commercial gain rather than professional ethical codes. 46 However, the problem may rise in communication mostly based on language and culture fluency.47

c. Chapter 3: Approaching Truth Telling From A Pluralistic Health Care Environment

Today health care involves different expertise from different backgrounds. Therefore, health care decisions are no longer private transactions between patients and physicians but quasi-public transactions involving patients, a team of health care professionals, and a bevy of administrators and insurers. The chapter will elaborate the thesis using the following paragraphs. The first section will analyze the relationship between different services rendered a patient in a health care organization. Many services provided to a patient within a particular health care organization overlap with the responsibilities of each other. For example, ethics and palliative care consultants should work together in order to meet the needs of a patient. 48 The rising of average life expectancy in the industrial world has come with a dependent group of people who can only realize their autonomy in a relationship that helps them to find their identity and cope with their condition. 49 Therefore ethics of care has to value the ties we have with particular other persons and actual relationships that partly constitute our identity in the sense that the interests of care takers and cared for are viewed as intertwined rather than as simply competing. 50 According to the highly specialized character of modern medicine health seekers must entrust themselves to a health team within the hospital and other outside professionals that all render
services to the patient directly or indirectly. 51 Differently, in the early 1900’s medical care was delivered by the solo physician and only family members would be interested in the transactions between the physician and his /her patient. 52 Patients are increasingly becoming suspicious of their physicians because of constraining options for controlling their health care. 53 Today personal information of all kinds is recorded electronically and seems to pass through semipermeable membranes to places and organizations of which patients have little knowledge. This poses a lot of questions regarding individual’s privacy and how to balance competing ethical values. 54

The second section will analyze confidentiality. Generally, physicians are obliged to refrain from divulging confidential information obtained from patients and ensure that such information is not inappropriately divulged to third parties. 55 Despite this obligation, the technologic developments in information, storage, retrieval and access may pose significant problems of confidentiality. 56 For instance the growing use of screening for genetic diseases produces information that may be of interest not only to patients and their physicians but to the patient’s relatives, employers and insurers. 57 This means that without regulating the access of such information may pose a continuing problem for health care institutions and policy makers. 58 These policies often directly affect the practice of medicine and patient/physician relations. Therefore, physicians and health plans need to be placed on the same ethical page in order to build a health care system with strong ethical foundations. 59 Health is both acutely personal and consummately public because an individual’s illness brings anguish to others and the need for their care. Therefore, the health care system should aim at fostering the common good and collective health of the society for a common benefit. 60
The third section will analyze the role of organizations in protecting patient’s information by introducing a culture of transparence. Organizations must, therefore, address the issue of employee satisfaction as means of risk reduction to patients’ information. However, staff should train as a team and work as a team as a way of increasing accuracy and developing a sense of communal responsibility and accountability. The environment in which teamwork, clear communication and openness about errors are operative may lead to safe guarding patient’s information through discussions involving members of the appropriate disciplines. The health care institution should have a moral obligation to assure safety over patients through awareness on the part of both the institution and its constituents about their collective and individual moral status, and by honoring the need for transparency and accountability. Therefore, there should be inevitable change of perspective in health care that includes creation of institutional structures which can assure ethical behavior. However, physicians are directly involved with their patients and should be in the best position to know patients’ interests so as to advocate for them within the health care system. There is need for an approach opposed to market organization approach which emphasizes profit, private enterprise, and competition. Therefore, the task of organizational ethics should aim at finding ways to institutionalize the establishment of principles to guide decisions and actions in order to institutionalize the social goals to which an organization should be committed.

d. Chapter 4: Developing the Gradation Approach

Telling patients the information about diagnoses and prognoses has been given great attention in bioethics as important for making their decisions in an informed manner. The chapter
will develop the gradation approach as the proposed way of making truth telling possible to apply in other cultures especially where it has seemed impossible to practice. This will be explained in the following paragraphs.

The first section will analyze disclosure as a process. The goal of disclosure is to ensure that patients have appropriate information to make an informed choice about their health care. Therefore, this should take place not as an event but rather as a process keeping in mind that each patient may be different and may wish for varying amounts of information at different times. 68 Important consideration should be given to the manner in which the truth is conveyed to a patient. 69 The determination of what news is bad news constitutes a subjective judgment in the mind of the receiver. However, physicians may inadvertently influence patient response when delivering bad news. 70 In most cultures a patient would be approached by talking about things not related to the illness first and gradually move the conversation to things indirectly related to the patient’s diagnosis by asking about symptoms experienced. 71 This would be followed by the physician asking some questions aiming at ascertaining the patient’s mental competency and then move the conversation closer to the issue at hand. 72 This process may involve more than one session over the course of few days so that the patient may digest the information and the understanding what is coming next evolves. 73 The legal precedent as well as moral concern prompts the physician and other health care professionals to furnish clear information concerning serious sickness or impending death even if the patient has not asked for it. 74 However, The Patient’s Bill of Rights in the US states that;

When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. 75
Therefore, the principle of respect for autonomy does not require inflicting unwanted information on patients but requires first finding out how much and what kind of information they want to know and then respecting that expressed wish. 76

The second section will revisit the notion of compassion in the effort to improve on physician-patient communication. Compassion is central to the purpose of medicine and the care of patients and their families especially on alleviating their distress and suffering. 77 This implies that in caring for others one tries to view the situation from another person’s perspective and also try to make some assessment of the other person’s objective needs. 78 The understanding of such care would aid the health care personnel in exercising their responsibility by trying to view the situation as the patient sees it and also be aware of his/her needs. 79 Therefore, a good physician is not recognized by applying cognitive data from the medical literature to the particular patient but rather by cosuffering with her/him. 80 However, the root of compassion resides in our shared humanity, the awareness that misfortune may befall anyone at any time. 81 In some desperate situation a patient may grab the physician’s hand with a terrible question wanting to know whether he or she will be all right. This requires a physician to be kind in providing an answer that does not present the bleak outlook in all its unpleasantness even if not necessarily the truth. 82 Generally, medical information is very hard for patients to digest more especially when diagnosis is serious. Therefore, the information should be given in small chunks in order to facilitate the patient’s understanding by beginning with a warning shot and then gradually introduce more serious prognostic points. 83 The physician can communicate to a patient something hard to explain by stating it in simpler terms using a drawing because patients mostly want to know the answers to their questions and not all the details of pathophysiology. 84
The chapter has tried to develop the gradational approach whereby the physician fulfills the duty of revealing the patient’s health information gradually in accordance with the patient’s ability to cope with such information. At this point one can conclude recommending the application of this proposed approach so as making truth telling possible especially in those cultures where this principle has seemed impossible to practice.

e. Chapter 5: Presenting the Sub-Saharan African Ethical Perspective

Africa is a continent of complexities, with a wide diversity in terms of climate, topography, culture, peoples, and languages. Despite this diversity, there is a common Africanness about the culture and world-view of Africans. The chapter will present the Sub-Saharan African ethical perspective in the following paragraphs.

The first section will focus on the African concept of the person. African ethics can be approached by being aware of how Africans understand the human person and the decisive role played by the community. 85 In African traditional life the individual does not and cannot exist alone except corporately. Therefore, the cardinal point in the understanding of the African view of person is summarized as: “I am, because we are, and since we are, therefore I am.” 86 Most African cultures emphasize the value of a holistic view of a person that affirms the importance of the community, society and the family, different from the Western view whose emphasis is on the individual. 87 Community means participation of life which forms communion. Therefore, old people are respected and taken care of because they are living expressions of the dignity of life. 88 Among the Acoli people of Northern Uganda the phrase bedo dano used for defining personhood can be translated as “a person who lives among people,” or “to become a person who
lives in society.” Therefore, to be a person among these people is not a singular activity. 89 Similarly, among the Kikuyu people in Kenya there is nobody as an isolated individual but rather, his/her uniqueness is a secondary fact about him/her; first and foremost he/she is several people’s relative and several people’s contemporary. 90

The second section addresses different concepts of individual. Besides being a social being by nature, the human individual is also capable of making choices and the community’s role can only be partial towards the realization of one’s goals. 91 One can therefore, rightly speak of an African subjectivism that is different from the Western one. The African conceptual frame work would be properly designed under the two words; I-WITH. 92 However, among the Bantu languages one term may signify both person and man at the same time but in Kiswahili which is another Bantu based language the two terms binadamu and mtu refer to man as in human being and person respectively. 93 This is why translating the Chiluba terms kufwa and kufwadidila as to mean “to die” and “to die” respectively would regarded as being erroneous to your audience. 94 Each group of people in Africa has its own distinct language and not simply a dialect but these languages are naturally related to one another as some scholars have classified them into families or stocks. 95

The third section will address implications for both health and disease. This African communitarian perspective will have implications on health care since health and disease are concepts shaped by a people’s philosophy and culture. For instance health in traditional African societies does not mean only the faultless mechanical functioning of the body but also prosperity and mutual coexistence and contentment. 96 This idea conforms to the World Health Organization (WHO) understanding of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. 97
The fourth section will discuss the implication for death and suffering. Death is taken to be a process that removes a person gradually from the present period to the past one. Most Africans believe that after physical death an individual continues to exist in the present period through remembrance of relatives and friends that knew him/her and have survived him/her. Death is therefore, conceived as a total breathing out, a passing from the visible to the invisible world of the ancestors and a departure to the abode of the deceased relatives, where blood-ties are conceived to be stronger and firmer, and no more death to break them. Most of the working people in Africa today maintain two homes, one in the urban and another one in the rural area meant for relaxing after retirement and burial besides their ancestors. The African idea of community is the starting point for African ethics that extends to the invisible community considered equally important for it embraces both the deceased ancestors and those to be born. The ethics in traditional societies of Africa holds that moral authority is enshrined in custom, the basis of which is the belief in ancestors who after death retain their authority over the living.

The fifth section addresses on the implication for truth-telling. Caring for the sick is not charity but an ethical obligation among people of Sub-Saharan Africa. Therefore, for the sick person, the empathic and supportive presence of the community confers a feeling of belonging and sharing in the life of the whole community, even as their individual life seems to be declining. Traditionally, a group would accompany the sick person to the medicine man or woman and listen for this person, or listen with this person. When they come out of the consulting room, what the doctor has said is also the concern of those who are waiting. The cultural factor in Africa for respecting autonomy makes it both individual and communal. Therefore, the
traditional healer or the family would decide for a patient in his/her interest. Such background may influence truth-telling today.

f. Chapter 6: The Application of the Gradation Approach

The discussion around patient’s rights emphasizes that the patient has a right to know the truth and the physician has an obligation to tell the truth to his patient. This chapter will present the application of the gradation approach whereby the physician reveals the patient’s health information attuning it to the individual situation of the patient. This will be realized by improving on medical dialogue among the medical personnel, the roles played by ethics committees and governments.

The first section elaborates on the gradation approach. Gradation refers to any process or change taking place through a series of stages, by degrees or in a gradual manner. Similarly, in the gradation approach to the truth-telling physicians will reveal patient’s health information attuning it to the individual situation of the patient, so that it is a calibrated to the needs and wishes of the patient. Therefore, breaking up amounts of information into more manageable segments over a period of time can encourage appropriate communication. At this point staged disclosure and cautious language about prognosis may be applied with the aspiration of maintaining the patient’s hope as bad news at an early stage may tend to overwhelm the good news.

The second section elaborates how the art of medical dialogue needed by health care personnel can be improved. The good physician is by nature of his vocation called to practice his art with high moral sensitivity. This extends to disclosure as well whereby the physician is surely
expected by the patient and society to give the information prudently keeping in mind the state of every patient. Physicians may use information as part of the therapeutic regime in confronting patients with terminal diseases. Therefore, the information should be given in amounts, in admixtures and according to timing believed best for patients as the dying response may be due to reaction towards shocking news or an abrupt a manner it is given to the patient. In order to avoid lying to the patient the physician may tactfully and skillfully explain the if’s and and’s, side issues and suggestions of the possibilities, while sufficiently befogging the issue but satisfying to the patient and remaining with clear conscience. Therefore, attentive listening is deemed essential for better diagnosis and illumination of the emotional and social components of illness as the physician needs to know patient before doing him good. The duty to disclose information is a professional duty to be carried out by a physician in a professional manner that aims at providing explanation while avoiding technical jargon and given in a relatively stress-free setting. Therefore, the transmission of information can and should be done sensitively and with due regard to the information gap between a physician and the patient.

The third section will analyze the role of ethics committees in helping physicians to facilitate truth-telling. There is still need for establishing, promoting and supporting ethics committees at all levels so as to engage the public in debates and education on ethical issues. This is why they should represent different schools of thought and accommodate personalities with recognized competencies and authorities. A well trained and effective ethics committee within a health care facility would facilitate understanding how some values of decision processes and other cultural concepts can interface with different ideas that may be foreign. For instance, most Africans appreciate what Western medicine offers but without rejecting the role of a traditional healer. Socio-demographic factors influence the interaction between a
physician and the patient. Therefore, ethics committees can help patients and their families to interpret medical terms into lay man’s language easy to understand keeping in mind that they are one of the sources of wisdom in that health care facility. However, in order to preserve the integrity of the physician-patient relationship the ethics committee should be envisioned as a group of persons fulfilling the rule of medical ethicist. Thus, they only offer education and consultation to health care professionals and their patients.

The fourth section will focus on the role of the governments towards improving on health care. This will facilitate truth telling as many people will be encouraged and attracted to health care profession. Such increment in the number of physicians will lead to the opportunity of having enough time needed for sharing information with every patient. Therefore, the governments should through the Ministry of Health encourage many of its staff to pursue programs in public health and receive additional training that can bolster their managerial capacities, decision-making abilities and analytical toolkits. Setting a comprehensive development agenda should aim at strengthening the country’s internal human capacities. This will place people as best experts on their own burden of disease and as able to address those burdens. Similarly, medical universities or schools should be encouraged in providing education and professional development opportunities for the healthcare workforce.

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12 Arnason et al., 111.


78 Noddings, N, A Feminine Approach to Ethics and Moral Education (Los Angeles: University of California Press, 1984), 24-25


Chapter Two

Explore the Norm of Truth Telling

The chapter will explore the norm of truth telling that forms part of the contemporary debate in clinical bioethics which centers on the patient’s right to receive information concerning his/her medical condition/illness and the duty of the physician to give this information to the patient. The emphasis on truth telling is associated with the leading principle in bioethics emphasizing on patient's autonomy, grounded in a strong tradition of privacy rights and personal liberty, whereby the sick person has a right to self-governance and to the information needed to become an active partner in health care. The chapter will then elaborate the problem/thesis in the five paragraphs.

a. The Notion and Implications of Disclosure in Physician-Patient Relationship

The first paragraph will try to explain the notion and implications of disclosure as an important component of physician-patient relationship. The physician-patient relationship is a complex concept in the medical sociology in which patients voluntarily approach a physician and thus become a part of a contract in which they tend to abide with the physician’s guidance.

Generally, the medical profession has under gone a great change especially on the attitude of informing patient’s illness and treatment. This has also affected the physician-patient relationship to the extent that a patient is considered to be a partner in his or her treatment. Therefore, physicians are supposed to be truthful to their patients in communicating so as to help patients in maintaining their autonomy. This includes even painful facts about the seriousness and prognosis of an illness. This is something that previously would be concealed from the
patient in the belief that such information could harm the patient. Therefore, in the past, when physicians failed to be truthful to their patients, neither they nor other people considered the physicians to be liars due to the above mentality.\textsuperscript{127} For instance studies in the US indicate that in early 1960s the physicians were not disclosing diagnosis of cancer to patients basing their argument on nonmaleficence reasons like not wanting to destroy patient’s hope. However by the middle 1970s the physician attitude changed by stressing the patient’s right to full disclosure of diagnosis and prognosis. The change of attitude is attributed to the growing of patient’s rights and autonomy movements both in philosophy of medicine and in public affairs. More so the treatment interventions for terminal diseases like cancer improved on modalities and begun to offer hope to patients. This implied that offering patients full disclosure of their diagnosis stopped being interpreted as equivalent to a death sentence.\textsuperscript{128}

Similarly, the legal doctrine of consent has progressively been developed. At first judges in courts perceived conflict to be one between liberty and caring custody. They later on realized that this was not addressing physician’s commitment to patients’ decision making needs. This led to fashioning of a doctrine of informed consent through which judges hoped that patients would secure their right towards better custody.\textsuperscript{129} However, it was not until the late 1950’s when physicians were asked to acquaint patients with both risks and alternatives to any proposed procedure.\textsuperscript{130} On the other hand Dalla-Vorgia and co-authors remark that although the issue of consent has grown immensely in importance in recent years. This seems to be a subject which philosophers and physicians faced in ancient times when, whether because of respect for their patients or because of fear of the consequences for themselves, at least some doctors sought informed consent, and even informed request, from their patients before treating them.\textsuperscript{131} Notably there are large differences in legal standards for what should be disclosed to patients.
For instance, UK and German law take as a standard what a reasonable doctor would disclose whereas both the USA and The Netherlands apply a reasonable patient standard: what a reasonable patient would need or want to know to be able to give informed consent. Unfortunately, there may be a danger of information overkill, threatening instead of strengthening patient autonomy. The ethical question here is what doctors should do when it is unclear whether a reasonable patient would want to have particular risk information.132

Modern medicine treats a patient as part of the treating team. Therefore, a patient needs to be kept regularly within the information loop although common experience indicates that this seems to have not been fully achieved. However, denying such information would be for a patient not only like an insult and paternalistic but also like a further wound because recovery ultimately comes from within the patient. More so preparative information has proved effective in the areas like pain management. This implies that information is power that is not simply rhetorical but rather needs involvement of both a patient and a physician to achieve the goal.133

For instance the first principle of the American Nurses’ Association Code, among other things, exhorts nurses that truth telling and the process of reaching informed choice should underlie the exercise of self-determination which is basic to respect for persons. Therefore, their clients should be fully involved as possible in the planning and implementation of their own care.134

Cabot seems to support the above idea by recommending that physicians working in the modern hospital setting should be able to observe a list of ethical duties which may be referred to as an ethic of competence. Among the enumerated duties of a modern physician include informing the patients of their diagnosis and their treatments explained to them by every attending physician. Cabot also calls for extensive requirement of cooperation between physicians and all other
professionals involved in the care of a patient and to keep and accurate records of patient care have to be kept and analyzed.135

However, a patient is also supposed to give as much information to the physician trusting that such information may also be disclosed to other professionals in the interest of giving proper treatment to that particular patient. This type of information should be distinguished from the one a teammate may be interested in knowing but has no bearing on the ability to offer the patient optimum care. This is why the health professionals are to keep secret information flowing from the patient not as an end itself but as an instrument that serves trust whose ultimate value is human dignity.136 Critically, this may sound like the health professional’s duty to benefit and refrain from harming a patient by keeping his/her secret has been pitted against a duty to prevent harm to the patient himself or herself, to someone else or to society. On the other hand the recommendation is that greater efforts should be made to consult with patients about their condition and medical options available to them. Therefore, patients should be informed of their right to information and invited to decide about the amount of information they require in order to give a free and informed consent. The reason here being that health care providers regularly underestimate the information that patients want concerning their condition.137

Similarly, the Code of Ethics of the American Medical Association of 1847 recommends that patients should faithfully and unreservedly communicate to their physician the supposed cause of their disease. However, the same code warns a patient not to weary his or her physician with tedious detail of events or matters not appertaining to their disease. Instead a patient should convey much more real information by giving clear answers to interrogatories than by the most minute account of his/her framing.138 One lesson learned from the history of health communication is that communication is not separate from health care but is therapeutic itself.
Communication is also the vehicle through which both patients and physicians learn about health and reach agreement about what is wrong and what should be done. Therefore, it is important to consider the role of communication not just in the exam or hospital room but also as means of uniting people and addressing other social issues connected with one’s health care.\textsuperscript{139}

Unfortunately, when the responsible physician persists in the efforts to conceal the truth from the patient and his or her working team may lead to the belief that they cannot discharge their functions responsibly until the patient has been informed. More so, the law and ethics alike require that patients admitted in medical crisis medical team to inform by dealing with another person qualified to speak on behalf of the patient until able to speak for himself or herself.\textsuperscript{140} Additionally, when offering truth both physicians and all involved with the patient are forced to recognize that patient’s choices should be respected not because they or others agree with those choices but simply because they are patient’s choices. Therefore, offering truth should not be inflicting it on the patient but rather to allow the patient choose his or her own path. This is why concealing families need to be helped to see that there may be many reasons for the patient’s failure to demand the truth and if the patient states an explicit desire to be informed such desire should be respected by the family as his or her right.\textsuperscript{141}

The American code of ethics exhorts physicians to respect the rights of patients and of other health professionals and safe guard the patients’ confidences within the constraints of the law.\textsuperscript{142} But a claim that patients have the right to know their diagnosis and prognosis has raised among the challengers the issue about the right not to know. Macklin would confirm that people have a right to receive information if they want it and also the right to refuse to receive that information. This implies that respecting a particular patient’s wish not to know is perfectly consistent with the general obligation to disclose to patients their diagnosis.
autonomy means, among other things, acting in a way that respects the values of individuals. Moreover, legal validity of consent to treatment rests on those elements necessary to establish the patient’s competence to make autonomous choices: broadly, provision of information regarding the treatment, understanding of such information, and the ability to appreciate the consequences of decision regarding treatment. Surprisingly, in the United States of America where consent has been better investigated, everywhere from 25 to 50 percent of patients do not understand what it is that they have agreed to. For instance among two hundred patients being treated at the University of Pennsylvania Cancer Center, 40 percent did not know the purpose or nature of the procedure they had undergone and 45 percent could not give even one major risk or cite a possible complication resulting from it. These findings were explained by age or education of the patients, poor communication by physicians, or blind trust by patients. This is an indication about how much consent is hardly informed.

On the other hand, it is important not to take patient-centered care as the obvious and only choice. When working patient-centered, physicians should not only focus on normative thinking regarding participatory decision making but they also have to pay greater attention to a broader set of considerations relating to respect for patients as individuals. More than enabling and empowering patients but this is perhaps even more important to enable and empower them to the degree that they desire. Therefore, the moral imperative to tell the truth may seem an insufficient guide as to what a physician should tell the patient unless its content is well described. For instance telling a patient that you have cancer of the rectum or that you seem to be falling rapidly may seem not adequate at best and may not be useful enough because of containing little information. This implies that the information carried in the simple declarative
sentence resides not in the sentence but in listener and the speaker. Otherwise the patient may misunderstand the physician’s words even they were truthful.147

Concretely, the offering of truth is about the patient’s diagnosis. This is a symbolic process that allows the patient to declare her/his preference regarding which norms shall be respected and how. This may become a little bit complicated due to the fact that patients, families, and health care professionals meet in the health care facility coming from different moral worlds as well as different backgrounds and biographies. These worlds involve not simply rights and privileges but duties as well. Therefore there should be an attempt to clarify on behalf of these different parties their own moral principles and associated moral commitments. Such attempt should proceed from a common shared premise whose goal is the well-being of the patient.148 McKinstry recommends that physicians need both communication skills and time in consultations, along with knowledge of their patients, to determine at which times, with which illnesses, and at which level their patients wish to be involved in decision making.149 Physicians therefore, do not treat disease but a patient who has disease and medicine is concerned with the care of persons by persons. While it may seem obvious that medicine is devoted to care of persons, but the truism “treat the patient as a whole person” remains a truism more honored in the breach than in the fulfillment. More so it is not at all clear what we mean by the notion of person and the physician needs to draw upon his/her knowledge of the patient as a person in his/her decision making process and vice versa.150

Generally, healing in its deepest sense implies the restoration of wholeness. That is why we can talk of a patient cured without being healed and healed without being cured. For instance a patient who remains in anguish of spirit even after physical recovery cannot be said to be healed.151 According to Cassell the relief of suffering is the fundamental goal of medicine which
can be achieved through the physician-patient relationship that requires becoming involved with the patient in order to effectively deal with suffering. Cassell recommends that making decisions should primarily be based on the sick person other than the disease, and trying to minimize suffering that leads to prevention and relief of suffering. The responsibility of the physician, therefore, entails caring for the sick even with imperfect means in a sea of uncertainty originating from emergent dilemmas of the current medical technologies.152

Today communication has become among six listed components that might form the ideal physician-patient relationship. Therefore measures such as training sessions on communication skills for the physicians should be encouraged while sensitizing clinicians to respond to patients emotional cues, encouraging physicians to communicate without/with minimal use of medical terminologies. This will facilitate feedback from the patients after consultation and accelerate the empowerment of the patients. This implies that teaching physician-patient skills should be given much weight during undergraduate medical curriculum so as to promote the culture listening among the physicians.153 However, for communication to be useful to a patient must meet two basic tests. First it should be weighed upon reducing the patient’s uncertainty both at present time and in the future. Secondly, such information should be checked whether it can increase the patient’s ability to act in his or her own best interest both at that particular present time and in the future. The implication here being that the relationship between the physician and the patient is taken to be the primary vehicle of medical care followed by other things that take place in medical practice. Remarkably, a patient may become a bit furious on the first hearing something but later comes to realize its importance. This is why any piece of information can easily reduce uncertainty, improve the ability to act, and even improve the physician-patient relationship if only it is used wisely. On the other hand, any information
poorly employed may increase uncertainty, paralyze action and even destroy the physician-patient relationship.  

b. The Seven Elements of Informed Consent with Emphasis on Disclosure

The second paragraph will discuss the seven elements of informed consent but the emphasis will be put on disclosure as one of them. Consent is defined by Polani to mean compliance or approval, especially of what is done or proposed by another. This signifies capable, deliberate agreement to, or concurrence in, some act or purpose, and implies physical and mental power. On the other hand the notion of consent in biomedical ethics usually means a voluntary uncoerced decision, made by a competent autonomous person, to accept rather than reject some proposed course of action. The argument being that consent in medicine should be based on adequate information and deliberation, and that it is therefore, by definition, an informed consent.

Remarkably, some institutions and authorities have presented this obligation of disclosing information to patients as the only major condition of informed consent. For instance in the United States disclosure is the main focus for the legal doctrine of informed consent as the way of reinforcing a physician’s general obligation towards exercising the reasonable care in providing the information. Therefore, disclosure still plays a pivotal role for patients to use as basis towards decision making. The implication being that the patient provided with all the necessary information would be able to make a prudent treatment choice on his or her own behalf. On the other hand, for information to be an element of informed consent entails that the patient has clear understanding of the following: Diagnosis and prognosis of the disease, benefits
and burdens of recommended treatment, benefits and burdens of reasonable alternative treatments, and the likely effect of no treatment. In addressing the physician patient relationship, the Catholic Bishops in the United States of America have also recommended that free and informed consent requires that the patient or his/her surrogate should receive all reasonable information about the proposed treatment, its benefits, risks, side effects and costs, plus any reasonable and morally legitimate alternatives. These should include even the no treatment at all alternative. The reason being that access to medical and moral information would help both the patient and surrogate to form their conscience and the decision that follows won’t contradict Catholic principles.

Furthermore, the modern disclosure within clinical work may not be an easy road because it is a process that involves paying constant attention to every detail and being able to think through what should be done, with reasons made explicit and if necessary made a note of. There should be efforts made to discourage some instances where a strangely trained physician may try to work without recording or watching himself or herself and without supervision or mentorship. Differently from the early days of bioethics that were mostly focused on principles, and morality was understood as a system of precepts or rules people are obliged to follow. This came to change with the introduction of the four-principle approach whereby nonmaleficence was added to autonomy, beneficence, and justice. According to this view, principles are now taken as normative generalizations that guide actions but leaving considerable room for judgment in specific cases. Therefore, the advantage of these four principles helps people to bring more order, consistency and understanding to our medico-moral judgments.

In struggling to determine which norms should govern the disclosure of information. The courts in the United States of America have cited two prominent standards of closure out of
the three and they are both morally and legally important. The first one is the professional standard in which a professional custom determines the amount and type of information to be disclosed. This may face the difficult of majority of physicians offering in adequate level of information and the standard ignores and may subvert patients’ right of autonomous choice. The second one is the reasonable standard whereby the information to be disclosed should be determined by reference to a hypothetical reasonable person. The authoritative determination of information needs shifts from the physician to the patient. The difficulty would be how to determine the material information and the reasonable person. The third one is the subjective standard that judges the adequacy of information by reference to the specific information needs of the individual person. This requires the physician to disclose the information a particular patient needs to know to the extent it is reasonable to expect the physician to be able to determine that patient’s informational needs. Nevertheless, patients do not know what information is relevant for their deliberations and physicians cannot do exhaustive background and character analysis of each patient to determine the relevant information.162

Generally, medical care is a process whereby both a patient and a physician have informed each other of how each feels and the interaction helps in forming the basis for the next decision. However, in handling cases the physician makes many ethical decisions respecting his/her patient and usually with patient’s consent.163 According to William E. May in situations where individuals are brought to the hospital in an unconscious state or with no decision-making capacity, consent can be presumed provided that the procedures performed are necessary and cannot be postponed until the person has gained consciousness or decision making capacity.164 This means that physicians and families of patients unable to participate in care discussions or decisions work to determine a course to determine a course that meets medical, legal and ethical
imperatives. Goals and plans of care are considered in light of the patient’s condition and prognosis, the benefits, burdens, and risks of therapeutic options, and what is known about the patient’s wishes and best interests. This has to be in line with the scope of authority that every state or country accords to informal surrogates.165

However, completeness of disclosure of options for treatment that the physician recommends should also include other options that are less desirable but which are still medically reasonable. In so doing physicians should keep in mind that coercion and manipulation should be carefully avoided. Similarly, limitations resulting from failure of many physicians not listening carefully to their patients may disrupt physician-patient dialogue. Yet the importance of improved communication between physicians and patients should be made obvious in this age of information.166 The patient comes to the physician in an effort to determine the source of his or her discomfort. If the possibility of a physical cause can be eliminated, the patient then has the information necessary to take the next step. However, the physician’s failure to listen or make an adequate examination may prompt to send away the patient without the necessary information for rational decisions. Therefore a physician needs to establish trustworthiness within the limits of the contract whereby communication is done with interest in a patient as person and not limited by self-interested motives. Adequate communication with patients will aid physicians in making proper diagnosis and carry on successful treatment or make accurate prognosis because patients retain fundamental rights over their bodies and the fundamental knowledge of how they feel.167 This is why health care professionals are considered as secondary decision makers who have responsibility to provide aid and care for the patient to the extent it is consistent with their own beliefs and values. For that matter informed consent policies and documents should be
geared to enhance patient autonomy and protection, never primarily to protecting hospitals and health care workers from litigation.168

Since the prevailing interest in informed consent and advance directives attest to the primacy of the patient’s wishes in medical decision making to the extent that a professional’s discretionary powers have become limited. In case of children, parents generally serve as surrogate decision makers and seek to protect their children’s best interest. Therefore, parents trust physicians to consult with them regarding diagnostic tests and treatment options. This trust should not be breached by physicians or other health professionals by usurping the parental role.169 Kelly remarks that in case of young children or others who are not able to make or express their autonomous wishes about treatment have been compromised by their surrogates. The argument is that sometimes the parents and other family members may rightly include their own interests in this decision although not generally accepted and has not been sanctioned by the courts. However, the health care providers should never act contrary to the best interests of a child or a never-competent person. So the clear best interests of the child prevail legally and ethically in emergence cases where transfusion is required and is contrary to the parents’ wish or belief.170 While the responsibility for the child’s health lies with parents or guardian and society. Health and social services represent society in this context. Therefore, physicians may decide to see a child without parental consent because they consider that, in view of their specialist knowledge, they are in a better position to know how to promote the child’s health than a parent. The implication being that seeing the child may ensure that the child avoids potential harms and achieves net benefits. For example, a schoolteacher may refer a child to the doctor because he/she has been repeatedly coming to school covered with bruises. The parent is contacted and the situation openly explained by the physician including the fact that the child must be
examined or referred to social services. In case the parent refuses to allow this, the physician’s statutory and moral duty is to ensure the child is assessed as the child’s life may be at stake.171

The parental role as surrogates of their children is in conformity with the law whereby in United States of America the law presumes that minors (in most states, persons below the age of eighteen) are incompetent to give informed consent of their own health care. However, there are statues that enable children of specific ages ranging between twelve and eighteen to give consent for treatment for specific medical conditions like alcoholism, drug abuse, emotional disturbance, mental illness, pregnancy, rape, sexual assault, organ transplantation, blood donation and sexually transmitted diseases.172 Historically, health care providers have downplayed the child’s capacity for decision making, but the current attitude is to give greater weight to the child’s developing decision-making capacity and future autonomy. This implies that parental autonomy is not and should not be absolute although still being relied on for making decisions of the children but remains open knowing that a child may have something important to add. Therefore, evaluating parental requests requires finding the appropriate balance between the child’s present and future needs and interests with the interests and needs of the families.173

Nevertheless, some children in the nine to fourteen age periods demonstrate sufficient capacities to make particular decisions to be deemed competent to make them. Physicians treating children in this age group should always explore treatment alternatives with children as well as parents in order to determine the children’s preferences regarding treatment, to understand the reasoning on which their preferences are based and to assess their competence for decisions. This means need for parent’s consent to signify their retention of decision making authority and the child’s assent to signify his/her agreement with treatment choice although lacking decision authority.174 Similarly, the Spanish law tends to favor the doctrine of the mature
minors and so the competence which adults are supposed to have is, in questions of health, frequently extended to sixteen year olds. The criticism has been that, the presumption of competence should not refer to a specific age but to sufficient maturity. To make an individual evaluation of a minor’s capacity protocols should be drawn up for application in medical practice. Unfortunately, there is little consensus as to how the capacity of minors can be assessed in this respect. Goldie insists that when the patient is a minor, competence is seen as a threshold above which they are able to understand their situation and make their own decisions about their health care. Some commentators suggest that from their early years children think and feel deeply about their relationships and experiences and try to make sense of them, and that children as young as 5 years use understanding that adults rely on throughout life. However, strategic thinking and the ability to plan do not become well established until later childhood or early adolescence. This why there is a presumption in English law that all children under the age of 10 years will not have sufficient competence to refuse to consent to medical treatment. On the other hand psychologists believe that children up to the age of 12 consider that the locus of control in their lives is external to them, which may result in them being easily swayed into making decisions.

The parental role applies also to medical screening of children for a health condition whereby the parental informed consent is normally required, especially when the condition is not a threat to others in the community. However, the observation made is that this basic ethical standard has been exempted in newborn screening. To the extent that newborns are screened without parental informed consent in all but few states here in America and parents often are not aware that they have option for refusing the mandated screening. Apart from those parents’ decisions that put children at great risk of losing their lives or their health, parental decision is
both necessary and sufficient for providing medical care for minor children.\textsuperscript{178} Unfortunately, Davis notices that almost all newborn screening is done without the informed consent of the parents and in many states parents can theoretically refuse screening, but are rarely told of the information beforehand.\textsuperscript{179}

When requiring researchers to obtain informed consent from individuals who participate in research satisfies the ethical principle of respect for persons, which reflects the right to self-determination. Kass would also add that providing individuals with information about a study’s purpose, its potential risks, and other elements related to the study reflects a commitment to transparency that is an important factor in fostering trust in research. Therefore, this should also be true for newborn screening because blood samples collected are stored and later used for research.\textsuperscript{180} This is why Wilkinson cautions health care professionals of their duty to ensure that consent given is valid and genuinely voluntary.\textsuperscript{181} However, under the new law, the newborn screening program must inform parents about the program’s storage policy and give parents the opportunity to opt out of having their newborn’s sample stored after being used for disease screening.\textsuperscript{182} The idea that is also supported by the Newborn Screening Task Force in stating that parental permission should be sought for the use of identifiable samples in research to validate tests for additional diseases, or for epidemiologic research.\textsuperscript{183}

Some advocates also support that individuals should make informed choices about their own health care, and that newborn screening should involve an informed consent process. However, some parents have a terrible fear in their gut that if they had been offered an option, they might have declined the test and their child might not have been diagnosed.\textsuperscript{184} Notably, the care of newborns has changed enormously over the last few decades following technological advancements. Additionally, decision making about the treatment of infants has become more
collaborative, including clinicians, parents and other family members, and occasionally lay persons who work outside the neonatal intensive care unit. Therefore, three guiding principles of beneficence, nonmaleficence and justice are used in neonatal intensive care decisions. Taking these ethical principles together create the obligation that newborns who are especially vulnerable receive heightened protection. This is because of the fact that parents and clinicians may have very different notions of what constitutes an acceptable or unacceptable quality of life for the child, consensus on these deeply personal issues is often difficult to achieve. Fortunately, parents tend to agree in most cases with the physicians when they recommend a course of treatment that is clearly in the newborn’s interest. When conflicting values and interests complicate decisions about neonatal care, such cases should be referred to infant bioethics review committee for special attention.185

Understanding is another element of informed consent. There have been variations exhibited among patients towards their understanding of information about diagnoses, procedures, risks, probable benefits and prognoses. This may be due to very many factors like illness, irrationality, and immaturity.186 Generally, the definition of understanding is that one understands if one has acquired pertinent information and justified, relevant beliefs about the nature and consequences of one’s action. In regard to biomedical ethics the focus has shifted from the physician’s obligation to disclose information as to the quality of a patient’s understanding and consent.187 Therefore, for the patient to gain a sufficient understanding requires information and that information lies with the physician. While at present the law simply requires that the patient is informed in broad terms about the nature of a procedure but without determining what is, or should be meant by the nature of a procedure, remains difficult to predict when sufficient information is imparted. This may engender the risk of inconsistency and
uncertainty, and also a difficulty may arise in determining whether altering a component of a medical procedure invalidates a prior consent.\textsuperscript{188}

On the other hand, there may also occur a problem of nonacceptance and false beliefs. For instance, a single false belief may be enough to invalidate a patient’s consent even when there has been a suitable disclosure and comprehension. At this point it may be permissible or possibly even obligatory to promote autonomy by attempting to impose unwelcome information. Furthermore, understanding may be faced with the problem of waivers whereby a patient delegates decision making authority to the physician or to a third party or simply asks not to be informed.\textsuperscript{189} Therefore, understanding other people’s perceptions and clearly expressing your own are important aspects of communication. This is why the definition of communication underscores such concerns by stating that communication is the process of understanding and sharing meaning. However this definition becomes clear when communication is examined in terms of process, personal goals, interdependence, sensitivity and shared meaning.\textsuperscript{190} Additionally, understanding refers not only to understanding the words but also understanding in the sense of being sympathetic to the values that are behind words. This implies that the moment medicine is conceived as a purely technological field, learning how to listen to these personal aspects of the patient’s concern may not be considered part of physician’s professional role by other professionals.\textsuperscript{191}

According to the traditional definition competence refers to the ability to do what is needed to perform a task. This definition focuses only on the intellectual ability because there are some patients who might understand and appreciate the information given them by the medical professionals but refuse treatment due to the depressive mood in which they are. This has prompted refining the definition of the competence in clinical decision making to refer to the
ability to make a rational decision. This implies that a rational decision is necessary for a competent person. Therefore, ability and rationality are two essential parts of the new definition. This helps patients during the deliberation process to apply reasoning capacity towards imagination of the possible consequences of their treatment. Competence is part of what is necessary for autonomous choices. This is why for children that are presumed not to be competent to make that decision is to be made by others and typically the parents must decide for them. There are proposed decision-making capacities that are needed for competence. First are capacities for understanding and communication. Second are capacities for reasoning and deliberation. Third is the possession of aims and values that can be used as the basis for selecting from among alternative courses of action. Assessing competence in the therapeutic context helps to determine whether the patient will retain decision-making authority or would be transferred to a surrogate to decide for the patient. For instance withdrawal of treatment should be considered for the child when there is little hope of survival despite all care, or when the quality of life may be unacceptably poor. At this time the physician in charge must inform the parents about all relevant aspects of diagnosis and prognosis and give a clear view of what he/she thinks is best. In case the parents decide otherwise contrary to the physician’s views, all measures will be continued in good faith but a physician should tactfully continue advocating for his/her views. The child’s interests are of central importance in all this.

Furthermore, competency implies that state in which patients’ decision-making capacities are sufficiently intact for their decisions to be honored and the converse for incompetence. Therefore, competency to decide can be assessed by examining its component parts; the ability to understand relevant information, to appreciate the nature of the situation and manipulate information rationally and to express a choice. This is why informed consent is the
process by which patients can participate in choices about their healthcare. In the legal context, the law assigns to adults the general status of competence to make health care decisions unless and until there has been a specific legal finding of incompetence. However, Buchanan and Brock also agree that some capacities are necessary for a person competently to decide about health care: the capacity for understanding and communication and the capacity for reasoning and deliberation respectively. The authors add the third element of competence that the individual must have a set of values or conception of the good. Unfortunately, there is no general consensus about the nature and level of understanding needed for an informed consent. Patients usually should be able to understand at a minimum what an attentive health care professional believes a patient needs to understand in order to authorize an intervention. However, there may occur a problem of information processing whereby some ways of framing information may be misleading for both health professionals and patients due to misconstrue of the content. Such framing effects reduce the understanding with direct implications for autonomous choice.

However, choosing other persons to speak on behalf of patients has been tacitly accepted in Anglo-American law but was rarely expressed in statutes. These surrogate decision makers are chosen in the situation when a patient is very sick and unable to communicate his/her desires about care. The appointed surrogates supersede any other party including immediate family members. The decision of the surrogates is guided by two sorts of standard. The first standard is called substituted judgement. Here the surrogate relies on known preferences of the patient to reach the conclusion about the treatment. This implies that the surrogate merely gives effect to the decisions the patient would have made for herself or himself. The second one is called the best interest standard. Here the patient’s preferences are not known instead the surrogate’s
judgment must promote the best interests of the patient. This requires that the surrogate’s
decision must promote the individual patient’s welfare by making choices that reasonable
persons in similar circumstances would be likely to choose. Remarkably, the best interest
standard if taken literally is implausible because no decision maker is held to it in practice. For
instance if every surrogate decision were taken to court, there would still be no absolute
assurance got that the best choice has been made. This is why according to Veatch, replacing the
best interest standard with a standard of reasonableness or what could be called a reasonable
interest standard makes sense.

Remarkably, having transferred the decision making authority to another person to
decide for the patient does not imply that the patient’s preferences will always be overridden but
is only that the decision no longer rests with the patient. Therefore, the surrogate may or may not
make a different decision than the patient had made or would have made. On the other hand, the
physician is to help in two judgments; whether the patient is competent to make the decision in
question, what treatment is justified. This why today, than ever, treating terminal diseases like
cancer patient compliance is needed to assure treatment efficiency. Therefore, physicians who
are convinced that communicating the diagnosis of cancer is beneficial will inform patients who
ask to be told and even patients who would have preferred not to know about their diagnosis. By
contrast, disclosure of a poor prognosis is still judged harmful and therefore many physicians
seem not to favor truthful information about poor prognosis.

The *Cruzan v. Director Case* (1990) demonstrates how Judgment on behalf of an
incompetent person can be complicated. In this case the Missouri Supreme court dismissed the
two standards for surrogate decision making it instead in accord with the State’s own values and
preferences. This opinion in a way undermines the consent process by denying the values of the
patient in question ought to set the parameters within which treatment decisions are made. The goal of all decision making in medicine and health care should always be to make choices that support and are consistent with the values and preferences of the patient. However, the Cruzan decision has clearly increased the importance of the durable power of attorney. For instance Justice O’Connor in her concurring opinion suggested the possibility of a future Court ruling whereby surrogates appointed by such power of attorney might have exactly the same right to decide as the patient would have if capable. This suggests that the durable power of attorney as one of the ways in which the states might acknowledge that the patient has given clear and convincing evidence of their wishes. Whereas in some states with strict requirements the durable power of attorney may remain to be the citizens’ best bet.

The Terri Schiavo’s case is also a good example of best interest judgment. Priority is generally given to substituted judgment. However, there is a founded critique against the supremacy of autonomy over beneficence. Scholars argue that for incompetent patients beneficence (best interest judgment) is at least equally as important as autonomy (substituted judgment). The argument here is that autonomy should not override beneficence. Autonomy, being “personal rule of the self while remaining free from both the controlling interference by others and personal limitations, such as inadequate understanding, that prevents meaningful choice,” is the most important factor to consider, even when the patient can no longer make decisions and someone else has to act on their behalf. Decisions should be in the best interest of the patient as much as possible. For instance, in the classic case of Earle Spring, the court raised a legal problem about continuing kidney dialysis as follows: “The question presented by modern technology is, once undertaken, at what point it ceases to perform its intended function.” The court held that “a physician has no duty to continue treatment once it has proven to be
ineffective.” The court emphasized the need to balance benefits and burdens to determine overall effectiveness.\textsuperscript{207} The court draws a demarcation line as it approaches the matter from the perspective of the physician. Here the emphasis ought to be given to the patient since the care is essentially about the recipient, not the care giver. Treatment should never be imposed. While it is good to view the situation from all perspectives ethically “decisions about health care ultimately rest with competent patients.” This is not advocating for the continuation of futile treatments, but underlining the importance of the patient in question. If the patient declines further treatment, the case should be considered decided.

Voluntariness is another element of informed consent that has come to have a prominent role in biomedical ethics. A person is said to act voluntarily if she or he wills the action without being under the control of another person or condition. However, not all forms of influence exerted on another person are controlling. Therefore many influences are resistible and some are welcomed rather than resisted. For instance a subjective response in which persons comply because they feel threatened even though no threat has actually been issued does not qualify as coercion. Coercion occurs only if an intended and credible threat displaces a person’s self-directed course of action thereby rendering even intentional and well-informed behavior nonautonomous. Nevertheless, our human decisions are typically made in a context of competing influences such as personal desires, familial constraints, legal obligations and institutional pressures.\textsuperscript{208} The law protects the rights of those patients that cannot make decisions about treatment, who have left no advance directives and who have no one in the family to serve as their surrogate. This is solved by appointing a guardian who is expected to make decisions in accordance with the pure objective standard. However, the most important is the problem of conflict of interest as most of the hospitals propose their social workers to serve as guardians in
such situations. The outside guardians that are available together with other professional groups tend to charge a fee and this would result into a problem of who would pay for that fee. Kelly supports that in such case calling the ethics committee would suffice.209

Furthermore, voluntariness as a condition for valid consent places a responsibility on the physician and other health care professionals to ensure that the patient’s consent is voluntary. However, a patient who has failed standard therapy may be warned about the dangers lying ahead of her/his not taking a required procedure. By doing so the physician is not coercing the patient but warning not even threatening him/her. This will not invalidate the patient’s choice. Otherwise, we would regard all patients with life-threatening illnesses as deciding under conditions of coercion, thereby freeing us to disregard their choices.210 This idea would be supported by Kelly who says that health care professionals are not to be reduced to silence especially when a patient refuses a treatment that would offer clear benefit or fix the problem. Instead as experts in medicine, health care professionals should try to convince the patients to accept the beneficial treatments. More so, Kelly believes that physicians are not merely providers of procedures to consumers who choose them and pay for them but they form a relationship that includes trust and is a covenant between people seeking a common goal. Even then, the final decision should rest with the competent patient.211

Generally, life without coercion and pressure is impossible. For instance some situations exist in which an intervention is required to avert danger and to preserve or improve the prospects of a safe voyage. But however much coercion and pressure may be necessary, they should never become routine. Therefore, a care giver and a patient should be able to express feelings such as frustration, fear and powerlessness, and attention must be paid to those feelings. In order to be able to evaluate the method of intervention, one has to be aware of the variety of
goals aimed at. One also has to be aware of the variety of methods of intervention, each with its own benefits and drawbacks. The pros and cons of a method are to be decided by the individual experiences of a patient. Finally, an intervention requires a context of care and responsibility, along with good communication and fair treatment, before, during and after the use of coercion and pressure. 212

Manipulation is another form of involuntariness. Like coercion, manipulation seeks to produce a choice that promotes the manipulator’s good or the manipulator’s conception of the person’s good, not the person’s conception of his or her own good.213 Therefore, manipulation also violates the patient’s autonomy if it is applied in a health care facility. James H. Flory and co-authors observe that this simple doctrine that, consent should be not just be voluntary but informed, has proven difficult to realize in practice. Therefore, the goal of truly informed consent poses serious challenges in policy and ethics.214 Kelly would also agree with this idea because according to him perfectly competent patients quietly take into account the wishes of their families and others who may be influencing their decisions and this will not mean that the consent is not free. Although the patient needs to be free from all openly coercive influence so that he/she may be able to understand in basic human terms the diagnosis and prognosis, and the risks and benefits of the treatment, as well as any reasonable alternative approaches.215

The basis for respecting freedom as the non-restriction of options according to Hayry can be found in the seventeenth century liberal doctrine usually attributed to John Locke. According to this doctrine, individuals have rights. The most important of these are the right to life, the right to health, the right to liberty, the right to bodily integrity, the right to private property, and the right to punish those who violate other people’s rights. These rights are, essentially, entitlements to non-interference. Other people should not actively attempt to end our lives, corrupt our health,
steal our property, or curtail our freedom of choice. If they do, or attempt to do, any of these things, they partly lose their original entitlements, and we have the right to punish them, or prevent them by threats of punishment. On the other hand clinical experience always has a paradoxical character. For instance physicians are taught to see their patients as autonomous moral agents. At the same time, the concept of therapy, as well as prevention of illness, presupposes a manipulative relationship with the patient, legitimized by the goal of pursuing the health of the patient. In seeking to protect the autonomy that physicians have learned to prize they still aspire to refrain from inappropriate manipulation of the patient. However, in attempts to put their medical knowledge about, for example, smoking, into practice, physicians actually sometimes try to manipulate the patient to change behavior through subtle coercions.

c. The Nature of Information Needed by Patients

This paragraph will address the nature of information needed by patients. A patient needs to know what kind of information would be relevant and beneficial for his/ her decision making. This requires physicians to disclose information according to their professional knowledge and criteria. Then patients can use this information to determine what meets their needs and expectation. This integrates the subjective standard with the professional practice standard which demands an in-depth communication between medical professionals and patients. Only in this way can professionals know what information patients care to have and what they do not. The reasoning would be that balancing the clinical and ethical demands cannot be achieved without first understanding the patient’s preferences. Preferences for full information and involvement indicate openness and readiness to discuss, and harm from discussion is likely
to be much reduced. Preferences ‘not to know’ suggest a potentially high risk of harm from imposing too much information on the patient too quickly. This requires skilled and sensitive judgements from professionals, and there is an urgent clinical need for tools to help this difficult process. Therefore, providing full information and involvement to a patient who expresses a preference for an open approach should be straightforward so long as appropriate communication skills are used.219

Arnason and co-authors would recommend that in order for patients to be adequately informed and understand the disclosed information, the professionals will have to use their imaginative, empathic and professional skills. This means that they should be aware of, look for, and try to prevent problems of different kinds that might stand in the way of patient’s understanding. The professionals are also encouraged to use comprehensible language so that they can draw analogies between the specialized information and ordinary events familiar to the patient. Otherwise there would be risk of facing the two barriers of understanding process described as information overload and under-disclosure.220 This is due to the fact that in physician patient relationship information is a necessary element for receiving the patient's full consent and information is regarded as a therapeutic tool. Therefore, lack of information can lead both patients and relatives to unsuitable behavior and unnecessary concern, which may generate stress in the therapeutic interaction between doctor and patient. However, patients may only need to be informed of what they want to know and for that matter their mechanisms of defense or denial should be respected. The reason here is that sometimes withholding information can do less harm than giving the information badly.221 As for Stuart and Byron would recommend that the information should be transmitted by the person who has it, normally the physician, although
the authors do not rule out that also other members of the health care team or even family members may be better at giving that information as well.222

Generally, a patient is not required to be on the same understanding level with his or her physician so as to make an informed choice. Instead the patient will be able to understand the information needed for making informed choice through the explanation given by the physician about the likely effects of the medical condition and possible treatments. Above all none of the capacities necessary for competence are typically beyond ordinary people. Nevertheless, sometimes the effects of illness, treatment, age or other circumstances may impair any of these capacities. Brock recommends that in such cases, the physician will have to evaluate the patient’s competence.223 This conforms to UNESCO’s recommendation that any preventive, diagnostic and therapeutic medical intervention should be preceded by free and informed consent of the concerned person based on adequate information. Such information should be adequate and provided in a comprehensible form. However, consent may also be withdrawn by the patient any time and for any reason without any disadvantage or prejudice.224

According to Beauchamp and Childress, an autonomous person who signs a consent form for a procedure without reading or understanding the form can act autonomously, but fails to do so. Of course we could re-describe the act as one of the placing trust in one’s physician, which could be an autonomous act of authorizing the physician to proceed; but it is not an autonomous authorization of the procedure because it is not informed regarding the procedure.225 This why Kelly would agree with Veatch’s position criticizing the generalization of expertise. But the later insists that physicians, nurses, physicians’ assistants and other health care professionals are still the experts in medicine and health care, and unilateral decisions can be made, even without consulting the patient or the patient’s surrogate. Medical expertise must
override any silly request from a patient especially when it proportionate. For instance a patient might request dialysis for treating cold. According to Kelly the expertise of the physician is needed in determining that a patient has died so as not to bury breathing corpses, or stop them from breathing and then bury the dead relatives. The Israeli policy would move one step further by allowing physicians to override the right of informed consent and to forcibly treat competent patients against their will when they feel certain that their patients are making the wrong decision about their medical care. In Israel, however, the legal and medical community has allowed a patient’s best interest to supersede his/her choice of care. In effecting this, a physician must ascertain that her patient receives the information necessary to make an informed choice. Secondly, treatment must significantly improve a patient’s condition. Finally, there must be reasonable grounds to suppose that, after receiving treatment, the patient will give retroactive consent. Although each of these conditions exhibits certain logic, a number of difficulties arise in practice.

Furthermore, the health care delivery in England also ascribes the responsibility to the general practitioner or consultant, for informing the patient of the treatment choices available to him, or what treatment he is likely to receive. Such an exchange is based on the physician's superior medical knowledge and may occur for a number of reasons, individually or in combination with one another. Where the patient trusts the physician's judgment, the patient may not value his own experience of the illness or condition enough to bring it to the discussion. The physician may not value the patient's viewpoint or experience of illness, or see its relevance to his medical expertise; so it is not sought. As a result, the opportunity to be told that one need not agree to a prescribed treatment is not as a rule offered to health service patients. In practical terms, in the majority of circumstances, the ultimate decision-maker remains the physician.
the other hand Madder would advocate for an approach to patient choice as a medical advisor rather than either a fact-provider or a rational non-interventional paternalist. For instance as an anesthetist entails provision of facts relating to different options of an anesthesia and post-operative analgesia, but in addition an evaluative judgment of which option he/she believes is best for that patient. Such a judgment is formed after an often complex process involving consideration of a body of medical evidence, medical values, and intuition based on past clinical experience. This is a judgment of what is best for the patient in a medical sense, not necessarily in an overall sense. The hope is that an evaluative medical judgment might better equip the patient to decide what is best for his or her self in an overall sense than either medical facts alone or an all-things-considered evaluation.229 Therefore, the above medical advisor model gives weight to patient autonomy and what patients care about, but has to accept that patient choices may have outcomes which contravene medical values and indeed what the doctor believes is right. However, problems with the medical advisor model arise when patients are unwilling or incapable of making decisions but even then the goal of the physician should be to facilitate the patient's ability to choose by reducing such factors.230

Holly Fernandez Lynch also supports the issue of disclosing information to patients as way of meeting the medical obligation of informed consent. Lynch quotes Canterbury V. Spence who states that patients need to get information from the physicians in order to make informed decisions about their medical care. The same idea that is supported President Reagan’s commission for the study of ethical problems in Bio-medical and medicine and behavioral research. Similarly, AMA is quoted saying that the physician has an ethical obligation to help the patient make choices from among therapeutic alternatives consistent with good medical practice.231 This obligation is entirely separate from any obligation to personally provide the
services disclosed. For example a woman won a case against a physician and nurse-midwife not based on refusal to terminate the pregnancy but on failure to informed consent. The patient was not told the information surrounding delivering and carrying on abortion as leading to life-threatening infection. This would be different from Mississippi conscience clause whereby a health care provider has the right not to participate and not required to participate in a health care service that violates his/her conscience. Under Mississippi statute, patients seem to be uniquely vulnerable to their doctor for information about their medical options and if not provided patients won’t know what they miss and need to protect themselves.232

Generally, informed consent must be treated as an integral obligation of each and every person wishing to become and remain a physician. To the extent that even refusing physicians are supposed to disclose all the treatment options and information about those options to the patient but have to be currently part of the standard care.233 However, consent may be deceptive. For instance in 1998 a team of South African physicians and public health workers questioned patients who had enrolled in an HIV-transmission study about their knowledge of the disease. These patients had accurate understanding of HIV transmission but 84 percent said they felt they had been compelled to participate and felt this was not clear. On the other hand, when asked to quit the study, 98 percent said no. This might mean so much for the voluntary nature of information.234

Not telling the truth normally involves telling lies, and physicians and other health care personnel have no permission to lie. The importance of open communication with the patients calls for the need of knowing when to say what. For instance a patient going for investigations may possibly have a discussion about whether he/she would like to know the details before they are known. This requires the skill and sensitivity to assess what a patient wants. Therefore,
allowing the time and opportunity for the patient to ask questions is the most important thing but the patient’s apparent question may conceal the one he/she wants answered. This may imply that the question is not of telling but listening to the truth. This is why the patient-physician relationship is normally initiated by autonomous patients who seek advice from physicians i.e., by a request; this can also be seen that patients maintain their freedom to terminate the relationship through withdrawal of that request. Such request does not connote role reversal or a provider-dominated relationship; instead enables patients through placing them not only at the center of care, as in a consent-based relationship, but also at the center of responsibility for decision making. Therefore, some patients will require more detailed information, and this will be reflected in the eagerness with which they pursue relevant knowledge. Physicians will necessarily be an important, but not the only, source of such knowledge. Rather the issues of health are primarily value judgments, and that a system based on request will place more emphasis on each individual’s own outlook and on his/her perception of the way in which his/her health needs ought to be addressed. Bottom line, with “request” patients remains in control and this encourages responsibility for their own health, and the doctors’ duty changes from obtaining an informed consent, to fulfilling an informed request.

Similarly, Toombs is quoted in her book admitting the existence of a fundamental disagreement between doctor and patient concerning mostly the nature of illness and yet there can be some congruence. According to Tombs this difference could easily be settled in a sensitive conversation while reflecting upon the manner in which the body is apprehended in everyday life and provide the basis for empathic understanding of the 'givenness' of illness. The main reason here is that this experience of the body as object, which both physician and patient have, although each in a radically different manner, does not preclude a shared world of
meaning. Thus, even sick and healthy people share a sufficiently congruent horizon of meaning about the body to establish a level of inter subjectivity and mutual understanding. Toombs is quoted continuing to argue that clinical narratives may also provide insights into the lived experience of illness and particularly into the meaning that illness has for a particular patient. However, this requires the care giver to go beyond objective, quantifiable, clinical data and elicit the patient's illness story. The care giver can gain insight in the particular experience of a unique patient through the clinical narratives which provide important information with regard to the patient's biographical situation, and, particularly, with regard to the meanings that determine the manner in which the patient construes illness.238

d. The Development Regarding Truth Telling

The fourth paragraph will address the development regarding truth telling. Today, the ethical question regarding truth telling is changing from the question whether physicians should tell to how the information should be shared with the patient. Therefore, patients should be told the truth not merely for the sake of fulfilling an abstract principle of truth telling but in the context of concern and compassion for promoting true human fulfillment. Since physicians may not be in a position to convey the information concerning serious illness or impending death in a fitting manner. The present-day setting of the hospital requires that there should be trained personnel in the dynamics of accepting sickness and death so that such crisis of counselling is well handled. This will help in avoiding the untrained persons that may try to help in such crises and end up doing more harm than good.239 Nguyen suggests that using the individualistic approach such as that of truth telling in an indirect way could possibly help the older Vietnamese
Americans to use preventative measures regarding their health concerns. Nguyen regards the issue of truth telling to be much more complex than just simply choosing between telling and not telling patients their diagnosis and prognosis. Instead the problem that arises with truth telling is rather how, who and when to tell. Possibly even a patient who does not want direct disclosure may wish to know the truth through other means: indirectly, euphemistically, or nonverbally. However, telling the truth is considered to be important in all human relationships based on three reasons. First the truth is told to the person as way of respecting his or her right. Secondly, truth is also a utility because people need it for making informed judgements about their actions. Finally, it is a kindness to be told the truth because persons to who have been told lies will withdraw from important relationships. This is why people who tell lies are considered to poison the relationship and render themselves incapable of virtue and moral growth.

According to Roger Higgs, telling the truth should be regarded as one of life’s basic rules. Yet doctors seem to have been allowed from time long past to treat truth like medicine especially when difficult news was to be given to a patient. Similarly, in most cultures politeness seems to prevent people from being immediately or totally sincere in their day-to-day conduct. As a person has the right to be, to know, to life but has also right to truth. Therefore, a person demands respect for his/her own intellect and must also show similar respect for his/her neighbor’s intellect by putting right order in the communications between his/her own mind and the minds of other people. This is why anyone who speaks is obliged to speak the truth. Information is usually communicated via an oral or written narrative. To communicate information to the patient, the provider of information must therefore decide what kind of story to use to do so or how to frame the information. The main concern here is the effect that the framing of the communicated information can have on the patient’s ability to make informed
decisions. Similarly, the way in which the recipients of the information receive and respond to the information offered will depend on their particular social and cultural context as well as on their values and preferences, which is sometimes referred to as the patient narrative.244

Generally, ordinary politeness requires little white lies whereby a person tells the other person only what he or she would only want to hear even if that is not exactly the truth.245 In spite of different social settings changing and making it very hard to strike the balance in the areas of human behavior but this should not tantamount to changing central issues. Higgs notices that there are still many from either old generations or other cultures that might want to be approached differently. Therefore, physicians are not to avoid the issues with an excuse of not wanting to add stress to the patient as this would leave the patient in dark and not able to make decision.246 The implication here is that stressful situations in which a patient finds herself or himself should not be an excuse for not disclosing.

The purpose of disclosing alternatives, costs and benefits in medical diagnosis and treatment is not to relieve the physician of the onus of decision or displace it on the patient. Rather, it is to permit the physician to function as the technical expert and adviser while allowing a patient consideration of his or her personal values.247 Truth telling could of course be taken to mean simply the accurate communication of a set of facts. However, Kirklin would argue that unless those facts are communicated in such a way that the patient is able to interpret them, meaning to understand what they mean for him or her. Then communication or offering of the truth will have been unsuccessful. Therefore, truth telling should be understood to mean a communication of the facts in such a way that the recipients are able, should they so wish, to understand the consequence of the communicated facts for them.248
Many of the guidance documents emphasize the importance of communicating with patients. But increased communication must be accompanied by an understanding of the relevance of non-medical values and the epistemic privilege of patients and family members regarding those values. Improved communication is necessary, but not sufficient, for strengthening patient autonomy.249 There have been arguments that some patients are not able to understand the information especially those with dementia. Such patients have difficulties in acquiring any new information complicated by memory deficits, impairments in the use of language and the ability to understand abstract concepts. However, because of the nature of dementia, patients should know well in advance about the threats to their intellectual functioning. These patients experience their illness and deserve an explanation of what is happening to them. Therefore, lying and deceiving seem to deny them due respect and degrade their dignity. This means that the truth may be neither fully understood nor remembered by the patient and difficult for the doctor, but neither of these problems should remove the obligation to be honest and truthful.250

According to Mitchell and co-authors recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.251 Therefore, human dignity requires that a human being be treated “never as means” but “always also as an end.”252 The above idea seems to be conforming to Bostrom’s definition of dignity as a quality, as a kind of worthiness on a par with moral virtues which calls for a response of respect. Bostrom believes that dignity resides in the choosing capacities of humans and how those capacities are exercised and for that matter bodily limits would not determine human dignity according to his version.253
Generally, knowing one’s patient’s expectations helps the physician to know something of the patient. In return such knowledge would help the physician to understand the conversation between him or her and the patient because words, sentences, conversations and even whole interactions acquire meaning because of context. Unfortunately, some physicians differ in their approaches to disclosure decisions mostly based on personal value systems. For instance some physicians view deception as therapeutic and therefore justifiable alternative in certain clinical settings. This implies that according to such physicians truth telling is not a moral imperative but a virtue with variable consequences for the patient’s health. However, other physicians hold that any deception is held to be wrong no matter what the consequence. According to this faction of physicians nontruthful disclosure may be considered destructive of the physician’s effectiveness with patients. Additionally, the rise of societal movements supporting individual rights and self-determination has impacted disclosure in a sense that physicians alter their practice in order to correspond in favor of truthful disclosure while recognizing the above rights.

There are some circumstances in which the health professions are probably exempted from society’s general requirement for truthfulness. But not telling the truth is usually the same as telling a lie and a lie requires strong justification. Higgs recommends that lying should be a last resort and physicians and others who work in health care facilities should always aim at respecting all other principles that govern interactions with the patients more so in preserving the patient’s autonomy. Higgs goes on to recount that whether or not knowing the truth is essential to the patient’s health, telling the truth is essential to the health of the physician-patient relationship. In some cases patients have requested written information, not only to help them understand the problem, but also to make the most of their consultation and legitimize seeking
help. Therefore, presentation of information for informed consent should involve up to date written material and visual aids, including drawings and diagrams to explain complex aspects of treatment. Written material, although not a substitute for appropriate discussion, is the main source of supplementary information and can be designed to cover at least the aforementioned areas. The same material is useful because of limited consultation times, and the underestimation of patients’ desire to cope with information and overestimation of their ability to comprehend verbal information. The argument being that there should be as much information available as the patient needs or desires and leaflets also have a role in risk management strategies.257

There is no evidence that patients in general will be debilitated by truthful information about their condition. Instead more has been learnt about the benefits that information brings to patients. They are able to follow instructions more carefully if they know what their disease is and why they are asked to take medication. Similarly, patients recover faster from surgery and tolerate pain with less medication if they understand what ails them and what can be done for them.258 Understanding the treatment of disease or patients is impossible without seeing that at every step the doctor, the sick person and their relationship are woven into therapy. Illness is to be understood as a story if only part of which occurs in the body or if pathophysiology is understood to extend into the personal, interpersonal, familial and even communal dimensions of the sick person.259 Therefore illness and the experience of illness can only be described as a social and cultural phenomenon all this affects how the patients understand their illness, how they respond to it, how they communicate about it and how it affects their life. This why according to Allshouse understanding and respecting patient’s values, preferences, and expressed needs is the foundation of patient-centered care.260
Usually patients on their first visit come with an intense forged relationship with their physician. Therefore the physician should not accept this unilateral psychological contract instead should clarify matters by exploring patient’s ill-sorted out expectations of what he or she will and can do for the patient, disappointment and resentment over unfulfilled promises so as not to eventually haunt their relationship. Patients may also wish to know such facts so that they can take better charge of their life during illness as they have been accustomed to being in charge of their life during health.261 Physicians are not to overestimate the sophistication or knowledge of those under their care and should not assume that all patients understand what medical services a particular physician will refuse to provide. Physicians are supposed to inform their patients that the refusal to provide the disclosed service is based on moral and not medical reasons so that the patient may not fail to seek the desired service elsewhere. On the other hand refusers might argue that informing patients of the availability of services seem to make them impermissibly complicit in wrongdoing. But this moral complicity cannot overcome the serious harms to patients that can result from being kept in the dark. Therefore, relevant information should be disclosed to the persons, patients so that they make medical decisions for themselves and avoid potentially deceitful paternalism that was exemplified by HMO confidentiality agreements-“gag” clauses.262

In some instances the providers may be reluctant to inform patients fully about treatment options, side effects, or outcomes, or to encourage them to take part in decisions, for fear that they will make a decision that is not in their best interest. Yet informed, rational patients may have a different view of their best interest than the professionals who care for them.263 Telling patients the truth can be difficult for all those concerned, but it is also essential if respect for patient autonomy is to be paid more than lip service. If, at the end of life, healthcare
professionals fail to tell patients the whole, unedited, often messy and sometimes disturbing truth, then patients are effectively denied the opportunity to make an informed decision about how they wish to spend the rest of their lives, and physicians and nurses can be left feeling distressed and confused about why patients sometimes make unwise and ultimately self-harming decisions.264

According to Jerry Menikoff the patient’s right of self-decision should shape the boundaries of the duty to reveal. The scope of the physician’s communications to the patient must be measured by the patient’s need. That need is the information material to the decision. It means then that the test for determining whether a particular danger should be disclosed or not is its materiality to the patient’s decision rather than standard care. All risks that potentially affect the decision must be divulged. The law must itself set the standard for adequate disclosure in order to protect the patient’s interest, instead of leaving it to the practice of medical community.265 Menikoff further observes that the Canterbury v Spencer case in addition to establishing adequate information as per the need of the patient, demonstrates how physicians or professionals can define for themselves the standard of care. The court, by basing the standard of disclosure of information required by the patient on the standard of care, or on good medical practice, or what a reasonable physician will do, was leaving it to the physicians or professionals to define for themselves the standard of care. The suggestion here is that the scope of the standard should not be subjective as to either the physician or the patient; rather should remain objective with due regard for the patient’s informational needs and with suitable leeway for the physician’s situation.266
e. Other Values Connected with Disclosure

The fifth paragraph of this chapter will talk about other values connected with disclosure. Truth telling, therefore, is not only a requirement for doctors in respecting the patient’s autonomy but is also part of the ethics of medicine in the aspect of showing respect for the patient. This requirement allows doctors to accept a patient’s refusal of what the physician takes to be the second best treatment option as long as the choice has been made by a competent patient. For instance a physician may accept a Jehovah’s Witness to refuse a blood transfusion even when the commitment appears irrational and silly to a non-believer. This goes hand in hand with the medicine’s fiduciary responsibility that requires physicians to use their knowledge and skills to promote their patients’ good. 267 Similarly, the physician should not, if he/she can avoid, put his/her religious patient in a situation where the patient will need blood transfusion if he/she knows that the patient will reject it. Therefore, in case of two kinds of therapy available, a surgical one and a medical one, the physician ought to choose or opt for the medical therapy. Rest the physician carries the blame of the patient’s death in case it happens that way.268 The implication here is that respect for patient’s autonomy has to be incorporated into the professional commitments of the physician in order to maintain trust. Traces of the meaning of truth indicate that there are connections with trust especially in regard to the virtues of truth. For instance in the Early and Middle English the word truth meant fidelity, loyalty, or reliability. Whereas in modern English the primary sense of honesty can be summarized as not lying, not stealing, keeping promises. This implies that truthfulness is a form of trustworthiness.269

The reasons for telling the truth have a basis in all human relationships where truth must be told as a right, a utility and kindness. However, truth may be trumped by values of recipient survival, community survival and the ability to absorb the full impact of the truth at a particular
time. These are only temporary trump cards to be played under certain limited conditions because respect for persons is a foundational value in all relationships. Otherwise, telling lies distorts the duty we owe to other human beings of taking each human being as an end in itself but not as means towards the end. People are challenged to tell others the truth so that they may exercise their own reason freely. Telling other people the truth is inviting them to reason together and to share deliberations. Therefore, cooperation with others demands giving them a voice in the decision to be done.

There may be authorization to deceive targets who are not opponents, who share values with the deceiver. For instance physicians may not feel guilty about deceiving their patients if they think it is for the patient’s own good. This applies to giving a patient placebo, a sugar pill identified as a useful drug. If the patient feels better or at least stops hassling the physician for an unneeded drug which might actually be harmful. In such situation, many physicians believe that the lie is justified. This means that the patient profits from the lie and since the liar is not gaining from the lie he/she will not feel any deception guilt. In analyzing the duties of disclosure, Sigman and co-authors support that if there is a moral justification for lying to the patient or willfully hiding the truth, it must have a strength that overrides the principle of veracity derived from basic human respect. However, these authors recognize the fact that people deserve to be told the truth and circumstances must be morally persuasive when considering deviating from this basic moral duty.

On the other hand, truth has been described as the first virtue of systems of thought. Therefore, any theory however elegant and economical must be rejected or revised if it is found to be untrue. In fact truth and justice are both uncompromising because of being the first virtues of human activities. This is why analogously; injustice is tolerable only when it is necessary to
avoid an even greater injustice. Telling a lie may never be right but nevertheless it is often prudent, preferable and if the way people behave is any indication at all of morals and popular as well. However, not only lying but giving misleading information is intolerable in the health care industry, for instance not mentioning the side effects of new drug. On the other hand, giving technical information to patients who cannot possibly understand it may involve neither false nor misleading information but nevertheless may be morally dubious due to mere adjectives such as scientific or natural. This is why truth may always be desirable but the whole truth and nothing but the truth is just as likely to be a nightmare. As matter of concern, a person should not think that telling a lie and any lie is just as good or right as telling the truth and needs no special justification for doing so.

Naturally, a person is a social being and the gift of speech is perhaps the chief means by which person’s social life is carried on. Therefore, lying is morally wrong because it is an abuse of the natural ability of communication, because it is contrary to man’s social nature which requires mutual trust among people, and because it debases the dignity of the human person whose mind is made for truth. In comparing secrecy and lies, Bok recounts that the two intertwine and overlap. Lies are part of the arsenal used to guard and to invade secrecy and also secrecy allows lies to go undiscovered and to build up. However, the difference is that lies are taken to be prime facie wrong, with a negative presumption against it from the outset, whereas secrecy need not be. Bok takes concealment or hiding to be defining trait of secrecy since the word secrecy refers to the resulting concealment.

Truth as one of the concepts in philosophy can be easily understood by talking about it in relation to its opposite. For instance when someone speaks a falsehood, it is either out of not having accurate information or out of intent to deceive the listener. Therefore, if the intent is to
deceive, we can say that the person is deceitful and the act is one of lying. This implies that the neglect to provide accurate information when one is morally obligated to do so is a form of lying although referred to as an act of omission. In the health profession context, information sharing is about making true statements on the basis that this best serves the patient well.\textsuperscript{279} However, physicians have employed some economic arguments by contending that greater fidelity to disclosure and consent may be costly both in physicians’ time and patients’ fees. While this argument can be given attention, but it may not be clear how much time conversation will take once physicians know what needs to be talked about, and how and why they should talk. Moreover, conversation with patients constitutes good patient care and should not be compared with cost which physicians have always maintained as not an impediment to good patient care. Instead this might be taken as the physicians’ avoidance of the uncomfortable role of being the bearer of uncertainty.\textsuperscript{280} Kant would recommend that the duty of being truthful should be unconditional. According to this influential philosopher of the formalist school to be truthful in all declarations is a sacred and absolutely commanding decree of reason, limited by no expediency.\textsuperscript{281} People should therefore develop their own rational capacities and promote one another’s rationally chosen ends. This is because of the fact that respecting someone as a rational being also means respecting his/her right to make a personal decisions about one’s own life and actions.\textsuperscript{282} However, this thought Kant might sound contrary to what Hartman a contemporary philosopher holds. According to Hartman in health care practice the health professional is sometimes required to tell the necessary lies in order to avoid inflicting great harm on the patient.\textsuperscript{283}

The moral question of whether you are lying or not, cannot be settled by establishing the truth or falsity of what one says but by knowing whether the statements are intend to mislead
others. Therefore, when undertaking to deceive others intentionally the messages are meant to mislead them and make them believe what we ourselves do not believe. This is why a lie is defined as any intentionally deceptive message which is stated either verbally or in writing. Such statements can also be conveyed through signals, Morse code, sign language and the like. Those who learn that have been lied to in important matters feel were manipulated and unable to make choices for themselves according to the available information. Such people become unable to act as they would have wanted to act had they known the information all along. Therefore, trust is not something that simply happens or intuited but is created through interaction and in the making of relationships. Additionally, trust is created and damaged through dialogue, in conversation, by way of promise, commitments, offers, demands, expectations, explicit and tacit understandings. This is not to say that trust is entirely linguistic but rather there is a good deal of trust embodied in our physical presence to one another through gestures, looks, smiles, handshakes and touches. On the other hand, lying betrays such kind of trust and is so damaging. Therefore, trust remains essential and existential dimension of our human relationship.

According to Rogers, physicians’ trust of patients lays the foundation for medical relationships which support the exercise of patient autonomy, and which lead to an enriched understanding of patients’ interests. Physicians’ reliance on patients to give accurate accounts can be related with the same way that they rely upon sphygmomanometers to give accurate blood pressure readings, or this is reliance better described as trust. However, trust is an all-encompassing term, ranging from limited domains in which A trusts B to do X, through to the ill-defined but all-pervasive interpersonal trust which characterizes deep relationships. Therefore, trust may extend to institutions as well as to individuals. For that matter deception clues or leakage may be shown in a change in the expression on the face, a movement of the body, an
inflection to the voice, a swallowing in the throat, a very deep or shallow breath, long pauses between words, a slip of the tongue, a micro facial expression or a gestural slip. Therefore, lies fail due to a failure of the liar to prepare his/her line or due to the interference of emotions because lies involve thinking and emotions.287

The new model of trust in health care is grounded in a number of assumptions. The first one is that no single right decision exists for how the life of health and illness should be lived. Therefore, physicians cannot decide alone which treatment is best but must consult the patient. The second assumption is that physicians and patients bring their own vulnerabilities to the decision-making process. This means that the identity of interests will be established through conversation as they cannot be presumed. The third one is that both parties need to relate to one another as equals and unequals. Physicians know more about disease and patients know more about their own needs but the two sides need to complement one another. The fourth assumption is that all human conduct is influenced by rational and irrational expectations. This implies that reason and unreason define human beings’ essence. Bottom line, the new conception of trust advanced here only expands the idea of trust which demands for mutual trust that extends from physician to patient as well as from patient to physician. Physicians need to trust themselves so as to trust their patients so as not to be embarrassed by their personal and professional ignorance and to trust their patients to react appropriately to such acknowledgements.288 When you trust someone to do something, you rely on them to do it, and you regard that reliance in a certain way. Therefore, trust is like a lens which colors our vision; if we trust a person we interpret their actions favorably in the light of that trust (conveniently for those who betray trust). Conversely, lack of trust may prevent us from ever seeing proof of trustworthiness. Placing these
observations about trust into the medical context leads to some important conclusions. Both trust and distrust take place within a relationship which allows for the possibility of praise or blame.

Trust is the concept representing the condition of confidence and expectation on which human life depends. Both confidence and trust refer to expectations which may lapse into disappointments. However, trust unlike confidence presupposes a situation of risk and uncertainty. For instance after a by-pass surgery a patient may have confidence in his/her physician skill but before the surgery a patient must have trust that the physician will be able to perform the indicated procedure. This is why trust behavior consists in action that increases one’s vulnerability to another whose behavior is not under one’s control and takes place in a situation where penalty will be suffered if trust is abused would lead one to regret the action.

Barber argues that the logic and limits of trust suggest that when the balance of power between parties becomes unacceptable, distrust becomes the functional equivalent of trust fostering social controls over the perceived dominant party. However, Barber does not concede that distrust is just opposite of trust but that distrust is also a functional equivalent for trust. This implies that a choice between trust and distrust is possible and necessary. Barbers argument faces several limitations especially when applied to the medical profession. For instance an erosion of public trust in physicians today is mostly due to the profession’s drift away from its commitment to trustworthy behavior and beneficence to a concentration on profit and prestige. Therefore physicians must be more trustworthy in order to regain the trust of the public.

The proportion of the American public expressing a great deal of confidence in the leaders of medical institutions and professions has fallen dramatically. One reason has been attributed to the shattering of the Osler tradition whose medical practice established a personal relationship with every patient based on trust and confidence as an explicit part of the therapeutic
process. Today physicians have become more and more narrowly focused on specific organs of the body and the system is so commercialized that there is no time for non-productive activities. This has resulted into patient’s common complaint that physicians won’t make time to talk to them. Actually, Osler’s system has been argued out as an old fashioned and dead one.

### Conclusion

The chapter has tried to explore the norm of truth telling that forms part of the contemporary debate in clinical bioethics which centers on the right to receive information concerning his/her medical condition/illness and the duty of the physician to give this information to the patient. The emphasis on truth telling is associated with the leading principle in bioethics emphasizing on patient's autonomy, grounded in a strong tradition of privacy rights and personal liberty, whereby the sick person has a right to self-governance and to the information needed to become an active partner in health care.

The chapter has explained the notion and implications of disclosure as an important component of physician-patient relationship which is complex concept in the medical sociology whereby patients voluntarily approach a physician, and thus become a part of a contract in which they tend to abide with the physician’s guidance. This includes some changes that have taken place in this relationship whereby today a patient is considered to be a partner in his or her treatment. Therefore, physicians are supposed to be truthful to their patients in communicating so as to help patients in maintaining their autonomy. On the other hand a patient is also supposed to give as much information to the physician trusting that such information may also be disclosed to other professionals in the interest of giving proper treatment to that particular patient.
The discussion has been made about the seven elements of informed consent but the emphasis was mostly put on disclosure as one of them. The obligation to disclose information to patients has been presented by some institutions and authorities as the only major condition of informed consent. For instance in the United States disclosure still plays a pivotal role for patients to use as basis towards decision making. Keeping to the fact that medical care is a process whereby both a patient and a physician have informed each other of how each feels and the interaction helps in forming the basis for the next decision. Therefore a physician needs to establish trustworthiness within the limits of the contract whereby communication is done with interest in a patient as person and not limited by self-interested motives. In case of children, parents generally serve as surrogate decision makers and seek to protect their children’s best interest. Therefore, parents will trust physicians to consult with them regarding diagnostic tests and treatment options. Understanding has been addressed by this chapter as another element of informed consent. Therefore, in biomedical ethics the focus has shifted from the physician’s obligation to disclose information as to the quality of a patient’s understanding and consent. Similarly, voluntariness has been cited in this chapter as another element of informed consent that has come to have a prominent role in biomedical ethics. The implication is that voluntariness as a condition for valid consent places a responsibility on the physician and other health care professionals to ensure that the patient’s consent is voluntary.

The chapter has also addressed the nature of information needed by patients whereby a patient needs to know what kind of information would be relevant and beneficial for his/ her decision making. However, a patient is not required to be on the same understanding level with his or her physician so as to make an informed choice. Rather the patient will be able to understand the information needed for making informed choice through the explanation given by
the physician about the likely effects of the medical condition and possible treatments. The care
giver will need to gain insight in the particular experience of a unique patient through the clinical
narratives which provide important information with regard to the patient's biographical
situation, and, particularly, with regard to the meanings that determine the manner in which the
patient construes illness.

The chapter has addressed the development regarding truth telling and recognized the
fact that today, the ethical question regarding truth telling is changing from the question whether
physicians should tell to the how the information should be shared with the patient. In order
communicate information to the patient; the provider of information must therefore decide what
kind of story to use to do so or how to frame the information. The main concern here is the effect
that the framing of the communicated information can have on the patient’s ability to make
informed decisions.

In the fifth division, the chapter has talked about other values connected with disclosure
whereby truth telling has been cited as not only a requirement for physicians in respecting the
patient’s autonomy but as also part of the ethics of medicine in the aspect of showing respect for
the patient. Similarly, the reasons for telling the truth have a basis in all human relationships
where truth must be told as a right, a utility and kindness. However, truth may be trumped by
values of recipient survival, community survival and the ability to absorb the full impact of the
truth at a particular time. Therefore, in telling other people the truth is way of inviting them
towards reasoning together and to share deliberations. This is why truth has been described as the
first virtue of systems of thought. In that regard there is no person who should think that telling a
lie and any lie is just as good or right as telling the truth and needs no special justification for
doing so. The next chapter will focus on the ethical issues and problems connected with truth
telling.


130 Katz, 59.


141 Freedman, 338.

142 AMA, “Code of Medical Ethics,” (Chicago: The Association 202)


Barlow, 267.


Junkerman, et al., 22.


Habiba: 187.


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Chapter Three

Focusing on the Ethical Issues and Problems Connected with Truth Telling

The chief ethical principle underlying the idea that patients should be offered the truth is consistent with the leading principle in bioethics emphasizing on patient's autonomy. However, autonomy is not a primordial principle in other cultures. The chapter will elaborate the thesis in the four following paragraphs: Cultural diversity, Meaning of autonomy, Health literacy and Medical tourism.

a. Cultural Diversity

The first paragraph will try to address the problem of cultural diversity. Culture is a complex whole which summates the most fundamental beliefs in art, language, literature, custom and law. Therefore, the culture in which one is born and raised has some long lasting effect. To the extent that violating a person’s cultural beliefs and practices is tantamount to assaulting one’s humanity. This is why imposing alien beliefs and practices on an individual or society is to violate their humanity and such violations are immoral. For that matter, human beings as either individuals or aggregates are inherently entitled to respect and they possess an inviolable dignity. However, this should not be confused with sanctioning the absolutization of either personal or cultural autonomy. Instead there should always be recognition for interdependence between the involved parties. 296 Furthermore, culture is more than a set of anthropological features. Weisstub defines culture as the body of learned, values, beliefs, and behaviors that characterize a group of people. Bottom line, culture provides a set of perspectives by which groups of people interpret their lives and what happens to them including sickness and death. This is why intercultural
communitarian ethics must rejuvenate bioethics discussion because this has become too complacent and reliant on standard autonomy analysis. Nie goes further to recommend that bioethics has to take cultural differences seriously. However, while taking culture seriously is very essential, this should always be treated as being pluralist, historically complex, full of contradictory elements and open to change. For instance in China most contemporary physicians along with patient’s family members, do not tell the truth directly to patients suffering from terminal illness. On the other hand contrary to that common wisdom of concealing the truth from the patients, more and more patients and medical professionals are making efforts to reform the current mainstream practice.

Elaborating further, Locke observes that culture is the capacity for understanding the best and most representative forms of human expression and of expressing oneself, if not in similar creativeness, at least in appreciative reactions and in progressively responsive refinement of tastes and interest. Leininger would argue further that culture refers to the learned, shared and transmitted knowledge of values, beliefs, and lifeways of a particular group that are generally transmitted intergenerationally and influence thinking, decisions, and actions in patterned or in certain ways. Additionally, Purnell and Paulanka have extended to Leininger’s basic definition by remarking that culture is largely unconscious; both implicit and explicit; and dynamic, changing with global phenomena. The implication is that at a practical level, physicians must be cognizant that culture affects individual and collective experiences which are directly and indirectly related to health. For instance, cultural influences on patient health beliefs and behaviors can be found in patients' perceptions of locus of control, preferences, communication norms, and prioritization of needs, as well as in their understanding of physical and mental illness and of the roles of the individual, family, and community.
In the broadest sense, culture is defined as the context in which one operates. In other words culture is the people with whom interactions are made such as family, coworkers, neighbors and friends. The list includes the shared ideas to which one is exposed through television shows and movies watched music listened to and books that are read without forgetting one’s back ground such as ethnicity, religious beliefs, level of education and political affiliations. Therefore culture includes all these things and so many others. In addressing the problematic of cultural diversity, Article 12 of UNESCO revisits the idea from the Universal Declaration on Cultural Diversity adopted in 2001 which points to dual interdependence of human rights and cultural diversity. Revel comments about Article 4 that proclaims the defense of cultural diversity as an ethical imperative, inseparable from respect for human dignity. Further illustrates on how human rights being universal guarantee individual cultures to express themselves. Culture should be regarded as a set of distinctive spiritual, material, intellectual and emotional features of society or social group which encompasses such as life styles, ways of living together, value systems, traditions and beliefs. However, Revel strikes the difference between human rights and culture by remarking that the former are natural-born rights and are defined by international law while the latter is not. Furthermore, the above dual relationship is also stressed by Beji by arguing that human rights emerge from erasing cultural differences, from ending the hierarchy of cultures. The affirmation is that the cultural argument cannot claim the authority of a legal principle. Therefore, human rights are subject to a civil law that controls them and is applicable to all whereas the cultural rights are left to the free appreciation of their proponents.

Further still, Nielsen-Bohlman would define culture as referring to the shared ideas, meanings, and values acquired by individuals as members of society. This implies that cultural,
social and family influences are of critical importance in shaping attitudes and beliefs. Therefore, people may know humanity, deal with the world they live in, and understand their place in the universe through cultural processes. In short, culture is very crucial for understanding, thinking and responding to human experiences and world events.\textsuperscript{306} On the other hand, Gbadegesin’s argument is that a cultured person is a refined person that has been worked upon by culture and liberated from nature. However, culture is a product of nature and yet can also change nature. For that matter, if culture tends to natural growth then there is a need of evaluating whether such activity goes on well. The author also observes that culture tends to have a double meaning: what \textit{is} and what \textit{ought to be}. The standard for what ought to be can be anything from morality to aesthetics.\textsuperscript{307}

Considering the world in all its diversity what is apparent is the need for achieving a common basis for policy transcending the viewpoints of each and every particular group. There is need for respecting all that is deeply important to people and this would include their religious convictions whatever they are. Therefore, the efforts should be turned towards identifying that core of principles on which people can agree and strive to have them adopted as a basis of an international code of ethics for health policy.\textsuperscript{308} The implication here is that as the health care providers deal with increasingly diverse patient populations. There is a need for preparations made to address such influence. Instead of looking at culture in health care scenarios as a stumbling block towards achieving the objective role of providing effective patient care, in fact serves as an opportunity to fulfil their obligation completely. By understanding a patient’s culture and its potential impact on his/her understanding, beliefs and comfort level helps the healthcare provider to connect to that particular patient on a level that is more likely to result in competent care and compliance with instructions.\textsuperscript{309} Sufficient attention should be paid to the
fact that not only do just situations vary but patients vary as well. For instance patients vary
evertheless in cultural and religious commitments and willingness to question such
commitments, medical knowledge, interest in acquiring medical information, respect for medical
authority, rigidity of values, and desire for guidance. Therefore, such considerations should never
be under rated instead may be particularly important in the process of improving on physician-
patient relationship especially in the present diversity society.310

In some cultures, individual autonomy is not recognized and a patient prefers making
decisions together with the family. This situation may necessitate physicians to carry out an
informed consent discussion in a manner that is appropriate to the patient’s beliefs and
understanding. However, this should not mean that the principle of autonomy is not valid but
only requires careful application that takes particular cultural aspects into account. For instance,
in a culture where a husband decides for the woman in medical matters, the best way would be
asking the woman whether she would like to receive the information and make decision herself
or leave it up to the husband. When choice to delegate decision making to someone else has been
made by the patient himself or herself, such would be considered autonomous.311 Similarly, the
Filipinos would treat the family as a social unit of greatest value. The primary focus of
assessment of good is not the individual but the family. Consequently, given a strong family-
centered and community centered ethos; Western ideals of individualism and self-reliance have
little purchase in the Filipino culture.312 However, Osuntokun would remind that biomedical
ethical issues, guidelines, principles, and regulations cut across national boundaries and often
have universal implications. Although the author admits the difference among the people and in
their cultures, but recognizes that certain values are common to all. In this context, the most
important value is respect for human dignity, and this should not be negotiable.313 Higgs would

92
argue further that in respecting patients’ autonomy all autonomous people ought to make choices for themselves in matters regarding their own welfare. Furthermore, to treat people as an end in themselves rather than as means to someone’s end must mean that their own views of such ends need to be given paramount attention especially when it comes to decisions about things that matter like treatment. Therefore, a patient has always to be the final arbiter and the health care professional has to avoid being more of a person than the patient by offering anything less than what is required. This is why autonomous people should be told the truth about their health condition so that their personal choices would be respected in health care.314

Furthermore, an example may be quoted from the Ethiopian people where the family’s importance dominates over individual members, any information, including diagnostic facts, belongs to the family. The family will then use such information at its discretion to benefit the patient. In the Ethiopian culture like many other African traditional medical practices, a patient relies on the physician to cure illness and help to manage pain. Therefore, a physician’s honesty is not questioned and all his/her actions are considered a form of caring for the patient. For instance an Ethiopian physician may tell his/her patient who has a 40% chance of surviving with treatment that the disease is 100% treatable because Ethiopians seem to do better when reassured. However, this is not to say that Ethiopians do not value honesty and truth but they do not want to tell another person something that may offend or hurt him/her. 315 Unfortunately, faced with patients from different cultural beliefs or background has led most physicians not wanting to go against the dictates of the culture they know nothing about especially when the surrogate rejects the medical advice as being against his/her culture. Such cases may become a nightmare of Western physicians and ethicists who hate being accused of cultural arrogance. Therefore, the veracity of the culture references must be ascertained by an independent body or
group which includes a member of the patient’s culture group in order to solve such problem.
Additionally, there is a need for confirming the claim about the cultural belief as the surrogate
may have it wrong. After discovering that the cultural belief of the patient is well represented by
the surrogate, the ethics committee should be called upon to address and when the decision is in
favor of the medical advice, a court of law would be called upon to enforce the decision.316

However, interviews conducted in Tanzania indicate that some physicians believe that
only relatives of elderly cancer patients should be told the diagnosis especially if the disease is
terminal and the family can decide on whether or not to tell the patient based upon their
knowledge of his/her temperament and mental state. The Tanzanian physicians’ argument is
supported by the fact that in many instances some elderly patients when told of their terminal
condition tend to give up hope and die prematurely. Differently, another group of both foreign
and Tanzanian physicians offered anecdotes about patients thanking them for being the first
person to be honest with them. On the other hand the cultural and economic situations may also
reduce the significance of non-disclosure in some countries like Tanzania where patients do not
die alone in nursing homes but are cared by the family members. Additionally, because of
poverty people are not worried who to leave their property as may be the case in the developed
countries and children of the deceased will also be cared by someone in the family.317 Similarly,
some interviews conducted in US among people who are seriously ill or with dying patients
reveal that they do not want to be kept continually in doubt about their condition. Surprisingly,
all the patients seemed to know about their terminal disease whether they were explicitly told or
not. At this point a physician can be of great help by making clear to such patients that he/she
would be available for open and direct communication. However, informing patients in a
brusque manner would not be helpful. Therefore, such information should not be delivered in an abrupt and brutal manner. 318

Further still, in some cultures the family excludes a patient from the process of information exchange in an effort to protect him/her from despair and a feeling of hopelessness. For instance in Spain and Italy the relatives oppose truth telling. Similarly, in Greece the caregivers take all the responsibilities, while the suffering patient remains in ignorance. This is not mentioning other cultures like Saudi Arabia, Egypt, Singapore, Japan and China where physicians also prefer telling the diagnosis of terminal diseases to the relative of the patient. The argument here being that relatives are likely to know the patient’s reaction better than the health-care professionals and for that matter they can even deliver necessary support and physical care. Therefore, the physician-patient relationship becomes a triangle consisting of the physician, the patient and the family with each part supporting the other two.319

Generally, the need for family involvement in health care decisions is obvious for people from all cultural backgrounds although to some this involvement might be somewhat different. For instance among African Americans aunts, grandmothers, siblings and children may play different roles. This creates a need for a more careful and different assessment of family connections so as to avoid having family members play unexpected roles in the health care decisions of their loved ones.320 Similarly, the American College of Physician Ethics Manual recognizes that in the care of the adolescent patient, family support is important. However, this support must be balanced with confidentiality and respect for the adolescent’s autonomy in health care decisions and in relationships with clinicians. The same manual advises physicians always to be knowledgeable about state laws governing the right of adolescent patients to confidentiality and the adolescent’s legal right to consent to treatment. Additionally, a physician
may also receive information from a patient’s friends or relatives and is asked to withhold the source of that information from the patient. At this moment the physician is not obliged to keep such secrets from the patient. Instead the informant should be urged to address the patient directly and to encourage the patient to discuss the information with the physician. The physician should use sensitivity and judgment in deciding whether to use the information and whether to reveal its source to the patient. The bottom line is that the physician should always act in the best interests of the patient.\textsuperscript{321} Additionally, in UK some patients also believe that their close family members should receive information about their illness only with their consent. This means that patients would wish their autonomy respected and consider that their needs should take priority over those of their families. Therefore, adopting a blanket policy of full disclosure may threaten the medical principle of \textit{primum non nocere}, since not all patients wish to be given all the details of their illness.\textsuperscript{322}

However, the problem may occur when the patient is assumed that being part of the traditional culture in which disclosure to the family other than to the patient is the usual custom he/she should have the family take over the decision-making. Such presumption may be wrong because there may be people from such traditional background that reject that view instead would want to be informed of their diagnosis and retain their decision-making authority. Therefore, the moral right to truthful disclosure should not be waived by a majority vote even if it can be shown that the patient comes from a culture that generally follow a pattern of nondisclosure.\textsuperscript{323} This is why the American College of Physicians Ethics Manual recognizes that physicians and patients may have different concepts of or cultural beliefs about the meaning and resolution of medical problems. Therefore, within such situation the physician is obliged to try to understand clearly the beliefs and the viewpoints of the patient. If the physician cannot carry out
the patient’s wishes after seriously attempting to resolve differences, the physician should discuss with the patient his or her option to seek care from another physician. However, the physician is required to notify the patient in writing and obtain patient approval to transfer the medical records to another physician and comply with applicable laws.324

The preoccupation with autonomy and self-determination in Western bioethics is an indicative of the extent to which cultural values influence our orientation to biomedical morality. This is why the very concept of informed consent is almost meaningless in societies that stress the overriding importance of an individual’s relationship with family and community. Thus the primacy of autonomy is not a resolution for worldwide bioethics but part of a more fundamental problem for most cultures.325 Pellegrino would argue that the duty of respect for the moral right of patient autonomy is grounded in rights and moral claims all humans have on each other which should be recognized due to its metacultural justification and not because of being Western product. Therefore, the dignity of the human person is not something that can be continually asserted or denied because it transcends even culture that resides inalienably in what is to be a human being. This is why an ethical system of any culture is morally defensible because of being grounded in truths that transcend that culture and not morally defensible simply because is the product of a particular culture. The fact of cultural difference does not necessitate absolute cultural relativism but should aim at searching for those elements that transcend particular cultures.326
b. Meaning of Autonomy

The second paragraph will try to analyze the meaning of autonomy. The principle of autonomy is grounded in respect for persons and the acknowledgment that as rational beings we have unique capability to make these personal choices. Therefore, autonomy is not in fundamental opposition with beneficence only that problems may arise when the content of what is beneficent is defined by others such as physicians or family members. However, in the absence limitations, competent humans are owed the freedom to define beneficence in terms of values. By the middle of the twentieth century, physicians were to provide patients with the amount of information that they believed was prudent and were very committed to the good of the patient to the extent that they would sometime overrule the wishes of the rational patient by providing less information than expected. However, the notion of patient autonomy began to influence informed consent and certainly by the late 1970’s patients were being offered information that they expect under patient-based standard. Within the decade the principle of patient autonomy was firmly ensconced in medical ethics. Some people have considered respect for autonomy along with fidelity to promises and honesty to be aspects of a broader principle of respect for persons while others see them as more independent. Childress argues that one aspect of respecting persons is to respect their autonomy and this is what it means to respect persons as independent ends in themselves. The word autonomy, therefore, is derived from the Greek words autos (self) and nomos (law or rule). However, autonomy does not imply that an individual’s life plan is his or her own creation and that it excludes interest in others. Rather autonomy simply means that a person chooses and acts freely and rationally out of his/her own life plan, however ill-defined. Likewise, autonomy does not mean that an individual is uninterested in the positive or negative impact on others.
Veatch would regard autonomy as both a psychological and moral term. On psychological level autonomy is a term describing the mental state of a person that is free to choose his/her own life plan and act on those plans without any constraints both internal and external. However, no one is fully autonomous in the sense of being totally free from constraints. Therefore, being autonomous is decision-specific as well as a matter of degree. This is why if a physician or a family member believes that such persons are totally lacking in competence there should be steps taken to inform the patient about that belief. Wilkinson seems to support Veatch’s idea about autonomy in defining it as a psychological property of persons and respect for autonomy as a term for moral constraints that a person’s having this psychological property places on the way in which others should treat him/her. For instance to interfere with an autonomous person’s body without her/his valid consent is among other things a failure to respect her/his autonomy, a failure to act in accordance with the moral constraints that her/his possessing autonomy places on other agents. Autonomy therefore can be used in two different senses. One sense is the one described above and the second sense is where autonomy is used to mean roughly being allowed to do what one wants and respecting autonomy would just mean letting people do or have what they want. However, Wilkinson would broadly support the common understanding of autonomy in terms of people’s capacity rationally and reflectively to endorse, reject and rank their desires or preferences.

In the view of Harris, autonomy would mean two views: First, autonomy is a form of independence and authenticity whereby a person’s preferences are to be honored if they accord with what one chooses or would choose under normal conditions. Secondly, autonomy is a form of independence meaning is also a side constraint such that a principle of respect for persons or bodily integrity may outweigh a person’s preference, even if such preferences are in accord with
their authenticity under normal circumstances. The author believes that these two above views are strong and rule governed approaches that are associated with theoretically rich in reasoning procedures.332

The principle of respect for autonomy in physician-patient relationship generally speaks to the bodily integrity of the patient and his/her control over any and all touching, manipulation, invasion, medication, or other intervention. Therefore, the patient must authorize any beneficent act and if they are acts performed without communication and his/her knowledge would be violating one’s autonomy. However, there are important limits to this generalization. In case of declared legal incompetence, patients cannot adequately express their choice instead others must give a substituted judgment for such patients. But the attending physicians are cautioned against certifying mental incompetence.333 This same principle of autonomy usually referred to as one of the important bioethical principles in the Western social context might not apply effectively within, for example, the Japanese cultural tradition. The reason behind is that Japanese culture nurtured in Buddhist teaching has developed the idea that egoistic self should be completely suppressed. This unique understanding of the Japanese culture explains further about the background of the sharing principle that they advocate for in their bioethics. In short to be autonomous and independent as an individual is regarded as an egoistic idea because of not addressing the need of the people as dependent on the family, social, economic and political community.334

Furthermore, autonomy viewed as self-understanding excludes evaluative judgment of the patient’s values or attempts to persuade the patient to adopt other values. However, in practice, especially in preventive medicine and risk reduction interventions physicians often attempt to persuade patients to adopt particular health-related values. For instance physicians are
encouraged to persuade their HIV infected patients to adopt safer sex practices in order to assume the responsibility for the good of other people. However, Winston recommends that before breaching such confidentiality the three following conditions have to be in place. First, there should be an identifiable person or an identifiable group of people who are at risk of contracting AIDS from a known carrier. Second, the carrier should have not or will not disclose his/her antibody status to those persons whom he/she has placed or will place at risk. Third, the identity of the carrier and his/her antibody status should have been known to a physician, nurse, health care worker, public health authority or another person privileged to this information. These circumstances justify revealing of the information in order for others to identify an AIDS patient and this will serve an effective means of protecting those at risk. Similarly, the disclosure of a physician who has become chemically dependent or addicted to cocaine will be constrained by the obligation to treat confidentially information revealed in the therapeutic relationship from his/her colleagues. This will be done in the effort to prevent serious harm the addicted physician may do to other people more especially his/her patients. However, before deciding on disclosure the physician should be reasonably certain there is no alternative way to assure that his/her colleague is properly evaluated. This will be followed by outside assistance as needed.

In support of the above idea, Ashley and co-authors would add that the right of privacy though important would be limited by other person’s rights and the right to help others. This is why a professional as a representative of society has also the responsibility to prevent harm to clients and other members of the community. Therefore, when information is given in confidence that might endanger patients or other people, professionals have the obligation to communicate this knowledge to those who would be able to prevent the anticipated harm. For
instance a professional has the right to report a client who reveals to him/her that might commit 
suicide or a crime against others. Additionally, Pellegrino would argue that the physician 
serves well as an expert witness, providing the basis for informed public decisions. At the same 
time each physician must honor his/her traditional contract to help his/her own patients in the 
sense that the larger social issues may not undermine that solicitude. In short, today’s 
conscientious physician is very much in need of an expanded ethic to cope with his double 
responsibility to the individual and to the community. Therefore, a well-functioning, stable 
society matches every right to responsibility in a sense that a person is either the philosophic or 
the social sense has both rights and responsibilities. This why no right is so broad that morally 
can extend to harming others. Thus there is a public right to use water but not to pollute the 
same. Similarly, an industry has rights to free conduct of their business, but no right to destroy 
the environment of other people.

Generally, the laws of most states require reporting of cases of sexually transmitted 
diseases such as syphilis, gonorrhea and hepatitis B, to public health authorities. For instance, 
today Aids is among the reportable diseases with exception of Colorado and Montana where they 
require confidential reporting. While physicians should violate their prima facie obligations to 
protect confidentiality only with great reluctance, it is morally permissible and may sometimes 
be obligatory for them to do so. However the ethical dilemma may be of balancing long-term 
societal benefits against short-term benefits to an individual. Although this may be a difficult 
decision and there may be exceptions to the rule, maintaining the patient’s confidentiality should 
be the first principle. This idea conforms to the American College of Physician Ethical Manual 
which reminds that physicians have obligations to society that in many ways are parallel to their 
obligations to individual patients. Therefore, a physician is expected to keep secret all that he/she
knows about the patient and release no information without the patient’s consent, unless required by the law or unless resulting harm to others outweighs his/her duty to his/her patient.343

Furthermore, Article 5 of the UNESCO Declaration stipulates limits to which autonomy is subject and should be highly restricted and enshrined by law. The right of exercising autonomy can significantly be abrogated in rare circumstances each of which involves the protection of the autonomy of other people. This is why medical personnel can compulsorily detain mentally ill persons for protection and treatment if they constitute a danger to themselves and the freedom and safety of others. This applies to those who suffer from very serious infectious diseases may be compulsorily removed from their place of abode or work to protect the health others.344 Savulescu also confirms that there are limits on the exercise of autonomy whether prudent or imprudent, rational or irrational. For instance distributive justice requires that our limited medical resources be allocated fairly. In that respect a physician can legitimately disconnect a person who has a very poor prognosis from a ventilator even though that patient was expecting a miracle, if a better prognosis patient requires a ventilator. Harm to others would be another form of limit on respect for autonomy. This why there have been cases where pregnant women have been incarcerated for engaging in behavior dangerous to their fetus. Savulescu also mentions public interest as a limit on respect for autonomy but says it should be invoked in most unusual circumstances due to commitment towards freedom and autonomy.345

The majority of patients in the United States would demand and are given information that enables them to make decisions either autonomously or with the physician’s advice about their health care. This would be held differently by an Italian patient whose attitudes perpetuate the belief that no patient can acquire enough knowledge to fully participate in health care without the physicians’ knowledge that is assumed incommunicable. This has something to do with the
Italian concept of autonomy that is held synonymous for isolation. Autonomy thus would easily become isolation for a person overwhelmed by complicated and frightening information that does not develop into knowledge. On the other hand the Italian culture is still strongly bound to the Greek and Latin approaches of medicine whereby benefit is the priority in the patient-physician relationship. Similarly, the perspectives held by Native Americans, African Americans and many immigrant groups entering the country legally or illegally, such as Hispanics, Latinos, Middle Easterners and Asians may conflict with Anglo-American values especially when it comes to clinical decisions. The reason is that most of these groups have had adverse experiences of some kind with the dominant culture in their initial and continuing contacts with that culture. This is why Ndebele would propose that in upholding the principle of respect for autonomy should not only entail respecting the individual person, but also to go as far as respecting their convictions, culture and traditions. The reason being that informed consent itself involves complex interactions between moral, cultural and political values. Such complex situation suggests the need for health care professionals to be trained in skills to make sensitive judgements according to the demands of the situation.

Stiennon explores further by admitting that autonomy and dignity are integral part of rights and fundamental freedom of human beings which must be recognized and respected in an effective and universal manner. However particular and precise arrangements on a legal and social framework have to be anticipated especially for persons and vulnerable populations and communities that are unable to formulate their consent and such group of people should have the opportunity to be treated in a just and fair manner. On the other hand, it is good to keep in mind that beliefs and choices may shift over time. At most the ethical and interpretive problems arise when a patient’s present choices contradicting his/her previous choices. Yet in some cases
this may have been explicitly designed to prevent possible future changes of mind from affecting the outcome. The key question here would be whether such person is acting autonomously if she/he revoked the prior decision. This is why in discerning whether particular decisions are autonomous may depend in part on whether they are in character or out character. The reason is that actions are more likely to be substantially autonomous when they are in character, but acting in character does not necessarily show autonomy.350

On the other hand the therapeutic privilege supports physicians in North America to withdraw information from the patient if such would lead to causing harm like social damage or suicide. Such privilege must be however, used rarely and with utmost care since it can be easily abused. Therefore, treating patients within the concept of beneficence defined by their own cultural ideas is a form of therapeutic privilege. This will entail that health care professionals must act in a manner that enables and empowers patients to make decisions and act in way that is most in accord with their values drawn from the circumambient culture.351 Cultural beliefs lie on a spectrum that extends from the benign to the totally indefensible. For instance, they are some treatments that rely on personal interactions, ritual and so forth whose content is harmless that are accepted thought they do not rely on medication. Therefore, some customs can for a good reason be permitted at a particular time. For instance information may be withdrawn about lethal disease in cultures where this is customary and where the patient understands that this is happening. Pellegrino recommends that in such situations the therapeutic privilege would be invoked.352

Similarly, during emergencies when the time taken to obtain informed consent might irreversibly harm the patient, a physician is justified to go ahead with the treatment. However, this should not go beyond such limited circumstances as there is no longer assumption that a
physician and a patient espouse similar values and views of what constitutes a benefit. However much important is the patient’s autonomy. This can neither be the primary nor the sole consideration but the personal good has to reflect the good from the society as well. The good that is sought for an individual person is not only a personal good because we receive our concept of good from the society. Therefore, physician should help the patient to discern what is good in light of the community’s understanding of the good because actions which affect an individual person also affect the community.

Commenting on autonomy from Chinese perspective, Fan notices the existence of two bioethical principles of autonomy that is the Western and East Asian. While Western principle of autonomy demands self-determination, assumes a subjective conception of good and promotes the individual independence. The East Asian principle of autonomy requires family-determination, presupposes an objective conception of the good and upholds the value of harmonious dependence. Bennet and Harris would argue further that while respecting individual autonomy allows competent individuals to choose whether to have diagnostic tests, undergo surgery, accept drug therapy or modify their life style. However, the moral situation changes significantly when the action of the individual is likely to cause harm to the third party. For instance pregnant women may have no right to refuse certain medical recommendations if they will significantly have harmful effect on the welfare of their future child. However, this should not imply that pregnant women’s autonomy has to be generally infringed in order to protect a future life. Instead the justification would require some degree of evidence that harm would indeed be avoided by such infringement. Similarly, autonomy that has been most centrally viewed in terms of self-determination may be viewed differently when it comes to infectious diseases because their particular characteristics undercut the familiar conditions for
exercising autonomy. This is not to deny the importance of autonomy, rights, plans and related notions as appropriately central concepts in bioethics and law but is to indicate how the ideal of the thoughtful chooser, deciding in accord with the preferences and interests is upset by the picture of the embedded agent. Therefore, the agent in exercising autonomy would then be expected to attend in his/her choices to the risks of infectiousness that he/she experiences and constitutes. This may call for the need towards enhancing the understanding of autonomy and its implications as a result.357

Respect for autonomy is an element of a more general moral concept of respect for persons which requires sometimes moral situations that do not maximize the patient’s well-being. However, there has been a frequent problem arising in health care referred to as the condition of doubt. This is a situation where a physician may be in a real doubt about what facts are when treating patients with terminal diseases like cancer. The doubt may arise when innovative therapies are contemplated and a physician is not clear about what the effects of the treatment will be. This means that there will be delay in delivering the “reasonably meaningful” information required for a patient to make autonomous choices about the treatment options. But faced with such situation the physician should simply respond by saying that he/she cannot know what the growth is until the lab results are back.358 This why contemporary theories of autonomy tend to challenge the minimalist notion and instead suggest that the agent’s or patient’s decision-making process must satisfy some extra positive conditions in order to secure autonomy. Therefore, Stoljar proposes that healthcare should adopt a richer conception of the requirement of patient autonomy and shift the focus from the actions of the healthcare provider to the situation of the patient; in particular to the social context that affects the patient’s preference formation and decision-making processes.359 Whereas Beauchamp and Childress would argue
that the principle of respect for autonomy provides only the foundation and may only apply if and only if either a prior autonomous judgement constitutes an authorization or such a judgement supports a reasonable basis of inference for a surrogate in case of incompetent patient. However, if there is no reliable trace of preferences left by the previously competent person, then surrogate decision makers should adhere only to the best interest’s standard.360

c. Health Literacy

The third paragraph will address on health literacy. Wachter defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. This includes the skills that a patient needs to communicate with the health care provider, read medical information, make decisions about treatment, carry out care regimens and decide when to and how to seek help. This can be mitigated through identifying patients with low literacy and provide them with simplified health materials. There has also a move towards training of providers to interact with such patients in appropriate ways to ensure that they truly comprehend their situations.361 Similarly, the American Medical Association defines literacy as a constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment.362 When the above definitions are taken together they seem to demonstrate that health literacy is an individual-level construct composed of a combination of attributes that can explain and predict one’s ability to access, understand and apply health information in a manner necessary to successfully function in daily life and within the health care system. The Joint Commission Resources confirms that health literacy goes beyond the
individual. Instead depends upon the skills, preferences, and expectations of health information and care providers. However, health literacy has many levels and is influenced by the composite of person’s life. Such kind of levels of health literacy can also be specific to different types of conditions. For instance patients with poor mental health literacy may not accurately identify common mental disorders and believe problems will be solved without help from outsiders.363

On the other hand, De Walt and Pignone approach health literacy from epidemiologic perspective terms whereby it is considered as the exposure variable which leads to the outcome of interest. Health literacy has been defined as the cognitive and social skills which determine the motivation and ability to individuals to gain access to, understand and use information in ways which promote and maintain good health. Using the patient’s ability to read as their main measure as most of the published studies have demonstrated would be simply like a surrogate measure.364

Furthermore, Osborne gives a working definition for health literacy that is general, focusing on outcomes rather than specific places or populations. According to that definition health literacy is a shared responsibility between patients or anyone on the receiving end of health communication and the providers or anyone on the giving end of health communication. This implies that both must communicate in ways the other can be able to understand.365 On the other hand, while many studies and publications have explored the relationships between literacy and health and have used the two terms somewhat interchangeably. Bernhardt and co-authors try to avoid this confusion and promote clarity that the term health literacy may be preferable for describing situations and settings in which individuals or groups receive health-related information and messages.366 However, health literacy, both conceptually and in practice, has often been siloed from interventions designed to overcome cultural and linguistic barriers. Health
literacy being an emerging field, examination of culture and language as determinants of patient health literacy has been limited. Fortunately, today strategies to address health literacy have often been distinct from, and at times inconsistent with, strategies to increase culturally and linguistically competent care.367

Culture is very important in discussing health literacy because it is the lens through which people view and attach meaning to health communication. Despite how challenging to define may be, culture shapes people’s beliefs, attitudes and values. For that matter culture also exerts considerable and significant influence on health literacy. This implies that in order to best serve patients, the health care industry as a whole must recognize both that culture plays a role in health literacy and how this is done. Therefore, is only by identifying and understanding the components of culture and the way they function in shaping each and every patient’s perspective that health care providers can truly care for their patient population.368 Osborne would argue in support of the above idea by emphasizing that culture impacts very much on how people understand and make sense of health information. In spite of the place one is born in this world, people bring their own experiences, values, customs and logic to each situation. Therefore, people from regions where health resources are scarce may not understand the importance of carrying up screening tests like mammograms, Pap smears, and blood pressure checks as routinely recommended. For instance some people may prefer that mammogram to be framed in terms of the family instead of talking about personal health benefits that this brings to an individual patient. This is why health care providers have to communicate in ways that all of their patients may be able to understand as part of good patient care.369

Furthermore, Porche and co-authors also supports this idea when recognizing that patient-physician communication is influenced by a variety of factors and that health literacy is
influenced by a patient’s entire belief system, based on family background, religion, ethnicity, social standing, values, and so on. When such factors are ignored may lead to trust being eroded. However, most physicians may also suffer from the misconception that only people from certain groups have limited literacy and other people that do not fit in one of those categories end up not seeking help. For instance skilled workers and highly educated professionals may feel that they should be able to understand medical jargon simply because they can understand the language of their own jobs. Similarly people in middle or upper income brackets do not want to risk the stigma attached to not being able to read and calculate well. This applies also to older people who worry about being viewed as incapable of handling their own affairs and living independently. Generally speaking, the inability of not recognizing poor health literacy of patients and health care professionals may lead to the difficulty of not addressing this problem fully.

Health literacy as a patient characteristic can affect the effectiveness of communication for all patients but is expected to play a larger role for patients who are culturally and linguistically different from the physician, for several reasons. Similarly, health literacy may be inversely associated with socioeconomic status and a higher proportion of the foreign born population which is poor and have lower educational attainment. Schillinger and Davis argue that health literacy may also prove to bring about barriers in office based clinician or physician-patient communication. The authors remark that patients with limited health literacy are reported to have greater difficulties accurately reporting their medication regimens and describing the reasons for which their medications were prescribed. Unfortunately, the health care providers may be unaware of the mismatch between the process of giving information and patient’s reaction towards that provided information. The health care providers may fail to detect
knowledge or comprehension deficits from their patients with limited health literacy as they may not disclose this poor understanding so as to be helped. This may lead to physicians misjudging the information needs of their patients and end up underusing interactive teaching strategies that could assist such patients with limited health literacy.372

However, because health literacy includes the word literacy it should not be assumed that it concerns only those who cannot read. Rather very many people may have difficulty in understanding health information for a range of reasons such as literacy, age, disability, language, culture and emotion. For instance a well-educated health professional and fluent reader may shut down for a while without understanding the communication from the provider due to the upsetting news.373 This is why Mayer and Villaire would argue that low health is not about what language one speaks or how well educated patients are. Instead health literacy is about access to care. This is about who has ability to use the health care system available to them in a way that is appropriate for their circumstances. Therefore, health literacy according to these authors is about the very nature of the relationship between patients and their providers. The implication here is that health literacy is around us in every clinic, community, country and state.374

Weiss would explore further that health literacy differs from general literacy although both are inextricably linked in such way that most individuals with limited general literacy also have in most cases proved to have limited health literacy. For instance many studies and reports indicate that individuals with limited general literacy are assumed to have difficulty reading, understanding, and using health care information. Bottom line, they are assumed to have limited health literacy.375 However, medical concepts and their expressions are influenced by culture, as discussed above. Meaning that the effect of low health literacy in reducing communication
effectiveness can therefore, be multiplied for patients from different cultural and language backgrounds. This is why in response to such situation Levine recommends training health care providers to identify very early and interact with a low health literacy patient in an appropriate way so that a patient can comprehend his/her situation. Keeping in mind that obtaining informed consent from uneducated populations faces the barriers of comprehension based on beliefs about health and illness that are inconsistent with the concepts of Western medicine. For instance, explaining the purpose of vaccination may prove hard to a person who believes that disease is caused by forces that western civilization is dismissing as supernatural and magical. Furthermore, the problem of illiteracy has mostly appeared during the documentation of informed consent. The situation that would require may be changing the process of informed consent whereby talking could replace reading.376

General observation made by Rasu and co-authors indicate that only one in 10 adults in the United States are health literate. According to results from the 2003 National Assessment of Adult Literacy are quoted showing that 12% of US adults were proficient in health literacy level, 53% and 22% reported having had intermediate and basic health literacy, and 14% had below basic health literacy. The authors indicate that health literacy is associated with healthcare utilization and expenditures. For instance individuals with below basic or basic compared to above basic health literacy individuals incurred more visits and spent more on visits and prescription medications. However, public health communications promoting health literacy driven appropriate strategies, such as adopting Health Literacy Universal Precautions Toolkit which may help to improve health outcomes and reduce unnecessary healthcare costs.377 On the other hand, the Institute of Medicine recounts that health literacy is intimately linked to many issues of critical importance to the nation and to our health policies. For instance health literacy
is concern to people addressing worker health and safety, product labeling, environmental health, patient rights and responsibilities, quality of care, or access to information, insurance and services. However, limited health literacy is often unreported by patients, unappreciated by policy makers and health care workers and unappreciated by the general public. The implication being that without improvements in health literacy, the promise of many scientific advances to improve health outcomes will be diminished.378

In the attempt to solving some of these problems, Peterson would propose learning how to communicate with and understanding individuals from all different cultural backgrounds by paying more attention to nonverbal behaviors such as facial expressions and gestures and being sensitive to differences in language use as part of all these efforts. By broadening the range and sense of communication, healthcare professionals will be able to understand better the kind of distress, discomfort or unhappiness that patients experience. Preferably, this humane response should not only be limited to physicians and nurses but should extend to other sectors such as secretaries, laboratory technicians and clerks.379 The reason behind this is that the ability to engage in conversations by speaking and listening as two-way communication ability is very essential for accessing, understanding and applying health information received from a physician or other interpersonal source. Therefore, differences between the two communicator’s spoken language, cultural heritage, perceived power, education level and other factors can make the positive exchange of health information in interpersonal interactions difficult or not possible.380 In United States of America most approaches have been employed towards improving health literacy which involves producing patient information materials that are at least written with simplified language and have an improved format or use pictograms or other graphic devices. Pictograms have been thought to be particularly beneficial for communicating information to
consumers who speak English as their second language and to people with lower reading ability levels. Furthermore, the Geriatrics Section at the University of San Francisco has developed an advance directive form that incorporates culturally appropriate text-enhancing graphics appropriate for individuals with limited literacy skills. This form is available in both Spanish and English and walks the patients through the process of filling it out.381 While there has been substantial improvement on health literacy approaches from 1980s and early 1990s. However, most of these activities seemed based on interest determination of a few people within organizations who are not even policy makers. The hope is that in the next decade there will be a significant increase of programs and approaches that are well developed and evaluated and with a national policy possibly.382 One person is often the way that health literacy initiatives may begin although takes a team to make a sustainable, long term difference. As teams experience success, may branch out into the community and from here they may unite as regional, statewide, multistate and even national coalition. For instance Health Literacy Missouri can illustrate this state wide organization that is a local one which has helped to form regional partnership and national coalition. This has now become its own nonprofit organization that reaches out across state boundaries.383

Generally, the purpose of informed consent is to provide the patient with all the information necessary to allow him or her to make a prudent choice for his/her treatment freely. In that regard, Junkerman and co-authors describe consent as the patient’s voluntary, autonomous authorization to proceed with the proposed intervention. Therefore, obtaining consent should always involve adequate disclosure of information, decisional capacity of the patient, patient’s comprehension of the information, voluntariness (freedom from coercion) and consent of the patient.384 Unfortunately, Flores observes that some 49.6 million Americans that
is 18.7 percent of U.S. residents speak a language other than English at home and 22.3 million (8.4 percent) have limited English proficiency, speaking English less than “very well,” according to self-ratings. This observation continues to indicate that between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million which is a 47 percent increase, and the number with limited English proficiency grew by 7.3 million (a 53 percent increase). The numbers are particularly high in some places: for instance in 2000, 40 percent of Californians and 75 percent of Miami residents spoke a language other than English at home, and 20 percent of Californians and 47 percent of Miami residents had limited English proficiency. Worse more, most patients who need medical interpreters have no access to them and one study indicates that no interpreter was used in 46 percent of emergency department cases involving patients with limited English proficiency. Exceptionally, many larger healthcare institutions have access to interpreter services, and the availability of professional translators has been associated with improvements in patient satisfaction, communication, and healthcare access. However, it is not only the availability of professional translators that helps ensure quality healthcare; it is also the individual healthcare provider’s cultural competence that is a cornerstone in reducing ethnic and racial disparities. Additionally to the logistical problem of providing adequate translation service, healthcare providers face individual ethical and epistemological predicaments in approaching patients with language barriers.

Routine health and health-care tasks are often complicated and may require more literacy skills than those needed to meet the demands of everyday life. However, the review of health literature indicates that research findings over three decades place a wide variety of assessed materials based primarily on reading level analyses, at levels that exceed the reading skills of most high school graduates. On the other hand, health literacy may also be more reliant on
domains of literacy such as oral ability and aural comprehension that are not measured by the tools currently used to measure health literacy. This is why the committee of National Adult Literacy Survey (NALS) considers health literacy to be a reciprocal function of the health context and the individual. Meaning that any person, no matter what literacy skills he/she possesses, may well have limited health literacy once he/she enters complex health care context. For instance a nurse with advanced degree and able to read on a college level may be total health illiterate. This person may not be able to understand everything needed to know about her/his condition when diagnosed with autoimmune disease in spite of the health care background. Hence indicating how difficult it may be to piece together all the health care system even when one has a knowledgeable support system and excellent reading ability.  

Additionally, language may become an increasingly important barrier to health care. This is due to the fact that effective communication is very fundamental to the practice of medicine; language differences may have an important impact on both patients and health care providers. For instance comparisons made between English and Spanish speakers suggest those patients not speaking English are less likely to have regular source of care such as eye care, dental care or physical examination and in most cases they have children with worse reported health status. Therefore language may represent a communication barrier to the extent that patients are not able to communicate with their health care providers even when seeking screening services and providers also will not be able to discuss or offer screening in an effective way. Similarly, language has been defined by Random House’s dictionary.com (n.d) as “a body of words and the systems for their use common to a people who are of the same community or nation, the same geographical area, or the same cultural tradition”. Therefore, language in its many forms is a primary purveyor of culture, yet it does so in ways that are not always easily
translated. 390 Hence definition of limited English proficiency as the restricted ability to read, speak, write or understand English by patients for who English is not the primary language. Although health literacy and its impact on health care are not related solely to language issues, health care providers must give particular attention to the challenges that language poses. The reason is that language has been argued in some cases that it can actually shape people’s cultural beliefs and values. However, for the health care industry, the problem of language differences extends beyond the exam room and permeates the entire health care experience. For instance a basic understanding of written language is necessary for a patient to find a way to the appropriate department in a health care facility.391 However, in the United States of America the limited information suggests that limited health literacy may be associated with increased consumer, health provider and the health care system costs. Such estimate was derived from predicted levels of functional literacy and estimates of health-care use. The differences in health care spending were estimated by comparing health care utilization by people with a lower probability of having functional literacy skills to health care utilization by people those with a higher probability of having functional literacy skills. These suggest that patients with limited literacy may interact with a complex health care system in ways that interfere with ideal utilization patterns and therefore could be more expensive.392

When certain beliefs are demonstrably false and such ignorance can prevent an informed choice, it may be permissible or possibly even obligatory to promote autonomy by attempting to impose unwelcome information. By and large physicians are encouraged to inquire in general terms about their patients’ wishes to receive information and to make decisions. This is due to the fact that respect for autonomy is not a mere ideal in health care but is a professional obligation. Therefore autonomous choice is not a duty but a right of the patient.393 Differently, in
India where physicians believe that informed consent cannot be obtained because of rampant illiteracy. Patients are taken as unable to make a reasoned choice because of their inability to appreciate the intricacies of alternative medical treatment, procedures or drug trials. In short, a physician knows best and providing information has proven troublesome and time-consuming to the extent that he/she expects the patient to agree with all medical suggestions. While in this part of the world the ethics of trust has been and continues to be in vogue. Today, the ethics of trust based on the goodness of the physician is slowly giving way to the ethics of rights based on an assertion of the individual’s right to decide for her or himself.394

However, even in an era of patient autonomy, a patient still wants to have caring and respectful relationship with his/her physician but at times there’s no communication of all issues directly during office visits. Instead patients may hint at such issues giving cues their physicians may respond to. Therefore, a physician should not forget that caring and recognition of the patient’s suffering can continue even when the opportunity for treatment or cure has passed.395 Some physicians might counter that the family can help the physician determine whether the patient is autonomous and capable of receiving information about serious risks. The same argument supports that families provide important care for many patients. However, an autonomous patient has the right to veto familiar involvement altogether. Therefore, it would be regarded unethical for the physician to first disclose information to a patient’s family without the patient’s authorization. Beauchamp and Childress regard this generalization to hold irrespective of the patient’s cultural background which often serves as an inappropriate excuse for going around the patient to another party.396 In regard to whether a physician should tell or not tell a patient his/her medical condition. Charaka and other physicians of the ancient days in India are quoted by Francis cautioning the physician to be very careful when telling the patient that her/his
illness may be incurable. Instead their advice would be not to tell a patient bluntly for such news may easily shock her/him. Preferably, such information can be made known to the patient’s relatives and even to the state officials in order to protect the physician from prosecution in case should the patient die under her/his care. However, at present physicians may differ in their opinions concerning how much information to disclose and even when to tell the truth to their patients who are about to die. Such conflicting considerations include the patient’s right to know, the benefit to the patient and possible harm.397

The importance of linguistic concordance to patient-provider communication has been emphasized as a means to create an accurate medical and social history and assessment of the patient’s cultural health beliefs. On the other hand, adverse consequences associated with ineffective communication can affect all patients and can lead to misunderstandings of a patient’s concerns, misdiagnosis, unnecessary testing, poor patient compliance, inappropriate follow up, and poor patient satisfaction. In many instances, a family member has served as an interpreter, which raises privacy and other concerns especially when this involves children. Some untrained interpreters also are more likely to commit errors in interpretation that can lead to adverse clinical consequences.398 Mosadeghrad would argue that quality of patient care depends directly on the quality of patient’s education and responsibility. Similarly, patients’ knowledge of their rights may influence their expectations of quality services as well. For instance if people know about their rights especially in hospitals, they would expect more from their care-givers and consequently the quality of medical services would increases. However, most of educated patients tend to have more realistic expectations of the healthcare providers. Therefore, a physician might unconsciously explain more to an educated patient assuming that she/he would understand better. Furthermore, the patient’s attitude and behavior may also affect the attitudes
of care-givers. If a patient behaves himself or herself, care-givers unintentionally provide better services. This would be different from the patient that is grumpy which may lead to the physician having no motivation for further examination.399

d. The Effects of Medical Tourism on Truth Telling

Medical tourism, an industry which facilitates the wishes of patients who desire affordable and reliable treatment alternatives compared to those found in their countries of origin. For instance patients travel to Thailand for fat surgery and parents from rich countries have children delivered by commercial surrogate mothers in India on their behalf. The problem communication may rise due to language and culture fluency among many other factors.

The fourth paragraph will analyze the effects of medical tourism on truth telling. Over recent decades there has been a rise of international travel for the purposes of medical treatment that is commonly known as medical tourism.400 In particular we are witnessing unprecedented numbers of patients travelling from richer, more developed nations to less developed countries to access health services. These shifts are largely driven by the relative low-cost of treatment in less developed nations, the availability of cheap flights and increased online marketing and consumer information about the availability of medical services. An overarching concern is how the growth of medical tourism contributes towards individual health being further commercialized and commodified. Under pressures of commercialization and commodification, relationships become shaped by the less elevated values of commercial gain rather than professional ethical codes.401 However, the concept of medical tourism started thousands of years ago. People have been traveling across the continents in search of cures for any imaginable illnesses and making
therapeutic trips for health wellness. For instance, in ancient Greece, pilgrims and patients came from all over the Mediterranean to the sanctuary of the healing god, Asklepios at Epidaurus, and from the 18th century wealthy Europeans have been traveling to spas from Germany to the Nile. On the other hand, in recent years medical tourism is becoming more popular with patients seeking treatment for health and well-being purposes abroad. But even though the term and concept of modern medical tourism may have been around for the last decade yet it seems to be still in its infancy stage and there are many challenges and obstacles ahead as with any burgeoning industry. 402

In Europe medical tourism has been also under discussion whereby different presentations from different viewpoints introduced a new definition. Medical tourism has been defined by Klinkmann as the branch of health and tourism economies that contributes to maintaining and restoring health and holistic well-being by using medicine-based services. Therefore, medical tourism has been cited to offer huge economic potential. When designing products it is vital to consider that different target groups are attracted by different motives, characteristics and wishes. Hence the proposition would be that the future development must abandon the concept of the lone fighter and replace it by net working in order to make embracing high-quality, customer-oriented, cross-sectional proposals.403 Broadly speaking, medical tourism is the act of traveling to obtain specialized or economical medical care, well-being and recuperation. Many patients are traveling great distances to obtain medical care. Purdy and Fam recognize that many patients find using medical tourism facilitators to be more convenient and expedient than seeking medical services abroad on their own. The reason is that facilitators have experience in the medical tourism process and can be able to address any concerns or questions that patients might have. The facilitators often provide assistance with logistics and travel
arrangements. Additionally, patients may even be able to get lower rates from medical facilitators than directly from clinical programs abroad, with some operators identifying an 80% savings through bulk purchases of procedures abroad for their client. Exploring further, Semple also commends facilitators for playing a very important role in the safe delivery of overseas health care and can function as bridge between the patient and health care provider. For instance, while among many foreign physicians speak English as being the language of the most medical text books. This may not apply to their receptionists. Similarly, medical tourism facilitators can help to contact for timely answers and move the process a long efficiently in a time zone problem. In case of flight delay, a patient can take care for the necessary scheduling changes through the medical tourism facilitator.

Today, medical tourism is different from the traditional form of international medical care where patients typically journey from less developed nations to major medical centers in highly developed countries for advanced medical treatment. For instance in 2003, approximately 350,000 patients from industrialized nations traveled to a variety of less developed countries for health care. The projection was that 750,000 Americans would have gone offshore for medical care in 2007, with this number was expected to increase to six million in 2010. Formerly, medical tourism was depicted as care associated with an exotic vacation or with an attendant spa recovery post-surgery. Yet the medical tourism industry is fueled and driven by patients who feel disenfranchised by the healthcare system in their home country. These informed patients shop outside the organized medical system to find services that are affordable, timely, or simply available. Hudson would argue that while tourism was initially perceived as travel strictly for medical intervention, but in recent years the term has been used to encompass both medical and health plus wellness tourism partly because of the line between medical treatments and health
improvements has become blurred. However, most the wellness centers are springing up all over the world, many differentiating themselves with unique offerings. Yet all these health vacations have in common a primary focus on helping people adopt a long healthy lifestyle, and for many visitors, the experience can completely change their lives.409

Medical tourism has been extended to the area of assisted reproductive technologies. There is a movement of citizens to another state or jurisdiction to obtain specific types of medical assistance in reproduction that they cannot receive at home. This has been referred to as reproductive tourism that may arise where treatment is prohibited in one country but is ethically acceptable in another. In some instances this reproductive tourism does not require the tourist to go to the less regulated jurisdiction but may involve a third party coming into a country to assist in the fertility treatment. Some arguments in support of reproductive tourism suggest that such business cannot and should not be regulated so that gametes can be accessible to people via internet especially in the restricted country.410 Similarly, the principle of respect for human vulnerability and personal integrity demands protection at the level of experimentation that goes beyond that which can be expressed in informed consent and which refers to the prohibition of the objectification of the body or part of the body. The same principle demands respect for personal identity in relationship between the subject of experimentation and the researcher. Neves hopes that in the field of health policies, the principle can play an important role in the prohibition of commercializing human body parts, in the regulating genetic manipulation, particularly in safeguarding the human genome and inconsideration of patentable human matter.411 Ten would argue further that as an ethical principle, respecting vulnerability should open up a range of opportunities that encourage solidarity, responsibility, assistance, mutual support and care. 412 Additionally, all biomedical practices are closely related to basic
prerogatives of every human being, namely the right to life and to both physical and mental integrity. This why notion of human dignity is beginning to be considered as the last barrier against the alteration of some basic characteristics of the human species that might result from practices such as reproductive cloning or germline interventions. While the human rights may not apply to existing individuals or groups of individuals, not to humanity as such but the above mentioned practices go beyond individuals, risking harming humankind as a whole, including the future generations.413

In medical tourism a problem may rise in communication based on language and culture fluency. This point is emphasized by CDC while talking about risks associated with medical tourism. According to this analysis the risks of medical tourism depend on the area being visited and the procedures performed but there are some general issues that have been identified. Among the issues identified is that communication may be a problem especially when receiving care at a facility where a patient does not speak language fluently. This may increase chances of misunderstandings about care to arise.414 Most people’s communication is influenced by their different cultures especially when it comes to using body language or nonverbal cues. For instance nodding the head up and down generally signals agreement or yes in most parts of the world and shaking the head from side to side indicates disagreement. This may hold a different meaning in other places such as India where a head wiggle can serve many purposes, from acknowledging a friend to giving thanks. Therefore, nonverbal communication is affected by culture both when transmitted and when received. So a nod or shaking of the head is culture specific.415 This is why Osborne would recommend that health care professionals to pay attention to tone of voice, pacing and sighs. The reason behind is that nonverbal utterances like these can be as expressive as words. For instance talking quickly and loudly may convey one’s
impatience while a more relaxed and quiet tone can indicate caring and concern. Additionally, making eye contact and smile from the health care provider may likely let patients get sense of caring and compassion. On the other hand Medical Tourism Magazine comments that the role of communication in medical tourism continues to raise a lot of worries as developing nations like Thailand begin to attract medical tourism patients suffering from Alzheimer’s. For instance Germany sends several thousands of Alzheimer’s patients as well as the aged otherwise ill to Eastern Europe, Spain, Greece and Ukraine. However, this has received a lot of criticism that while some with Alzheimer’s may adjust to an alien place but most find it difficult because they live in a world of earlier memories. More so people with dementia especially should stay in their familiar environment as long as possible. The reason is that they are better oriented in their own living places and communities. Friends, family members, neighbors can visit them. Other reasons would be due language and culture. So would be best for most to stay in their home country.

The worry would be extended to health care providers and their interpreters when dealing with patients from different cultures whether they become sensitive to nonverbal communication so as to communicate accurately. However, a study conducted by DiMatteo and co-authors suggests that health care providers who can accurately interpret their patients’ nonverbal messages and who can themselves express emotions nonverbally have patients who are more satisfied. The implication here is that health care providers who understand their own nonverbal behavior may be able to use that to improve communication with their patients, thereby improving patients’ outcomes. Timmons reminds that in seeking medical procedure in another country, communication plays a key role towards having consistent, medically-appropriate follow-up care. Unfortunately, if a health care which a patient should be part of is not
communicating adequately, the patient will be at increased risk for complications and inadequate follow up care. Timmons recognizes that physician to physician communication might sound simple but has challenges based on different native languages which may influence the language of health care. For instance abbreviations and codes and medicines may have different names in different countries. Therefore, this may complicate a needed follow up care for the patient who sought treatment outside his/her country if no written record of the procedure.419

The research performed on a dozen facilities in South Korea indicates that they provide lower cost high quality health care for international patients. However, there is language barrier inherent in that country. This commences from initial visit to the hospitals websites, very few of which have an option for English translation. On the other hand, most of the physicians and staff do not have a great knowledge of the English language. This implies that as South Korea plugs a head at a very rapid rate to play catch up in the medical tourism industry some changes may be possible.420 This would be a different case in Dubai that has developed a health care city and become the first international integrated free health care zone developed to promote medical tourism. Dubai is the home of two hospitals that are international accredited, over 100 medical centers offering expertise in more than 80 specialties, over 2,500 licensed professionals speaking over 40 languages which include English.421

According to research conducted in Delhi hospital India a manager made the responsibilities clear: doctors are bearers of medical expertise, while interpreters translate their words. Yet interpreters lack practical experience which might impede communication, particularly when patients speak a dialect. Furthermore, interpreters usually belong to either the source or (more commonly) the destination culture, and often have limited experience of the other, conveying the accurate meaning is challenging. Therefore, there is a need to acknowledge
the full complexity of trans-cultural doctor-patient communication needs. Interpreters with a high level of language proficiency, in-depth knowledge of the source culture and a medical background should be a major part of achieving this goal. In response to such problem, Phelan and Parkman recommend that the best option for most patients would be a fluently bilingual health care worker; this is a clinician who is fluent in both English and the patient’s language. A certain interpreter who is trained in cross-cultural communication and is an experienced clinician would be ideal but unfortunately such individuals with broad-based training are very rare to find. The reason being, that patients need to be acknowledgeable about health problems affecting their lives and interpreters help in bridging the language gap by converting the spoken word from one language into another one. Therefore, professional medical interpreters are the best source of help as they are not only trained in medical vocabulary but are also instructed in how to maintain neutrality, adhere to confidentiality and not impose personal views. In some instances where language help may be sought from bilingual volunteers, perhaps staff members or people in the patient’s family. This may lead to problems of misinterpreting terms or even interjecting their own opinions and also violating privacy and confidentiality.

Generally, care can be compromised or delayed in the absence of any language services (trained or untrained). In other instances, the consequences can be catastrophic. For example, a healthcare team misunderstood an eighteen-year-old man who said that he was *intoxicado*. The team misunderstood the term to mean “intoxicated” rather than “nauseated.” As a result, the patient was treated for a drug overdose for thirty-six hours before the doctors realized that he had a brain aneurysm. That raises concern for physicians and all involved in medical tourism must have received training on how to interact with an interpreter. Rather than speaking directly to the interpreter and ignoring the patient, they should speak directly to the patient, while the interpreter
facilitates communication. In such much-improved encounter, the patient’s level of satisfaction would be likely improved. Yet participatory decision making has been considered to be ethically grounded in the principle of respect for autonomy that is defined as self-rule which is free from controlling influences and limitations such as inadequate understanding that may prevent meaningful choice. Therefore, participatory decision making can be defined as a process that considers the input of both patients and physicians to be equally important and involves each of the three elements of information exchange, deliberation, and decision making. However, in situations where bilingual staff members may serve as effective interpreters, they should have been specifically trained to fill such role. However, the following eight rules may suffice to be observed by bilingual staff members with no formal training when interpreting for patients. First is the use of universal form of language whenever possible. Second is to refrain from assuming the role of interviewer or decision maker. Third is to let the patient lead the discussion. Fourth is being aware of culturally significant issues that affect patient care and translate in a way that conveys the cultural framework. Next would be meeting the patient prior to the medical encounter. Seventh is to develop interpreter-physician work plans for each patient. Lastly is to seek continuing education. Similarly, Indian hospitals that attract international patients for low cost treatments need to access well trained medical specialists qualified to fit in international arena. There is still lack for training in international marketing for staff well-versed in health care industry operations. This means that the sector needs skilled man power to explore markets for Indian hospitals. Furthermore, patient culture is also misunderstood and considered a challenge to medical tourism in India as well.

While an interpreter as collaborator is mostly considered to be effective type of interaction, Beltran would warn against cultural brokering, or the shared exchange of cultural
information on the part of the interpreter that would be dangerous from two levels. The first level is that this may offer cultural information only as the interpreter views it and not as the patient views it. The second level is that this may be seen as a quick fix that covers up the shortcomings of the institution. Bottom line is that if the interpreter is skilled as a culture broker, the provider need not do any better in terms of achieving cultural competence. The implication here is that in the absence of the interpreter in future would mean that the provider will have to begin again from scratch.429 For the purposes of consent and ensuring that information given or received from the patient is not being censored or altered by the interpreter. Trained and impartial interpreters are needed for South Asian patients not fluent in English. For instance South Asian women patients prefer trained female interpreters who are familiar with the traditions and culture of origin and would also exhibit a strong preference for a same sex physician especially when it comes to uro-genital examination. In addition to interpretation issues the style of communication to be used would entail planning for a longer interview and adopting an indirect conversation approach so that the physician or health care worker may learn more from the patient. The physician also needs to be alert to non-translatable Hindu or Punjabi words commonly used to express psychosomatic symptoms.430

Frequently, words or their underlying concepts have little or no meaning, or a different meaning, for a person from another culture. This is true both of specific terminology as well as the essential meaning of health and illness to different people. For instance the Hmong language is said to have no word for cancer or even the concept of the disease. Therefore, in trying to explain radiation treatment to the patient one inexperienced interpreter mentioned to the patient that “we are going to put a fire in you,” and this misinterpreted statement scared off the patient who ended up refusing treatment.431 Exploring further, Goodwin recognizes that different
religions and cultures may have a major role in affecting health care. Therefore, there is a great need for being prepared for one’s patients’ religious and cultural beliefs so as to gain their trust and fully understand their medical history. For instance Muslims observe certain diet non-pork or strictly vegetarian meals. This implies that the hospital receiving such type of patients’ needs to be prepared and take into account how this will affect the patients’ medical history as well. Bottom line, paying attention to both social/cultural and gender requirements will help health care providers to communicate effectively with patients hence developing a trusting and long lasting relationship.432

On the other hand because prospective travelers source information from intermediaries, direct from websites and internet marketing, and amongst networks, this complicates practical attempts to regulate and enhance the quality of information provided to prospective medical tourists. Website and marketing materials contain a plethora of details. However, the ways in which External Quality Assessment and registration details are currently presented require significant health literacy among website users.433 Edelheit expresses disappointment from hospitals and governments involved in medical tourism saying handsome brochures that point captivating websites are no longer enough to sustain patient flows. Instead these organs must accept the responsibility for bringing employers or insurance executives on board. The reason is that they are at times unaware of the processes involved including the communication vehicles that transmit program information to potential medical travel consumers.434 However, medical tourism seems to be still struggling to perfect some areas far as communication is concerned. For instance Cook reports on the situation whereby a patient was in desperation scanning around the room searching for a friendly face or someone that would be of some help. Surprisingly, the patient was greeted by a hospital admission areas filled with patients, family members and
hospital staff all speaking exotic-sounding languages. Additionally, the surgeon though nice and attentive yet his English language skills were moderate at best and that made communication process painfully slow. This is why patient experience may be very important in discouraging or encouraging medical tourism.435

Furthermore, Salimbene also recognizes that the internet is the main source for marketing to potential patients, hospitals and insurance agencies in medical tourism. Unfortunately, these services are offered in foreign language targeting people and organizations belonging to cultures different from their own. This raises the need for having a trained speaker of the language of the targeted patient population to assist in writing on their website. According to Salimbene both the ability of medical and non-medical staff to communicate effectively in the patient’s language is valued as second only to proof of medical expertise for someone in search of treatment abroad. Additionally, there is difficulty in trusting a physician who a patient cannot understand more so who cannot understand him/her. This means that clear physician-patient communication also lowers the risk of medical errors.436 The patient has always to be considered as a partner of the health care professionals. The implication being that there would be no need for any physicians or health care professionals if the patient wasn’t there. Therefore, in order for the patient to be the central point of health care professionals’ actions, there must be improvement in communication with him/her, meet him/her at eye level and give him/her the evidence based information, he understands and needs. This would save the patient from getting lost in the system to certain degree.437

Kovaks and Gabor observe that in Hungary medical tourism has been associated with the shifting attitudes of patients to healthcare whereby individual healthcare behaviors and health consumption are altering due to increased health literacy, easy access to health information and
the priority of health as a value among certain populations. Moreover technological development has also supported an increased focus on patient-centered care and a shifting physician-patient relationship, away from hierarchal interaction and toward a more informed, empowered and proactive patient. Thereby a patient is rather a client, a customer who is responsible for his/her health and so can enroll for services besides health prevention and alternative medicine. Therefore, international patients, medical tourists are very likely to belong to those groups, where medical service use, health practices and intention for improved health is more common.\textsuperscript{438} Commenting on medical tourism especially taking health care as a public service, Penning’s comments that patients lack necessary knowledge to make informed decision about the care they need. In evaluating the conditions for acceptable cross-border health care, the poorly educated people who are not used to travelling and who only speak their mother tongue; will find travelling for medical reasons very burdensome. Furthermore, the quality of health care not only concerns the success rate of the intervention but also counseling, psychological support and follow-up. This has become an important issue especially during serious health problems and these aspects depend on fluent communication with the staff which may be hampered by language problems and cultural differences. However, medical tourism could be argued for at least offering the possibility of making a change for the good in the health care of the hosting country but the absolute minimum is that everything should be done to prevent the situation from aggravating for the local population.\textsuperscript{439}
Conclusion

The chapter has focused on ethical issues and problems that are connected with truth telling. This is in conjunction with the chief ethical principle underlying the idea that patients must be offered the truth. Again it is consistent with the leading principle in bioethics which emphasizes on patient's autonomy. Unfortunately, autonomy may not be a primordial principle in other cultures. Hence, becomes an important issue to be addressed in doing global bioethics.

The chapter has tried to address the problem of cultural diversity and observed the fact that the culture in which one is born and raised has some long lasting effect on that person. Pellegrino would add that to violate a person’s cultural beliefs and practices tantamount to assaulting one’s humanity but there should always be recognition for interdependence between the involved parties. Locke’s observation, however, explores further that culture is the capacity for understanding the best and most representative forms of human expression and of expressing oneself, if not in similar creativeness, at least in appreciative reactions and in progressively responsive refinement of tastes and interest. Unfortunately, in some cultures, things may be different whereby individual autonomy may not be recognized and a patient prefers making decisions together with the family. For instance, among the Ethiopian people where the family’s importance dominates over individual members, any information, including diagnostic facts, belongs to the family. The family will then use such information at its discretion to benefit the patient. Such cases may become a nightmare of Western physicians and ethicists who hate being accused of cultural arrogance. However, Veatch would advise that the moral right to truthful disclosure should not be waived by a majority vote even if it can be shown that the patient comes from a culture that generally follow a pattern of nondisclosure.
In analyzing about the meaning of autonomy, the chapter recognizes that the principle of autonomy is grounded in respect for persons and the acknowledgement is that as rational beings we have unique capability to make these personal choices. However, autonomy does not imply that an individual’s life plan is his or her own creation and that it excludes interest in others. For instance, based on the public interest physicians are encouraged to persuade their HIV infected patients to adopt safer sex practices in order to assume the responsibility for the good of other people. The implication is that today’s conscientious physician is very much in need of an expanded ethic to cope with his/her double responsibility both to the individual and to the community. However the ethical dilemma may be of balancing long-term societal benefits against short-term benefits to an individual. Exceptionally, the UNESCO stipulates limits to which autonomy is subject and should be highly restricted and enshrined by law. Similarly, the therapeutic privilege supports physicians in North America to withdraw information from the patient if such would lead to causing harm like social damage or suicide. But such privilege must be however, used rarely and with utmost care since it can be easily abused. Therefore, the right of exercising autonomy can significantly be abrogated in rare circumstances each of which involves the protection of the autonomy of other people. On the other hand, Stoljar would propose that healthcare should adopt a richer conception of the requirement of patient autonomy and shift the focus from the actions of the healthcare provider to the situation of the patient; in particular to the social context that affects the patient’s preference formation and decision-making processes.

The issue of health literacy has also been addressed where by it refers to the degree which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. While health literacy has many levels
and is influenced by the composite of person’s life and such kinds of levels of health literacy can also be specific to different types of conditions. Osborne provides a working definition for health literacy that is quiet general, focusing on outcomes rather than specific places or populations. According to the above definition health literacy becomes a shared responsibility between patients or anyone on the receiving end of health communication and the providers or anyone on the giving end of health communication. This is why the importance of linguistic concordance to patient-provider communication has been emphasized as a means to create an accurate medical and social history and assessment of the patient’s cultural health beliefs.

On the other hand, adverse consequences associated with ineffective communication can affect all patients and can lead to misunderstandings of a patient’s concerns, misdiagnosis, unnecessary testing, poor patient compliance, inappropriate follow up, and poor patient satisfaction. The implication being that language may become an increasingly important barrier to health care. This is due to the fact that effective communication is very fundamental to the practice of medicine; language differences may have an important impact on both patients and health care providers. For instance comparisons made between English and Spanish speakers suggest those patients not speaking English are less likely to have regular source of care such as eye care, dental care or physical examination and in most cases they have children with worse reported health status. Similarly, culture has been mentioned as playing a very important role in discussing health literacy because this is the lens through which people view and attach meaning to health communication. Therefore, culture also exerts considerable and significant influence on health literacy. This implies that in order to best serve patients, the health care industry as whole must recognize both that culture plays a role in health literacy and how this is done.
Analyzing the effects of medical tourism on truth telling the chapter observes that during the past recent decades there has been a rise in the number of patients traveling internationally for the purposes of medical treatment that is commonly known as medical tourism. In particular our world is witnessing unprecedented numbers of patients travelling from richer, more developed nations to less developed countries to access health services. However, the concept of medical tourism traces its originality from thousands of years ago when people would travel across the continents in search of cures for any imaginable illnesses and making therapeutic trips for health wellness. Some traces indicate that patients came from the Mediterranean areas to the sanctuary of the healing god, Asklepios at Epidaurus, and some wealthy Europeans have been traveling to spas from Germany to the Nile. Differently, in recent years the term is used to encompass medical and health plus wellness tourism as if no line between medical treatments and health improvements. However, medical tourism may face a problem in communication which is identified by CDC as one of the issues that may occur especially when receiving care at a facility where a patient does not speak language fluently. Hence need for employing interpreters to counteract such situation.

However, a research conducted in India indicates that even interpreters may lack practical experience which might impede communication, particularly when patients speak a dialect. Worse still if interpreters happen to belong to either the source or (more commonly) the destination culture, and have limited experience of the other, conveying the accurate meaning may be challenging. Therefore, there is a need to acknowledge the full complexity of trans-cultural doctor-patient communication needs. This is why Salimbene observes that both the ability of medical and non-medical staff to communicate effectively in the patient’s language is valued as second only to proof of medical expertise for someone in search of treatment abroad.
The chapter has tried to focus on the ethical issues and problems connected with truth telling but it concludes by recommending for further research on this topic as way of contributing towards addressing truth telling in global bioethics.

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Chapter Four

Approaching Truth Telling from a Pluralistic Health Care Environment

Today’s health care involves different expertise from different backgrounds to the extent that physicians are no longer the sole or necessarily the most important health care professionals with respect to patients’ treatment or care, nor is their power as great as it used to be. Therefore, health care decisions are no longer private transactions between patients and physicians but quasi-public transactions involving patients, a team of health care professionals, and a bevy of administrators and insurers. The chapter will then elaborate the thesis using the following paragraphs: The relationship between different services rendered a patient in a health care organization, Analyzing on confidentiality, and the role of organizations in protecting patient’s information by introducing the culture of transparence.

a. The Relationship between Different Services Rendered a Patient in a Health Care Organization

The first paragraph will analyze the relationship between different services rendered a patient in a health care organization. Many services provided to a patient within a particular health care organization overlap with the responsibilities of each other. For example, palliative care consultants may have basic ethics knowledge and skills relating to end-of-life decision making but may lack knowledge and skills to address a more complex ethical issue. Therefore, it would be advantageous that ethics and palliative care consultants work together in order to meet the needs of a patient. The American Society for Bioethics and Humanities recognizes the presence of many individuals, departments, committees and services that share service
responsibilities for maintaining sound ethical climate in a health care organization. Those include patient services, risk management, compliance, human resources, chaplaincy and quality assurance among the many. 440 Gallagher refers to health care as a common good of society, an essential element of the general common good and admits that it neither is, nor could it be produced by a single person. Instead health care is the result of the coordinated efforts of a large number of persons even of many not directly involved in health care. Since health care is distributed to all members of the society then the rendering of it is not just a matter of commutative justice, a simple exchange of goods and services between the provider and the patient. Rather, it has to be governed by the principles proper to distributive justice so that it is accessed by all members of society.441 However, Hall expresses fears connected with the number of health care professionals attending to the patient. In the situation he calls ‘no captain of the ship’, Hall observes that a number of clinical ethics problems require organizational solutions. There are some issues that take place in hospitals that require one member of the medical team to be ultimately in charge. For instance, a single member of the medical team needs to take a responsibility for making the decision to stop treatment. Otherwise such cases may drag on without a solution until the patient dies. In the meantime, such lack of coordination and failure to assume responsibility can devastate not only the patients but also their families. Therefore, sooner or later, the administration may not have a responsibility to make clinical decisions, but has a responsibility to see that such decisions are made for that matter.442

Winkler and Gruen argue that health care has been specialized a social good. Therefore, health care organizations are expected to play different roles as care givers, employers, citizens and managers respectively. Additionally, organizations have become stakeholders in the delivery of health care in many countries instead of being of solo and small-group physician practices.
Today physicians are but one group of professionals, part of the team, which serve the goals of the health care organization. However, the emergence of health care organizations has resulted to the need for ethics that deals with more than just the physician-patient relationship. Therefore health care organization ethics requires a perspective that is broader than the clinical and narrower than the society. Peters and co-authors seem to support the above idea when they address science also as being social and global. The authors notice that a researcher can no longer flee to the privacy of a laboratory. Instead his or her work is tested not only in other laboratories but also in the public square. For that matter the public demands that standards be observed. This is why there is need for formulating appropriate moral standards that enhance the advance of salutary research while protecting human dignity and human welfare as an ongoing task of the ethicist.

Further still, Willian Osler, one of the founders of the John Hopkins Hospital, taught that it is the role of the health care professional, not of the hospital to provide care to patients. Osler further held that this care is grounded in Christianity. Therefore, it is the health care professionals who are to be the agents of the trust, of that trust which is at the core of the patient-physician relationship. Winkler and Gruen also refer to health care as special, and held in a dual sense, health care is a basic social good. However, unlike other social goods, any person in need of health care must rely entirely on the expertise of others to make their quality and quantity of life better. Additionally, Continuity of care is highly desirable. For instance patients and family members appreciate seeing the same faces from one day to the next and developing relationships with those who hold their lives in their hands or perhaps the lives of the loved ones. Such would therefore require more than a passing acquaintance but deep understanding the concerns and risks perceived by individual patients. Keeping in mind that
patients represent an enormous resource for monitoring their own treatment and progress and ensuring that the right things happen. This entails providing information and also change the attitude of a patient from passivity and submissiveness to being more engaged in his/her treatment. That information will assist patients and their families in monitoring their own care ranging from mundane to more complex one such as the details of their planned surgery and anesthesia.447

Emanuel recognizes that there have been recurring attempts made to change the model of health care from an individual patient-focused model to a social or community-focused one. For instance in 1960s an effort was made to improve health outcomes by shifting the focus of medical care from high technology, research oriented tertiary care facilities focusing on the intervention for the very sickest patients to primary and preventive care in the community. At the turn of 21st century the focus on community-based care has re surfaced with the name of population-based medicine.448 The United States of America health care and public health delivery has been found to be a complex task involving numerous layers of bureaucracy, procedures and processes. Worse more, the patients, clients and their family members are typically unfamiliar these systems and associated jargon. Some of the complexity arises from the nature of health care and public health itself. Unlike in the past when health management is the domain of the physician, today the greater responsibility for health management was shifted to the patient for self-management approach. In this health care system there are complex relationships of organizations and programs patients are expected to navigate through. This is complicated further by the mix of private and public financing mechanisms and interrelationships. Therefore, individuals and families must interact with employers,
supplemental private insurance companies, federal and state government programs and providers who are paid directly.\textsuperscript{449}

The average life expectancy has risen significantly in the industrial world. However, such rise comes with a price of the fastest growing age group experiencing a compression of dependency. The societies will have to deal with a higher incidence of chronic illnesses whose patients need help from professional carers or informal caregivers like family, partner, neighbors or friends. This group of people who have become dependent upon the care of others can only realize their autonomy in a relationship that helps them to find their identity and cope with their condition.\textsuperscript{450} This fact of dependency is very real in the modern world where persons and groups are interdependent on one another in innumerable ways. Held argues that the human relations are part of what constitute their identity. However, this should not mean that people cannot become autonomous since the society is composed of free, equal, and independent individuals that can choose to associate with one another or not. Therefore ethics of care has to value the ties we have with particular other persons and actual relationships that partly constitute our identity in the sense that the interests of care takers and cared for are viewed as intertwined rather than as simply competing.\textsuperscript{451} Ten Have comments on how the ethics of care has developed through stages within circles of care expanding from private to the public, even to the global domain. While initially care was concerned with the private sphere whereby specific relationships would be between particulars and received in concrete arrangements. This may not be the case with today where theories of care are becoming more encompassing and are being applied to broader settings. The implication is that care as notion accomplishes a wider perspective because it involves personal practices that are within the context of social structures and social relations. The challenge here would be based on developing the account of care that embraces personal and
social relationships in a broad context. The argument of Ten Have helps the field of bioethics in realizing how much globalized the ethics of care has become in our time.452

Friedman also recognizes that persons are fundamentally social beings who develop the competency of autonomy. Therefore, people’s reflective capacities and their identities are always partly constituted by communal traditions. This means that people are reared in a social context of some sort, typically although not always that of a family, itself located in wider social networks such as community and nation. This is at least some of which partly define people’s identities and ground their highest values.453 Commenting on human interaction and cooperation, Ten Have elaborates the view that individual beings are human because they are social beings. The author seems to agree with the idea that human existence is not primarily characterized by competition and conflict but by interconnectedness.454 This idea is shared by other philosophers such as Levinas and Butler who also argue that our being in the world is always a being-together. Bottom line, the ethical relationship of responsibility between human beings is prior to self-interest and individual choice. Therefore the fundamental connection between oneself and others comes first. Similarly, Ertin and co-editors recognize the fact that in our world today we are living in an age when sociocultural as well as biomedical changes are rapidly accelerating, a thorough investigation of the ensuing tensions appears all the more essential. While the basic issues regarding health and illness may be the same all around the world, but different cultures have responded differently throughout history, and the solutions to universal problems are not always universal. Every society needs to make its own decisions, while transnational interconnectedness requires mutual attention and respect. However, research banned in one region can easily be outsourced to some countries with less strict regulations, but interestingly the outcomes may well affect the entire biosphere of the globe. Additionally, treatment
disallowed in one country can be purchased in another one where a ban either does not exist or is not being enforced. Sass explores further on the human interconnectedness by observing that individual bios cannot live without other species in biotopes and environments. For instance someone’s physical, emotional, spiritual, economic, and cultural and political life is interconnected with his/her nutrition, one’s friends and neighbors, workspace, the culture and individual grows up in and in which he/she thrives and develops or loses himself or herself with interacting influence from other lives in his or her biological and social environment, with her or his geographical space and cyberspace too. Biological and social sciences are both sciences of the bios-in-interaction and of the bios-in-interdependence. Therefore, Sass suggests that codes of ethics need to correlate between partners in cooperation. We also need to include non-geographic environments into the concept of integrated bios. For millennia, humans interacted with angels, devils, good and bad spirits; today we have added real personal, business and professional interactions and communities in digitally-based cyberspace clouds. For instance someone can communicate and cooperate with colleagues, business partners, and friends in cyberspace, and can have friends in the internet clouds that are closer and more intimate to him or her than some of the neighbors in one’s condominium complex or in the geographical neighborhood. However, interconnectedness may lead to biological risk. One example may be cited where by half a dozen people attending a family reunion in Hong Kong unfortunately become infected with a new strain of an HIV virus; they leave the festivities and fly to various destinations in Europe, Asia and America where they unknowingly infect more people, who then themselves infect others, causing a global pandemic. This scenario can be used as well by half a dozen suicidal criminals who infect themselves with a naturally occurring or specifically manufactured microbe and fly to one or more countries in order to infect strategically, during the
incubation period and before their own death, as many people as possible by visiting sports events, riding the subway, or going to movie theaters.\textsuperscript{458}

According to the highly specialized character of modern medicine health seekers must entrust themselves not to a single physician within the hospital but to a health team. The medical staff of such team may include physicians, dentists, podiatrists, psychologists and paramedics or medical assistants. However a health care facility also makes use of the services of outside professionals like architects, accountants, attorneys, special consultants and sales representatives. All these persons render services to the patient directly or indirectly.\textsuperscript{459} Differently, in the early 1900’s medical care was delivered by the solo physician out of his /her head, hands and little black bag. Therefore, only family members would have much interest in the transactions between the physician and his /her patient. As medical knowledge and technology advanced, health care has come to involve many stakeholders both in its delivery and production.\textsuperscript{460} Originally nurses were concerned with caring for the patient and in continuous contact with the patient. Today this personalistic, mediating function has been taken over by the medical or psychiatric social worker. These have been added to the healing team. For instance the social worker interviews patients to discover possible social factors of ethnic culture, economic status and family structure that may have caused the disease that may be helpful towards treatment. On the other hand the role of physician is more specialized as is focused precisely on the diagnosis and treatment of a pathological condition or its future prevention. To the healing team some hospitals have added pastoral care as a regular part of patient care as all patients are likely to have problems ultimate concern that may affect the success of the healing process.\textsuperscript{461}

The involvement of many partners in health has led to physicians’ resentment towards the growing intrusions as they may feel held accountable for care but denied the autonomy and
authority to control the necessary resources. The same thing applies to nurses also complaining for having less control over the conditions in which they operate although they are expected to assume more responsibility for supervising less-educated staff. However, on the side of the patients they are increasingly becoming suspicious of their physicians because of being bombarded by information about the promises of new technological advances and offering increased opportunities to make decisions about health yet constraining options for controlling their health care.\textsuperscript{462} Within the list of various diversified professional and sub-professional roles required by a modern health care a patient enters a hospital confronted by a small army persons all supposed serve him/her. Therefore, a patient must protect himself/herself and there is need of discussing on the issue of the protection of the patients’ rights by some type of advocate.\textsuperscript{463} On the other hand, Emanuel reminds that for the first 2000 or so years of medical practice, medical practice ethics was governed by a physician paradigm. At that time medical practice was a small industry with little effect on outcomes and there was widespread social consensus. However, medical practice begun consuming an ever larger share of social resources as the issues began to have social impact after World War II whereby challenges to the physical paradigm begun to arise.\textsuperscript{464}

Today personal information of all kinds is recorded electronically and seems to pass through semipermeable membranes to places and organizations of which patients have little knowledge. This poses a lot of questions regarding individual’s privacy and how to balance competing ethical values.\textsuperscript{465} Paul Ndebele states that researchers and information technology experts need to consider the best ways of ensuring confidentiality because “the cabinet, lock and key are no longer adequate.”\textsuperscript{466} Other important elements in this interaction are the competence of the physicians, their ability to communicate and inform patients so they can make informed
decisions, the physicians’ compassion and continuity of care. This superior position of physician over a patient should inspire and regulate physician’s role as an advocate of the patient. This kind of relationship is analogous to the relationship between health care organizations and the systems which depend on it to survive and to function with other systems harmoniously.

b. Analyzing on Confidentiality

Confidentiality as medical duty is an ancient one originating from the Hippocratic Oath whereas modern medical ethics bases this duty on respect for the autonomy of the patient and the royalty owed to the patient by the physician. However, confidentiality may sometimes be treated rather carelessly by providers. The second paragraph will try to analyze confidentiality.

Generally, physicians are obliged to refrain from divulging confidential information obtained from patients and ensure that such information is not inappropriately divulged to third parties. Beauchamp and Childress argue that confidentiality is a branch or subset of informational privacy. However, the authors also strike a difference between privacy and confidentiality that an infringement of a person’s right to confidentiality occurs only if the patient or hospital to whom the information was disclosed in confidence fails to protect the information or deliberately discloses it to someone without first party consent. Junkerman and his co-authors seem to support Beauchamp and Childress idea about confidentiality. The authors recognize that patient’s confidence that information given to a physician will remain private should be held as an important element in the physician-patient relationship and in its absence; patients may not be willing to divulge information critical to their medical care. Additionally, the physician duty of confidentiality is supported by both federal and state laws which restrict
disclosure of information to their physicians. However, Junkerman and co-authors present some legal exceptions to the maintenance of confidentiality that may necessitate divulgence. Such legal exceptions include testifying in court, reporting communicable disease, reporting child abuse, spouse abuse, or elder abuse, reporting gunshot or suspicious wounds if there is a reasonable cause to believe they are the result of crime and reporting for workers’ compensation cases.468

Confidentiality refers to the boundaries surrounding shared secrets and to the process of guarding such boundaries. Bok recognizes that while confidentiality protects much that is not in fact secret, personal secrets lie at its core. Therefore, it is good to distinguish confidentiality from the testimonial privilege that protects information possessed by spouses or members of the clergy or lawyers against coerced revelations in court. The author also commends that the principle of confidentiality postulates a duty to protect confidences against third parties under certain circumstances. This is why professionals appeal to such a principle in keeping secrets from all outsiders and seek to protect even what they would otherwise fell bound to reveal.469 Elaborating further, Hall comments that confidentiality of medical and personal information is a principle as old as Hippocrates and as modern as the most recent version of the American Medical Association Code of Ethics. However, both the new version of the principle and the old one all appear to presume that medical care is a matter of one physician in a relationship with one patient, with information limited to what the patient discloses. This may be different in today’s situation where by medical information seems to be anything but confidential due to many hands and procedures that this information is exchanged.470 This problem may be further exacerbated by the variety of ways in which information can be stored and transferred electronically and by the ease with which paper or electronic copies can be made.471 Meanwhile the question of when
and why physicians should disclose information given to them in confidence is still important but is being eclipsed by questions about the security of this information in medical records systems. Today confidentiality is an organizational problem and with respect to the privacy of personal information, an important distinction should be made between the security of information and access to it. However, legal access seems to be the more serious problem from an ethical perspective. For instance, while public attention has been diverted to the issue of security of medical records from unauthorized use, the circle of authorized access has been expanding. Some instances have been noticed where by employers have used the medical information legally disclosed for their employment decisions and in 1995 the research on 500 Fortune Companies indicated that 35 percent reported as using medical information in making decisions about hiring and firing.472

However, Murrell provides the definition for confidentiality that is derived from a prefix “con-” which means “with” or “thoroughly” and a Latin verb “fidere” which means “to trust.” Therefore, confidere or confidence implies a relationship of trust and reliance on another’s discretion regarding what belongs to the one who places the trust. The author recommends that physicians should consider as scared the reputation of those who confide in them. Murrell also supports the previous idea that when it is detrimental to their patients, physicians cannot divulge the information which their position has permitted them to observe or to be informed of.473 Hodge and Gostin remark that ethical conceptions of medical confidentiality were featured more prominently in laws of medicine and practice in the beginning of the 20th century. This implies that courts have imposed legal duties of medical confidentiality for decades where by law makers and policy makers both focused on privacy as legal and ethical norm worthy of significant additional protections. However, ethicists also justified strong respect for data confidentiality
through utilitarian and normative principles. The utilitarian argument was based on the hope that confidentiality would facilitate honest communication between a physician and a patient. Whereas regarding privacy it would be expected to allow patients towards feeling comfortable in divulging the personal information that is often needed for accurate diagnosis and treatment. However, Hodge and Gostin also recognize that unauthorized uses or disclosure may subject individuals to embarrassment, social stigma and discrimination, later on impact their health and interfere with the physician’s ability to render effective medical care.474

Addressing medical confidentiality, Kipnis argues that within medical ethics it can better be understood as a part of a broader area of inquiry that can be called information management. However, the concept of information management calls attention to certain ethical standards that are applicable to this body of material. For instance a single patient in a hospital has a medical chat that contains recounted conversations, an advance directive, a medical history, addresses and telephone numbers, test results, reports from consultants, hour by hour nurses’ notes and others. This information on the medical chat is updated constantly and circulated freely among the caregivers in order to facilitate an empowering interdisciplinary team work. But the medical chat contains information that may not be capriciously revealed beyond the narrow circle of caregivers unless the patient’s permission or restrictions on the scope of what is disclosed are involved. Kipnis further reminds that the information belongs to the patient and the chat’s contents must generally be withheld from anyone that is not directly involved in the patient’s care as this may jeopardize patient’s trust they owe health care professions.475 Today, perhaps the public’s greatest concern relevant to the privacy of health information relates to macro-issues such as the intrusion of modern techniques of communication into the health field, with potential for broad access to individual health data by wide range of agencies and individuals. On the
other hand, it is possible to embed all of the health information on a plastic smart card and this health profile will follow the patient as he or she makes his or her way through increasing complex health care systems. The risk here may be obvious that such information could be available to people with less than charitable interest in that particular patient.476

The expectation that information disclosed to health professional will remain confidential encourages patients to be open with their physician so that they may not withdraw information that is necessary for effective treatment or for protection of the others. Therefore the rule of confidentiality gives the physician duty to respect the patient’s autonomy in medical decision making and a physician who shares patient’s information with others without his/her consent will not be respecting the patient’s autonomy.477 On the other hand Higgs notices that a strong commitment to absolute confidentiality continues to pose problems to physicians especially when two apparent absolutes are in conflict and only one can triumph. This implies that a modified promise of confidentiality might in practice be best perhaps amongst others unless a legitimate court orders someone to do otherwise. Therefore an obligation to tell the truth may be different from an obligation not to reveal. For instance if a physician declared himself or herself to be under a professional obligation not to say anything in response to a question, a court would have to take a view as to whether the issue was serious enough to warrant compelling a disclosure from the physician.478 However, the understanding of confidence is important to an understanding of confidentiality. Murrell contends that confidentiality comes out of our respect for the dignity and privacy of each other and it is also rooted in the understanding that each person’s life is lived in relationships and that relationships help define the individual as a person. Therefore, those who might be privy to certain confidences do not have the right to disclose them to others without the approval of the person whom the knowledge is about.479
Confidentiality like truth telling invokes the patient’s trust in and reliance on the healthcare professional’s integrity. Whereas the common perception of confidentiality holds that it binds only the patient and physician. Post and co-authors observe that this professional obligation also extends to other clinicians and includes others such as chiropractors, clinical social workers, dentists, nurses, podiatrists and psychologists. There has been dramatic change in health care delivery in the sense that medical treatment has moved from the home to the institutional setting; multiple disciplines and subspecialties, legal and government bureaucracies, and third-party payers now converge on each case and computers connect all parties to the clinical interaction. This implies that a number of people with both legitimate and non-legitimate that might access medical information have increased geometrically. For instance in 1982 there was a reported instance whereby medical information about a patient whose case not unusual or complex was available to at least seventy five people who provided either direct or support health care services. In the past most especially in Western culture, confidentiality of medical information has been presumed to be a matter of professional ethics. But today, Hall observes that organizational mission statements seldom mention the confidentiality of medical information. Something that one would expect to find in the American Medical Association Code of Ethics and other similar codes of other healthcare professionals can now be found in an organizational mission statement. Since medical records are now held and used by health care organizations as well as by individual physicians, the confidentiality of medical information is no longer just a professional matter. On the organizational level, principles regarding confidentiality are often required by accreditation standards and are generally found in various statements of patient’s rights. Among those statements of patient’s right there is one mostly widely used that was published by American Hospital Association (AHA) and addresses confidentiality in a very
forceful means that the patient has the right to expect that all information and records pertaining to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. This bill also states that the patient has the right to expect that the hospital will emphasize the confidentiality of this information in those records. Unfortunately, the bill also leaves it up to the hospital to decide; on its own which parties are entitled to the review records.

Exploring further on confidentiality, Beyleveld contends that a third party to whom information is given in confidence which has a quality to which confidentiality can attach has a duty to keep it confidential. This implies that not all information is information to which a duty of confidence can attach but rather it is necessary for both conditions to be satisfied for there to be a duty of confidence. Even when qualifying information is disclosed to those who have a duty to disclose it confidential, Beyleveld advises that it must have been disclosed to them with the understanding that it is to be kept confidential. On the other hand, Kipnis recommends that a physician should be able to tell his/her patient that certain things he/she learns from the patient may have to be disclosed to so and so under the following conditions or circumstances and be able to say that the following things might occur to him or her as the result of such disclosure. This implies that physicians need to say in advance what will be passed along, when, to whom and what could happen then so that they may not betray their patients afterwards as this betrays also the value of trustworthiness. However, some critics have held that if patients must understand in advance that the physician will report evidence of threat to another person then patients will only be willing to disclose what they want to be disclosed and withhold some other information. But others have argued contrary that this does not have any empirical evidence and that in spite of reporting practices patients still talk openly to their physicians.
Similarly, some countries have statutory legislation requiring physicians to respect patient confidentiality. For instance a legislative survey of confidentiality law in the United States of America found that 37 states impose a duty on physicians to maintain confidentiality of medical records while 42 states protected information received during a clinical consultation from disclosure in court proceedings but with some exceptions. However, if identifiable data are used or disclosed in ways that are unlikely to achieve a strong public benefit or if the personal risks are high, individual interest in autonomy should prevail. Such unauthorized disclosures may lead to a loss of patient trust in health care and health care professionals, as well as other potential harms. Therefore, releasing of information without the patient’s consent should be prohibited. Slowther and Kleinman advise that in case of disclosing information, it is necessary to consider to whom the information should be given and how much should be disclosed. Regarding breaching of confidentiality the authors support that this should be done but limited to prevent the foreseeable harm at least and in case the information is shared without explicit consent, it is good practice to inform the patient this possibility by either explaining this in patient literature or notices in the clinic.

Article 9 of UNESCO also stresses that confidentiality of personal information should be respected and such information is not to be used or disclosed for other purposes other than those for which it was collected or consented to. However the article expresses that confidentiality is mostly complicated by the fact the flow of information is in the interest of the patient and other problems have resulted from the computerization of health administration. However, privacy is not the only value involved in the issue of medical information. Instead Gostin who is former chair of the Privacy Working Group of the President’s Task Force on National Health Care Reform, explores his argument that the right to confidentiality is neither absolute nor intrinsic
and that it must be balanced against public good. The author goes on to say that health
information can be used, for instance, to promote access to health care, more equitable
distribution of services to vulnerable populations, better research and more effective public
health interventions. According to Gostin such above mentioned uses would be ethically
appropriate if applied.\textsuperscript{490}

Slowther and Kleinman also agree with Beauchamp and Childress that once information
is given to someone in confidence there is an obligation of the person receiving the information
not to disclose it to someone else unless the provider of the information states that it must be
shared. Therefore, there is both individual and public expectation that information given to
health care personnel in the context of the clinical relationship will not be disclosed to the third
parties. However, despite of the above physician obligation towards confidentiality, the
technologic developments in information, storage, retrieval and access may pose significant
problems of confidentiality as individual confidentiality seems to go beyond the context of
individual patient care.\textsuperscript{491} For instance the growing use of screening for genetic diseases
produces information that may be of interest not only to patients and their physicians but to the
patient’s relatives, employers and insurers. This implies that confidentiality is a strict but not
unlimited ethical obligation. The ethical issue may reside in determining what principles and
circumstances justify exception to this rule. But the two grounds may sound to be generally
accepted for exception to confidentiality: concern for the safety of other specific persons and
concern for public health.\textsuperscript{492} Murrell contends that the reason for keeping secrets is mostly based
on the natural understanding that human beings live their lives in a society of other human
beings. The implication is that secrecy is necessary for the public peace and for prosperity. The
author goes further to observe that physicians are entrusted with two types of secrets that are
directly to them. These two types are: the natural secret and the professional secret. The natural secret is referred to be that one that someone happened to find out and which the person is unwilling to have disclosed. On the other hand professional secret would refer to a committed secret binding in justice by reason of the professional position of the one who receives the secret knowledge and the professional duty to keep secret is morally binding as well. For instance whatever secrets are imparted to the physician in the doctor-patient relationship should be kept inviolate and can be used only as far as necessary to achieve the purpose for which the patient entered the relationship.493

Furthermore, the American Medical Association of 2006 advises that the duty of the physician is to inform the patient of the need to discuss implications of the test results with family members and to offer to facilitate this discussion.494 Above all, truth is not meant to overwhelm people, but rather people can develop their personality only by serving the truth and bearing witness to it. So when truth is thus appropriated we can never communicate it without at the same time communicating something of ourselves. This is why giving truth to another is not merely to give him or her something external and thus increase what he/she has but it does much more than that by increasing what he/she is. This helps him or her to discover his/her own truth by means of the truth offered to him or her. One can therefore, ask that what would be therapy other than a way of helping a patient become aware of his or her own truth?495 While health care professionals are encouraged to tell the truth to their patients perhaps a balanced view provided by Rowling would suffice. The Truth, Dumbledore sighed. ‘It is a beautiful and terrible thing and should therefore be treated with great caution. However, I shall answer your questions unless I have a very good reason not to, in which case I beg you will forgive me. I shall not, of course, lie.’496 On the other hand, Comeau and Levin would argue further that having routine and
universal newborn screening as public health measure is widely acclaimed for early disease
detection and intervention in clinical outcomes for more than 5000 infants a year who would
otherwise suffer severe mental retardation, life-threatening morbidity, and many cases, death.497
Additionally, screening is an important form of secondary prevention that has developed into a
major branch of public health. The basic idea behind screening is identifying people who will
benefit from the early detection of the risk factors, or the onset of, a disease.498

In exploring further, Beauchamp and Childress recommend that anyone who learns to be
having serious genetic conditions should take action to reduce risks to themselves or their
offspring or to seek treatment. However, breaching confidentiality and informing relatives about
genetic risks entails observing the following: First when the attempts to elicit voluntary
disclosure fail. Second is when there is a high probability of irreversible or fatal harm to the
relative. Third is when the disclosure of the information will prevent the harm. Fourth is when
the disclosure is limited to the information necessary for diagnosis or treatment of the relative.
Lastly is when there is no other reasonable way to avert the harm. This means that while health
care professionals should respect the confidentiality of a patient’s personal genetic information
but they may also have a right or obligation to disclose that information in order to protect others
from harm even when that individual patient objects.499 In the UK according to 2004 General
Medical Council if the physician cannot persuade the patient to stop driving, or is given evidence
that a patient is continuing to drive contrary to advice, medical information should be disclosed
immediately, in confidence to the Medical Advisor of the Driver and Vehicle licensing
Authority.500

The role of parents in the newborn screening is upheld for its importance as well. Botkin
observes that newborn screening programs in most states are conducted without parental
permission, and the lack of an informed permission process in clinical application means there is no established foundation for an informed permission process for research. For that matter, several measures are recommended to mitigate risks, including parental notification, public awareness, a careful protocol for results disclosure and approval by a genetics advisory committee. According to Virginia A. Moyer and her co-authors, medical screening of children for a health condition normally requires parental informed consent, especially when the condition is not a threat to others in the community. However, the authors observe that this basic ethical standard has been exempted in newborn screening. To the extent that newborns are screened without parental informed consent in all but few states and parents often are not aware that they have the option for refusing the mandated screening, Jeffrey R. Botkin observes further that newborn screening involves a complex system which includes parental education, bloodspot acquisition, and laboratory analysis, plus results disclosure, confirmation of the diagnosis, initial interventions and long-term management. According to Botkin, weaknesses in any of these elements of the system may lead to limited efficacy or a failed program in general.

Commenting on the role of information in genetic screening, Benjamin S. Wilfond points out that the overall policy goal should be to provide information so that individuals are allowed to manage the impact of genetic conditions on their families in ways that respond to diverse family needs and preferences, and in a manner that is both cost-effective and respectful of basic ethical values. Stephen Wilkinson says that parents need reminder for their duty not to fore close their children’s options but to be kept open without compelling reason. Cohen’s suggests for predicative testing of children to enhance family dynamics and bolster relationships. This is based on the fact that members share the same vulnerability and the same information
which can lead families openly to air their concerns and options with one another as appropriate to their age.506

Wilkinson would argue further that children are gifts to be cherished unconditionally and this claim goes hand in hand with unconditional parental love.507 This would imply that parental requests for genetic information about their children, without immediate relevance to medical intervention or disease prevention should generally be resisted.508 On the other hand, Ted Peters and his co-authors would argue that parents are to be reminded of being good stewards over God given gift of life that entails working towards the betterment of their children as people have been given talent for creative transformation.509 Mischler seems to support the idea that the goal for newborn screening is family-centered and psychosocial. This goal involves providing information to parents that allows them to avoid the diagnostic odyssey that sometimes occurs between the initial appearance of symptoms and the time of diagnosis. Another thing is that the newborn screening information can be useful for parents in their further reproductive planning.510 Davis would also say that the information got during screening benefits parents by having a heritable disease diagnosed early, before they embarked on another pregnancy. However, parents (and arguably the child) could also benefit by being spared a diagnostic odyssey when the child becomes symptomatic. But guarding the child’s future privacy must fall before the very real benefits of information parents of their own genetic risk and to their future children.511 Baily and Murry point out that ideally, expectant parents should be aware that their newborn will be screened for variety of disorders before leaving the hospital. Parents receiving a positive result should receive basic information about the specific condition, and the detailed information and support they need to understand their child’s conditions and manage its impact on the child and the family. Obstetricians should be able to tell parents where to find more
However, Shah recommends for attempts to be made to promote efficient diagnosis through clinical care with education programs for clinicians and perhaps parents, or through selective screening. Such system would help to identify severely affected infants with illness like galactosemia as done by population screening.

Gold and co-authors express their fears that without regulating the access of such information may pose a continuing problem for health care institutions and policy makers. The increasing numbers of physicians practicing in large groups and work as employees of, or under contracts with, health plans. These policies often directly affect the practice of medicine and patient/physician relations. Therefore a great deal of collaborative work is needed to place physicians and health plans on the same page ethically in order to build a health care system with strong ethical foundations. Additionally, the individual physicians, group practices, and health plans have to develop a greater sense of common aims and responsibilities, and a mutual recognition of each party’s important role in establishing and sustaining integrated sets of ethical standards to support the health care system. For instance Federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) create a comprehensive system defining the value, scope and limits of confidentiality. According to HIPAA regulations there must be a reasonable effort to limit the use and disclosure of individually identifiable information to the minimum necessary for its use. However, these regulations do not require the patient’s authorization when the physician must share information for proper treatment. Surrogates and family members may also be disclosed the information only with patient’s consent and other inquiring parties would only be disclosed limited information such as description of the patient’s condition in general without specific medical condition. Patients are
similarly given a chance of explicitly refusing the release of any information to inquiring parties or limit release to certain persons. 516

Notably, the role of federal government is to translate new knowledge into public health programs for newborn screening. According to Michele A. Lloyd-Puryear and her co-authors one of the greatest accomplishments of preventive public health services over the past 40 years have been the development, implementation, and improvement of state-based public health newborn screening programs. Newborn screening programs and systems have continued to be influenced by federal funding. However, there has been a bit of tension in this translation process between the government and the private sector because at times the general public expects rapidity, while the government is more cautious and deliberative towards implementation. This has made the general public and private sector to see this role as ponderous and slow.517 According to Virginia A. Moyer and her co-authors both states and the federal government should objectively evaluate each condition on the basis of prevention potential and medical rationale, availability of treatment, public health rationale, available technology, and cost-effectiveness before recommending its inclusion in mandated screening panels. The states choosing to expand newborn screening should include disorders for which the evidence of benefits and harms is incomplete commit to collecting longitudinal data on infants who test positive. The following examples will help to illustrate the role of Federal government in translating new knowledge into public health programs for newborn screening programs.518

Health is both acutely personal and consummately public because an individual illness brings anguish to others and the need for their care. Callahan believes that illness itself is as much social as individual in its characteristics. For instance illness is heavily determined by forces other than individual choice and behavior. A society may be considered to be in the wrong
track when thinking of illness as simply an individual phenomenon with an occasional public face. Therefore, the health care system should aim at fostering the common good and collective health of the society for a common benefit. There is need for allocating the place of health as individual and social. The place to begin that effort is by examining the place of health in human life and of the pursuit of health as part of a societal or communal way of life. This is supported by Held’s recommendation that with the ethics of care and understanding of its intertwined values such as those of sensitivity, empathy, responsiveness and taking responsibility. This may provide grounds for arguing that people should care about one another as fellow members of communities, including gradually the global community on which the future of our mutual environments depends. The implication is that fairness and the maximizing of individual utility should always be considered as everyone’s the overriding moral considerations.

Callahan reminds that a good part of the satisfaction of life lies in people’s relationships with others and some would say all of it. This is why Callahan contends the social and interpersonal health care system. The argument here is that the goal of the health care system should be that of helping people to meet their occupational and social roles and duties while at the same time helping them to live effectively within the interpersonal sphere of their lives within communities. This idea seem to concur with the Islamic concepts of health and illness whereby the concept of health in Islamic sources is not limited to physical wellness but refers to a holistic concept that embraces physical, mental and spiritual well-being. Illness is viewed not only for the patients but also for their relatives and friends in dealing with the patients and caring for them. For instance, the sickness of the parents is considered to be a divine trial for their children, who are advised to care for their parents and treat them with the utmost respect and
compassion. Callahan argues further that health care consists of the organized methods used by a society to promote the health of its members, ordinarily encompassing the fields of public health and medicine. The author defines health in a way that may be considered best but in simple terms, as an individual’s experience of well-being and integrity, of mind and body. This definition makes a room for age-relative standards of health, out of recognition that, with aging, there will be a decline in many physical and some mental capabilities but that a person can be considered in good health for his/her years despite that decline.

There has been much interest in applying communitarianism in public health ethics debates, either explicitly or implicitly, in order to counter the assumption that liberal objection is well grounded. The point of the communitarian critique is that liberalism emphasizes the former set of features, in particular the individual and their freedom to live as they choose. Instead the communitarians argue that the community is, and should be, at the center of our moral thinking so as to restore the notion of community to proper prominence. The implication is that communitarianism provides a political-philosophical discourse in which to couch support for public health interventions that prioritize communal over individual goods. So, the communitarian critique of liberal individualism should be allowed to inform public health ethics issues in whatever ways naturally arise.

Having seen that liberal objection to public health interventions is that they infringe on personal freedom by stopping people from pursuing their choices. For instance banning smoking in public places is said to be objectionable because it infringes on the smoker’s freedom to choose to smoke. There is a great need for striking balance between the negative and positive conceptions of freedom because according to Berlin all freedoms are both “freedoms from” and “freedoms to.” WHO publications of 2007 report that preparedness planning for influenza
pandemic involves balancing potentially conflicting individual and community interests. The document continues to say that in emergency situations, the enjoyment of individual human rights and civil liberties may have to be limited in the public interest. Generally, a pandemic is considered as a worldwide emergency where all or almost all individuals are susceptible and therefore threatened. WHO publications of 2007 describes a pandemic as an epidemic occurring worldwide or over a wide area crossing international boundaries, and affecting a large number of people. While an epidemic described as the occurrence in a community or a region of cases of an illness, specific health-related behavior or other health-related events clearly in excess of normal expectancy.527

However, Swift argues that policies such as smoking in public places, aggressive health communication campaigns such as fear messages intend to shock smokers into giving up, sin taxing cigarettes, and such like, are all justified on the same grounds. Instead they aim at protecting and enhancing the effective freedom of citizens.528 Swift further distinguishes freedom as autonomy from freedom as doing what one wants. This will help to understand that the addict who reaches for the bottle or another shot might well be doing what they want, or be fulfilling their present desires, but their autonomy, their capacity for self-rule, is compromised by their addiction. Meaning that, such addicts are free in one (negative) sense, not free in another (positive) sense. Nonetheless, public health interventions aiming at providing the required information about health behaviors and risks are justified on the grounds that they increase freedom as autonomy.529 The argument here is that while advocates of the liberal objection to public health tend to take a negative conception of freedom for granted, there are viable positive conceptions of freedom on which some liberty-limiting public health activities can be justified. So it seems plausible that some support for preventive health campaigns is provided by the fact
that they promote effective freedom by enabling people to do more of what they want than they could otherwise. 530

Furthermore, WHO recommendations remind countries about their obligation to minimize the burden of disease on individuals and communities, but they must do so in a way that is respectful of individual rights and liberties. The need to balance the interests of the community and the rights of the individual is of particular importance in the implementation of public health measures such as isolation, quarantine, social distancing and border control. However, with appropriate international financial and technical assistance, countries should develop core capacities for public health surveillance and response that comply with the international legal obligations in the framework of the International Health Regulations (IHR) 2005.531 On the other hand, Gostin and co-authors present the ICESCR seemingly in support of this idea by including a “right to health,” where by one can conceptualize any measures necessary to attain health protection for the population as valid limitations on other rights. For instance, the Covenant requires states parties to take steps to prevent, treat and control epidemic, endemic, and occupational diseases. Thus, compulsory measures such as vaccination, treatment, or isolation would be permitted if only they are meant to protect the public’s health.532

According to Mill’s harm principle stresses that the only purpose for which power can be rightly exercised over any member of a civilized community against his/her will, is to prevent harm to others. This means that the only part of the conduct of any one, for which one is amenable to society, is that which concerns others. However, Mill calls for distinguishing between actions that affect one self and others, plus those actions that cause harm and those that create benefit.533 Therefore, in some instances where an individual is morally obliged to be vaccinated, the government would be justified in coercing people for vaccination through
forceful vaccination policies such as making school enrollment conditional on vaccination status. This is done in the hope of getting people to fulfill their moral obligations. However, Escobar-Koch and Solari recommend that public health campaigns involving a segment of the population highly sensitive to sexuality values should be carried out under the willing consent of recipients. For that case professionals who administer the vaccines must therefore be trained in advisory skills and have the utmost respect for the confidentiality of the recipient.

Furthermore, International human rights principles stress the importance of individual rights and freedoms, but make it clear that these freedoms can be restricted when the public’s health is threatened. Striking this balance between the individual and the collective can be a difficult task, especially under conditions of scientific uncertainty and crisis. Therefore, it is important to articulate the values of public health ethics that should influence pre-pandemic planning. Public health powers are exercised under the theory that they are necessary to prevent an avoidable harm. Gostin and co-authors would recognize that public health measures, both pharmaceutical and non-pharmaceutical, can be important mechanisms for protecting a population’s health during a pandemic. Unfortunately, these measures are likely to impose significant burdens on individual rights (e.g. autonomy, privacy, and liberty) and economic and social welfare (e.g. trade, tourism and business). Verweij’s idea would also seem to support that version when describing equity principle as involving giving equal weight to equal claims and supports rejection of discrimination. Under this principle if priorities are set on the basis of personal preferences of those in power, this will normally lead to a situation where groups who are suppressed or otherwise worse off will be neglected. According to Verweij such policies will probably not protect the health of the public in any efficient way. In fact equity supports attempts to minimize unfairness. However, some forms of unfairness may be inevitable in the principle in
order to save most lives but priorities should be devised in such a way that unfairness is 
minimized where possible. Equity supports giving priority to groups at high risk of severe 
disease and death. At this point the principle says that priority to worst-off: risks considers the 
fact that the groups who will be at risk will depend on the specific features of the pandemic these 
groups may differ from the well-known risk groups for seasonal influenza for instance. Equity 
supports giving priority to persons who are relatively young. According to the fair innings 
argument a child or young adult has a stronger claim to protection than an elderly person who 
has been able to live a long life. However this argument does not specify age groups or cut-offs 
points for prioritization.538

c. The Role of Organizations in Protecting Patient’s Information by Introducing the 
Culture of Transparence

The third paragraph will analyze the role of organizations in protecting patient’s 
information by introducing a culture of transparence. An approach adopted by Sarasota 
Memorial Health Care System in Florida has shown that employee’s sense of responsibility, 
professionalism, stewardship and general efficiency can be increased by the satisfaction they 
receive from their work. Organizations must, therefore, address the issue of employee 
satisfaction as means of risk reduction to patients’ information. However, staff should train as a 
team and work as a team as a way of increasing accuracy and developing a sense of communal 
responsibility and accountability. 539 Hebert explores on the importance of disclosing medical 
error as way of respecting patients as persons and denying them such information would not help 
the patients to properly consent for further treatment unless they know what went wrong. If
practitioners are unable to be honest with patients or families regarding the untoward event, they are unlikely to be entirely candid in reporting the incident to the appropriate authorities within health care setting. However, some physicians argue in support of non-disclosure that may be justified out of concern about needlessly increasing patient anxiety or confusing the patient with complicated information thus obscuring true choice. Hebert and co-authors advise that professionals must be prepared to share some of the burden of the incidents and not always attribute blame to the system.  

According to the common-law doctrine of respondeat superior that was established in seventeenth century in England defines the legal liability of an employer for the actions of an employee. Respondeat superior is from a Latin translation that literally means “let the master answer” which is also referred to as “master-servant rule.” Regarding to this doctrine an employer is responsible for the acts of his or her employee (agent). In other words a master is liable for torts that his/her servants committed if such acts were performed within the scope of the employee’s duties/services. Similarly, Judson and co-authors consider physicians in a health care setting to be legally responsible or liable for their own actions of negligence, and for the negligent acts of employees working within the scope of their employment either directly or indirectly under their supervision. The question encountered is of determining whether an employee was or was not acting within the scope of employment when a negligent act was committed. However, according to Judson and his co-authors this can be determined by finding out whether or not the employee’s behavior serves the interest of its employer or in some way promote the employers business. For example, a nurse aide causing an IV stand to fall on a patient during transport within the hospital, the nurse aide may be sued, but the hospital may also
be sued. The hospital is liable for hiring and supervising an employee who commits a negligent act.

There is another phrase worth explaining because of being closely related to Respondeat Superior and this is “Captain of the ship” doctrine. This doctrine pertains to the physician who takes primary responsibility for the patient’s course of treatment. If the physician makes an error in diagnosis, prescription or the patient’s course of therapy, he/she is held liable for the error. This doctrine has been modified, but remains an important benchmark for the plaintiff and defense attorneys involved in medical malpractice. Legal precedents in a medical malpractice laws outline the responsibilities that neurosurgeons have for other physicians, nurses, and support staff both inside and outside of the operating room and this help the physician to anticipate situations where malpractice liability may arise and safe guard against any liabilities. 544

The environment in which teamwork, clear communication and openness about errors are operative may lead to safe guarding patient’s information through discussions involving members of the appropriate disciplines. 545 Tong recognizes the necessity of working as a team in solving health issues. The fact that a health care professional has graduated an accredited school and licensed or certified by appropriate authorities and is probably competent to practice medicine. This does not mean that this particular health care professional is equally talented or equally in command of his/her respective field. This means that in some instances whereby patient’s problems may prove puzzling, perplexing and overwhelming to an individual health care professional he/she should be honest enough to ask for help from more able colleagues. This applies also to the situation whereby a health care professional may become impaired and unable to provide competent care to his/her patients. When such situation undermining competence
arises, then health care professionals are supposed to honestly admit to themselves and their colleagues about their inability.\textsuperscript{546}

The health care institution should have a moral obligation to assure safety over its patients through awareness on the part of both the institution and its constituents about their collective and individual moral status, and by honoring the need for transparency and accountability. The crucial point being that health care institutions are aware of and responsible for errors that happen within their systems. \textsuperscript{547} Commenting on the role of institution to supporting professional ethics, Daniels and Sabin commend that to be publicly accountable for the reasonableness of incentive schemes; physicians should be comfortable with the evidence that those schemes pose no threat to the primacy principle and their patient’s welfare. This implies that public accountability for reasonableness supports a collaborative physician-patient relationship. However, physicians cannot meet this challenge without institutional support. Compliance with ethical principles such as the primacy principle requires not just individual commitment, but support of colleagues, the profession, other institutions and the culture quite broadly.\textsuperscript{548} This would concur with Kutz idea that our life in general is very much connected to regrets and reproaches. As much as one tries to live the best life, is just connected to harms and wrongs. Therefore, Kutz addresses individual moral accountability in the context of collective action. The author recognizes that harms and wrongs are collective products that individual agents rarely make a difference to their occurrence. The implication here is that if no individual makes a difference, then no individual is accountable for the collective harms.\textsuperscript{549} On the other hand, De George commends whistleblowing as morally required, when it is, because people have a moral obligation to prevent serious harm to others if they can do so with little cost to themselves.\textsuperscript{550} In justifying the presence of the whistleblowing, Davis clarifies that this role
involves revealing information that would not ordinarily be revealed and only a member of an organization can blow the whistle either as current or former member of that same organization. So the whistleblower cannot blow the whistle using just any information obtained in virtue of the membership in the organization but has to reveal information with which one is entrusted and does not breach that trust to save his/her own skin. However, the whistleblower is often at once loyal to the organization from his/her own perspective and disloyal to it from its official perspective.551

Gerald Magill and Lawrence Prybil recognize the need for organizational culture of transparency and problem solving. These authors provide five steps which they hope should be followed in establishing a culture of transparency and corporal responsibility in health care organizations. Those steps can be used both in problem solving to identify the root cause of errors and in preventing their recurrence. First, in order to assure patient safety, a health care organization needs to establish an organizational environment in which personnel are encouraged to point out problems and to participate in analyzing them with the purpose of finding solutions and avoiding recurrences of the problem. The second step is the identification of the root of the problem. This includes systematic identification of all relevant aspects of the problem while discerning goals and all the obstacles that are encountered. The third step is the estimation or evaluation of the cause/effect relations in the problem. According to the two authors, this step helps to get to the root cause of the problem in the midst of all the symptoms or quasi causes.552

Having identified the problem, the organization should engage itself in the process of ethical resolution. This fourth step includes identification of possible options which can then be followed by the process of determining the best solution to the problem before eventually making a rational and objective ethical decision. Finally the fifth step is the implementation of
the decision followed by frequent evaluation of the outcomes. This criterion of Magill and Prybil for establishing a culture of transparency and problem solving will help organizations to maintain their integrity, good stewardship and assurance of patient safety. Without this demonstrated procedure in dealing with error or violation in health care, it might be almost impossible for a health care organization to assure patient safety.

In introducing the culture of transparency in an organization so as to protect the patient’s information includes addressing on complicity as moral problem. According to Kutz’s argument, restricting our discussion of accountability to individual objects makes us lose sight of an important category of harms and wrongs resulting from collective action and that could not be the product of any one individual. Therefore, ignoring individual differences among agents undermines the resulting responses of accountability attached to agents in such way that they can be integrated into the understanding of their position with respect to their victims. However, Kutz discourages confusing individualistic bases of judgments with a more disputable claim. Rather, responses of accountability are always functions of the basis and the object of accountability as well as of the position of the respond-end. On the other hand, the author tries to clarify the confusion between the object and basis of accountability relating to collective harms in particular and complicity accountability in general. The author expounds his point further by applying two principles; Individual difference principle and control principle.

Exploring further on accountability, Kutz points out the fact that each person is accountable in some way for the collective wrong. This leads the author to addressing about the complicity principle which holds that: I’m accountable for what others do when I intentionally participate in the wrong they do or harm they cause. I’m accountable for the harm or wrong we do together, independently of the actual difference I make. According to Kutz the complicity
principle is best supported from the second-person perspective of the person who is harmed. These inconsistent moral principles and responsive perspectives will be reconciled by theory of individual accountability that will foster and constitute the moral and psychological and social relations among agents that make their lives good. Kutz points out the inadequacy of moral theory to collective wrong doing based on individual consequentialism. Consequentialist theories present two initial complications to discussing their conception of accountability; both stemming from the purely instrumental role played by responses of accountability. According to consequentialist theories agents can therefore be said to have acted objectively wrongly though subjectively rightly, if they mistakenly but reasonably believed the act they chose would have the best consequences. The basis for accountability is on the dependence of individual agents’ choices upon the choices of others even when individuals are uncertain about the participation of others. Consequentialists also consider habituating and corrupting effects of single choices upon the agent’s character.555

Arguing further, Kutz recognizes that there is incompatibility of collective consequentialism and individual accountability. In this argument Kutz goes to say that consequentialist theories that take individuals acts as their objects cannot adequately treat complicity because they cannot account for the moral significance contributing marginally to a collective wrong. For example Derek Parfitt offers the principle that an act may be wrong even if it harms no one because it is one of a set of acts that together harm people. This implies that each harmless torturer act is among a set of acts that together are wrongful. Such a principle is criticized for leading into inconsistent or incoherent conclusions in comparative contexts. For example an individual cannot decide between contributing marginally to a great harm and bringing about lesser harm.556
However, Kant’s scholars dispute that there is no universalized world in which agents act upon a maxim of keeping only convenient promises and that no agent may permissibly act upon such a maxim. But some maxims can be conceivably universalized without being willable as universal laws. According to Kant, agents have an imperfect duty or general but occasionally defensible obligation not to act on such maxims. Kantian tests are rather rigorous but helpful aids to moral deliberation addressed to agents who are basically morally inclined, but perhaps puzzled by what the world demands of them. However, there is a need for a modified form of the “contradiction in will” test that justifies universalizing the effects of what we do together while retaining the connections between what each does and what we do together. Kant’s procedure needs to incorporate the logic of collective action in order to explain the special moral relation of complicity. On the other hand, Kutz criticizes both Kantian contradiction in will test and Parfitt collective consequentialist principle because of obscuring or ignoring the relation between individuals and collective harms.557

Kutz develops the understanding towards collective action and individual accountability. He cites the need for forming an ethical assessment that takes collective harms as objects of accountability while retaining a solid basis in features of an individual intentions, actions and characteristics. This would help us vindicate the complicity principle and reflect the way in which jointly acting individuals see themselves as promoting a common good. According to Kutz the complicity principle assumes participants in a collective harm to be accountable because their intentional participation in a collective endeavor links them to the consequences of that endeavor. This means that acting together makes us accountable for what we all do because we are each authors of our collective acts. Collectively acting agents render themselves the authors of their group’s actions. Kutz goes on to say that the ascription of actions to us, as
individuals and members of groups, provides a basis for accountability. He also says that our intentional activity manifests our attitudes towards others because of the teleological relation between our aims and our actions.\textsuperscript{558}

Kutz would say that under Kantian tests of impermissibility, we should universalize an intention to do one’s part, albeit marginal, in a collective act. This accurately reflects the structure of the moral agent’s intentions. However accountability for unintended consequences can also be made sense of in terms of participatory intentions. Whereas consequences are ascribed to an individual when they are causal products one’s intentional actions. For that matter unintended consequences warrant some response like apology, compensation or repair whose response is rooted in the more primitive basis of causality, in the simple fact that my agency has led to one’s suffering. Kutz says that consequential complicity forms a central part of our ethical experience. Whether or not we act on the moral reasons that obtain in virtue of our participation and others respond to our complicity by unforeseen and unfortunate actions of our groups’ give us pause.\textsuperscript{559} Complicity looked at from this angle we find that in one way or another becomes a problem for moral agency and should be addressed in order to improve on the organizational way of protecting the patient’s information through transparency.

In the United States of America, corporations are by and large treated as fictional persons although they are granted unlimited life by their state charters. Corporations have also been granted some constitutional rights guaranteed to individual persons including equal protection, due process, freedom of speech and freedom from self-incrimination and unreasonable search. This legal analogy between corporations and persons has raised the questions whether corporations are sufficiently like individual persons to be considered moral as well as legal agents. Werhane and Freeman would argue that in the ordinary language
corporations are referred to as actors and are held, like individuals responsible. This seems to conform to French’s argument in defining a legal person as an eliminable subject of right. In order to be a moral person one must be an intentional agent. This means that intentionality is a necessary condition for moral agency. Applying such analysis to corporations, then a corporation can be said to be a moral person if it is an intentional agent, if it engages in reciprocal responsibility relationships and if it is a non-eliminable subject of a right. There is a general consensus that a human person is the moral agent. However the definition of personhood is philosophically, socially, and morally contested concept.

Depending on the school of thought, personhood may include not only human biological properties but also distinctive human psychological properties; that is, properties exhibiting the distinctively human mental functions of awareness, emotion, cognition, motivation, intention, volition, and action. Logically, moral agency is dependent upon and derives from moral status. Beauchamp and Childress provide two moral-capacity criteria by which an individual qualifies as a moral agent. One of the criteria is the ability to make moral judgments based on the rightness or wrongness of actions. The second criterion is that the individual has motives and that those motives can be judged morally. Using these two criteria for establishing moral agency, only human persons qualify as moral agents because only human persons can make judgments based on the morality of actions or non-actions and only human persons can be said to have a conscience by which they distinguish what is right and wrong. However, the capacity for personal action and motive engenders personal moral rights. This argument is based on the fact that individuals can govern themselves, therefore, they can be held responsible for deeds which result from their autonomous actions. Similarly, moral rights can be attributed to an organization
in so far as it shares the capacity for moral action and moral motive. Notably is that such capacity exists only by analogy.564

Werhane analogously applies the Beauchamp and Childress criteria for moral agency of individual persons to the moral agency of organizations. Werhane argues that organizations can have objectives or motives and can make decisions and take actions as they relate with stakeholders, their customers, their neighbors, and even with the society at large. Hence all personal moral rights, which include freedom and autonomy, applied to individual decisional persons can be analogically applied to institutions or organizations as well. As a result, Werhane suggests that it would be absurd to argue that organizations are moral.565 According to Spencer an organization is looked at as a subunit of the larger society comprising individuals in various roles and authorized by the larger society to function for specific, often narrowly defined, purposes. There are laws that govern organizations at different levels and these laws are applied to health care organizations as well. Although health care organizations are expected to operate within the limits of the law that does not exhaust their ethical obligation. They have obligations in many areas in which the law cannot affect them. There are many characteristics of individual human moral agents found in organizations that make the organizations identical to moral persons. For example organizations are full-fledged moral agents. Spencer and his co-authors say that organizations have no purpose for being but only have mission statements, credos or other statements of purpose that set the framework for organizational decision making. The authors affirm that organizations are moral agents and they, like individuals can be held morally accountable, although they are not identical to individual moral agents because they do not literally have motives, they do not likely make choices or act. However these organizations have
an ethical climate that refers to how issues should be addressed and its correct behavior. This ethical climate according to these authors is the character of the organization.566

Furthermore, health care organizations having intrinsic human nature require that their identity as moral entities should be made clear to those who relate with them or associate with them in any way and should also be articulated as part of their mission statements. Hall recommends that six principles adopted in the 1995 seminar at Woodstock Theological Center to be reflected both in the mission statement of any health care organization and manifest its relationships with people. These principles are; respect for human dignity and compassion, commitment to professional competence, commitment to a spirit of service, honesty, confidentiality, good stewardship and administration.567 These principles are also human virtues, the recognition of which undergirds the health care organization’s status as a secondary moral agent, based on its human constituents and mission. Furthermore, Hall argues that the role of health care institutions as moral agents is not only assumed and expected by the people who deal with these institutions but moral agency must also be part and parcel of the institutional identity as articulated in the mission statement. The health care organization ethics committee is an essential part of any health care institution by virtue of its role in generating and articulating the institutional mission statement. Organizational ethics should find its rightful place within the health care organization not as an outside critic.568

Importantly to address is the contingent nature of an organization’s moral agency. Generally, organizations exist only as a result of their constituency who collectively establish and take action thereby establishing the secondary moral agency of the organization. Spencer and co-authors talking about the ontology of an organization, they define an organization as an association given legal status by a state charter to operate as a single unit with limited liability.

187
over an indefinite period of time. Although the organization is created by a group of individuals for purposes, it is neither identical to an individual moral person nor is the organization by any means free from moral responsibility. Organizations have goal-defined roles and role obligations which are constitutive of their morality. In setting goals and role obligations, the organization is demonstrating the ability to make a moral judgment, choosing between what is right and wrong, which is the first criterion for moral agency. The health care organization’s primary objective is to provide health care. In regard to responsibility and liability for actions, corporations are treated as official persons under the law. The motives and consequential actions of the organizations are subject to critical moral judgment, thus meeting the second criterion for moral agency. To argue that organizations are not tangible persons, or truly autonomous or independent, does not eliminate the possibility of collective action of the constituents on behalf of and derived from the motives of the organization. However it should be noted that the actions of an organization are not literally actions of a physical entity, but rather actions that are represented and carried out through constituent persons. Consequently, no organization can be said to act on its own. Corporations have no existence without their constituents, because they are created by and function only because of them. Thus as argued by Spencer and his co-authors, organizations cannot exist independently of their constituency in any ontologically independent manner. In short we can say that completely independent of human agents, organizations cannot exist nor can they function as moral agents. Their morality and moral agency is dependent on and derived from their constituents. That is why it is important to connect moral agency and truth telling in health care ethics.

Spencer and his co-authors address the relationship between an organization and its primary moral agents. In doing so, the authors point out that even if an organization can and
should be held responsible for its actions, not all actions of an organization can be analyzed in terms of the actions of individuals who operate on behalf of the organization. Organizations are praised, blamed or accused of actions which be applied equally to constituent individual persons independently. The authors argue further that even if an organization cannot function as a single unit in most instances, it is, none the less dependent on the people who constitute the organization, while at the same time remaining distinct from them. Organizations are not primary moral agents because they do not act directly, but are considered secondary or contingent moral entities. They are secondary because organizations cannot act in the way a primary moral agent takes action, but at the same time, because of its corporate human nature, at least in its constituents, an organization can and should also enjoy the moral rights of freedom and autonomy which include moral obligations and accountability on the part of the corporation to its customers, to its constituents and to society just as they apply to autonomous individuals.

Spencer and his co-authors also note that an organization has limits resulting from its status as secondary moral agent. This is mainly due to the fact that an organization lacks the primary moral autonomy of human person, the organization is limited in its ability to decide and act. Law treats organizations as quasi-persons because of their lack of personal autonomy which is necessary to perform primary action. An organization acts only when it performs a secondary act by way of its constituents. Consequently, because organizations can perform only secondary moral action they are appropriately called secondary moral agents. As secondary moral agents, organizations are subject to ethical analysis and study. Edwin Hartman makes this case succinctly when he states that if a businessperson’s moral obligations all derive just from being a person, then business ethics is nothing more than ethics, essentially the same whether applied to business people or others. Hartman says that if on the other hand, a businessperson
had better not be moral, then business ethics is truly an oxymoron. There is a clear and direct connection between the action of an organization and the various actions of the constituents who act on the behalf of that organization and that is the manner in which the organization acquires its secondary moral status as a corporate and representative entity. Thus the organization is limited by virtue of its status as secondary moral agent.

According to Werhane organizations must be moral agents. According to this argument, although organizations bear responsibility for moral action and motives judged apart from the constituents since they are the source and origin of motive and action. However, Werhane clarifies this concept further by placing the responsibility for the continued existence of the organization, as well as its moral character, in the context of the recognition of moral claims of individuals, maintaining that while organizations and individuals may seem to have equal rights, the rights of persons ultimately take precedence. Persons taking precedence over organizations, however, does not lessen the organization’s moral agency and the contingency of the individuals does not lessen their responsibility. Mary Mitnick enumerates three different ways in which an organization can be considered an agent. First, corporate action is, in reality, how discrete individuals act. Second, an organization acts vicariously through the constituents. Third, an organization may even be an agent in its own right. And so we judge organizations just as we judge individuals, that is, in terms of role morality and from the ideal of moral minimums. The same criteria used to judge the morality of persons are used to judge the morality of organizations. Spencer and his co-authors include these values to be used as criteria for judgment; equal opportunity, mutual respect, avoidance of harm, fairness, respect for basic rights and honoring promises and contracts. A valid ethical analysis of decisions and actions taken by an organization can be therefore be made. Robert Hall explains that if decisions and actions
taken on behalf of the organization can be evaluated ethically as right or wrong, then organizations must be moral agents as well. For instance in July 1996 The Charleston Area Medical Center operating three hospitals began constructing a new medical waste incinerator at its General Division in the working-class East End of the city but the community response to this announcement was negative because there had been no public hearings on permits other than a Health Care Cost Review Authority. This made the residents of the area sue the Kanawha County Circuit Court claiming that there was absence of required permits and that the facility would emit dangerous levels of dioxin. Although Judge Robert Smith ruled for the project to go forward but the issue was for a while a public standoff. This was an organizational ethics problem, an institutional mater that is beyond the scope of the ethics committee and needed another committee with no relevant expertise and none of the stakeholders involved in order to address the ethical issues surrounding the construction of the incinerator. 577

Exploring further, Emmanuel recommends that there should be inevitable change of perspective in health care. According to this position, there is a need for changing the rules and principles which although were relevant for individual cases, are no longer relevant in the complex world of current health care. Therefore, the situation calls for the creation of institutional structures which can assure ethical behavior.578 Ideally, health care organizations should be able to relate to their systems as physicians relate to their patients. Just as physician-patient relationship is based on trust, confidentiality, competence, information and continuity, so also should the relationship between health care organization and its systems. A system refers to a set of interdependent elements that interact to achieve a common aim. Examples of health care organizational systems are fellow health care institutions related to a specific health care organization and smaller units within the organizations such as, surgical room or pediatric
department or radiology department. Sometimes health care organizational systems may be of a different nature, not delivering care directly to patients, such as insurance company.\textsuperscript{579} According to Gerard Magill a systems approach as the kernel of health care organizational ethics would be the right tool for patient safety. Magill says that health care organizations must adopt a systems approach in dealing with errors, violations or conflicts that happen within them. A systems approach is one which does the necessary in-depth analysis and evaluation of the conditions in the systems which contribute to or facilitate occurrence or recurrence of error. This model deals with medical error by seeking and effecting changes in the systems that facilitate the practices enabling individuals to make mistakes.\textsuperscript{580} The argument of Magill refers to and underlines the existence of a relationship between the health care organization and its systems. The systems approach encourages ongoing communication, information and direction between the organization and its systems. It also requires transparence between an organization and its systems.\textsuperscript{581}

Furthermore, Magill argues that there is analogous, fiduciary and symbiotic relationship in both physician-patient and organization- systems interactions. A fiduciary relationship exists between the central administration of organization and the organizations’ systems. The systems rely on, and report to the central administration on the status of their operation. The systems also report cases of need, correction or issues of concern with trust, just as a patient would report symptoms to the doctor. The organization, on its side, will inform the system and attend to the needs of the system so that there is synergy in the functioning of the organization in the realization of its objectives. If the physician and/or patient fail to function synergistically and fail to live up to their responsibilities in the relationship, the patient won’t be healed and may die. If the organization and its systems fail to function synergistically and fail to live up to their
responsibilities in relationship, the organization’s stewardship will falter which is tantamount to failure of the entire organization. Thus, just as the physician-patient relationship is guided by a code of ethics, so also should the relationship between an organization and its systems can foster a virtuous organization whose ethical principles inspire high standards of ethical conduct, greater integrity and credibility from the stakeholders and from the community at large. Good organizational stewardship demands the existence of such a relationship. Daniel Callahan advances an approach that is grounded in the meaning of health, in appropriate medical goals, and in economic sustainability. According to Callahan this would be opposed to market organization approach emphasizing profit, private enterprise, and competition.

However, physicians are directly involved with their patients. They are entrusted with very personal and private information that patients would not disclose to any other person without solid assurance that it would be used solely for the patients’ good. Therefore, physicians are in the best position to know patients’ interests and to advocate for them within the health care system. This implies that without the physician’s commitment to place the patients’ interests first and act as advocates and representatives for the patient, there is no certainty that patients’ health and information will be protected. However, Callahan advances for an approach that is grounded in the meaning of health, in appropriate medical goals, and in economic sustainability. This would be opposed to market organization approach emphasizing profit, private enterprise, and competition.

Therefore, the task of organizational ethics should aim at finding ways to institutionalize the establishment of principles to guide decisions and actions in order to institutionalize the social goals to which an organization should be committed. Today unlike before health care and all that surrounds it have become a major social force in the present culture. Health care
professionals are expected to practice their medical responsibility in public and explicit dialogue rather than in the relatively protected privacy of the physician’s office. Therefore, a physician is expected to use less explicitly scientific language in dialoging with the recipients of care and families that are today involved than they were in earlier decades. This is in conjunction with today’s clinical ethics that is committed to the social principle of shared decision making as it involves other social issues such as patient and family rights, and values.587

Magill and Prybil regard the two ethical principles of stewardship and integrity as being crucial towards upholding the mission of a health care organization that focuses on healing and trust and therefore speak to who we are in health care. These ethical principles should be interpreted in a foundational manner as related to an organization’s mission rather than construing them as merely providing operational directions for management functions. While the effective implementation may lead to the success of an organization but this should be conducted reflecting the more basic mission that the principles are intended to highlight.588 The principle of stewardship safeguards the organization’s mission by ensuring its independence and strategic success which includes the proper management of limited resources that address community needs. Whereas the principle of integrity ensures that the mission permeates the organization making it possible for the organization’s members to provide competent care that meets needs through services such as community benefit programs.589 Another area of interest would be the process component whereby an organization aligns the principle of stewardship and integrity with ethical conduct by engaging in appropriate decision-making process. This process is expected to contribute indispensably towards the development of a virtuous organization and indicates how we function in an organization. Therefore, trustees should discharge their duties by structuring the board in a way that is appropriate to the organization, specifically in a way that
facilitates proper deliberation and communication and admits of relevant diversity thinking. Such emphasis on the board decision-making process within a health care organization highlights the significance of assessing community needs in a collaborative process.\textsuperscript{590}

Conclusion

The chapter has tried to approach truth telling from a pluralistic health care environment where by it involves different expertise from different backgrounds to the extent that physicians are no longer the sole or necessarily the most important health care professionals with respect to patients’ treatment or care, nor is their power as great as it used to be. The chapter has elaborated the thesis further by analyzing the relationship between different services rendered in a health care organization. In doing so the chapter realizes that many services provided to a patient within a health care organization overlap with the responsibilities of each other the situation that calls for mutual cooperation amongst health care personnel. This idea is supported by Ten Have who seems to agree with the idea that human existence is not primarily characterized by competition and conflict but by interconnectedness and that human beings are human because they are social beings.\textsuperscript{591} On the other hand Hall would recommend that a single member of the team should take responsibility especially when it comes for instance in matters of making decision to stop treatment.\textsuperscript{592}

The chapter has also analyzed the issue of confidentiality whereby physicians are obliged to refrain from divulging confidential information obtained from patients and ensure that such information is not inappropriately divulged to third parties. However, the chapter also recognizes that there are some legal exceptions to the maintenance of confidentiality that may
necessitate divulgence. Such legal exceptions include testifying in court, reporting communicable disease, reporting child abuse, spouse abuse, or elder abuse, reporting gunshot or suspicious wounds if there is a reasonable cause to believe they are the result of crime and reporting for workers’ compensation cases. The chapter recognizes that today confidentiality has become an organizational problem basing on the fact that the circle of authorized access has been expanding. For instance some companies have been reported as using medical information in making decisions about hiring and firing.

Therefore, since medical records are now held and used by health care organizations as well as by individual physicians, the implication is that confidentiality of medical information is no longer just a professional matter. This would concur with Slowther and Kleinman advice that in case of disclosing information, it is necessary to consider to whom the information should be given and how much should be disclosed. This implies that a great deal of collaborative work would be needed to place both physicians and health plans on the same page ethically order to build a health care system with strong ethical foundations.

Furthermore, the chapter has tried to analyze the role of organizations in protecting patient’s information by introducing a culture of transparency in which case staff should train as a team and work as a team as a way of increasing accuracy and developing a sense of communal responsibility and accountability. The idea that concurs with Hebert and co-authors advice that professionals must be prepared to share some of the burden of the incidents and not always attribute blame to the system. Therefore, the health care institution should have a moral obligation to assure safety over its patients through awareness on the part of both the institution and its constituents about their collective and individual moral status, and by honoring the need for transparency and accountability. The implication is that if the physician and/or patient fail to
function synergistically and fail to live up to their responsibilities in the relationship, the patient won’t be healed and may die. Similarly, if the organization and its systems fail to function synergistically and fail to live up to their responsibilities in relationship, the organization’s stewardship will falter which is tantamount to failure of the entire organization. This is why Spencer would argue that corporations would have no existence without their constituents, because they are created by and function only because of them.

The chapter concludes with a remarkably hope that this contribution will help health care organizations to embrace the multiple stakeholders involved with them both from within and outside to safeguard the patient’s shared information. Hence making the principle of confidentiality regain and remain with its credibility that goes as far back as Hippocrates.


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Developing the Gradation Approach

Telling patients the information about diagnoses and prognoses has been given great attention in bioethics as important for making their decisions in an informed manner. However, some cultures hold alternative views whether or not to tell the truth about diagnoses and prognoses. The chapter will develop the gradation approach as the proposed way of making truth telling possible to apply in other cultures especially where it has seemed impossible to practice. This will be explained in the following paragraphs: Analyzing on disclosure as a process, and Revisiting the notion of compassion in the effort to improve on physician-patient communication.

a. Analysis on Disclosure as a Process

Disclosure refers to the process during which the physicians provide information about a proposed medical investigation or treatment to the patient. Therefore, disclosure along with capacity, understanding, voluntariness, and consent, makes up the main elements of informed consent. In support of the above idea, Kelly commends on how it is important, therefore, that patients are well informed and then later allowed to give free and well informed consent on their own behalf. However, decision making should be based on patients’ ability to understand their diagnosis, prognosis and its implications, ability to evaluate and ability to communicate their choices.
The first paragraph will analyze disclosure as a process. Generally speaking, the goal of disclosure is to ensure that patients have appropriate information to make an informed choice about their health care. Therefore, this should take place not as an event but rather as a process keeping in mind that each patient may be different and may wish for varying amounts of information at different times. This requires that the physician seeks regular feedback from patients about their treatment and desire for more information. In some instances the dying patient may ask the physician if he or she is dying. Physicians may not want to play God and tell the patient how many days, months or years are left to live. Thomasma proposes that such truth may gradually be revealed in such way that the patient learns about his or her dying even before the family or others who may be resisting telling the truth. Therefore, interpretive truth may be used and comfort the patient. For instance if a car driver that has been involved in the accident asks about his/her family members who are already dead and is also dying. The polite way would be to tell him/her that the family members are being cared for and now what matters is that he/she be comfortable and not in pain. It would not be necessary to tell that particular patient the truth as such may lead to feeling responsible and guilty ridden during the dying hours knowing the rest of the family were already passed.

Generally, medical information is very hard for patients to digest more especially when diagnosis is serious. The cardinal rule, therefore, should be applied which is to give the information in small chunks. This process will facilitate the patient’s understanding by beginning with warning shot and then gradually introduce more serious prognostic points while waiting for the patient to respond at every stage. However, there should not be an excuse for a physician not to tell a patient on pretext that something is hard to explain when it can be stated in simpler terms even using a drawing. Additionally, patients in general do not usually want to know all the
details of pathophysiology but rather the answers to their questions. This is the reason why Cassell recommends that a physician should strive to know what the patient wants to know. The physician may even later strive to provide explanation to a patient speaking a different language from his or hers by using less artistic pictures pointing to the disease. On the other hand, Cassell also believes that information wisely used can easily reduce uncertainty, improve the ability to act and enhance the physician-patient relationship, then information poorly employed can increase uncertainty, paralyze action and destroy the relationship. Therefore, it should be remarked that information has specific features each of which can be varied to fit particular situations. For instance some patients may require an explanation all the way down to the mitochondrial level before they feel that they understand their situation while others only mind a rather vague picture of the problem. However, the author believes that information should involve timing and has to be employed in a way as to maximize its effectiveness.598

Furthermore, Shattner seems to support the above idea when arguing that despite of insistence on disclosure not all patients may want to know details of their condition. Therefore, to such group of patients the author advises that the truth should be offered but not forced on them. This implies that in all cases of disclosure, just how and when to discuss the patient’s situation, and how much to say at any one time, will always vary from one patient to the next. For that matter the art of disclosing which relies on the skills and attitudes of the physician taking the patient into his/her confidence would offer him/her true impression of one’s sickness.599 Similarly, Liang in advocating for educating patients about their role in health care, patients are supposed to actively get involved in it. For instance the agreement should remind patients about the fact that medical care is complex and sometimes complicated but as partners, physicians and other health care personnel would be there to make sure that they provide safe
and effective care. While patients are assured such co-operation from the side of the health care personnel but they also need to exchange information so that the best health delivery may work for everyone.\textsuperscript{600}

In determining the adequacy of disclosure of information by a physician, Jonsen and co-authors recommend for the approach whereby one should ask what a reasonable and prudent physician would tell a patient. However, this has increasingly been replaced by a new standard namely, what information reasonable patients need to know in order to make reasonable decisions. This reasonable patient standard is more patient centered. On the other hand, there is also subjective standard that is also patient specific in the sense that the information provided is specifically tailored to a particular patient’s need for information and understanding.\textsuperscript{601} Breaking bad news has been considered to be one of the difficult circumstances whereby it involves explaining and planning to build supportive and trusting relationship with the patient and significant others who are present, tailoring information giving to the patient’s needs, attempting to understand the patient’s perspective and working in a collaborative partnership. More so, in breaking bad news the patient’s hopes on entering the room are focused on the possibility—however faint—of receiving good news and the physician has to gradually move the patient’s attention towards the worrying facts that he/ she must now begin to communicate. Similarly, the physicians appreciate the communication issue to be a problem and find it difficult. However, the psychological sequelae of breaking bad news in an abrupt and insensitive way can be devastating and long lasting. Unfortunately, despite of the attention given to this issue in both hospital and family practice, physicians still perceive considerable difficulties when delivering bad news to patients and their families. For instance a physician may tell patient news which he/she may consider to be important or bad but which the patient does perceive to be so. This means that
physicians are at times unaware of the importance the information given to the patient and its likely effects.602 Breaking bad news especially to parents about the sickness of their child mostly depends on the communicator as there may be no general answer as how it should be done. However, Myerscough and Ford would recommend that all parents be present. When the father is involved and whether married or not, the authors recommend that it is important for the couple should be given such news together - the same information in the same language at the same time. For instance, a physician may frankly tell the parents that I am sorry to tell you that your child has Down’s syndrome, which means that he/she will present special difficulties for you over this coming period of time. The distressed couple needs to be helped by having some people come to surround them at that time of disclosing the news for support. These may include close family members, a social worker, the general practitioner or even nursing or medical student if found appropriate.603 When dealing with patients who have diminished understanding may entail a physician to identify with a patient and spend more time in settings like family practice so as to allow for the exchange take place. This may be a different case with the more educated patients who may express more a wish for being informed. On the one hand, routine disclosure might seem to be needed but on the other hand a formula might swiftly lead to the sort of openness that could be regarded as cruel or even abusive. Therefore, Higgs recommends that an individual assessment of what a particular patient in his/her own individual circumstance wants has to be done in advance but keeping in mind that such views may change and some time for follow-up work may also be required.604

Kagawa-Singer and Blackhall remind that patients bring their cultural, religious and ideological beliefs with them as they enter into relationship with the physician. Surprisingly, such beliefs may challenge or conflict with the physician’s professional duty to disclose mostly
based on the way people from different parts of the world may give value to the principle of autonomy. For instance in most of European and North American cultures the principle of autonomy is highly valued and thus it is expected that a patient be the best person to whom to disclose pertinent medical information. However, other cultures may not support the idea of full disclosure when it comes to sickness and others may prefer that the family or community be responsible for receiving and disclosing the information and make decisions about the patient care. In such situation one may be asked to negotiate and accept each person’s terms of preference for information and decision making so as to provide ethical cross cultural care while applying the concept of autonomy. In case the patient designates someone else to be given the task of decision making, d’Agincourt-Canning and Johnston recognize that such preference should be documented in the patient’s chart. However, Hebert and his co-authors point out some suggesting numbers of patients ranging from 10-20% that may not want to know the details of their condition. The authors suggest that for such patients, truth should be offered but not forced on them. This implies that in all cases of disclosure, just how and when to discuss the patient’s situation and how much to say at any one time should vary from one patient to the next. Therefore, the art of truth telling should rely on the skills and attitude of the physician to take the patient into his/her confidence and give him/her a true impression of his/her illness. Henderson suggests that acting truthfully is consistent with acting beneficently. Therefore, in order to discern what is best for the patient cannot be achieved by the health care professional who is acting independently on behalf of the patient because care entails sharing pertinent information. Rather trust has to be maintained in the best way possible by sharing relevant information with patients but this has to done according to the way that will be supportive them. This is why the
learned health care professional has to approach the patient on the equal footing especially in those moments where matters of the patient’s life and health are at stake.\textsuperscript{608}

In general, patients have the right to the truth concerning their condition, the purpose of the treatment to be given and the prognosis of the treatment. This conforms to the Patient’s Bill of Rights of the American Hospital Association which also states that; the patient has the right to obtain from the physicians complete current information concerning diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand.\textsuperscript{609} The Ethical and Religious Directives for Catholic Health Care Services also recognizes that a patient should receive all reasonable information about the essential nature of the proposed treatment and its benefits, its risks, side effects, consequences and cost and any reasonable and morally legitimate alternatives which include no treatment at all. The directives argue that each patient should have access to medical and moral information in order to be able to form his or her conscience.\textsuperscript{610}

Additionally, Stirrat and Gill argue firmly that the best practice that expresses a proper patient–physician relationship in which each fully respects the true autonomy of the other has several components. The first component is an unspoken covenant of trust between the physicians and patient whereby the latter’s wishes expressed in the consent process will be honored. Another component also typically involves a full and comprehensible explanation by the physician of the problem(s) requiring intervention followed by an authoritative statement of the benefits and risks of the various options, including doing nothing. However, in order to reach a freely arrived at decision about their preferred choice which include no intervention and a wish not to make a decision, patients must also understand the information provided and be given time to consider the options. Remarkably, that appropriate length of time may vary depending on, for instance,
the urgency of the situation and a patient’s state of mind, need for reflection and, perhaps
discussion with family members.611

Vangu recommends that important consideration should be given to the manner in which
the truth is conveyed to the patients. This should be done keeping in mind the fact that while
truthfulness can do harm but what one does not know cannot hurt. Therefore, the author provides
five conditions that must be observed during the process of conveying the truth to the patients.
The first condition is putting into consideration the issue of time when the information is
supposed to be given the patient. The second condition is concerned with focusing on the
environment in which the information is given to the patient. The third condition deals with the
manner in which information is given to the patient. The fourth condition focuses on the words
chosen in order to convey the information to the patient. The fifth condition has something to do
with the attitude of the person bringing the information to the patient.612 However, Mystakidou
and co-authors argue further that the determination of what news is bad news constitutes a
subjective judgment in the mind of the receiver. Therefore physicians when delivering bad news
they may inadvertently influence patient response. For instance a patient may realize sometimes
from little more than a smile or the firm touch of a hand that the person speaking to him/her
wants to help. This why the authors advocate for communication strategies that include clear and
simple language while avoiding the use of words such as death and dying but cautious in
phrasing other words such as hope and better. The fact remains that poor delivery of bad news
stems from being too blunt, discussing it at an inappropriate place and time, and conveying a
sense of no hope. Yet other patients may accept blunt talk as long as they are not suffering from
scaring diseases such as cancer. 613
On the other hand, Spikes and Holland observe that like patients and families, health care providers also may often be found very uncomfortable in discussing issues to do with death. Similarly, the anxiety about one’s own mortality may also lead clinicians towards avoiding frank discussions about death or even end up providing false reassurance that everything is alright. The implication here is that clinicians also face the troubling thought of a medical failure. Elger and Harding would argue from a different angle insisting that patient compliance is needed to assure treatment efficiency. Therefore, physicians who are convinced that communicating the diagnosis of cancer is beneficial will inform patients who ask to be told and even patients who would have preferred not to know about their diagnosis. The authors argue further that by contrast, disclosure of a poor prognosis is still judged harmful and therefore many physicians do not favor truthful information about poor prognosis.

In most cultures a patient would be approached by talking about things not related to the illness first and gradually move the conversation to things indirectly related to the patient’s diagnosis by asking about symptoms experienced. This would be followed by the physician asking some questions aiming at ascertaining the patient’s mental competency and then move the conversation closer to the issue at hand. This process is never brief as it may involve more than one session over the course of few days so that the patient may digest the information and the understanding what is coming next evolves. However, the above procedure conforms to the standard of valid consent where the first component invests a physician with the responsibility of providing understandable information about diagnosis and prognosis including the available alternative treatments with their risks and benefits. Similarly, physicians are also responsible for ensuring that the patients’ choices are voluntary, which can mean helping to free patients from coercive pressure when necessary. This why Brock argues that the patient’s physician has the
initial responsibility for assessing the patient’s decisional capacities although this does not put a side others such as psychiatric consultants who may be called in for help in the assessment.618

The legal precedent as well as moral concern prompts the physician and other health care professionals to furnish clear information concerning serious sickness or impending death even if the patient has not asked for it. However, in difficult situations like where knowing truth may harm the patient, physicians can fulfill their obligation by telling some friend or member of the family about the patient’s condition and the prognosis. Those difficult situations include, for instance, a patient with serious case of cancer if happens to know about her/his true condition might become despondent and lack the desire to live, thus contributing to his/her illness. The same thing applies to the dying person who happens to know his/her true situation may become despondent and even suicidal.619 This is in conjunction with The Patient’s Bill of Rights which states that; when it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf.620 Similarly, the current code of Brazil in medical ethics prohibits physicians from keeping information from the patient. The code puts a positive obligation on doctors to provide patients with information about diagnosis, prognosis and risks together with the aims of treatment. However, the code exempts doctors from providing direct information to the patients if such may cause harm to them.621

On the other hand physicians should discuss with their patients whether they want to receive information and make decisions about their medical care or whether they want the physician to discuss such matters only with the family. Therefore, the principle of respect for autonomy does not require inflicting unwanted information on patients but requires first finding out how much and what kind of information they want to know and then respecting that expressed wish. By interpreting the principle of autonomy in this way would solve the problem
regarding whether patients need to be told the truth about their diagnosis. Chiu and co-authors recognize that when a patient has a serious illness such as cancer, it may be helpful to document his/her preferences regarding the involvement of family members. On the other hand families who resist disclosure should be counseled about the importance of truth telling, much as they might be counseled about the appropriate management of any medical problem. However, the authors also note that ongoing and respectful communication often, but not always can overcome family and cultural barriers to disclosure.

Limiting the right of determination would propagate an injustice. However, concealment would be possible in special circumstances, and for that matter the physician is expected by the patient and society to use disclosure prudently. For instance this mode must be adapted to the patient’s educational level, psychological responses, and physiological state. This means that the physician is to function as the technical expert and adviser, inviting the patient’s participation and understanding as aids in the acceptance of the decision and consequences of that decision. Pellegrino advises that there should be a place for examining intersection of values inherent in every medical transaction that have not been recognized in the Hippocratic tradition. This will help in dealing with and meeting the demands of several sets and subsets of values: those of the patient, the physician, sciences, and society. Perhaps the most subtle influence that limits the freedom of the physician and patient is the intersection of their value systems. However, the patient’s values must be respected whenever possible and whenever they do not create injustice for others and when the patient is un able to participate for the known reasons, the physician or the family should act as a surrogate to preserve these values as close as possible. The physician is highly advised to constantly guard against imposing his own values as the good to which all must subscribe if they desire to be treated by him/her. Miyata and co-authors in a general
population survey conducted in Japan to investigate people’s preferences on receiving the information about a cancer diagnosis and its prognosis. The findings of these authors surround the importance of properly evaluating patients’ preferences especially in regard to prognosis disclosure. The authors considered it as an important finding that the majority of respondents wanted gradual or partial disclosure. On the other hand, the results suggest that a disclosure policy of providing patients with full information on diagnosis and part information on prognosis could satisfy the preferences of most patients. However, the authors also caution that providing information to patients who do not really want it has to be avoided, as well as giving too little information to those who especially want more.625

According to David C. Thomasma and Thomasine Kushner say that given both social constraints and the way that physicians are educated today. Compassion as heroic virtue beyond pale is considered important for the care of patients, certainly for the process of healing. But we cannot expect that from our physicians, given our social milieu and the nature of medical school curricula that neglect personal for professional development. For that matter, this virtue must be taught, and the readiness of spirit to leap over gulfs created by personality and culture must be encouraged.626 In the situation where a patient requests or refuses treatment and it is in disagreement with a relevant family member’s decision. Fan would recommend that the physician should not simply follow the patient’s wish but should urge the patient and the family to negotiate and come to an agreement before the physician will act. Fan feels that respect for autonomy is perfectly consistent with recognition of the important role that families play when a loved one is ill. More so most patients want and need the support of their families whether or they seek to be autonomous agents regarding their own care. Unfortunately, the early days of bioethics in the United States focused on the patient intending to counteract the predominant
mode of paternalism but never discussed where the family would enter in. This implies that no presumption that a family centered approach to sick patients was somehow a violation of the patient’s autonomy.627

On the other hand, Hebert and co-authors comment on how hard it may be for a physician to predict what information may be upsetting and difficult for different patients. Yet the authors go ahead and cite the possibility of delivering the truth in a way that softens its impact especially to the patients who may explicitly or implicitly indicate their desire not to know the truth about their condition. However much brutal the truth may prove to be. The authors recommend that the telling of that truth should not be that way in delivering it. At this point, therefore, the task would be for a physician to know how to combine honesty and respect for patient autonomy with caring and compassion.628 Myerscough and Ford recognize that sometimes one has to decide whether to attempt to complete an interview there and then or to agree and plan with the patient a second instalment when more time may be available. In anticipating further interview, the physician may have greater freedom to plan the stages of the consultation. For instance, a full physical examination may not take place during the first visit but just deliberately defer exploration of the patient’s close personal relationships until a second or even third interview and just leaving the exposition. However, during all these moments the patient should always be given explanation of how and why such stages are to proceed. It would also be a good idea to give a patient impression that an hour could be spared for him/her and even if satisfied within few minutes. This will be considered invaluable gift other than a half an hour spent with the patient and during every minute he/she is made to feel like encroaching the physician’s time.629
Surprisingly, the dying patients might seldom want their diagnosis discussed or repeatedly explained as they may want confirmation that they are dying so that they may be ready to tackle the business in hand. According to Doyle, this may be in the effort to live out what is left of life with minimal suffering and with dignity. So whether old or young, as people approach death, they seem to invite the health care professionals to change from their roles of being advisers and attendants to intimate companions more especially on that loneliest journey every human being undertakes. On the other hand, physicians involved with the care of the dying are often taken by surprise at how much many patients know about their diagnosis. So in most cases physicians spell out diagnosis like confirming the patient’s suspicions which often were aroused even before help was sought. This is why a patient should be invited to speak of anything that troubles him/her, however trivial it may sound. In turn the physician should be able to listen rather than expounding, writing out a prescription or ordering further investigations that in normal circumstances would be more comfortable for him/her to do. Rather they should do all that for the sake of the patient.630 There have been frequent concerns expressed over active listening done by physicians as time consuming. Physicians already working under severe time pressures, it would be understandable they would be concerned that such skill would encourage patients to talk more. However, Bellet and Maloney would see it differently. According to these authors, physicians in clinical practice may feel that they do not have enough time for empathy, in the long run, though, empathy may save much time and expense. Additionally, without a sense that his/her physician is empathic, a patient feels alone and alienated. On the other hand, with empathy the patient feels that the physician understands. More so, this may indeed decrease anxiety, so that the patient is more amenable to accepting the physician’s advice.631
Furthermore, Lipkin and co-authors seem to support the previous idea by presenting the long-range list of outcomes from empathic listening to advocate physicians taking the time to listen. According to these authors, when one begins to listen to patients several things may happen. The major one as opposed to initial, complaints are clarified and addressed. The personal style of the patient becomes clear, so individualized treatment may be used with the enhanced patient comprehensiveness and compliance. Psychological and social complaints and maladjustments are put into proper context in the care process. McCollum is quoted by Laing about a speech addressed to physicians by a patient which was a knowledgeable and insightful about physicians taking the time to listen to their patients. In that speech the patient expressed that; I suspect at this point some of you must be thinking, “This is all well and good, but who has the time to develop this kind of rapport?” However, the patient continued to mention that none of us ever has enough time. But the patient invited the audience to think about how much time one will spend over the year practicing defensive medicine-the minutes you spend considering whether to order that test or that procedure-just in case this is the person who will haunt you for five years later with a subpoena. The patient remarkably reminds that investigating in a trusting relationship is the best defense against a law suit. At this point one may concur with the above ideas that this method of communicating empathy, understanding, and acceptance has such general usefulness that might be called the all-purpose skill as its versatility can be proven in wide variety of situations.
b. Revisiting the Notion of Compassion in the Effort to Improve on Physician-Patient Communication

Compassion is defined by Tom L. Beauchamp and James F. Childress as one of the five focal virtues for health professionals. The importance of such virtues is in part for development and expression of caring presented as the fundamental orienting virtues that provide a moral compass of character for health professionals. The virtue of compassion in particular combines an attitude of active regard for another’s welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another’s misfortune or suffering. According to Beauchamp and his co-author compassion presupposes sympathy that is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person.634

The second paragraph will revisit the notion of compassion in the effort to improve on physician-patient communication. Compassion is central to the purpose of medicine and the care of patients and their families. Therefore, compassionate healthcare should mean caring deeply about the well-being of the patients and their families and being committed to alleviating their distress and suffering. This is why compassionate care is not separate from other kinds of care but rather fundamental to all patient-physician relationships and interactions. Without it, care may be technically excellent but depersonalized and cannot address the unique cultures, concerns, and distress of patients and their families.635 Furthermore, the trust that patients put in their physicians whom they believe that genuinely care about their good should in turn expect them to be compassionate. Rhodes believes that caring is a prophylactic against the ethical danger of making clinical judgments that reflect self-interest rather than patient interest and it also protects against the moral hazard of finding good excuses rather than doing what one
should. Therefore, patients will trust their physicians and accept their medical recommendations as long as they act from caring rather than selfishness.\textsuperscript{636}

According to the above argument physicians are primarily trusted by their patients because of their role and have to act in accord with the ethical standard of care to the extent that a patient who arrives in an emergency department would not expect Catholic medicine from a Catholic physician or Jehovah’s Witness medicine from a Jehovah’s Witness physician. Therefore, medical practice is not a matter of private judgment. In other words physicians are expected to consult the clinical and ethical standards of care, rather than their individual heart of hearts in making medical decisions.\textsuperscript{637} On the other hand, according to Robert H. blank and Janna C. Merrick regard compassion as a critical principle for end-of-life since at that time patients are undergoing extreme suffering. For that matter compassion includes relieving pain, providing appropriate care, and helping the dying patient deal with psychological problems. The authors recommend that compassion should be extended to the family members of the dying patient and provide emotional support done by the medical personnel. Therefore, physicians are recommended to instruct members of the family on how to care for the patient in preparations for their loved one’s death and fulfill their moral duties. Additionally, this will give family members relief from sorrow especially when their patient passes away.\textsuperscript{638}

The very intelligibility of health care practices presupposes care. Therefore, all health care services provided to the patient are to be credibly conceived as responses to human suffering which presuppose care on the part of the responders. This implies that in caring for others one tries to view the situation from another person’s perspective and also try to make some assessment of the other person’s objective needs.\textsuperscript{639} When this understanding of care is well exploited would aid the health care personnel in exercising their responsibility by trying to
view the situation as the patient sees it and also be aware of his/her needs. Lynn would advise that residents and young physicians should perhaps have to get close enough to dying persons in order to feel their sufferings, to work within excellent care systems enough to recognize them and to learn the skills and attitudes necessary for gaining a commitment to reform systems so that good care is more possible. More so the author recommends that there should be dedicated efforts put towards reforming the health care system so that everyone may be expected to live well more so as go through the valley of death. However, Lynch would view the issue of physicians from a different angle. The author observes that today’s physicians, particularly the young generation seem to take stand against the traditional style whereby physicians tended to sacrifice themselves completely to their professional calling. Instead physicians may seem to regard themselves as having other important duties that compete with their duties to patients. For instance a physician may refuse to see patients outside of emergency situations because taking extra appointments may take away from his/her family time. In short, the author notifies that balance between looking out for oneself and looking out for one’s patient may often seem to be unclear and in very much flux. On the other hand, Lynch admits that there may be limits on when, how and why a physician can engage in conscientious refusal. However, demanding full renunciation of that interest is considered to be both unnecessary and overbearing.

Furthermore, Tronto would define care by suggesting on the general level that caring should be viewed as a spurious activity that includes everything that we do to maintain, continue and repair our world so that we can live in it as well as possible. According to Tronto that world includes our bodies, ourselves and our environment, all of which we seek to interweave in a complex life-sustaining web. Tronto argues that during life people pass through various stages and periods of dependency and independency, of autonomy and frailty. This implies that in
delivering care more especially long term care, it would be considered worthy to recognize the vulnerability and dependency of the people wanting care. However, Meulen would address ethics of care by quoting Verkerk who places it as opposed to contract perspective whereby a society is seen a treaty between autonomous individuals each having their own conception of the good life. The negativity part of such relationship is that can always be revocable as soon as the advantages do not outweigh the disadvantages. According to Meulen contract perspective would be an example of so-called ethics of justice which should be distinguished from ethics of good which tries to answer the question about good life or good care. The author regards this one to be the substantial branch of ethics because it says something about how we like to shape our lives, how we should relate to our fellow beings and the kind of meaning we can give to our existence. At the back of all this should be the central ethical obligations of compassion and advocacy with which every virtuous individual physician should endeavor to treat all patients who need care especially the most vulnerable. This value should extend to the health care organizations too. However, a medical bibliographic data base shows more entries on empathy in the general nursing literature than in the general medical literature. There are so many nursing theories that define nursing with reference to a principle of care. Diers would confirm this by stating that: Nurses observe, listen, test, assess, diagnose, monitor, manage, treat and cure. But above all, nursing is caring. As a profession we have any number of divisions among us…. But the one thing upon which nurses agree is that the essence of the practice, and thus the knowing, is caring.

On the other hand Thomasma commends that a good physician should not only be recognized by applying cognitive data from the medical literature to the particular patient but rather by cosuffering with her/him. Rather compassion should also be a necessary habitual
attribute of the morally authentic healer as the physician cannot heal without feeling and knowing the nuances of a particular patient’s predicament of illness. However, recounts that excessive cosuffering may also impede and even paralyze the physician in a state of inaction. Another danger noted by the author is that the physician may unconsciously impose her or his values on the patient as a result of identifying with his/her suffering. However, the relief of suffering is the fundamental goal of medicine. According to Eric J. Cassel this fundamental goal can be achieved through the doctor-patient relationship which requires becoming involved with the patient in order to effectively deal with suffering. Cassel recommends that making decisions should primarily be based on the sick person other than the disease; maximize suffering that leads to prevention and relief of suffering. The responsibility of the physician, therefore, entails caring for the sick even with imperfect means in a sea of uncertainty originating from emergent dilemmas of the current medical Technologies. Junkerman and co-authors remind that it is the physician’s duty to treat pain whether a patient wants to exercise his or her right to life or death. However, pain management carries a risk for patients who are terminally ill as most pain management treatment may lead to depression of respiration and, in turn, hasten death. The authors argue further that in cases of terminal patients, pain management is a priority because their situation is irreversible, and they have the right to die without unnecessary suffering. Therefore, physicians must always balance benefit and burden, for instance side effects. The implication here is that physicians may determine whether treatment will be discontinued in the process of pain management.

Generally, a patient is by definition held as the undergoer, the sufferer, the one put upon. This definition is drawn from the Latin word patiens that means to undergo. According to Kelly the poking and prodding and looking at and talking about the patient all symbolize and remind
the patient that he/she is the sufferer, the one in pain. So the more a patient is confidently and actively involved in the healing process, the more it is likely to work keeping in mind that human illness is not purely physical. According to Eric J. Cassel treatments have been developed so that may intervene at some point in the process of disease. However, characteristics of the patient, social factors or even the political setting in which an illness occurs may modify treatment but none is part of the disease. Therefore, all one would have to do is to look up the disease, find out its treatment and –bingo- it’s done. On the other hand David Kelly regards suffering as an essential mysterious reality in human life and there is no one-dimensional answer to the question of suffering, evil and sin in God’s creation has been adequate. Whereas according to hermeneutic themes take human life as a whole appeal for all people to both accept suffering and fight against it. This seems to contradict what some contemporary ethicists’ stand towards technology as useless attempt to avoid suffering that ennobles people and through which are able to share in the redemptive power of Jesus. On the other hand there are other ethicists together with some scientists tend to think that all suffering can be eliminated by the right quick fix by the right expert with the right technique. The kind of mentality that Kelly criticizes for taking people as commodities because of involving human kind as experimental object open to limitless manipulation. Furthermore, Kelly would argue that though suffering can be redemptive, it can as well be destructive. However, God wants us to relieve suffering whenever people can and should. This is based on the fact that God gives people a great deal of control since we are not only creatures but also stewards, co-agents with God.

However, this relationship should not be confused for empathy but rather think about what is meant by the term “feeling with” the other. Noddings quotes the Oxford Universal Dictionary defining empathy as “The power of projecting one’s personality into, and so fully
understanding, the object of contemplation.” However, according to the author this perhaps is a peculiarly rational western way of looking at “feeling with.” According to Noddings the notion of “feeling with” should not involve projection but reception and has calls it engrossment. This implies that one does not project but receive the other into one’s self and feel with the other then become duality. In the same way a mother feels quiet naturally to an infant. For instance when a child cries, naturally we react with the infant and feel that something is wrong. Although this is an infant’s feeling, it is also ours and we receive it and share it without projecting ourselves with the infant and ask, “How would I feel if I were wet to the ribs?” but this comes naturally unless our impulse has failed. In this case, the mother as one-caring, however, wants first and most importantly to relieve her child’s suffering. So when a person receives another one, he or she should totally be with him or her.  

Spiro would define empathy as the feeling that “I might be you” or “I am you,” but the author goes ahead in the explanation that it is more than just an intellectual identification rather, empathy must be accompanied by feeling. So according to this author, sympathy brings compassion, “I want to help you whereas empathy brings emotion. This implies that without feeling there cannot be empathy, the two go together. Unfortunately, hospital practice has become so precise that many people may think it as a waste of time, destructive even, for physicians to get emotionally involved with their patients. More so empathy gets drained of the medical students early in their academic careers. This is verified by the way medical students get chosen for victories, grades, scientific experience and energy instead of introspective and loving adjectives. Therefore, physicians come out with mentality of don’t get too involved because by getting involved would let him/her die with each patient. However, empathy can be retained and strengthened through reading, studying the humanities and conversations. Physicians can learn empathy by putting themselves in their patients’ place by
trying to feel the story as the patient feels. So by attentively listening what the patient tells to the physician goes straight to the heart and creates empathy which in turn opens the eyes to see what even, for instance CT scan has missed.655

Levasseur and Vance make traces of the word empathy as having entered the English language as a translation after a Greek ematheia, of the German Einfühlung, the word that was coined by Theodor Lipps while discussing aesthetic experience. Therefore, a less artful English rendering might be “feeling into.” From this background the authors provide a thought about empathy as a process or event by which one perceives and understands the subjective experience of another person.656 However, Spiro argues further, that empathy is the feeling that persons or objects arouse in us as projections of our feelings and thoughts. This is mostly evident when “I and you” becomes “I am you or at least “I might be you.” However, empathy is much more than illusion and very difficult to distinguish from sympathy simply because; where empathy feels “I am you” sympathy may well mean “I want to help you.” Therefore sympathy involves compassion but not passion.657 According to Freud, empathy was the mechanism by means of which we are enabled to take up any attitude at all towards another mental life.658 Whereas Jung is quoted saying that projection accounts for empathy and includes a merging of the viewer with the viewed. In the same line Harries takes empathy a feeling of being at home with the object contemplated, as a friend and not as a stranger.659

On the other hand, arguing about what compassion is not, Reilly holds that compassion is a far and nobler thing than pity. According to the author pity has its roots in fear and carries a sense of arrogance and condescension, sometimes even smug feelings of ‘I am glad it is not me.’ Therefore, when fear touches some one’s pain it becomes pity whereas when your love touches someone’s pain it becomes compassion. The author further holds that compassion is a “suffering
with” other beings that engenders sufficient concern for those beings’ overall good to motivate one to perform helpful actions. The implication being that compassionate response is not to another’s pain per se but to the being who suffers unnecessarily.660 In a similar vein, Aristotle is quoted by McKeon defining pity as a feeling of pain caused by the sight of some evil, destructive or painful, which befalls one who does not deserve it, and which we might expect to befall ourselves or some friend of ours and moreover to befall us soon.661 However, Aristotle’s conception of pity omits any motivation dimension while anger involves an impulse to avenge an undeserved wrong. At this point pity is not said to involve an impulse to relieve an undeserved suffering.

Rigon treats compassion differently for he sees it as a sister to empathy, a feeling together, and a perception that the other person’s world is partly his world too. The author continues to argue that compassion is a positive attitude, it is an option in favor of the other person; it is to embody here and now the person one is facing and in whom you decide to take an interest.662 Katz argues for a conception of empathy that bridges the subjective and objective. According to the author empathy is conceived as an intuitive perception arising from subjective involvement but when then aimed to retrieve this mode of perception for scientific knowledge by attaching a component of objective detachment. Katz holds that empathy consists of feeling whereby the inner experience of feeling oneself becomes similar to or nearly identical with the other person. However, the author strikes the distinction between simple empathy and the use of empathy as a technical and specialized cognitive technique. But both simple or raw empathy and empathy as the tool of the scientist are capable of yielding objective information not attainable through ordinary rational and intellectual techniques. When empathy is used in a professional way together with discipline, it can become a fully reputable scientific technique.663
Myerscough and Ford argue that empathic remarks are a commonplace of everyday friendly conversation wherever people are communicating in a warm cordial way. However, the authors also refer to empathy as a limited but positive response to the feelings experienced by another person whether these feelings are expressed openly or not. This is may not be an indifferent aloofness or an open rejection of the other person’s feelings nor is it a sympathetic joining in the feelings. Therefore, the physician must keep in mind that each patient’s feelings are experienced as something very personal to that particular individual. However, empathy provides an appropriate controlled, professional response to the patient’s affective reaction to illness and it protects the physician delimiting the extent of his/her effective involvement with the patient’s problem. On the other hand, Vance and Levasseur would add that empathy is not a psychological or emotional experience, nor psych leap into the mind of another person but openness to and respect for the personhood of another. Therefore, the basis of any helping profession is the welfare of the individual, a kind of sensitivity to people as human beings rather than people as cases. In that regard, empathy should belong equally to nurses and doctors since all them require empathy in both developing and exercising expert judgement.

However, in eighteenth century British moral theory based on altruistic conduct developed pity into the more complex notion of sympathy. This is why Hume is quoted as recognizing that pity is an uneasiness arising from suffering of others and that such uneasiness naturally tends to produce hatred and that allows for an altruistic response. Hume regards this one to be an operation within us of the sentiment benevolence that is extended through imagination. Therefore, from Hume’s explanation of benevolence denotes a desire for happiness or well-being of those one loves. The suffering of another human being awakens in us benevolence that motivates altruistic conduct. This account of Hume allows pity to extend more
in general than that of Aristotle because it does not require a stranger’s suffering to resemble in character or social position with either one-self or one’s loved ones. Schopenhauer’s analysis continuously recognizes that the compassionate person is another being and not oneself that is suffering. Rather, by sharing with another a suffering which belongs to him/her, characterizes his/her situation, the other’s distress becomes a motive for me. This means that according to this analysis compassion involves one’s identifying to a certain extent with another. However, saying that the barrier between ego and non-ego is for a moment abolished should not mean wholly identifying with the other by assuming his/her character as if no distinction still existing between oneself and another.

After discussing the work of the French phenomenologist Emmanuel Houset who published a remarkable study in which he reflects on compassion as basis for morality. Leget and Olthuis have come up with an argument that supports compassion to be an important source and basis of moral education. The argument of the two authors is based on the three following points; First, the authors hold that compassion helps one to remain close to one’s inspiration and motivation: by “being moved”, that means that one is set in motion towards morally good action. Second, compassion helps one to remain close to the suffering of a concrete and unique other person, without the risk of a universal appeal that results in losing sight of both the concrete other person and one’s own limitations. Third, the authors believe that compassion helps one to experience, understand and stay aware of the nonnegotiable, non-appropriable and non-calculable core of morality. The above idea seems to concur with the stand in China about end-of-life which mostly refers to those places that accept incurable dying patients whose main aim is to help the dying patients. These services are meant to help improving the patient’s quality of life. These include looking after patients, relieving their psychological problems and
comforting, controlling pain, soothing the anxiety and terror towards death so as to maintain their dignity so as to die easily in comfort. This seems to have resulted from the influence of so many kinds of myth in China that were mostly created by their ancestors to comfort humanity supported by the conviction that each individual’s life is doomed to move toward death from the moment of birth.\textsuperscript{669}

In the ordinary course of events, we expect some action from one who claims to care, even though action is not all we expect. Therefore, to care, we feel, requires some action in behalf of the cared-for. This implies that in considering the action component of caring in depth, we shall have to look beyond observable action to acts of commitment, those acts that are seen only by the individual subject performing them.\textsuperscript{670} In order to achieve qualitative health care there is great need for striking a difference between the relationships in curative medicine and care as the former seems to be brief and superficial. The paper would concur with Meulen who argues that care aims at supporting people and alleviating their pain and symptoms. In short care means a certain attitude which includes affection, compassion, dedication, patience and involvement. Therefore, care is more fundamental than curing since care tries to respect the uniqueness and value of a fellow human being. Meulen would argue further that care is in the first place a relationship between individuals whereby one side there is an individual who cannot take care of him or herself and is need of support by another person. While on the other side of relationship, there is somebody who can supply that support. Such individuals offer to help and support because of their concern for the needs of the patient or needy person to whom they feel should do something about his/her situation.\textsuperscript{671}

Click holds that all the compassion and empathy in the world cannot replace the skills and knowledge of the internist or surgeon, but still another aspect of the education of the
physician is its practical rather than theoretical nature. The author believes that much teaching takes place at the bedside, and students might be helped by what they see rather than what they hear in the lecture hall that may even influence their ultimate behavior. Otherwise in the modern times there seems to be tension between what patients want from their physicians and how in contrast they perceive the encounter. There seems to be a major dissonate between the patients and the physicians’ perception. Yet patients need caring as much as curing. Unfortunately, modern physicians enthralled with their newly discovered ability to cure seem to be seeking gratification in this capacity and forgetting about the caring mode and sometimes leaving patients frustrated and angry even after being cured from their illness. Myerscough and Ford explore the difference between curing and care. According to the authors’ view, curing is portrayed in a rather stereotyped view as a detached activity on the doctor’s part in which a patient is essentially passive. While on the other hand care would be taken to imply involvement, a holistic concern with all aspects of the patient’s situation. The word care can be used in different settings, but in the present context a physician who cares is not some sort of do-gooder, technically rather inept but always compulsively eager to immerse himself/herself in his/her patient’s emotional problems. In providing a simple mnemonic list the student may use for developing communication skills. The authors also say that the word care implies; comfort, acceptance, responsibility and empathy.

Noddings addresses the issue of reciprocity in the effort towards knowing the terms of the contribution by the human cared-for. In doing so the author claims that the recognition of caring by the cared-for is necessary to the caring relation. The cared-for need not be one-caring in order to constitute the relation. Yet needs to respond somehow, meaning that there is necessary a form of reciprocity in caring. At this stage the interest may be of developing a
coherent account of the part played by the cared-for in caring, but it is worth noting that there is empirical support for what emerges in the logical component of such conceptual framework. Therefore, the cared-for is free to be more fully himself/herself in this caring relation. Indeed, this being himself/herself, this willing and unselfconscious revealing of self is his/her major contribution to the relation. The implication here is that the cared-for plays also a vital role in the caring relationship. However, there are active moments of caring in which the engrossment must be present when one is caring, but even then, the cared-for is not an object. So whatever the cared-for gives to the relation either in direct response to the one-caring or in personal delight or in the happy growth before her/his eyes is genuine reciprocity and maintains the relation, and helps in preventing the caring from turning back on the one-caring in form of anguish and concern for self. Rogers recommends some degree of reliance as a necessary part of interactions between doctors and patients as the doctor relies upon this testimony to guide his/her subsequent history-taking and examination. Therefore, a trusting stance is taken by the author to be central to the physician-patient relationship. This is why some degree of trust would be necessary to allow patients to express their concerns without fear of being disbelieved or disparaged. Rogers continue commend that over time, the presence of trust facilitates the development of deeper physician-patient relationships, which may be necessary for certain types of care, such as disclosure and management of sensitive or potentially stigmatizing problems. Additionally, when a patient is trusted, his/her experiences are validated and her competence recognized. On the other hand, the untrustworthy patient does not share the overt goals of the consultation but feigns symptoms which might be to obtain drugs of addiction. Furthermore, physicians may have difficulty believing patients with surprising or unusual symptoms as the acceptance of astonishing reports requires both a high degree of trust in that person’s veracity.
and also a willingness to suspend accepted medical orthodoxy. Rubin makes an observation following different interventions he has performed in emergency situations. The author has realized that in Good Samaritan situations, doctors and other providers are assuming risk of reputation and livelihood. Fortunately, his experience suggests that the individual victim and family often express their thanks and other emergency workers seem grateful to have someone else step in. But unfortunately the author has been repeatedly baffled by the lack of acknowledgement by those “in charge” especially of the public places where these emergencies have occurred. Therefore, the physician and victim, strangers no more, enter into a relationship based on assumptions and expectations. Perhaps society holds a different set of expectations and standards for this privileged group, assuming that the Hippocratic Oath and the privilege itself include 24/7 availability, duty and obligation as part of the deal.

Furthermore, Evans addressing on the role of the patient in his/her health care, the author recommends that in seeking medical care a patient does in fact have, and should be recognized as having, at least the following 10 duties. The first duty is to participate in a “‘healthcare jurisdiction’” This implies that the patient should ensure that he is a recognized member of an institutional or social form of healthcare provision. The second duty is to uphold his/her own health. This means that the patient should preserve and promote his/her own health and well-being so far as it is reasonably open to him/her to do so. The third duty is to protect the health of others. In that regard, the patient should avoid being a source of ill health for others within the same health jurisdiction. The fourth duty is to seek and access healthcare responsibly. For instance, general practice surgeries already expect that patients with non-urgent conditions should accept the need to wait for an initial primary care appointment on a later day. The fifth duty is of truthfulness. For instance, the patient should divulge everything that is relevant, and
he/she should avoid embellishment and evasion. The sixth duty if of compliance whereby the patient should comply with his clinical management and medication unless he has good reason to think that these have not been properly arrived at. The seventh duty is of inpatient conduct. For instance if the patient is required to stay as an inpatient during the course of his treatment, he/she should be a responsible member of any inpatient community in which he/she finds himself or herself. The eighth duty is of recovery or maintenance. Such duty requests that during and after treatment, the patient should wherever possible promote his own recovery or, where this is unrealistic (for instance, in the case of chronic illness), try to maintain a reasonable quality of life. The ninth duty is of research participation whereby the patient should take part in clinical research relevant to his treatment when he/she is asked to do so. The tenth duty is of citizenship which exonerates the patient that whenever the opportunity arises should promote the healthcare jurisdiction that he/she has accessed.677 Lynch would argue further that patients are asked to make relatively minor sacrifices in order to respect physician’s conscience. This kind of idea seems also to be supported by different sources among which the author quotes AMA and Pellegrino when they provide recommendation for mutual respect that is expected from both physicians and patients’ two sides. However, the author recommends that patient’s responsibility and obligation should extend beyond the community care to physician interests.678

Unfortunately, according to Meulen, in places like United States of America, the impact of legal rules on health care has seriously affected the relationship between care providers and patients in a very negative way. For instance doctors and other health care practitioners are afraid of litigation and take a defensive attitude limiting themselves only to basic care and only when the patient has explicitly given his or her consent. This has come about resulting from ethics of justice and the contract perspective that favor emancipation of the patient in the health care
system that should be replaced by ethics of good which emphasizes on responsibility, involvement, solidarity and other values that are promoted by ethics of care. While Lynch argues in favor of physicians putting the patient’s interest and care first, but the author also calls for consideration so as not to impose a lot of obligations on physicians especially when it comes to emergency situations. Some sacrifices may under compromise approach go too far and eliminate too much of physician freedom and moral diversity. However, this is not to say that individuals facing an emergency situation should not receive needed attention from physicians. Instead, this will require a comparative assessment of sorts of consequences likely for patients who are denied care in such contexts and those considerations that counseled against enforcing physicians’ nonemergency hard-case obligations. Furthermore, there are pronouncements throughout the history of medicine that reinforce on health care quality. For instance The American Medical Association’s (AMA) first code of ethics states that a physician should not only be ever ready to obey the calls of the sick but also his/her mind ought to be imbued with the greatness of his/her mission, and the responsibility he/she habitually incurs in its discharge. However, such obligations are the deeper and enduring, because there is no tribunal other than his/her own conscience to adjudge penalties for carelessness or neglect.

However, according to Marcum the root of compassion resides in our shared humanity, the awareness that misfortune may befall anyone at any time. For that matter compassionate love permits a physician to be engaged emotionally in an appropriate manner for addressing a patient's suffering and thereby allows for a connection at a fundamental level with that suffering. The implication here is that a physician so affected cannot help but react with authentic and genuine compassion to a patient's suffering. On the other hand Jos V.M. Wellie understands compassion as having basis from sympathy. Wellie holds that the moral virtue of compassion
presumes the anthropology of sympathy and also presumes that human beings are in fact able to share in one another's "passions," develop an intersubjective rapport, assess and evaluate another's best interests, and, on that basis, act beneficently. The author goes further to demonstrate how the first philosophers devoted special attention to sympathy as a key notion in ethics that seem to have been the British Moralists of the 18th century. The notable examples are mostly of Joseph Butler, David Hume, and Adam Smith. For instance Smith explains the working of sympathy in terms of imagination and holds that humans have no immediate experience of what other men feel, but can only conceive what we ourselves should feel in the similar situation. For instance in a sympatric relationship I imagine myself to be that other person in his or her misery. Some two centuries later, the German philosopher Max Scheler took up the challenge again to explain our evident capacity to be in touch with the other in his or her otherness and, on that basis, behave compassionately toward him or her. Scheler says that one must be aware of somebody else's suffering in order to help. For instance I must know a child's crying to be an expression of pain, if I am to sympathize with such suffering.

Thomasma and Kushner would further propose compassion as being a virtue that strengthens empathetic feelings of suffering with another being which traces its origin from the word to co-pati, suffer-with. The feelings themselves arise naturally in our sensorium and cause us varying degrees of shock, horror, sadness, negative reactions, even repulsion. The author continues to say that there is a huge range of feelings caused when another being suffers and because of this range of feelings, compassion, which should not be identified with the feelings themselves, is a virtue that urges us forward from the feelings, prompting toward explicit activities of care. Therefore, compassion as a virtue in medicine is more than pity or sympathy. Rather true compassion is more than the complex of feelings but flows over in a willingness to
help, to make some sacrifice, to go out of one's way. Henri Nouwen is also quoted remarking that no one can help anyone without entering with his whole person into the painful situation; without taking the risk of becoming hurt, wounded, or even destroyed in the process. However, the term end-of-life care has been given different meanings. For instance in China this term has the same meaning as the English term of hospice care that refers to those special places which accept incurable dying patients. The purpose of these places is not to lengthen the patient’s life span but to improve the patient’s quality of life. This includes relieving their psychological problems, comforting them, controlling and easing their pain, soothing the anxiety and terror of death for both patients and their family members. Among the Chinese each individual’s life is doomed to move toward death from the moment of birth. Although in the present time humanity is beginning to regard death in a more objective way but still raises the concerns over care at the end of life because both the public and many medical personnel still find this as a strange concept difficult to understand. China’s end-of-life system aims at one focal point which is to relieve pain because of the belief that just before the end of life many patients suffer from extreme and unbearable pain. So this approach is hoped to help reduce the family members’ spiritual, psychological and economic burden, and save labor and material resources for promoting economic development.

Additional to the previous point, Kelly would argue that by suffering people should be able to relate to others and help them carry their burden. The implication is that the experience of human suffering and hardship makes it possible for people to understand what others are enduring, be less judgmental of them and their behavior, and be able to join them in empathy and sympathy. According to Kelly sensitive persons would be better caregivers than those without such virtue. MacIntyre would also ask how one can account for the trust that seems a
necessary component of the doctor–patient relationship without relying on an ethic of virtue.

“Medicine is a practice in which the goods internal to the practice extend our powers in a manner that we are habituated in excellence.” However, Lo”fmark argues further that compassion and fidelity with the patients would lead to a deeper patient–physician relationship, which could open up for an ongoing dialogue. On the other hand, the author expresses that modern healthcare, with its shorter and shorter hospital stays; it has to find other forms for patient–physician–family relationships. Therefore, courage, honesty and justice are required to develop uniform procedures of communication and decision-making in order not to cause wrong expectations and to organize satisfactory care for all patients. 689

In some desperate situation a patient may grab the physician hand with a terrible question wanting to know whether will be all right. This requires a physician to be kind in providing an answer that does not present the bleak outlook in all its pleasantness even if not necessarily the truth. If such question is repeated then time would be set aside for discussion and other companions may be called in as well. The process would require being done gradually in small stages or repeated without irritation so as to let the physician enter the patient’s frame of mind and discuss what needs to be done in an atmosphere of prudence not panic.690 However, Beauchamp and his co-author recommend that nurses and physicians need to understand the feeling and experiences of patients to respond appropriately to them and their illness and injuries. Generally, compassion focuses on others’ pain, suffering, disability, and misery. For that matter, physicians and nurses who express no compassion in their behavior often fail to provide what patients need most. However, compassion also may cloud judgment and preclude rational and effective responses. This problem can be counteracted by medical education and nursing education designated to inculcate detachment alongside compassion. The language of detached
concern and compassionate detachment appropriately appears in health care ethics expressly to identify a complex characteristic of the good physician or good nurse.691

Talking about the order of ethical responsibility, Edmund D. Pellegrino mentions compassion among the moral imperatives that fall in the first order of responsibility which clinicians and physicians must have in order to remain with patients they undertake to treat. Pellegrino refers to this as being a prime ethical concern for each physician to consciously establish this hierarchy of values and priorities which will define his individual and social ethical postures. The author recommends that the ethical responsibilities of the professional group should be broad since those of the individual may of necessity be narrow. However, compassion and other priorities need to be made more relevant to our times by extending them towards the right direction. Failure in this realm is to violate the trust underlying the personal relationship which characterizes medical care as nothing is more unconscionable or socially unacceptable.692

According to Scot D. Grosse justification for economic evaluation is the principle of opportunity cost defined as the value of what could be done if resources were otherwise employed. For that case decision makers should ask themselves whether funding an intervention is the best use of resources. A health intervention is cost-effective if compared favorably with other policies in terms of the ratio of desired outcomes to resources expended. The author observes that there are two main types of economic evaluation: cost-effectiveness analysis (CEA) and cost-benefit analysis (CBA). Cost- effectiveness analysis is preferred for dominating contemporary economic evaluation approach in public health, except in regulatory analysis where cost-benefit analysis has long been favored.693 However, cost-effectiveness analysis compares interventions in terms of the relative cost to achieve a desired outcome. According to Grosse cost refers to the resources required to provide an intervention or to care for someone with a particular condition. In the
health system perspective, only medical costs are included, whereas in the societal perspective all direct costs should be included. Therefore, according to cost-effectiveness analysis can facilitate the systematic comparison of policies or programs in terms of relative cost per unit of achieved outcome on average. On the other hand, Garber and co-authors are quoted as saying that when cost-effective analysis results do not guide health policy decision making, this is not because costs do not matter, but that costs are not systematically considered relative to expected outcomes. Another thing is that cost-effectiveness analysis can be used to calculate either health outcomes directly or intermediate outcomes such as the cost per case of disease detected or averted. Compared to other approaches, there is no single approach used to calculate utility weights for health states because different methods can yield different estimates. Furthermore, Weinstein and authors are also quoted proposing that the results of cost-effective analysis must be interpreted to determine whether an intervention yields good value for money and an intervention can be considered relative to another intervention or to a threshold or benchmark value. While Neumann is quoted commenting that adherence to cost-effective analysis guidelines is inconsistent. On the other hand, the author admits that such seems to promise improvement over time. 694

Roger Crisp quotes Aristotle in defining compassion – eleos – as follows: Let compassion be a sort of distress at an apparent evil, destructive or distressing, which happens to someone who doesn’t deserve it, and which one might expect to happen to oneself or someone close to one and this when it appears near. 695 Furthermore, Charles J. Dougherty and his co-author define compassion as the word having traces from two Latin roots: com meaning "together with" and pati "to bear or suffer." This same word pati is also the Latin root of the word patient. For that case the etymology of this term suggests the ability to share or to enter into
another's experience of suffering. In explaining meaning of how one enters into another's experience of suffering. The authors recommend one useful insight that can be drawn from the work of the philosopher Arthur Schopenhauer, who claimed that compassion is at the very core of the moral life, not only for physicians but for everyone. Schopenhauer is quoted as holding compassion to be a stirring within oneself by which another person's "weal and woe go straight to my heart... Consequently the difference between me and him/her is no longer an absolute one."696

Unfortunately, today's society discourages the actions one would hold to be a necessary component of compassion. Unlike traditionally whereby the community underlines compassionate care of sick individuals by providing the structures needed for individuals who are sick to be surrounded by those who both loved them the most and also knew their values. According to this perspective, decisions about healthcare were made within a context of compassion and respect for the values of the patient. The care of such individuals was impervious to marketplace economics. This was an act of mercy, not a commodity to be traded or delivered. Whereas today the worry is instead about the resources the sick person may divert from our other projects.697 According to John Rawls there is an underlying equality which gives us all rights and ties us together, in spite of our different endowments. Rawls makes a reference to it in his theory of justice using the image of “veil of darkness.” In as much as we all share the concept “human” there is a certain degree of equality among us and there are certain rights which belong to each of us. We also have responsibility for and toward each other.698

According to Tom L. Beauchamp and James F. Childress define justice as “fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation.” On the other hand, the authors refer to an injustice as involving a wrongful
act or omission that denies people resources or protections to which they have a right. The authors argue further that distributive justice refers to the distribution of all rights and responsibilities in society, including civil and political rights. Hence distinguishing it from other types of justice, criminal justice included. Justice therefore implies societal consensus or agreement. This implied agreement regarding justice, even if it is not explicitly articulated, is crucial. This would seem to concur with Kant’s concept of justice whereby according to the author justice applies only to external and practical relationship of one person to another in which their actions can in fact exert an influence on each other. On the other hand, Kant argues that every action is just that in itself or in its maxim is such that the freedom of the will of each can coexist together with the freedom of everyone in accordance with a universal law. Hence, the universal law of justice according to Kant is an act externally in such a way that free use of your will is compatible with the freedom of everyone according to a universal law.

Furthermore, according to Aristotle, justice would be approached as complete virtue to the highest degree because it is the complete exercise of complete virtue. Therefore, according to Aristotle, the person who has justice should be able to exercise virtue in relation to another. On the other hand, the worst person is the one who would exercise his/her vice towards him/herself and friends, as well towards others. The author strikes the difference between justice and virtue saying that for virtue is the same as justice, but what is to be virtue is not the same as what is to be justice. Therefore, in so far as virtue is related to another, it is justice, and in so far as it is a certain sort of state unconditionally it is virtue. Aquinas would argue differently that justice does not seem be virtue. The reason being that we look to a profit that is estimated not by pecuniary gain but by the acquisition of godliness, therefore, to do what one ought to do is not a virtuous deed although it may be an act of justice. For that matter justice is not virtue. Instead
human virtue is one which renders a human act and man himself good. The same applies to justice. A man’s act is made good through attaining the rule of reason which is the rule whereby human acts are regulated. So justice regulates human operations it is evident that it renders man’s operations good. This is why good men are so called chiefly from justice and the luster of virtue appears above all in justice. However, Daniels would bring another point to light that even if the “specific content of a right to health – the entitlements it includes - cannot be specified independently of the context in a given state with given resource limits and health needs.” Therefore, it would be considered unjust that human beings should be forced by the socioeconomic and geographical situation in which they find themselves to face the threat of incurable diseases for instance HIV/AIDS alone.

However, Daniels and Sabin would interpret some situations differently. The authors observe that although some may blame scarcity of resources, yet true scarcity may not be in existence. Rather, scarcity according to the authors may very well be the result of only waste or irrationality or the frivolity of trivial pursuits. Therefore, the authors would argue further that there is no real scarcity of food, education, health care and resources when billions are spent on unnecessary tests and procedures, or to highly pay health care executives or as dividends to investors. According to Norman Daniels there is something of a social and natural lottery that assigns people to different fortunate and unfortunate socioeconomic, geographical and political locations, but still asserts that “just health has global dimensions.” However, this affirmation does not imply literal egalitarianism but, that there is a line below which one should not go as Engelhardt likewise states in The Foundations of Bioethics. Seemingly, it would be the responsibility of the fortunate to provide justice to the unfortunate. Otherwise it would appear unjust not to save those we can and who cannot save themselves from inhuman and deadly
situations wherever they are. The implication here is that human society cannot be truly free while some of its members are suffering under the oppression of some pandemics, which are mostly facilitated and accelerated by extreme poverty.

On the other hand, Beauchamp and Childress would regard compassion, fidelity, empathy and love as traits to be valued and emphasized by ethics of care for intimacy in personal relationships. Therefore, the emphasis here is not only on what physicians and nurses do but also about how they perform those actions, the motives that underlie them, and whether their actions promote or thwart positive relationships. Marcum observes that although biomedicine is responsible for the "miracles" of modern medicine, paradoxically it has also led to a quality-of-care crisis in which many patients feel disenfranchised from the health-care industry. The author adds that today, biomedicine is the prevailing approach to medical knowledge and practice which reduces the patient to a physical body composed of separate components that occupy a machine-like structure. On the other hand the biomedical practitioner's emotionally detached concern is to identify a patient's diseased body parts and to treat or replace the diseased parts in a fashion analogous to a mechanic. This is followed by commendable results mainly; to cure disease, to relieve pain, and to prevent death. These biomedicine's technological advances need to add a human face to its practice so the patient is recognized as a person occupying a lived context or a socioeconomic environment. The general concern goes beyond the biochemical or biophysical problem to address the patient's disease in a fuller context but the patient's experience of his or her illness is considered important as well.

Furthermore, according to Beauchamp and his co-author remark that many human relationships in health care and research involve persons who are vulnerable, dependent, ill and frail. So feeling for and being immersed in the other person are vital aspects of the moral
relationship. Otherwise, a person may seem morally deficient who acts according to norms of obligation without aligning with the feelings of concern and sympathy for a suffering friend. The fact here being that good health care must often involve insight into the needs of patients and considerate attentiveness to their circumstances, which often drives more from emotion than reason. Furthermore, John Paul II comments that when life is challenged by conditions of hardship, maladjustment, sickness or rejection and earthly existence is drawing to a close. There should be places where suffering, pain and death are acknowledged and understood in their human meaning. In today’s cultural and social context in which science and practice of medicine risk losing sight of their inherent ethical dimension, health care professionals can be strongly tempted at times to become manipulators of life, or even agents of death. However, their responsibility should be supported by the intrinsic and undeniable ethical dimension recognized by the ancient and still relevant Hippocratic Oath which requires every doctor to commit himself to absolute respect for human life and its sacredness.

Generally, while the mere businesses of taking care of a person may be entirely a matter of efficiency and quiet impersonal. Caring for a person on the other hand is a decidedly moral relationship. For instance, a man is said to care for his wife and that means vastly more than providing for her physical needs but that he has an attitude of respect and solicitude toward her in all things. The same attitude is expected of a physician toward his/her patient. So that a patient may not be viewed as a problem but as a person with a problem and that the patient is a person with feelings of hope or despair, of purpose or defeat, of loneliness or fraternity. However, the challenge extends towards maintaining the physician competence especially in today’s environment where the patient has a right to access to the vast stores of new medical knowledge. Therefore, for the physician to meet with such type of challenge, the physician is encouraged to
function as one element in a vast matrix of consultants, technicians, apparatus, and institutions, all of which may contribute to his patient’s wellbeing. According to Pellegrino competence is also the prime humane precept and the one most peculiar to the physician’s function in society. While the consequence of a lack of compassion may be remediable, yet medicine cannot clearly attain in the ethical eminence to which it is called without both compassion and competence. This is why according to Cassell the idea of empathy is not only important for the caregiving professions because illness is a threat not just to a person’s interests but also to the very possibility of having interests of the sort that make human life worth living. So the main goal of the caregiving professions is the amelioration of suffering which according to Cassell can easily lead to the destruction of the person. Since personhood is not just by human body or as a subjective inwardness, but by a complex of social rules, identifications and relationships. Physical illness can undermine a person’s ability to function as a parent, spouse, friend, scientist, artist or even citizen. In short physical illness can threaten the constitution of a person and cause suffering. Similarly physicians may cause suffering through a failure of knowledge and understanding. This lack of knowledge may come about due to the working in dichotomy contrived within a historical context far from the one of the physicians and end up artificially circumscribing the task of caring for the sick. This concurs with the idea that true empathy should focus on the impact that disease and its treatment should have on a patient’s ability to lead a meaningful life.

According Connelly the professional ethical standards, especially the call to “do no harm” and to benefit patients, are breached when patients feel abandoned, rejected, or let down by physicians’ failure to acknowledge and uphold the intrinsic value of human relationships. This situation will make physicians miss the experience of human openness and vulnerability
and the chance to experience unconditional love and the power of human connection. Furthermore, by failing to experience the healing nature of presence itself, the physicians will miss the opportunity to experience the profound satisfaction and joy of being a medical professional, one of the fortunate persons invited to intimately experience the lives of others. The above ideas would concur with that of Compte-Sponivile when arguing that the point of abandoning outmoded concepts of cause and seeing illness in terms of events unfolding over time is to realize that proper treatment is what most simply and effectively changes the story. According to Compte-Sponivile compassion as a virtue should let us open not to all humanity but also to all living beings or, at the very least, to all suffering beings. This is why according to Cassell understanding the treatment of disease or patients would be impossible without seeing that at every step the physician, the sick person and their relationship are woven into therapy. Therefore, illness is understood as a story if only part of which occurs in the body and pathophysiology if it extends into the personal, interpersonal, familial and even communal dimensions of the sick person.

Justice plays a big role in health care. In that regard, Beauchamp and Childress would argue that by the fact that we are human like other people then we all have some responsibility for them too. According to these authors injustice would, therefore, involve “a wrongful act of omission that denies people resources of protections to which they have a right.” For instance, one can ask whether it is unfair that life expectancy in Swaziland is half of that in Japan. Similarly, one can also argue that it is unfair that a child born in Angola/Africa whose chance of dying before age five is seventy three times of that one born in Norway. However, one can also ask whether it is just that a mother giving birth in Sub-Saharan Africa has a one hundred times higher chance of dying in labor than one delivering in industrialized country.
In comparing between the ethics of justice and the ethics of care, Held commends that an ethic of justice mostly focuses on the questions of fairness, equality, individual rights, abstract principles and the consistent application of them. On the other hand, the author describes an ethic of care as focusing on attentiveness, trust, responsiveness to need, narrative nuance and cultivating caring relations. Furthermore, Held argues that while an ethic of justice seeks a fair solution between competing individual interests and rights. On the other side an ethic of care sees the interests of carers and cared for as importantly intertwined rather than as simply competing. Whereas justice only protects equality and freedom, care fosters social bonds and cooperation. However, Wikler contends that rationing may happen at personal level, organizational level and even at a national level. Within such situation the author would recommend that those who have more will have to give up some of their own for those who have not. This implies that they will, therefore, have to go without some luxurious or secondary services. Unfortunately, the reality seems to take rationing as part and parcel of life with resources being finite. Beauchamp and Childress agree that rights to health and health care encounter theoretical and practical difficulties of allocating, rationing and setting priorities. The authors observe that rationing originally did not suggest harshness or an emergency. Rather, rationing meant a form of allowance, share, or portion and only of recent has been rationing linked to limited resources and setting of priorities in the health care budget. At least the authors attribute three relative meaning or types to rationing. The first type is related to denial from lack of resources. The second type of rationing derives not from market limits but from social policy limits whereby the government determines an allowance or allotment and individuals can be denied access beyond the allotted amount. The third type of rationing is an allowance or allotment is distributed equitably but those who can afford additional goods are not denied access.
beyond the allotted amount. The authors seem to favor the third type of rationing by focusing on rationing by age and on highly expensive treatments for instance heart transplantation.\textsuperscript{723}

Remarkably, Jonsen argues that since a person is taken to be a social, spiritual, psychological, emotional and intelligent being, the distinction between ordinary and extraordinary means of sustaining life and that between withholding or withdrawing treatment should consider the all of the individual’s dimensions. For instance there should be consideration about one’s domestic economic, familial obligations, the neighborhood that has become a part of his/her human existence, the personal and the common good and whether a man’s fiduciary relations with God and with his fellow man have been settled.\textsuperscript{724} Cahill would additionally argue that the person’s autonomy, liberty and dignity must also be respected. Furthermore, having given priority to the autonomy, liberty and dignity of the patient, the agents involved should also consider the risks and benefits involved in, for instance, initiating or terminating life support or hydration and nutrition to the persistent vegetative state or terminal patient. Cahill proposes that there should be consideration done on the availability of resources, economic capability of the family or patient and that of the community as secondary factors.\textsuperscript{725}

Furthermore, Baily develops rationales for public health programs under efficiency and equity. Efficiency argument holds that the government organizes and finances activities that produce diffuse benefits for many people, for less money achieved through individual actions. The equity rationale arises in these public activities because they exist to provide health care for people who cannot afford to pay for it. This societal moral obligation to achieve fairness, or equity, in access to health care for all is acknowledged by many world countries, including United States of America.\textsuperscript{726} However, the principles of clinical ethics seem to have proved insufficient for the resolution of many of the ethical problems that arise in organizations. In the
effort to solving such problem Winkler and Gruen propose that there should be “care with compassion” as one of the principles which health care organizations can apply more especially in protecting the physician-patient relationship and to ensure that health care givers are able to provide non-conflicted patient-oriented care. The authors argue that compassion and kindness are supposed to be the appropriate responses to suffering and can be promoted by role models and professional and informal emotional support. This is why the authors would propose that within a health care organization’s care giving role, therefore, competence, compassion, trust and ethical decision making from the basis of an overarching principle, preferably, care with compassion.727

Additionally, Bailly proposes that during the assessment of the benefits and costs of care there should be a possible inclusion in the adequate level, benefits and costs. These should be understood broadly as the positive and negative effects or the good and bad consequences, including those that would be difficult, may be impossible to measure satisfactorily.728 This goal can be achieved by establishing a health care system with universal coverage and a cost-conscious bottom morally adequate but also generous enough that the average person in the population considers the care satisfactory and only occasionally feels the desire to purchase more. For instance in the United States of America health care system has been referred to be as a patchwork of uncoordinated public and private financing and delivery structures that fail to meet the equity standard outline here, for any reasonable definition of adequacy and excessive burden.729

However, according to Cody there seems to be a widening gap between the medical “haves” and “have-nots.” The increase in health care disparities moves from the purely medical efficacy realm into the social justice realm. Consequently, in the effort to finding answers to
these questions it has led to the newborn screening, for instance, becoming one component in the complex tug-of-war between socialism and capitalism in health care.\textsuperscript{730} According to Mackler when a member of the society cannot afford to pay for basic health care, the society, which is under God’s reign who is holy and just would be challenged to be like him, acquires the obligation to provide for his/her health needs. Therefore, it is an implied Jewish tenet that all people have decent minimum health care and that society is responsible in assuring that decent minimum. Since the concept “decent minimum” is philosophical and rather arbitrary, Mackler clarifies “that the standard for health care that must be provided is that of need.” However, its importance in the Jewish community, it is to meet the needs of the poor is a “perfect obligation which must be met fully in every case.” This has to be done at both a societal and personal level. In the case of limited resources, only few would get it especially those who did not contribute to their own illness should be given priority.\textsuperscript{731}

**Conclusion**

The chapter has tried to develop the gradational approach whereby the physician fulfills the duty of revealing the patient’s health information gradually in accordance with the patient’s ability to cope with such information and also recognizing the time left for the patient to deal with such knowledge.

In expounding the thesis the chapter has tried to analyze on disclosure as a process whereby the physicians are supposed to provide information about a proposed medical investigation or treatment to the patient. However, the preference here is that decision making should always go according to the patients’ ability to understand their diagnosis, prognosis and
its implications, ability to evaluate and ability to communicate their choices. Unfortunately, medical information may prove to be very hard for patients to digest. Therefore, it would be advisable that such information be provided in small chunks so that a physician may not find an excuse for informing a patient on pretext that something was hard to explain when even it can be stated in simpler terms using a drawing. This is why if the information is used wisely can as well easily enhance the physician-patient relationship. On contrary, the information that has been poorly employed has a big possibility of destroying that same relationship.

Furthermore, in order to improve on disclosure the psychological sequelae of breaking bad news in an abrupt and insensitive way should be avoided. Instead some efforts should be dedicated in encouraging the art of truth telling that relies on the skills and attitude of the physician which take the patient into his/her confidence and give him/her a true impression of his/her illness. This may also help in avoiding poor delivery of bad news which stems from being too blunt, discussing it at an inappropriate place and time, and conveying a sense of no hope. For instance, a patient from a particular culture may prefer being approached by talking about things not related to the illness first and gradually move the conversation to things indirectly related to the patient’s diagnosis by asking about symptoms experienced. Therefore, a patient should be invited to speak of anything that troubles him/her and the physician should be able to listen because by listening to patients, the physician will be able to address and clarify the patient’s complaints.

In the second paragraph the chapter has tried to revisit the notion of compassion in the effort to improve on physician-patient communication whereby compassion has been presented as being central to the purpose of medicine and the care of patients and their families. However, compassion should not be confused for empathy but rather think about what is meant by the term
“feeling with” the other. For instance, empathy has been defined as a process or event by which one perceives and understands the subjective experience of another person. However, empathy should be taken to be much more than illusion and very difficult to distinguish from sympathy simply because; where empathy feels “I am you” sympathy may well mean “I want to help you.”

Furthermore, compassion should not be confused for pity because pity has its roots in fear and carries a sense of arrogance and condescension, sometimes even smug feelings of ‘I am glad it is not me.’ Therefore, compassionate response is not to another’s pain per se but to the being who suffers unnecessarily. However, compassion has also been presented or viewed from a different angle whereby it has been seen as a sister to empathy, a feeling together, and a perception that the other person’s world is partly his world too. This is why the basis of any helping profession is the welfare of the individual, a kind of sensitivity to people as human beings rather than people as cases.

Similarly, in order to achieve qualitative health care there is great need for striking a difference between the relationships in curative medicine and care as the former seems to be brief and superficial. This is why care refers to a certain attitude which includes affection, compassion, dedication, patience and involvement. Unfortunately, modern physicians seem to be enthralled with ability to cure and forgetting about the caring mode which sometimes leaves patients frustrated and angry even after being cured from their illness.

Conclusively, the chapter having tried to analyze on disclosure as a process and revisited the notion of compassion in the effort to improve on physician-patient relationship. These topics are still open for further research. However, at this point can conclude recommending for the
application of this proposed gradation approach as one of the ways towards making truth telling possible especially in those cultures where this principle has seemed impossible to practice.


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Chapter Six

Presenting the Sub-Saharan African Ethical Perspective

Africa is a home to a variety of between 800 and 1200 peoples with different cultures. It is a continent of complexities, with a wide diversity in terms of climate, topography, culture, peoples, and languages. Despite this diversity, there is a common Africanness about the culture and world-view of Africans. This characterizes the people’s relationship with the environment and with each other. The chapter will present the Sub-Saharan African ethical perspective in the following paragraphs; focusing on the African concept of the person, different concepts of individual, implication for health as well disease, implication for death and suffering and implication for truth telling.

a. Focusing on the African Concept of the Person

The first paragraph will focus on the African concept of the person. African ethics can be approached by being aware of how Africans understand the human person and the decisive role played by the community. Ikuenobe seems to support the above idea when arguing about the African conceptions of personhood and community. The author recommends that in order to appreciate communalism in the African cultures, there is need for understanding the conceptions of a person, community, and the relationship between a community and a person. The relationship between an individual and her/his community and the responsibility that is dictated by this relationship indicates the foundation for moral reasoning and moral principles in African cultures. Thus the moral view of a person which is based on the social and moral identity that a person has or acquires comes from social recognition. In other words the moral self is not the
Western liberal, rational, autonomous, solipsistic, atomistic and individualistic self that is exemplified in Kantian ethics and metaphysics. Rather, the moral person in the African view is a rational, emotional, and autonomous person who has been sufficiently equipped by the normative attitudes, structures and principles of his/her community.733

Generally, in African traditional life the individual does not and cannot exist alone except corporately. Therefore, whatever happens to the individual affects the whole community and vice versa. This leads to the cardinal point in the understanding of the African view of person where an individual can only say: “I am, because we are, and since we are, therefore I am.” 734 According to Bujo the above principle would articulate the conviction that each one becomes a human being only in fellowship of life with others. However, behind this lies the view that the human person acts more effectively to the extent that he/she holds fast to solidarity with those like him/herself but rather the entire community and indeed for the whole humanity. Thus one is ultimately related to all human beings.735 Menkiti also recognizes Mbiti’s description of an individual’s relation to the group that “I am because we are” and regards this formulation as useful starting point for his discussion. However, commends that such claim connection between the individual and community takes on a particular form moving in a trajectory that should not be confused with others. According to Menkiti, the notion at work here is the notion of an extended self and looking at the African conception of the person should not be confused to mean that every individual has a body part from the body of every other individual within his/her community but rather it is conveying a message that each stands alone as a biological fact. The author however, admits that in the stated journey of an individual towards personhood, a community plays a vital role both as a catalyst and as prescriber of norms. Therefore in African tradition societies, the project of being or becoming persons is believed as a serious project that
stretches beyond the raw capacities of the isolated individual and it is laden with possibility of triumph but also failure.

Most African cultures emphasize the value of a holistic view of a person that affirms the importance of the community, society and the family. According to this view the community always comes first which is opposite to the Western view whose emphasis is on the individual. In this setting an individual is seen as an architect of his/her own personality. This emphasis of the individual rights has culminated among many other good things but also into a litigious society where individuals no longer value harmony but rather trust in the quest to be individual and different from others. This would sound contrary to what goes on among African cultures whereby an individual is born out of and into the community; therefore he/she will always be part of the community. This is why there are proverbs used in day-to-day speech among Bantu languages in Africa that discourage individualistic tendencies and even individualistic people are looked down upon. Interestingly enough, in examining the importance of moral sense in the defining of the person within the African context, such traditional understanding in this area may make a great deal of sense given the special worth attached to person, not only to Africa but also elsewhere in the world. For instance, John Rawls in defining what is meant by the general ethical requirements of respect for persons. The author further notes that those who are capable of a sense of justice are owed the duties of justice with this capability construed in its sense of a potentiality which may or may not have been realized. The author holds that equal justice is owed to those who have the capacity to take part in and to act in accordance with the public understanding of the initial situation. Therefore, according to Rawls, the sufficient condition for equal justice is the capacity for moral personality.
According to Nkurunziza community means participation of life which forms communion and there is life when life received by the individual is understood as life received and shared. This implies that solidarity and brotherhood make the network of the life in the community. On the other hand, the African traditional community is organized in such way that satisfies the basic needs of all its members and human need would be taken as a criterion of behavior to the extent that no traveling stranger would lack for instance water to drink. Furthermore, people are valued not because of what they have achieved but because of what they are. Their presence is more appreciated and achievements come as second factor to one’s integrity. For instance old people among African traditional societies are respected and taken care of because of what they are and stand for; they are living expressions of the dignity of life.739 On the other hand, Ikuenobe defines the community as a normative structure that involves various kinds of formal and informal processes of education by virtues of which the individuals in the community are fused together as a collective entity. Therefore, according to the author the community in African cultures is a community of both learning and learners and a community can be defined by its ability to guide its people towards achieving personhood. In that sense the author argues that each adult members have the responsibility of morally educating a person. Hence the bases for the view in traditional African cultures that, it takes a whole community or a village to raise a morally good child and in that perspective the morally good child is considered as the pride and proper representative of the community.740

According to Bujo the African relatedness does not only mean in terms of blood relationship. Instead one can even become a relative without having a purely biological origin in common. For instance among the Banyarwanda when they speak of Ubupfura, which is fundamental quality for characterizing every person. This nobility of heart is an ideal toward
which every member of the community should strive in order to enrich others. The same thing applies to Burundi people when they speak of *Ubushingantahe*, they also refer to the idea of being in a state of being so thoroughly humane and that makes one self all things to all persons. Ultimately, a community can enjoy a life worthy of the name only if each member makes the other another “him/herself.”

Among the Bakiga people of Western Uganda friendship used to be sealed by a blood pact or covenant between people that are not even related biologically and such relationship would have far reaching impact on both two individuals and their families. Each of the individuals promised not to kill the pact-brother and if this happened the former’s house would be destroyed and both his wife and milk cow be killed by the pact. The wife would not refuse food to her husband pact-brother so as not be killed by that pact. If enemies fall upon on the pact-brother and raises an alarm the other one is obliged to save him rest be killed by the pact. All these would be exchanged through the promise made the two people taking a blood pact or covenant.

In addressing the issue of personhood, Kagame claims that the Bantu do not only possess intelligence but also “the heart.” The author argues that with the intelligence, the human being is not only capable of reflecting and meditating upon the data of his/her senses but also able to compare the facts of knowledge one has acquired to invent something new by combining previously acquired knowledge. Therefore, the author regards the heart to be the one integrating al the interior that a person is, it harmonizes the operations and acquisitions of intelligence. By just looking at Kagame’s argument one may take it to be misleading but holding to the fact that he claims that Bantu regard this human heart to be in charge of the operations of the intelligence, then it would follow that other animals may be denied to be in possession of such a “heart.” However, Kaphagawani argues in support of the idea of “heart” by assuring that in almost all
Bantu cultures and in particular the Chewa culture the “heart” is meant the personality of an individual human being. The author claims that it is in the heart that lies the personality of man and it is the heart that by which this man is himself and not another. Therefore, the heart understood in that position of personality would quite be in unison with the most sayings and practices extant to most parts of African cultures in general but more especially among the Chewa culture where by in their language saying that “So-and-so has sweet heart” would mean that such person has good or kind personality.744

Furthermore, another instance can be traced in defining personhood among the Acoli people of Northern Uganda whereby the phrase bedo dano is fundamental to understanding and for defining personhood. However, that same term can be translated as “a person who lives among people,” or “to become a person who lives in society.” When dano is used in the plural sense then to be a person often concerns the physical, social, age-related, productive, emotional and spiritual connotations. Therefore, to be a person among the Acoli people is never a singular activity.745 Similarly, in the traditional life of the Kikuyu people in Kenya there is nobody as an isolated individual but rather, his/her uniqueness is a secondary fact about him/her; first and foremost he/she is several people’s relative and several people’s contemporary.746 While arguing in support for interdependence of human beings mostly found in the African traditional societies. Nussbaum quotes Battle’s idea that a person is a person through other persons. According to this argument is that we don’t come fully formed into the world and we need other human beings in order to be human. This implies that we are made for togetherness, we are made for family, for fellowship, (for community) to exist in a tender network of interdependence.747

However, the principle of solidarity does not in the least mean that an individual loses his/her identity in and because of the group. Instead an individual is indispensable since each
person must express his/her ethical conviction in such a way that he/she includes the entire community. For instance, individuality is emphasized in Africa by the fact that each one has his/her own name which is different from that of his/her parents. More so African ethics attaches great importance to intentionality in the ethical conduct of the individual so much that the ethical identity of an individual is not dissolved by the group. Rather, the heart of each individual is an important locus of ethical conduct and of the integration of ethical norms. Grageda argues that personhood in African tradition is defined by looking at one’s past and present life; and one can even look at oneself in the future as being understood, the past, present and future are but one category. According to the author such definition answers questions like who am I? What am I? Where did I come from? Why am I here? What is my constitution? What is my internal character and my external form and my relationship with other creatures? The reason here is that the concept of self-recognition is very high among the African societies. Therefore, people are taught at all times to be aware of their origin, purpose in life and final destination. However, for someone not knowing all the departed ancestors does not negate their existence and contribution in terms of having transmitted their love, life, blood and general culture. According to Osuji the concept of an individual in African thought is seen in terms of interactions and interrelations. The author observes that if anything exists or is believed to exist must have some connections with the community. This implies that the idea of community serves as a conceptual base in which most African concepts, beliefs, values, ontology, cosmology and ways of life are grounded.
b. Different Concepts of Individual

The second paragraph addresses on different concepts of individual. Besides being a social being by nature, the human individual is also by nature other things. These other things include essential attributes of the person such as rationality, having a moral sense and capacity for virtue so as to evaluate and make moral judgments. This means that an individual is capable of making choice and the community’s role can only be partial towards the realization of one’s goals. Maurier argues that the African thinking is mostly concerned with the problem of living of life other than the problem of knowledge as the Western philosophy may seem to be polarized by it. However, the author clarifies that the African subject is not drowned in a crushing collectivism. Instead one can therefore, rightly speak of an African subjectivism that is different from the Western one. The difference will be based on relational setting used in developing the African subjectivism where the subject affirms oneself not by isolating himself/herself but by cultivating contacts with others, constantly exchanging with others. Therefore, the African conceptual frame work would be properly designed under the two words; I-WITH. The “I” marking the anthropocentric aspect of both subjectivist and vitalist, whereas the word “WITH” marks the relational attitude characterizing the “I”. However, Maurier admits that the present move may be different in Africa because of biting deep and deeper into individualism. Fortunately, this may be a post-communitarian individualism which intends to retain the best of what its communitarianism has produced. This seems to agree with Bujo’s comparison between African ethics with North American communitarianism whereby the two emphasize on community but the difference comes in the process by which the norms are established. For instance communitarianism is concerned with critique of the unfettered self or atomism against liberalism whereas African ethics rejects the idea that being a human person and acting
responsibly is merely the result of having assented to rational principles, or arguing and thinking rationally. Similarly, while one section holds to the Cartesian *cogito ergo sum* (I think, therefore I am), for African ethics takes an existential *cognatus sum, ergo sumus* (I am related, therefore we are) that is decisive. An individual person among the Bakiga people is also seen as a member of a community and always should be understood in such context. According to Rwomukubwe’s argument is that in order to understand a person in a Bakiga society there is need for considering the cardinal point whereby an individual always mentioned that “I am a son or daughter of so-and-so and adds the name of the clan.” This implies that an individual considers him/herself a member of the family, lineage and clan. This is why one’s conduct had to be in conformity with the philosophy of the above three that he/she belonged. The understanding might be different especially among those living in urban areas whose conduct may seem as though cut from the family, lineage and clan. Yet in case of problems such as death, they will always look back to their places of origin for help or even a relative may step in to rescue their kin. I would therefore concur with the fact that there is a conflict of values due to some changes in the society that are not called for.

However, among the Bantu languages one term may signify both person and man at the same time where as in Kiswahili which is another Bantu based language there are two terms *binadamu* and *mtu* which refer to man as in human being and person respectively whereas in Chewa language has only one term *Munthu* which signifies both “person” and “man” at the same time. The same term *Munthu* may be used in a manner that may call for clarification. Therefore, there is need for paying attention in clarifying such terms used in different African languages in order to avoid being prone to misinterpretation. For instance one term may be used in two occasions to mean different things. According to Temples would warn about such practice as
being erroneous to translate the Chiluba terms *kufwa* and *kufwadidila* as to mean “to die” and “to die” respectively. Misfortune diminishes one’s vital force, and all those natural conditions which are perceived to contribute to the diminution of one’s vital force are classified as morally bad simply because they do not sustain or augment the vital force. This idea of diminishing and augmenting the vital force is regarded by Temples as being dynamic when compared to the Western one.756 However, Bewaji admits that the wellspring of morality and ethics in African traditional societies is the pursuit of a balance of individual with communal wellbeing. Therefore, African cultures extol the virtues of community that moral obligations are primarily social rather than individual and that communal factors often take precedence over individual rights. This is why each person is a representative of him/herself as well as of his/her family and one has to pursue his/her goals in a very careful manner in order not to tarnish any tradition of excellence in conduct established by one’s lineage. However, this does not diminish the responsibility that the society also has to the individual.757

Each group of people in Africa has its own distinct language and not simply a dialect but these languages are naturally related to one another as some scholars have classified them into families or stocks. There are some attempts which have been made here and there to foster indigenous languages like Swahili and Hausa on national level in some countries hoping to raise it later on to the international level. This comes following concerns that some of the traditional languages might be dying out partly because the peoples who spoke them are dying out but also due to modern education and the drift of population from rural to urban areas.758 Nyerere would argue further echoing the approval of the traditional ideal of community by stating that the first step must be people to re-educate themselves in order to regain their former attitude of mind. The author recognizes that in African society that people are individuals within a community.
Therefore, people take care of the community and the community takes care of them and there should not be any wish for exploiting our fellow human beings.\textsuperscript{759} Chuwa would argue further that a person is both ontologically and socially a product of other persons. Arguing it in the plural form, the author commends that a human being is a human being through otherness of other human beings. This seems to suggest that cut off from all others; no individual personal life is possible let alone personal consciousness. Yet such kind of personal consciousness not only bases on the living members of the community but also on those who have died from whom the present members descended. Similarly, Chuwa observes that whatever happens to an individual also affects or impacts the community and each member of that community. Just like whatever affects the community also impacts the individual member of that community.\textsuperscript{760} In addressing the importance community, Kaunda recognizes that an individual’s capacity to communicate involves a celebratory outlook in life. According to the author to be cut from our fellow human beings is to die in the soul because our whole life is nothing but togetherness as we are known for our laughter, music and dancing. More so rhythm is the very expression of life force within us. This is symbolic both for our relationship with other people and with other created beings. Kaunda commends that we are conscious of only one world- living generations away in rhythm with gods and ancestral spirits.\textsuperscript{761} However, that might be a different story for Theron who argues against the predominance of relationality in Africa ethics as a threatening idea of individual autonomy and the ability to make personal decisions and take personal responsibility for them. This implies that according to the author if a person is a person through person then no one is a person for that matter.\textsuperscript{762} On the other hand Gyekye expresses conviction that a person comes to know who she/he is in context of relationships with others not as isolated lonely star in
a social galaxy. Thus the articulation of a deep sense of personhood as well as of individuality, the community plays an important and indispensable role.763

c. Implication for Health as well as Disease

The third paragraph will address implications for both health and disease. This African communitarian perspective will have implications on health care since health and disease are concepts shaped by a people’s philosophy and culture. For instance health in traditional African societies takes into account a whole person and his/her social environment. In short, health means personal integration, environmental equilibrium, and harmony between the integrated person and the environment. A person is not regarded as being healthy for instance if one the above mentioned three factors is missing. Therefore, according to African traditional societies one can easily state that health does not mean only the faultless mechanical functioning of the body but also prosperity and mutual coexistence and contentment.764 Never the less the holistic approach may set a challenge that should never be ignored knowing that health care may not be adequate concentrating only on the body but also psychological, social and environmental aspects of the person as well. However, the above idea conforms to the World Health Organization (WHO) understanding of health whereby health means a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.765

According to Nkurunziza healing is considered as an important aspect of protecting and sustaining life in the organic universe. However, the art of healing in the Bantu philosophy of life is both religious and physical act. This is why even a physician also plays the double role of functioning as both physician and psychiatrist in Western terminology. Similarly, the medicine-
man has had continual influence among the Bantu societies because of the double attribute and in particular the emphasis on the psychiatric approach one. Therefore, healing has to take into account the interaction of number of dynamic vitalistic and a continuity of forces. However, one negative aspect that needs collection is the medicine-man often launching into stories of malevolent witchcraft and necromancy instead of making inquiry on the disease that affects both body and mind.766 Furthermore, Bujo argues that healing in African tradition indicates that human being and the elements in the cosmos are not isolated atoms. Instead they live in a continuous interaction, thanks to which they survive. This is why during traditional healing; a medical practitioner sometimes administers the medicine together with minerals, pieces of dry wood, animal bones, and others which must be applied to the patient. For African rationality, these natural elements, although they are apparently impersonal and inanimate but are paradoxically full of life and communicate the abundance of this life. The touching of a natural element or smelling the scent of plant creates harmony with the entire cosmos and reestablishes health in the holistic sense.767

Among most of the African societies there are important individual specialists in medicine with physical properties, in magic, in divination and in witch-finding. Such specialists are usually called by one term which means ‘doctor’ and they most often combine all the above specialties. Therefore, according to Shorter the term witch-doctor is not good for such type of individuals because it suggests that the doctor is himself a witch. Instead the task of the traditional doctor is to find witches although they may not have a sense of vocation to make them feel obliged to help but often charge fees for good results. However, the author recognizes that the traditional doctor may be the pillar of belief in sorcery and witchcraft although such fact may not be appreciated.768 According to Osuji the gods, spirits and ancestors are believed to influence
human affairs which include health and disease. In that regard, both disease and ill health are always attributed to mystical forces or spirits. However, the author also notes that illness may be attributed to other evil forces retaliating or punishing for moral and spiritual failings such as a religious and cultural taboo. On the other hand, the individual illness may be fully explained in two realms of existence; first may be manifestation of the broken relationships within the community, second may be a sign that there is dissonance between the communities of the living and the dead ancestors. Patients preferred medicine man from their own community who used methods with which they were accustomed to and such people were respected and trusted in the community because of the belief that they were using a spiritual gift from God to enhance people’s health and moral well-being. Therefore, from that medical and social perspective, illness was viewed as a culturally patterned social, psychological and physical process which involves recognition and reaction to human condition. Furthermore, Mungazi argues that illness responded to therapeutic procedures of all kinds of both medical and ritualistic. Keeping to the fact that an individual is intertwined with the life of other members of the community, therefore when person does not want to seek healing, he would be encouraged or even persuaded by relatives and community to seek medical care. The reason here being that when an individual is sick, the whole community is also sick and they are encouraged to urge and accompany the sick person to seek healing.

In traditional African culture, health was seen as a function of the supernatural acting in concert with ancestral spirits while sickness and death were very much regarded as the result of witchcraft. Therefore, in case an individual felt sick, it was not uncommon to believe that malevolent spirits caught hold of the body hence inflicting pain. Mungazi argues further that such belief influenced interpreting and treating sickness depending upon the context of
occurrence, rather than upon the actual physical symptoms. Similarly, the author notices that the belief in divination was very much practiced by Africans to gain control of the various medical situations that they faced and the ancestral spirits were used as guardian angels to protect the health of the people. Murove argues that sickness occurs because of the tendency of the living to forget their ancestors. Therefore, through the traditional healer, the ancestors can impart knowledge of diagnosis and healing. This is why the traditional healer when receiving a consultation fee does not take it into his hands but instructs the patient to put money on the ground. This gesture symbolizes that the work will be performed on behalf of the ancestors and also implies that this work is not for individual healer’s self-aggrandizement but for the common good. Therefore, traditional medical knowledge is not an individual’s personal privilege but is rather transmitted to an individual by the ancestors for the wellbeing of the community.

Among the Nyakyusa people there is a belief that certain people have supernatural power of causing sickness and even death to others. The word oulosi refers to “aggressive witchcraft” whereas another word amanga refers to “defensive witchcraft” which is said to be good. These people have another phrase embepo sya vandu which means “the breath of men” which means the power of witchcraft used in accordance with the general public opinion and the effect of which is the curse. Witchcraft is believed to reside in the stomachs of certain people in form of pythons and can be inherited. However, no one readily admits to the possession of the power of defensive witchcraft because that would be considered a boastful thing to do and not good manners to do so. The only witches called aggressor witches are those who are believed to abuse their power by trying to choke people or animals without securing the approval of the defender witches or the responsible members of the age-village, for their case. Therefore, medicine against the power of witchcraft exists and is used mostly in reconciling with the angry age-villagers who
have sent the curse but does not give immunity from its attack. Magic among the Nyakyusa people involves using medicine leaves, roots and other material objects in order to realize some particular desire of the moment. Shorter argues that white magic is no moral problem but sorcery must be judged morally wrong because there is a danger of harming someone. Therefore, the gravity of the harm intended by the sorcerer has to be considered. Addressing on witchcraft, Shorter holds that witchcraft belief is the standardized nightmare of a society and the author considers witches to be a threat to the group as a whole. While the author notices that witchcraft vary in detail from one African society to another but accepts the similarity that a witch is a human being who possesses a mysterious and inherent power to harm others by secret means either voluntarily or not that he/she either inherits or can enter him/her at behest of another witch. The author commends that witchcraft is by definition irrationally vindictive or explicable persistent in the sense that when misfortunes are overwhelming, inexplicable, irrational, they are attributed to witchcraft. For instance, if children die one after the other and mostly of sudden death with symptoms beyond explanation, is attributed to witchcraft.

Furthermore, among the Bakiga people like other African surroundings, diseases and misfortunes were very eminent hence needed certain approach to deal with them. Most of the practices involved in dealing with illness and misfortunes or other misfortunes were psychologically vital in the healing process of the patient or sufferer. The medicine-person “omufumu” is considered to be the pillar of the society. Some characteristics were expected of such people for instance, being trustworthy, morally upright, friendly and willing to perform their duties in the interests of the society as a whole. However, “omufumu” would play both negative and positive roles in the society; for instance, he would diagnose the disease, indicate the cause and prescribe the cure but on the negative side “omufumu” could exercise such
potential for evil or even lead to death. This role of becoming a medicine-person among the Bakiga people would be inherited from parents by mostly the male children. Unfortunately, Shorter argues that in most African languages there is often no verbal distinction between magic and medicine or between sorcery when referring to these two types of magic. However, the author recognizes that objectively one can distinguish good and bad magic or medicine from the effects they cause. For instance, good magic is designed to bring about good effects, such as to cure, to protect and to profit a person. Whereas for bad magic on the other hand is designed to produce a bad effect, for instance, to harm or hinder a person. As a result most writers sometimes speak of white and black magic, or of magic and sorcery when referring to the two types magic. However, from the African practitioner’s point of view, good magic includes ritual undertaken to harm someone whom the practitioner feels he/she has a right to harm, while bad magic includes ritual which prospers a wicked or antisocial person.

Ngorogoza defines traditional medicine-persons among Bakiga people as clever folks who devise ways of getting things from other people by conjuring tricks although some use shrubs to cure people. The author recognizes that some are assisted by Satan and medicine-person would perform nothing without conjuring tricks in preparing medicine. However, there are others who practice medicine to cure diseases of their friends such as ekookoro (cancer), ganglions, pneumonia, constipation, obuhasha (nettlash), worms and infertility. According to the author such type of medicine is considered as being very useful and harmless. Leonard seems to support Ngorogoza’s idea about traditional healers when he refers to them as being a source of health care for which Africans have always paid for. However, traditional healers seem to have remained popular even in the modern times because they have access to valuable and effective therapies that may not be available to modern providers and another reason may be that they
might be charlatans who consistently dupe their clients. According to Leonard all the two reasons would be extreme views. Instead traditional healers remain popular despite of accessible modern medicine simply because their relationship with their patients is mutually advantageous and even they have wisely used a particular form of contract suggested by the economic theory as the best ways to deliver quality care. Murove would argue further that most Africans rely on the African traditional doctor for most health needs. For instance somebody may get involved in a car accident and taken to hospital, examined by a physician, prescribed medicine and later discharged but still proceeds with the family to consult a traditional doctor. This is followed by inviting the entire community for an ancestral ceremony that involves singing and dancing, eating and drinking to their fill. The implication is that the western-trained physician missed to diagnose the relationship between the accident and the ancestral realm. Moreover, most people do not discard the medication given them at the hospital but rather take it together with whatever the traditional doctor prescribes too. The Africans knew that good relationships with the ancestral spirits would enable them to employ methods of both treatment of sickness and prevention of disease to either restore or maintain good health. Therefore, a medicine man or magician would be employed as a general practitioner to ensure harmony and peace between the physical and the mental, between the living and the dead. Mungazi recognizes another role played by the spirits as that of interpreting ritual dances, which were also very symbolic of African traditional medical beliefs and practices.
d. Implication for Death and Suffering

The fourth paragraph will discuss the implication for death and suffering. Death is taken to be a process that removes a person gradually from the present period to the past one. Most Africans believe that after physical death an individual continues to exist in the present period through remembrance of relatives and friends that knew him/her and have survived him/her. Therefore, the departed person remembered by name is not said to be really dead but alive and such one would be called the living-dead. Paradoxically, death lies in front of the individual as the future event but when one dies, enters the state of personal immortality which lies not in the future but in the past. Sickness and disease are considered to disrupt people’s well-being and have always been unwelcome. However, when such are experienced in the community or by individuals, there are attempts made in order to restore a state of wholesomeness using both natural and supernatural means. So the African people’s ethics is rooted in life-affirming and societal activity centering on the promotion of vitality and fertility of human beings, livestock and the land on which their livelihood depends.

Generally, death among the Bantu life-thought system, it was never conceived as the end of life but seen as a total breathing out, a passing from the visible to the invisible world of the ancestors. This is why an old person can be heard saying, “I am going soon” meaning that time for dying is near. In this perspective to die is to go, to depart towards the place defined in terms of ancestors. Death is traditionally conceived as a departure to the abode of the deceased relatives, where blood-ties are conceived to be stronger and firmer, and no more death to break them. Again what is significant among the Bantu people is the belief that after one’s death will not be forgotten. This implies that the whole family and clan community will be remembering the dead relative. On this account, the Bantu people strongly believe in the support of their
ancestors through whom they hope human life is both communicated and preserved. Therefore, life is lived in a series of events of which death is one of them that tends to threaten the very core of man’s existence but is never looked upon as sort of extinction rather as a passage towards the ancestors. Among people who believe that the hereafter is in another world or distant place, food and weapons may be buried with the dead body to sustain and protect the person on the journey between the two worlds or places. For instance the Chagga people in Tanzania hold that after death the soul must travel to the next world through a dangerous desert region. Therefore, the corpse is anointed with fat, given milk in the mouth for feeding and protecting from the scorching desert sun. Once again, although death is a dissolution and separation, man does not accommodate this radical change and African peoples both acknowledge and deny the disruption of death. This is why when a person dies continues to live as a leaving dead. On that vein, Ndebele and co-authors argue that most of the working people in Africa today maintain two homes; the rural home where all relatives live and the urban one where they go to work but maintaining close links with their rural kin. The rural home is where they go back after retirement to relax in the familiar environment and even when people die from urban areas; their bodies are transported for burial in rural areas where their ancestors are buried. Death has been accepted by man as part of the natural rhythm of life and yet paradoxically, every human death is thought to have external causes, making it both natural and unnatural. Therefore, someone is often blamed for using certain method to cause death of another. This is why by far and large death is attributed to magic, sorcery and witchcraft without excluding the living dead and spirits. Death is also referred to as being cruel; it stiffens, cuts down or evaporates a person even if he/she continues to exist thereafter. Thus, death is such a monster before which man is utterly helpless and his/her relatives watch their loved one dying without any help to escape it.

283
becomes an individual affair that no one can interfere or intervene with whose agonies and pain has neither cure nor escape.\textsuperscript{787} The Bakiga people had a belief that if a person died having a grudge with someone then his/her spirit would come back and attack in sort of revenge. A person suspected to have been attacked by the spirit would fall on the ground and start talking words that had a relationship with the dead person. However, Karwemera opposes such belief as not being real. The author bases his argument on the different testimonies that he was given by people who at one time had claimed to have been attacked by the spirit that this was always done with a hidden agenda of wanting to get some things of their own interests. For instance one lady testified that she had pretended to have been attacked by the spirit in order to cover up her shame over her act adultery and feared the husband would retaliate by divorcing her.\textsuperscript{788}

The African idea of community is the starting point for African ethics, this is not limited only to the visible community but the invisible community is equally important for it embraces not only one’s deceased ancestors but also those not yet born. This is why the main goal of African ethics is fundamentally life itself in general. Therefore, the community must guarantee the promotion and protection of life by specifying or ordaining ethics and morality.\textsuperscript{789} Kasenene would argue further that the ethics in traditional societies of Africa holds that moral authority is enshrined in custom, the basis of which is the belief in ancestors who after death retain their authority over the living. In these societies, rights actions are defined as those forms of conduct which are approved by the traditional standards or customary modes of behavior of a particular society to which an individual belongs. Therefore, every member of that society is expected to conform to those established norms and standards. However, the author also observes that an aspect of custom is a people’s philosophy of life.\textsuperscript{790} Interestingly, among the Japanese people also a dead person is still considered to be a member of the family and that has been exemplified
by the way they hold their memorial ceremonies and how they deal with the personhood of the
dead. According to Namihira the relationship between the dead spirit and offspring of a family is
very reciprocal. The author commends on the belief among the Japanese people whereby if the
offspring of a family perform the memorial ceremonies and make sufficient punctual offerings to
the dead spirits, the spirits receive the power to bless the family and the family can get prosperity
and the perpetuation of the family. Therefore, the author argues that the prosperity and the
perpetuation of the family enable the family member to make offerings. This has also been
confirmed by Radcliffe-Brown whose interpretation has been quoted by Namihira saying that
death marked the end of the person but Japanese people believe that a person can exist for many
years after death although his/her identity partially changes. Even then his/her physical identity is
also retained because the family takes care of the jar which contains one’s bones which are
believed to be his/her actual body.791

Among the Bakiga people of Western Uganda death was considered as a threat in spite
of every effort to avoid it. However, according to Nkurunziza then Bakiga people had recourse to
the importance of having many children using the principle that death would take some but
others would remain and life will continue. The author recounts on most common saying that
would be heard among old people. For instance an old person would tell his/her children that
“when I am dead you will remember me.” This implies for the old person that even he/she was
dead but his/her life would continue to be manifested in one’s offspring. Similarly, the authors
recognizes that such vitalistic-dynamic conceptual framework was also held esteem among the
Batoro, Banyankore, Bafumbira and Banyoro people whereby life is lived and shared by all
people in the community. Generally, life is taken to be both the vital participation of all and the
vital link uniting the living and the dead, the common denominator between the visible and
invisible world, the past and the present. Furthermore, the above thought has been also underlined by Byaruhanga as an important issue among the Banyoro people of Western Uganda. The author argues that Nyoro traditions and religion lay great stress on the matter of life. Therefore, most of what the Banyoro people do cannot be explained without this high value which they place upon life, its source and its maintenance. Similarly the Banyoro people have a great desire for having children to remember them when they are dead. In that perspective a childless person is believed to have practically nobody who will remember him/her when he/she is dead.

The Baganda people believe that death as many efforts may be made to stop it but there is nothing can be done about it as it is creator’s program. Therefore, issues of birth and death are like the sun rising and setting. The Baganda people look at dying as one of the life transitional stages, not an end in itself, but a means to an end. The one that Kawuma refers to as *obulamu bw’Emagome* but like other Africans the Baganda people also recognize death as an intruder in the pattern of things and death sets human beings scampering around in order to respond towards circumstances that go with it. However, death is not a strange thing in the Ganda traditions and people accept it as a natural transitional stage and even prepare for it as women prepare for birth of children even though it is always feared. Before burial, the corpse had to be washed, smeared with perfumes and dressed in its last clothes. The belief here is that death was not an end but there is life after life. Since the dead person will be proceeding to the abode of all who pass on, Baganda believe that such person needs to arrive there when is very smart. Even taking the corpse from the house the part of the feet would come out first and this was to show that such person though would continue doing activities as other normal people such as walking on one’s feet. With such belief that there will be an afterlife, the Baganda people would desire to see
someone die while at peace with each and every one so that no one goes to emagombe (the abode of all who pass on) bearing anger, resentments, hostilities and a bad heart. Such negative aspects would be ironed before departing including making of a will and if one died without making one, the clan leaders would sit and decide on all matters to do with the heir, property and its distribution.794 Furthermore, Shorter argues that funeral and mourning rites in African societies are taken to be long and complex rites of passage for both the living and the dead and in some societies for instance the Chagga of Tanzania perform the first and second burial whereas the Shona of Rhodesia perform the laying of the ghost or calling of the dead person home. According to Shorter the African traditional transition of the dead person to the spirit world would be concurrent with the corruption of the body, with a process of embalming, with the washing and laying out of the corpse or with the procession to the grave.795 However, most Africans believe that if someone dies harboring negative thoughts such as hatred, jealousness, hostility, anger and so on. Byaruhanga-Akiiki and co-author commend that such person will still need to be treated for the above negative thoughts in the spirit world. Similarly, the living people may participate in such treatments through culturally and religiously defined rituals. This may be different from the modern way whereby healing is only reduced to the physical senses and there is no entertaining of any notions of invisible realities and powers.796

e. Implication for Truth Telling

Truth telling mostly centers on the right to receive information concerning his /her medical condition/illness and the duty of the doctor to give this information to the patient. This may work differently within the African perspective mostly influenced by her communalism.
The fifth paragraph addresses the implication for truth-telling. According to Chuwa’s argument, health care issues among most of the African societies are a concern of all members of the community. Therefore, caring for the sick is not charity but an ethical obligation especially among people of Sub-Saharan Africa. The author recognizes that for the sick person, the empathic and supportive presence of the community confers a feeling of belonging and sharing in the life of the whole community, even as their individual life seems to be declining. However, their declining becomes an eschatological hope-filled process of personal growth into the destiny of human life. This is why the role of community is regarded by the author as meant to give dignity and courage to the dying person as well as the living ones to face their own mortality as they help others go through the tough times. Traditionally, whenever a member of the society was ill a group would accompany the sick person to the medicine man or woman and listen for this person, or listen with this person. When they come out of the consulting room, what the doctor has said is also the concern of those who are waiting.

In health care it is important to help those in need in order to enhance their vital force. In doing so, however, it is also important to consider the social nature of a person and to balance the patient’s needs, rights and interests with those of other patients, the family and the community as a whole. Similarly, would be important to avoid any action or no-action which weakens the vital force and harms the patient. This is why in African thinking; harm may be done to avoid greater harm either to the patient or to the community as a whole. While problems concerning health and suffering which were almost seen as the outcome of magic seem to have been resolved by acquiring better knowledge about the cause of illness. However, there is still ancestral tradition of magic component that has proved capable of survival, namely, the idea of community is confirmed rather than weakened by modern medicine and dialogue with Western culture. Good
neighbors or good, healthy, peaceful community can play a decisive role in the health of the individual members and this is the contribution of African thinking as far as magic is concerned-for the community that is devoid of love “consumes” the vital force of its members and leads to their death. This implies that the African thinking in wider sense may provide food for thought to the individualistic perspective of the West.

In Africa, there is cultural factor in respect for autonomy hence making it both individual and communal. Therefore, a person is expected to conform to communal decisions and an individual who disregards the family or community and does what he/she thinks to be right is regarded as being anti-social. However, this should not be misunderstood as to mean that a person does not have an individual existence, personality and a certain degree of autonomy. In African ethical thinking a person has to think and act independently and that’s what distinguishes one person from another. Furthermore, in African traditional health care beneficence is higher value than autonomy. This is why commonly the traditional healer or the family would decide to do something against the wishes of a patient without consultation if that is in his/her interest. This may also prove problematic more especially in our modern health care that involves technology whereby both the patient and even family may not be having a minimal required knowledge of the problem and how to deal with it. So one would wonder whether a physician also cannot act without consulting both the patient and the family or even ignore their views for the good of the patient. However, illness in Black Africa always has a community dimension and mostly concerning the earthly community and its dead members. Therefore, the cause of illness lies primarily in interpersonal relationships and it is always a sign that something has gone wrong in the community. So the reestablishing of such broken interpersonal relationship cannot be a matter for physician and patient alone but the entire community needs to participate. This
begins with the dialogue between the physician and the patient, confesses his/her guilt and accepts his/her own responsibility. The confession of guilt is a new beginning in the community, in the way they deal with one another bearing the illness in common. This is why a patient is not left alone in his/her suffering. Byaruhanga-Akiiki and Kealotswe observe that both diagnosis and prognosis which are part and parcel of the healing process take place in the community according to the African traditional practices. Therefore, the community prescribes the correct relationship with oneself, others, physical nature, spirits and with the creator. This implies that the first treatment in socialization is to one’s community beginning with the family. Like all other human beings Africans desire full health, and will do anything to avoid sickness. Therefore, they can forego all costs to procure medicines for their ailments. The authors comment that this may be one of the reasons as why Africans have been observed as heirs to cultures that emphasize the therapeutic value of correct relationships and interactions at all levels of life. I would concur that with such above mentioned background may influence issues to do with truth-telling today.

Conclusion

The chapter has tried to present the Sub-Saharan African ethical perspective that is derived from variety of cultures. Yet despite of such diversity, one can still argue that there is a common Africanness about the culture and world-view of Africans.

The first paragraph has tried to focus on the African concept of the person where by a community plays a big role. This implies that in African traditional life the individual does not and cannot exist alone except corporately. Therefore, whatever happens to the individual affects
the whole community and vice versa. Interestingly to note that the principle of solidarity does not necessarily make an individual loses his/her identity in and because of the group. Rather, in the African traditional setting an individual is indispensable since each person must express his/her ethical conviction in such a way that he/she includes the entire community. The chapter argues that there some instances whereby individuality is emphasized in African tradition. For instance each individual person has his/her own name which is different from that of his/her parents. Therefore, the ethical identity of an individual is not dissolved by the group in the African tradition. Rather, the heart of each individual is an important locus of ethical conduct and of the integration of ethical norms. However, the idea of community continues to serve as a conceptual base in which most African concepts, beliefs, values, ontology, cosmology and ways of life are grounded.

The second paragraph has addressed on different concepts of individual whereby there has been a realization made that human individual is also by nature other things such as essential attributes of the person for instance, rationality, having a moral sense and capacity for virtue so as to evaluate and make moral judgments. The implication is that an individual is capable of making choice and the community’s role can only be partial towards the realization of someone’s goals. Therefore, one can rightly speak of an African subjectivism that is different from the Western one. The difference is mostly based on relational setting used in developing the African subjectivism whereby the subject affirms oneself not by isolating himself/herself but by cultivating contacts with others, constantly exchanging with others. This is why an individual in the African traditional society considers him/herself a member of the family, lineage and clan. This implies that one’s conduct had to be in conformity with the philosophy of the above three that he/she belonged. However, this understanding might be different especially among those
living in urban areas whose conduct may seem as though cut from the family, lineage and clan though not completely cut off. Therefore, African cultures extol the virtues of community that moral obligations are primarily social rather than individual and that communal factors often take precedence over individual rights, although this does not diminish the responsibility that the society also has to the individual. The Africans believe that what affects an individual member of the community has an impact on the others and vice versa.

The third paragraph has tried to address implications for both health and disease whereby the African communitarian perspective has been indicated to have implications on health care. For instance health in traditional African societies takes into account a whole person and his/her social environment. In short, health means personal integration, environmental equilibrium, and harmony between the integrated person and the environment. This is why most of the practices involved in dealing with illness and misfortunes or other misfortunes were psychologically vital in the healing process of the patient or sufferer and the medicine-person is considered to be the pillar of the society. The chapter remarks that traditional healers seem to remain popular despite of accessible modern medicine simply because their relationship with their patients is mutually advantageous and even they have wisely used a particular form of contract suggested by the economic theory as the best ways to deliver quality care.

The fourth paragraph has tried to discuss the implication for death and suffering whereby most Africans take death as a process and believe that after physical death an individual continues to exist in the present period through remembrance of relatives and friends that knew him/her and have survived him/her. However, sickness and disease are considered to disrupt people’s well-being and have always been unwelcome. Therefore, whenever such are experienced in the community or by individuals, there would be attempts made in order to
restore a state of wholesomeness using both natural and supernatural means. Among people who believe that the hereafter is in another world or distant place, food and weapons may be buried with the dead body to sustain and protect the person on the journey between the two worlds or places. Yet the belief in African tradition is that someone is often blamed for using certain method to cause death of another. However, other groups believe that death as many efforts may be made to stop it but there is nothing can be done about it as it is creator’s program. Therefore, people look at dying as one of the life transitional stages, not an end in itself, but a means to an end.

The fifth paragraph has tried to address on the implication for truth-telling and doing so the chapter has realized that health care issues among most of the African societies are a concern of all members of the community, and caring for the sick is not charity but an ethical obligation especially among people of Sub-Saharan Africa. For instance, traditionally, a sick member of the society would accompanied to the medicine man by the group and listen for this person, or listen with this person and what is shared in the consulting room would also be concern for those remaining outside. Africans still hold the belief that good neighbors or good, healthy, peaceful community can play a decisive role in the health of the individual members. In African traditional health care beneficence seems to be of higher value than autonomy and may be ground the traditional healer or the family would commonly decide to do something against the wishes of a patient without consultation if that is in his/her interest.

Concluding remark is that the African thought polarized by the vital relationship where everyone necessarily maintains with others and with the world requires that health care should extend to the whole person and involve both the patient and the family. This approach will turn health care into a personal relationship aiming at wholesomeness for the person and easy
application of truth telling. Therefore, the emphasis in African ethical thinking should always be on the good of the patient and the welfare of the community, and this will have effect on truth and truth telling in general calling for some adjustments.

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788 Karwemera, Festo *Emicwe N’emigenzo Y’abakiga* (Kampala: Fountain Publishers, 1994), 131


Chapter Seven

The Application of the Gradation Approach

The discussion around patient’s rights emphasizes that the patient has a right to know the truth and the physician has an obligation to tell the truth to his patient. However, the physician needs to know how to convey the truth to the patient. This chapter will present the application of the gradation approach whereby the physician reveals the patient’s health information attuning it to the individual situation of each patient. This application is hoped to be realized by improving on the following; medical dialogue among the medical personnel, the roles played by ethics committees and governments.

a. Elaboration on the Gradation Approach

The first paragraph elaborates on the gradation approach. Gradation refers to any process or change taking place through a series of stages, by degrees or in a gradual manner. Similarly, in the gradation approach to the truth-telling physicians will reveal patient’s health information attuning it to the individual situation of the patient, so that it is calibrated to the needs and wishes of the patient. Ackerman seems to support the above idea when arguing that breaking up amounts of information into more manageable segments over a period of time can encourage appropriate communication. Similarly, the author admits that crucial information may need to be communicated repeatedly to the patient. However, this has to be discussed in details taking into account the features of the patient setting in their proper perspectives. On the other hand, the author recognizes that the physician may need to alter the tone of discussions with the patient but emphasize a positive attitude with the patient. This will be geared towards neutralizing the
patient’s psychological constraints. Regarding communication, Beauchamp and Childress would propose that staged disclosure and cautious language about prognosis may be applied as the way of disclosing news to patients. The authors’ argument is mainly based on the aspiration of wanting to maintain the patient’s hope because they do believe that bad news at an early stage may tend to overwhelm the good news. For instance, in most cases patients are not ready for the cold hard facts the minute they arrive at places such as rehabilitation hospitals. Therefore, patients need some time to come to terms with the reality first. On the other hand, the physician also needs care and sensitivity to understand the patient’s preferences and later manage the information towards those preferences.

On that vein Post and co-authors argue that disclosure should not be a matter of rattling off results of lab tests or physical examinations. Rather the authors opt for physicians to use their clinical skill of judgment and knowledge to communicate with their patients. For instance the explanation may be broken into every few sentences such as “does that make sense?” in that sense patients may be able to indicate what they want to know but also health care professionals should pay attention to both spoken and unspoken signals. More so, the patient should be reassured of another chance of addressing such issues next time as it may not be easy for him/her to absorb every piece of shared information at once. Furthermore, Bok seems to argue that one visit or talk between a physician and a patient may not be enough. Instead the author recommends for some time of waiting and listening so that a physician or any other health care professional may gain an idea of what to say. The author believes that silences and gaps are often more revealing than words when the health care professional is trying to learn about what a patient feels about his/her illness. This implies attending to communication without words which
may be given indirectly. Such process may entail waiting quietly for clues from each patient so that they may feel secure enough to give such when they wish.808

b. Improving the Art of Medical Dialogue Needed by Health Care Personnel

The second paragraph will present on improving the art of medical dialogue needed by health care personnel in order to bring about the realization of the gradation approach. According to the Hippocratic Oath the good physician is by nature of his vocation called to practice his/her art with high moral sensitivity.809 According to Pellegrino such above mentioned physician responsibility should be extended to disclosure as well keeping to the fact that the physician is surely expected by the patient and society to give the information prudently keeping in mind the state of every patient. The author takes this as being the only basis for mature, just and understandable physician-patient relationship.810 This same idea is shared by Farber Post and coauthors in their argument that physicians may also use the medical information as part of the therapeutic regime in confronting patients with terminal diseases. However, the authors express their ethical concern over how health care professionals are to share such information especially when their obligations conflict in one way or another.811 This seems to concur with Bok’s argument favoring that the information may be given in amounts, in admixtures and according to timing believed best for patients. According to the author’s argument seems to imply that such right to manipulate truth would be left for doctors as they are trained to help patients and their relationship to patients carries special obligations and they know much more than lay people about what helps and hinders recovery and survival.812 One may criticize Bok’s idea as taking us back into paternalism but we cannot rule out the fact that physicians are experts in medicine.
Purtilo and Haddad propose that in disclosing the information to patients. The goal should be to maximize the patient’s autonomy as much as possible and in doing so the language used by both health care professionals and other employees to describe the details should be personalized in order to maximize each person’s comprehension. Additionally, the authors prefer that in determining the type and amount of disclosure should be derived from the knowledge of each individual patient. Therefore, patients should be told about the proposed treatment in terms they can understand and this includes information about the diagnosis and prognosis, a general notion of the treatment involved and desired outcome. Similarly, Bok seems to support the previous point when arguing further that unhappy news abruptly conveyed or a great shock given to someone unable to tolerate it could also bring on such a dying response quite unintended by the speaker. On the other hand, the author agrees to the fact that sometimes the dying response may also be due to natural organic reaction of the body’s weakness although this can also be inappropriately brought on by news too shocking or given in too abrupt a manner to the patient. On that same vein Buckman remarks that generally the breaking of any bad news depends very much on the abilities and techniques that each physician uses or applies in coping with the patient’s reactions. Therefore, the physician would be required to apply the approach by which he/she can assess patient’s reactions based on the criteria of social acceptability, adaptability and fixability in order to offer the patient support that really fits or more nearly fits that particular individual. The author reminds that the physician has to keep in mind the fact that when a patient receives bad news there is a wide normal range of reactions. For instance some of these reactions may appear in the form of unacceptable behavior which may entail the attending physician to give as much latitude as he/she can, trying to stay calm, and speak softly, and being gentle while he/she is being firm. Furthermore, in assessing the patient’s reaction to the bad news
would be better to decide whether the response is helping the patient. On the other hand the author also recognizes that in complex clinical situations it may not be possible to decide instantly whether a particular response is adaptive or maladaptive because such situation requires observation of the patient over the period of time in order to see if the stress is improving or worsening. This is why Buckman recommends that it is important to remember that one does not have to make the diagnosis of either adoptive or maladaptive response at first sight.815

Presenting the crudest materialism, Fletcher argues that the physician is just as responsibly related to the patient as a moral subject as any priest could be, for the spirit and the body are one. Therefore, the author seems to suggest that the physician may avoid lying to the patient by tactfully and skillfully explaining the if’s and and’s, side issues and suggestions of the possibilities, while sufficiently befogging the issue but satisfying to the patient and remaining with clear conscience.816 On the other hand, research done by Blackhall and companions indicates that both Korean-Americans and Mexican-Americans would want to be told the truth so that may be helped to feel better and look for the way of cheering up but not getting to the end of the road like the doctors thought. However, most of them preferred to be told gently. Therefore, the physician may approach the patient for instance, by saying that their team is doing everything in their hands to make him/her feel better but this might not stop him/her from dying. Additionally, the patient also needs to be reminded that he/she needs to spend the remaining days happily and not to think about leaving because may be it won’t happen. The main point here may not necessarily be the truth but hope.817

Furthermore, De Blois and coauthors would argue in support of the above idea saying that the bottom line should be to save a patient from injudicious words that may be swallowed with a real relish by him/her. Therefore, the authors recognize the need for interactional skills as
not only for medical effectiveness but also for ethical reasons. Surprisingly, patients may also often know their diagnosis and prognosis without being told by their physicians. For instance, research conducted among the Korean-Americans by Blackhall indicates that some patients would suspect that they have cancer following how sickly they would feel and many visits to the doctor all the time to get medications intravenously. However, this way of learning about their sickness seems to be more acceptable among this group of people. According to this group of Korean-American such knowledge leaves room for hope and the reason would be perhaps because it comforts the patient to know that his/her doctor and children love him/her enough to try to give him/her hope.

Furthermore, today attentive listening is deemed essential for better diagnosis and illumination of the emotional and social components of illness as the physician needs to know patient before doing him good. According to De Voto clinical interactions influence the possibilities of ethical relationships. This is why in case of a professional lacking the skill to hear a patient’s history will not only reduce on diagnostic accuracy but also the capacity for appropriate response. Therefore, the author observes that effective listening and careful observation remain to be among the important skills for health care professionals when communicating with the patients. The thesis would concur with the above idea that such skills are needed in applying the gradation approach. In dealing with cases such as of a patient who is depressed, Navarra and coauthors propose the question that a physician may pose to the patient such as “How have your spirits been lately?” or “How have things been going for you lately?” However, the authors remind that in such circumstances the health care personnel need to be prepared to listen quietly while the patient unburdens him/herself. Therefore, according to the authors to be a good listener entails having patience and in some other situations the patient may
only be in need of a shoulder to cry on and once he/she has opened up, such cleansing process
may also be very therapeutic. This is why American Society for Bioethics and Humanities
would recommend striving to possess and exhibit among other attributes that of compassion as it
may help one to work constructively with feeling more especially in times of tragic situations.
At this point the thesis would concur with this board’s idea that even during sickness health care
personnel require compassion when it comes to disclosing diagnosis and prognosis realities.

Ashley and O’Rourke would argue further that communication according to modern
text theory depends upon good emotional relations among communicators and emotional conflict is a
powerful barrier to communication and may bring about into play all sorts of uncontrollable,
unconscious factors. Therefore, the authors recommend that every institution should promote an
emotional openness among both the staff and patients. However, health care professionals in the
effort to fulfil their obligations have the responsibility to establish and preserve trust at both
emotional and rational level, share information, avoid lying, and protect secret information that is
not legitimately needed by others. According to Browne in order to make verbal
communication providing details as the patient wishes, the perception of what was said is what
counts and repetition is deemed necessary based on the fact that patients may not be able to
recall especially under conditions of stress and anxiety. The author also recounts that much
understanding takes place on nonverbal level. Therefore, it would be good for care givers to be
clear about such signals and keep them consistent with the verbal ones. However, in some cases
a patient may clearly prefer and communicate willingness for a physician to act unilaterally,
having surrendered autonomy to that caregiver. For instance the patient may allow the caregiver
that if it is terminal disease such as cancer, to do what he/she deems better for him/her.
Emanuel and coauthors would argue further that physicians should be in position to help their
patients explicate their experiences, values and feelings. Therefore, physicians need to have good communication skills to enable them explain to patients in clear and comprehensible language, the nature of their disease, the diagnostic and therapeutic treatment alternatives available, and how they are likely to fulfil or undermine the patient’s values. This would be the meaning of good communication skills according to the authors.  

Further still, Buckman argues also in support of the fact that the duty to disclose information is a professional duty to be carried out by a physician in a professional manner that aims at providing explanation while avoiding technical jargon and given in a relatively stress-free setting. The author also encourages health care professionals to reinforce and clarify the information frequently and one of the best ways of checking this is to get the patient repeat the general drift of what the physician has been saying. Buckman remarks that for instance, a patient sitting quietly, nodding at appropriate intervals may have missed the drift of what has been said or he/she has not understood. The author claims that clarification may help to resolve such problem. Additionally, Maclean seems to commend that the transmission of information can and should be done sensitively and with due regard to the information gap between a physician and the patient. This may also be the reason as to why Pellegrino would remind about the role of a physician in suggesting what he/she deems good for his/her patient. The author’s argument is based on the fact that the patient may not necessarily know what is good for them and even end up making wrong choices. Therefore, leaving the patient to decide difficult issues about which the physician may be uncertain is considered by the author as complicity in harm. However, Pellegrino observes that a patient needs a physician that protects his/her moral right to reject any or all treatment after frankly disclosing the options without using deception or ill-placing emphases in order to change the patient’s mind.
According to A.M. Guy with coauthors would argue further that while the role of the physician is to provide information and present treatment options. The physician should not bring any values to the discussion with the patient but rather investigate and explore those values by dealing with questions concerning the good life. This implies that the physician’s role is to help the patient to clarify and elaborate her/his values. This idea seems to make autonomy sound as a process of moral development. On the other hand, the above idea would also concur with the collegial model which describes a physician and patient as colleagues in mutual pursuit of goals of healing. According to this model the value contributions are equal. However, this may be unrealistic as there are differences in knowledge and values that are inherently in existence. However, Shams and coauthors would describe values as special form of beliefs. According to the authors values help in guiding people’s decisions just like a map. The authors argue further that values are the basis of attitudes, motives, behaviors, and basic assumptions underlying the existence of society. In short, the authors regard values to be abstract, internal, and subjective concepts.

Regarding breaking bad news to children, Buckman considers them to be very special people that may require special expertise or special qualities of one’s own. Just like it is with adults, good psychosocial adjustment for children is associated with the early knowledge of the diagnosis and not concealment or evasion. The author recommends some important principles to bear in mind while breaking bad news to children. The first principle is making sure that there is a closest adult relative present if at all possible and it is this adult who will be talked to first and agreeing on the manner in which the information will be shared with the child. The second principle is checking your communication level frequently because children’s understanding of the world advances with age and maturity. Therefore, it is recommended to pick the language to
match the child’s questions and check frequently to make sure that your messages are being received. The third principle requires being ready to repeat things because children often require repetition of information as the way of assuring themselves that they have understood the message correctly and that you really mean what you say. The fourth principle is the understanding of “magical thinking”. This refers to the way children tend to believe that their thoughts or actions can magically cause events to happen in the outside world. Therefore, it is important to tell the child that illness is nobody’s fault. The last principle is getting professional help as soon as possible. One may need to find someone who does such job most often to help or even do the communication because talking bad news to children is not an area for the inexperienced or uncertain health care worker. This seems to go hand in hand with the American Society for Bioethics and Humanities board’s recommendation regarding interpersonal skills as critical to nearly every aspect of ethics consultation. The list of interpersonal skills includes the ability to listen well and to communicate interest, respect, support and empathy to involve parties. Among others listed by the board, there is also the ability to recognize and attend to various relational barriers to communication. The thesis would concur with the ASBH board that such interpersonal skills if acquired by health care personnel would also aide in resolving some issues to do with truth telling.

c. The Role of Ethics Committees in helping Physicians to Facilitate Truth-Telling

The third paragraph will analyze the role of ethics committees in helping physicians to facilitate truth-telling. There is still need for establishing, promoting and supporting ethics committees at all levels so as to engage the public in debates and education on ethical issues.
Ethics committees begun to be established in hospitals during the mid-twentieth century as effort to answer questions and help in making decisions about health care issues with ethical dimensions. However these committees had their roots in several other types of small decision-making groups which were intended to address specific ethical problems. Furthermore, 1970s and 1980s ethics committees were established by hospitals aiming at providing guidance about health care issues with ethical dimensions. Later on the ethics committees took up additional functions such as advising on resource allocation and other institution’s commitment regarding certain values. Therefore, in order to avoid misconception and miscommunication among parties coming from different cultural backgrounds. There should be a valuable ethics committee to act as educating care providers about the personal and cultural differences that influence the clinical dynamic and may affect patient care. In our case that may affect truth telling.

Huriet in addressing about ethics committees supports the above idea that they should foster debate, education and public awareness of and engagement in bioethics but the author adds that these committees are to provide advice on ethical problems in clinical setting. This would be facilitated by the fact that ethics committee members really represent different schools of thought and accommodate personalities with recognized competencies and authorities. According to Moodley well trained and effective ethics committee within a health care facility would not only facilitate understanding of how some values of decision processes take place but also how other cultural concepts can interface with different ideas that may be foreign. This is why Purtilo and Haddad cite the need for having an approach that puts into account cultural differences in order to understand others. This means that health care professionals have to be sensitive towards the cultures of their patients in order to respect a patient’s decision and or action. The authors
call for exercise of judgement while incorporating the beliefs and values of the patient into the
treatment plan for achieving mutually desirable outcomes.  

Navarra and coauthors also admit the cultural influence towards a patient’s therapy as
two patients may not react the same way to pain, illness or injury. Some patients may respond in
a manner similar to one’s expectations or even like a member of one’s family. On the other hand
there are others who may act in a manner totally different from one’s concepts of so-called
“normal behavior.” Therefore, the physician-patient relationship will depend very much on the
efforts to recognize the patient’s attitudes towards such mentioned cultural values in order to
help patients. Remarkably, most Africans appreciate what Western medicine offers but
without rejecting the role of a traditional healer. Therefore, Van Niekerk and Benatar site the
need for training effective ethics committees who can handle such African values with
hierarchical decision-making process and other cultural concepts that can interface with ideas
such as individualism, autonomy, informed consent, and civil and political rights.

Furthermore, Mosadeghrad argues supporting that the socio-demographic factors may
also influence the interaction between a physician and the patient. On the other hand, Navara
and coauthors notice that some patients may be senile while others are just too timid to speak up
against the authority of the health care in charge. However, at times a patient may for various
reasons also fail to give the important information to his/her physician and instead open up to
speak freely with the therapist. This does not mean that a physician should lose objectivity and
sensitivity for his/her patient but must be very cautious not to prejudge him/her as the therapist
may alert him/her for preventive measures to be instituted.
According to Kelly ethics committees can be of great help for both patients and their families towards interpreting medical terms into lay man’s language easy to understand keeping in mind that they are one of the sources of wisdom in that health care facility. On the other hand, Beauchamp and Childress commend ethics committees for helping in resolving disagreements; generate reasoned options and also help the parties conform to institutional guidelines and governmental regulations. The role of these committees is vital especially in circumstances whereby physicians acquiesce too readily to parental, familial, or guardian choices that prove contrary to a patient’s best interests. According to Slowther ethics consultation has been commonly seen in terms of conflict resolution and mediation while recognizing that many of the issues that are referred to the committee arise from seemingly irreconcilable differences between either different health professionals or between physicians and patients’ families. This implies that consultation done by the ethics committee acts as a neutral facilitator with mediation and counselling skills providing common language of ethics which can be used to move towards a consensus solution. Whereas in the medical model, ethics consultant has been as a member of multidisciplinary team with skills drawn from variety of backgrounds such as philosophy, sociology, theology, law and health care.

However, in order to preserve the integrity of the physician-patient relationship the ethics committee should be envisioned as a group of persons fulfilling the rule of medical ethicist. This implies that ethics committee only offers education and consultation to health care professionals and their patients. This task of ethics committee is also emphasized by Junkerman and coauthors that they are mainly to educate the committee members, staff and the community. The same committee formulates policies. However, it has to be noted that the ethics committee is not a policy-making body but only suggests policy on request of the medical staff.
or hospital administration. The third task of the ethics committee is described by the author as being that of case consultation and the committee does that especially on request.848

d. The Role of the Governments towards Improving on Health Care

The fourth paragraph will focus on the role of the governments towards improving on health care. This will facilitate truth telling as many people will be encouraged and attracted to health care profession. Such increment in the number of physicians will lead to the opportunity of having enough time needed for sharing information with every patient. Therefore, the governments should through the Ministry of Health encourage many of its staff to pursue programs in public health and receive additional training that can bolster their managerial capacities, decision-making abilities and analytical toolkits.849 According to research conducted by Yarney and coauthors and based on the patient interviews, 40% (8 of 20) felt that if more health workers are trained and employed, the problems they face with health workers with regards to interpersonal relationship and ethical issues would be minimized. In addition, those interviewed also mentioned that health workers are usually stressed out because of heavy workload, and that makes them impatient most of the time. However, they hope that if health care workers are many, the work load will be less and would have time to better interact with patients, and make sure that their rights as patients are upheld.850 Similarly, the research conducted by the President’s Emergency Plan for AIDS Relief in Uganda indicates that the country still faces the problem of understaffing the factor which leads to low performance according to the District Health Officers’ report. According to this research there has also been frequently cited insufficient health sector funding, poor health infrastructure, lack of transport,
and negative community attitudes towards the health system. An example was provided by one health sector leader referring to Uganda as having poor infrastructure for health services to the extent that some facilities designed to serve catchment area populations up to 20,000 people at the sub-county level cannot be given a mandate to handle deliveries due to poor infrastructure. As a result, people can’t even access such health facility and also health personnel may not want to reside there. In our case there is dire need for government intervention through the ministries concerned to address such issues so that there will be enough health care personnel in order to implement the proposed model of truth telling.

Generally, health workforce shortages in sub-Saharan Africa have been widely recognized, particularly of physicians. This has been implicated for relatively high rates of morbidity and mortality in the continent. In the effort of responding to this problem there has been shift or delegation of tasks to non-physician clinicians whose deployment has finally gained full acceptance by local health sector leaders. This implies that Medical training Institutions in each sub-Saharan country need to be aware of possible roles their graduates can have with their health system and make appropriate adjustments of set of skills and competencies. Eyal and coauthors seem to support the above idea when arguing that curricula and training modules should build capacity in leadership and team management, program management and implementation, health service delivery research (which includes operational research, monitoring and evaluation, and impact evaluation), and other pertinent pedagogical areas. The authors continue to observe that in order to foster synergy and cooperation with non-physician clinicians and other members of multidisciplinary health teams, a significant portion of physician training ought to take place together with non-physician clinician trainees and other health workers in training. Fortunately, some medical schools such as in Jimma and Gondar in
Ethiopia, the School of Medicine at the University of Rwanda, and the Faculty of Medicine at Mbarara University in Uganda already emphasize inter-professional training as a way to prepare future health workers for the complexities of delivering health services in remote rural areas and specifically for interacting effectively with cadres different than their own. However, the authors commend that medical schools need to prepare future physicians to play these roles effectively. And they should also prepare them to be excellent clinicians for local underserved populations, because in a non-physician clinician-based health system physicians retain a significant clinical role. Furthermore, Fulton and coauthors in their research discovered that by providing healthcare services at the productively efficient skill referred to as mix—the mix produces the maximum number of healthcare services at a given quality and cost—more healthcare services are going to be accessible and affordable to populations seeking care. The authors recommend that task-shifting is a policy option that should be considered to help achieve productive efficiency and provide access to services that otherwise might not be available. Furthermore, the authors believe that a more productively efficient skill mix will partially dampen the effect of health workforce needs-based shortages and better enable countries to meet the health-related United Nations Millennium Development Goals.

Binagwaho and coauthors place their hope in the fact that setting a comprehensive development agenda should as well aim at strengthening the country’s internal human capacities. This will place people as best experts on their own burden of disease and as able to address those burdens. Quoting from Rwanda’s progress over the past two decades, Binagwaho and coauthors recognize this to be a testament to the value of the integrated approach, based not only across various Ministries in the public sector, but also through public-private partnerships. More importantly the authors remind that Rwanda’s collective progress as a nation in terms of
improving healthcare indicators has required not simply strengthening of the health system, but the strengthening of an entire national vision for a better and healthier tomorrow. The implication being that this is a vision that promotes social protection while embedding health system strengthening in the entire development of the country. According to Monekosso human resources for health experts would all agree that training programs in sub-Saharan Africa should formally and fully prepare physicians for clinical and non-clinical tasks. For instance, many schools and faculties of medicine emphasize biomedical, clinical, and epidemiological sciences but only a few include in the curricula training modules. Future health professionals would learn together so as to be able to work comfortably together for improved health outcomes. On that vein the author reminds that teachers should be aware that medical students and other health professional trainees spend a better part of a decade preparing for practice and this ought to be an opportunity to bond the future doctor with population groups, health services, research projects, in-country academic and economic opportunities in medical practice, and in this way fight external migration or brain drain. Therefore, medical schools should miss this opportunity. Mosadeghrad seems to support the above idea when arguing that medical universities or schools should be encouraged in providing education and professional development opportunities for the healthcare workforce.

On the other hand patients need to know their rights and responsibilities to ensure that they take actions and ask questions relevant to their care and delivery. However, according to the research conducted by Yarney and the group found out that half of the patients who participated had never heard of patients’ rights. The authors noted that establishing patients’ rights would be a step towards protecting patients’ rights, yet violation of patients’ rights was common in healthcare institutions, and this is attributed to systemic and institutional obstacles, such as
insufficient healthcare staff and inadequate acquisition and maintenance of technological equipment. In our case the government would play a big role in introducing and implementing of the patient charter which actually is meant to target the relationship between health professionals and users of health services, providing information on standards of care that patients can expect to receive and demand as a basic human right. Van, Niekerk and Benatar taking from the example of Patients’ Charter in South Africa would propose that what is professed in theory should be translated into actual practice. According to the authors that what is being practiced in several hospitals in the public sector proves opposite of what is loftily professed in the Charter. Similarly, the authors recognize that there is a significant gap between theory and practice in terms of the rights of patients espoused in the Charter. Therefore, it is not enough to formulate a charter of patients’ rights but also to make sure that it provides a guarantee that actual lives of the patients in practice are significantly being improved. The thesis would concur with Van Niekerk and Benatar that while the government may strive to achieve the formulation of a charter of patients’ rights in their countries but making a follow up about its implementation would also help in favoring and supporting truth telling. Furthermore, Souliotis and coauthors would commend that since patient involvement in health policy decision-making has been declared as a necessary premise to improve the quality and performance of health systems and services as well as the health outcomes of the population. Therefore, it is important to explore the barriers patients and patient organizations tackle throughout this process. In this way, the authors hope that this would bring about the possibility of developing appropriate and adequate interventions and policies that would foster the patient’s participation in a sufficient and effective manner. At this moment the hope is that the above observation if given attention will indeed facilitate the gradational approach.
Conclusion

The chapter has tried to present the application of the gradation approach whereby the physician would be encouraged to reveal the patient’s health information attuning it to each individual patient’s situation. In some instances the physician may need to alter the tone of discussions with the patient but emphasize a positive attitude with the patient in order to neutralize psychological constraints. The gradation approach recognizes the fact that patients are in most instances not ready for the cold hard facts. Therefore, patients may need some time to come to terms with the reality. However, the patient should be reassured of another chance of addressing such issues next time as it may not be easy for him/her to absorb every piece of shared information at once.

The chapter has presented on improving the art of medical dialogue needed by health care personnel keeping in mind that nature of their vocation calls for practicing their art with high moral sensitivity. More so the disclosure of information prudently keeping in mind the state of every patient has been hailed by this chapter as basis for mature, just and understandable physician-patient relationships. Therefore, physicians would be encouraged to disclose the information in amounts, in admixtures and according to timing believed best for patients. Furthermore, the chapter recognizes that unhappy news abruptly conveyed or a great shock given to someone unable to tolerate it could also bring on such a dying response quite unintended by the speaker. Therefore, breaking of any bad news will depend very much on the abilities and techniques that each physician uses or applies in coping with the patient’s reactions.

The chapter further analyzed the role of ethics committees in helping physicians to facilitate truth-telling. This is important because it will help in avoiding misconception and
miscommunication among parties coming from different cultural backgrounds when valuable ethics committee happens to act as educating care providers about the personal and cultural differences that influence the clinical dynamic which may also affect patient care. Therefore, the chapter highlights that trained and effective ethics committees within a health care facility would not only facilitate understanding of how some values of decision processes take place but also how other cultural concepts can interface with different ideas that may be foreign. However, offers some caution that in order to preserve the integrity of the physician-patient relationship the ethics committee should be envisioned as a group of persons fulfilling the rule of medical ethicist. When it comes to the formulating of policies, the chapter brings it to notice that the ethics committee is not a policy-making body but only suggests policy on request of the medical staff or hospital administration. However, their role can aid truth telling in many different ways.

Lastly the chapter has tried to focus on the role of the governments towards improving on health care. The main reason for involving the governments in improving health care is vital because for gradational approach to succeed there will be a need for many physicians so that they may have enough time to spend with patients. Therefore, governments can help in setting policies which will encourage and protect this career. The chapter recognizes that if health care workers are many, the work load will be less and would have time to better interact with patients, and make sure that their rights as patients are upheld. The chapter highlights on the health workforce shortages in sub-Saharan Africa that have been widely recognized, particularly of physicians and in responding to this problem there has been shift or delegation of tasks to non-physician clinicians whose deployment has finally gained full acceptance by local health sector leaders. This implies that medical schools will need to emphasize inter-professional training as a way to prepare future health workers for the complexities of delivering health services in remote
rural areas and specifically for interacting effectively with cadres different than their own. The chapter remarks that the time spent by medical students and other health care professionals trainees preparing for practice would ought to be an opportunity to bond the future doctor with population groups, health services, research projects, in-country academic and economic opportunities in medical practice, and in this way fight external migration or brain drain.

The conclusive remark for this chapter is that gradation approach can be possible through improving on the physicians’ art in communication while in collaboration with other roles played by ethics committees, the governments and other concerned organizations. The implication here is that applying the gradation approach will be one way of enabling physicians to treat people from different cultural backgrounds while respecting their rights as well as autonomy.

804 Webster, Noah, Webster’s Third New International Dictionary of the English Language: Unabridged with Seven Language Dictionary, Volume 1, A to G (US: G and C Merriam Co, 1966), 984.


Chapter Eight

Conclusion

The thesis has tried to revisit Truth Telling which happens to be an ethical component of Western medicine. Unfortunately this seems to present a challenge for practitioners especially among some of the communities that are well known for their social inter-connectedness and the way they value their extended family relations. For instance, the thesis has pointed out that the African perspective has been mostly influenced by her communalism based on the cardinal point that “I am because we are; and since we are therefore I am.” However, such point presumes prior recognition of the individuality of those making the “we.” Therefore arguing from that line the implication here would be that the involvement of family members in treatment decisions may serve to respect patients’ and families’ autonomy while at the same time benefiting the individual patient. This way of understanding may be different for instance in the American cultural context whereby truth telling has been considered essential to obtain individual consent for the treatment, to challenge the disease, and to be in control of the situation.

In regard to the African perspective the thesis hopes that indirect approach should suffice by being more sensitive to the desire and readiness of patients to be informed or to remain ignorant of their diagnoses and prognoses while fulfilling the physician’s fundamental responsibility of respecting the patient’s autonomy. This approach is expected to become a great contribution in bioethics in terms of enabling physicians to gradually bridge the gap between patients’ knowledge and understanding of modern medicine and their cultural beliefs and interpretations of disease. Therefore, the gradation approach will help in striking a balance between these differences and bring about some complementarity in the field of health care. Furthermore, this thesis has tried to elaborate that the gradation approach will also enable
physicians to treat people from different cultural backgrounds while respecting their rights as well as autonomy and this may be one of the ways through which truth telling may be possible to apply in other cultures where this principle has seemed impossible to execute in practice.

Furthermore, the thesis has tried to explore the norm of truth telling that forms part of the contemporary debate in clinical bioethics which centers on the right to receive information concerning his/her medical condition/illness. This goes hand in hand with the duty of the physician to give such information to the patient. In elaborating further still, the thesis has tried to explain the notion and implications of disclosure as an important component of physician-patient relationship. Therefore, this has become a complex concept in the medical sociology whereby patients voluntarily approach a physician, and thus become a part of a contract in which they tend to abide with the physician’s guidance. However, the thesis makes notice about some changes that have taken place in this relationship whereby today a patient is considered to be a partner in his or her treatment. This implies that physicians are supposed to be truthful to their patients in communicating so as to help patients in maintaining their autonomy. Meanwhile a patient is also reminded about his/her role to provide as much information to the physician trusting that such information may also be disclosed to other professionals in the interest of giving proper treatment to that particular patient.

Discussing on the seven elements of informed consent the thesis tried to put emphasis on disclosure as one of them. However, this seems to go hand in hand with some institutions and authorities which present obligation to disclose information to patients as the only major condition of informed consent. This has been upheld in United States whereby disclosure still plays a pivotal role for patients to use as basis towards decision making. This would conform to
the fact that medical care is a process whereby both a patient and a physician have informed each other of how each feels and the interaction helps in forming the basis for the next decision.

Understanding and voluntariness have also been addressed by thesis as other elements of informed consent. However, the thesis remarks that a patient is not required to be on the same understanding level with his or her physician so as to make an informed choice. Rather the patient will be able to understand the information needed for making informed choices through the explanation given by the physician about the likely effects of the medical condition and possible treatments. This is why the thesis recognizes that today the ethical question regarding truth telling is changing from the question whether physicians should tell their patients to the how physicians should share the information with the patients. In other words, the main concern here is the effect that the framing of the communicated information can have on the patient’s ability to make informed decisions.

While focusing on ethical issues and problems that are connected with truth telling considered as the leading principle in bioethics which emphasizes on patient's autonomy. Recognition has been made that autonomy may not be a primordial principle in other cultures. This why the thesis has tried to address the problem of cultural diversity based on the fact that the culture in which one is born and raised has some long lasting effect on the person. However, the thesis recognizes that the principle of autonomy is grounded in respect for persons and the acknowledgement is that as rational beings we have unique capability to make these personal choices. On the other hand, health literacy and adverse consequences associated with ineffective communication can affect all patients and can lead to misunderstandings of a patient’s concerns, misdiagnosis, unnecessary testing, poor patient compliance, inappropriate follow up, and poor patient satisfaction. Similarly, medical tourism has been addressed by the thesis as having
chances of facing a problem in communication. This is one of the issues that may occur especially when receiving care at a facility where a patient does not speak language fluently. Therefore, the thesis points out a need to acknowledge the full complexity of trans-cultural doctor-patient communication needs.

In approaching truth telling from a pluralistic health care environment, the thesis recognizes the fact it involves different expertise from different backgrounds to the extent that physicians are no longer the sole or necessarily the most important health care professionals with respect to patients’ treatment or care, nor is their power as great as it used to be. This is why the thesis has gone to elaborate further by analyzing the relationship between different services rendered in a health care organization whereby many services provided to a patient within a health care organization overlap with the responsibilities of each other the situation that calls for mutual cooperation amongst health care personnel.

The above situation has led the thesis to analyze on the issue of confidentiality whereby physicians are obliged to refrain from divulging confidential information obtained from patients and ensure that such information is not inappropriately divulged to third parties. However, the thesis recognizes that today confidentiality has become an organizational problem basing on the fact that the circle of authorized access has been expanding to the extent that some companies have been reported as using medical information in making decisions about hiring and firing. This implies that a great deal of collaborative work would be needed to place both physicians and health plans on the same page ethically in order to build a health care system with strong ethical foundations. However, the thesis emphasizes on the role of organizations in protecting patient’s information by introducing a culture of transparency in which case staff should train as a team and work as a team as a way of increasing accuracy and developing a sense of communal
responsibility and accountability. The implication here is that if the organization and its systems fail to function synergistically and fail to live up to their responsibilities in relationship, the organization’s stewardship will falter which is tantamount to failure of the entire organization. At this point the thesis hopes that this contribution will help health care organizations to embrace the multiple stakeholders involved with them both from within and outside to safe guard the patient’s shared information.

In chapter five the thesis has tried to spend some efforts developing the gradational approach whereby the physician fulfills the duty of revealing the patient’s health information gradually in accordance with the patient’s ability to cope with such information and also recognizing the time left for the patient to deal with such knowledge. In the same chapter the thesis went further to analyze on disclosure as a process whereby the physicians are supposed to provide information about a proposed medical investigation or treatment to the patient. However, as medical information may prove to be very hard for patients to digest. The thesis proposes that such information would be provided in small chunks so that a physician may not find an excuse for informing a patient on pretext that something was hard to explain when even it can be stated in simpler terms using a drawing. The hope being that if the information is used wisely can as well easily enhance the physician-patient relationship. Similarly, the information that has been poorly employed has a big possibility of destroying the physician-patient relationship as well.

Furthermore, the thesis has tried to propose that in order to improve on disclosure, then the psychological sequelae of breaking bad news in an abrupt and insensitive way should be avoided. This would probably be replaced by applying the art of truth telling that relies on the skills and attitude of the physician which take the patient into his/her confidence and give him/her a true impression of his/her illness. This move may also help in avoiding poor delivery
of bad news which stems from being too blunt, discussing it at an inappropriate place and time, and conveying a sense of no hope. For instance, a patient from a particular culture may prefer being approached by talking about things not related to the illness first and gradually move the conversation to things indirectly related to the patient’s diagnosis by asking about symptoms experienced. Therefore, a patient should be invited to speak of anything that troubles him/her and the physician should be able to listen because by listening to patients, the physician will be able to address and clarify the patient’s complaints.

The thesis recognizes the importance of compassion in the effort to improve on physician-patient communication whereby compassion has been presented as being central to the purpose of medicine and the care of patients and their families. However, the thesis cautions against the danger of confusing compassion for empathy but rather encourage towards thinking about what is meant by the term “feeling with” the other. On that vein the thesis has tried to define empathy as a process or event by which one perceives and understands the subjective experience of another person. However, empathy should be taken to be much more than illusion and very difficult to distinguish from sympathy simply because; where empathy feels “I am you” sympathy may well mean “I want to help you.” On the other hand, neither should compassion be confused for pity because pity has its roots in fear and carries a sense of arrogance and condescension, sometimes even smug feelings of ‘I am glad it is not me.’ Therefore, compassionate response is not to another’s pain per se but to the being who suffers unnecessarily. However, after analyzing on disclosure as a process and revisited the notion of compassion in the effort to improve on physician-patient relationship. There is hope that this proposed gradation approach would be applied as one of the ways towards making truth telling possible especially in those cultures where this principle has seemed impossible to practice.
The Sub-Saharan African ethical perspective has been presented in this work as derived from variety of cultures. Yet despite of such diversity, one can still argue that there is a common Africanness about the culture and world-view of Africans. On the other hand, the focus on the African concept of the person reveals that a community plays a big role. This kind of idea seems to imply that in African traditional life the individual does not and cannot exist alone except corporately. Therefore, whatever happens to the individual affects the whole community and vice versa. However, the thesis has remarked that there are some instances whereby individuality is emphasized in African tradition. For instance each individual person has his/her own name which is different from that of his/her parents. Similarly, in addressing on different concepts of the individual the thesis presents realization that the human individual is also by nature other things such as essential attributes of the person for instance, rationality, having a moral sense and capacity for virtue so as to evaluate and make moral judgments. This implies that an individual is capable of making choice and the community’s role can only be partial towards the realization of someone’s goals.

On the other hand in addressing implications for both health and disease the thesis indicates that African communitarian perspective has implications on health care. For instance health in traditional African societies takes into account a whole person and his/her social environment. In that regard, most of the practices involved in dealing with illness and misfortunes or other misfortunes were psychologically vital in the healing process of the patient or sufferer and the medicine-person is considered to be the pillar of the society. However, discussing the implication for death and suffering the thesis remarks that most Africans take death as a process and believe that after physical death an individual continues to exist in the present period through remembrance of relatives and friends that knew him/her and have
survived him/her. Therefore, people look at dying as one of the life transitional stages, not an end in itself, but a means to an end. Similarly, health care issues among most of the African societies are a concern of all members of the community, and caring for the sick is not charity but an ethical obligation especially among people of Sub-Saharan Africa. For instance, traditionally, a sick member of the society would be accompanied to the medicine man by the group and listen for this person, or listen with this person and what is shared in the consulting room would also be concern for those remaining outside. Therefore, the African thought polarized by the vital relationship where everyone necessarily maintains with others and with the world requires that health care should extend to the whole person and involve both the patient and the family. One can argue that the emphasis in African ethical thinking should always be on the good of the patient and the welfare of the community, and this will have effect on truth and truth telling in general and calls for some adjustments to be made.

On the other hand, the thesis has also tried to present the application of the gradation approach whereby the physician would be encouraged to reveal the patient’s health information attuning it to each individual patient’s situation. However, the gradation approach has been presented in this thesis as recognizing the fact that patients are in most instances not ready for the cold hard facts. Therefore, this may entail giving patients some time to come to terms with the reality but reassuring them of another chance of addressing such issues next time so as to absorb the shared piece of information.

The thesis has recognized the need for improving on the art of medical dialogue that is needed by health care personnel keeping in mind that nature of their vocation calls for practicing their art with high moral sensitivity. On the other hand, physicians have been encouraged to disclose the information in amounts, in admixtures and according to timing believed best for
patients. The thesis bases its argument on the fact that unhappy news abruptly conveyed or a
great shock given to someone unable to tolerate it could also bring on such a dying response
quite unintended by the speaker. However, breaking of any bad news will also depend very much
on the abilities and techniques that each physician uses or applies in coping with the patient’s
reactions.

Analyzing on the role of ethics committees in helping physicians to facilitate truth-
telling has been regarded as important. The thesis hails this as help in avoiding misconception
and miscommunication among parties coming from different cultural backgrounds when
valuable ethics committee happens to act as educating care providers about the personal and
cultural differences that influence the clinical dynamic which may also affect patient care.
Therefore, the trained and effective ethics committee within a health care facility would facilitate
understanding on decision processes and how other cultural concepts can interface with different
ideas that may be foreign. However, the ethics committee should be envisioned as a group of
persons fulfilling the rule of medical ethicist and it is not a policy-making body but only suggests
policy on request of the medical staff or hospital administration. However, their role can aid truth
telling in many different ways.

In applying the gradation approach the thesis has also recognized the role played by the
governments towards improving health care. In our case involving the governments in improving
health care is vital because the gradation approach requires a big number of physicians that must
have enough time to spend with patients. Therefore, governments can help in setting policies
which will encourage and protect this career so that there are many health care personnel in order
to reduce on the work load. This will result into a situation where physicians have enough time to
better interact with patients, and make sure that their rights as patients are upheld.
Unfortunately, the thesis has highlighted on the health workforce shortages in some parts of the world especially in sub-Saharan Africa where it has been widely recognized, particularly of physicians. However, some efforts have been made in responding to this problem whereby there has been shift or delegation of tasks to non-physician clinicians whose deployment has finally gained full acceptance by local health sector leaders.

The thesis has proposed that medical schools will also need to respond towards solving the above problem by emphasizing inter-professional training as a way of preparing future health workers for the complexities of delivering health services in remote rural areas. More so the training has to help candidates be ready specifically for interacting effectively with cadres different than their own. The thesis hopes that the time spent by medical students and other health care professionals trainees preparing for practice would ought to be an opportunity to bond the future doctor with population groups, health services, research projects, in-country academic and economic opportunities in medical practice, and in this way fight external migration or brain drain.

The conclusive remark for this thesis is that the gradation approach can be possible and if applied can help us in solving some of the problems faced by truth telling. More so the thesis believes that by applying the gradation approach will be one way of enabling physicians to treat people from different cultural backgrounds while respecting their rights as well as autonomy. However, this is not to say that the work has been fully exhausted but there remains room for further research on this area.
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363


