The Philippine Clinical Practice Guidelines on Ethics in ID Practice

PHILIPPINE SOCIETY FOR MICROBIOLOGY AND INFECTIOUS DISEASES

ETHICS HANDBOOK *for* INFECTIOUS DISEASES PRACTICE *in the Philippines*

Philippine Practice Guidelines Group - Infectious Diseases
Philippine Society of Microbiology and Infectious Diseases
No. 116 9th Avenue, Cubao
Quezon City 1109 Philippines

ETHICS HANDBOOK
for
INFECTIOUS DISEASES PRACTICE
in the Philippines

TABLE OF CONTENTS

COMMITTEE MEMBERS:

Chair:	**Angeles Tan-Alora, MD**
Co-Chair:	**Mediadora C. Saniel, MD**
Members:	**John S. Delgado, MD**
	Elfleda A. Hernandez, MD
	Rozelle Jade R. Javier, MD
	Mary Ann D. Lansang, MD
	Jaime C. Montoya, MD
	Esperanza F. Rivera, MD

CONTRIBUTORS

Marissa M. Alejandria, MD, FPCP, FPSMID
Secretary, PSMID
Professor and Chair, Department of Clinical Epidemiology, UP College of Medicine
Clinical Associate Professor and *Training Officer*, Section of Infectious Diseases, Department of Medicine, UP-PGH

Marie Yvette C. Barez, MD, FPCP, FPSMID
Past President, PSMID
Head, Section of Infectious Diseases, Davao Doctor's Hospital

Lina Casiple-Amsua, MD, FPSMID
Medical Specialist II, West Visayas State University Medical Center
Faculty Member, College of Medicine, Western Visayas State University

John S. Delgado, MD, MHPEd, FPCP, FPSMID
Member, Faculty of Medicine and Surgery, UST
Member, Institutional Review Board, UST Hospital

Mari Rose A. De Los Reyes MD, FPCP, FPSMID
President, PSMID
Head, Medical Department, Research Institute for Tropical Medicine
Chief, Infectious Diseases Section, Department of Medicine, Asian Hospital and Medical Center

Rosalina Q. de Sagun, MD, FPPS, FPNA, FPHSD
Member, Faculty of Medicine and Surgery, UST
Head, Subcommittee on Bioethics, Department of Pediatrics, USTH

Ellamae S. Divinagracia, MD, FPCP, FPSMID
Past President PSMID (Western Visayas Chapter)
Professor IV, Chair and Coordinator, Department of Microbiology and Infectious Diseases Iloilo Doctor's College of Medicine
Head, Section of Infectious Diseases and Infectious Control Committee, St. Paul's Hospital, Iloilo

Rozelle Jade R. Javier, MD, FPCP, DPSMID
Member, Faculty of Medicine and Surgery, UST

Ludovico I. Jurao, Jr. MD, FPCP, FPSMID
Past President, PSMID
Professor V, Iloilo Doctor's Medical College

Mary Ann D. Lansang, MD, FPCP, FPSMID
Former President, PSMID
Chair, Standards of Care Committee, *PSMID Member,* Scientific Advisory Group, South East Asia Community Observatory, University of Monash, Malaysia

Vegloure M. Maguinsay, MD, FPCP, FPSMID
Treasurer, PSMID
Chair, Infection Control Committee, San Pedro Hospital, Davao City
Associate Professor, Davao Medical Center Foundation

Ricardo Manalastas, Jr., MD
Professor of Obstetrics and Gynecology, College of Medicine, UP Manila

Felice G. Molina, MD
Treasurer, PSMID
(Western Visayas Chapter)
Chair, Infection Control Committee, Western Visayas Medical Center
Head, Section of Microbiology and Parasitology, College of Medicine, Central Philippine University

Jaime C. Montoya, MD, PHD, FPCP, FPSMID
Former President, PSMID
Professor VIII, UP College of Medicine
Executive Director, DOST-PCHRD

Mario M. Panaligan, MD, FPCP, FPSMID
Vice President, PSMID
Head, Section of Infectious Diseases, Department of Medicine, St. Luke's Medical Center – Bonifacio Global City
Chair, Department of Medicine, UERMMMC

Minette Claire O. Rosario. MD. FPCP, FPSMID
Asst. Professor, Department of Medicine, College of Medicine UERMMMC

Esperanza F. Rivera, MD, FPPS, FPSMID, FPIDSP
Chair, Bioethics Committee, PCMC, FEUH
Co-Chair, Bioethics Committee, Cardinal Santos Medical Center
Chair, PPS Ethics Committee
Past President, PPS

Mediadora C. Saniel, MD, MBA-H, FPCP, FPSMID
Former President, PSMID
Chair, UTI Guidelines Task Force, PSMID

Angeles Tan-Alora, MD, MA Ed Mngt, FPCP, FPSMID
Former President, PSMID
Head, Bioethics Committee, USTH

Larissa Lara Q. Torno, MD, FPCP, FPSMID
President, Philippine Society for Microbiology of Infectious Disease - SMC
Member, Board of Councils PSMID

FOREWORD

The "Ethics Handbook for Infectious Disease (ID) Practice in the Philippines" was prepared in response to an expressed need of ID physicians for a practical handbook that they can refer to when faced with ethical dilemmas in clinical practice.

In a particular situation, the handbook aims to help the ID physician identify the problem, propose potential solutions, and come to the right decision; all in the context of the individual patient under particular circumstances influenced by a specific culture.

The "Ethics Handbook" will neither answer all questions nor eliminate all controversies. We anticipate that many issues will remain, but readers might be motivated to pause and reflect on ethics. This might challenge them to engage in dialogue with others to discuss what really matters, helping develop more informed and more sensitive doctors – individuals who are more willing to become not just *learned* ID physicians but *good* ID physicians who will serve as blessings to others.

Ethical and legal standards are not always concordant. The "Ethics Handbook" deals with what is ethical. A different reference will be needed for legal considerations. However, documenting the process of ethical decision-making and the decision makers involved in the process may help protect against possible litigation.

The "Ethics Handbook" is a living document. Although principles may be constant, their application may vary. Improvements will be needed with experience, time, debate and new thinking. We need your contribution to further understand what we, as ID physicians, are doing, and to decide how it should be done. We look forward to better future editions of this handbook.

Thank you.

INTRODUCTION

Enlightened ethical decision-making relies on many fundamental approaches. The most common of which considers consequences, principles and virtues.

Consequences seek the most good for the greatest number.

Ethical principles value the dignity of man as one who should not be harmed or exposed to harm (non-maleficence), who should be benefited (beneficence), who should decide what is best for self (respect for person), and who should be treated fairly (justice). Other moral principles like double effect and lesser evil are also cited.

Virtues characterize the one performing actions as a good person and doing what a good person would do. They often come into play when consequences are in conflict with principles; or when different principles contend.

The "Ethical Handbook" attempts to translate these considerations into specific statements on how an ethical ID physician should act.

The "Ethical Handbook" is grouped into three main sections: the relationship of the ID physician with the patient; his/her relationship with colleagues and other healthcare professionals; and his/her relationship with the profession, healthcare institution, the society and the pharmaceutical industry.

The section on Physician-Patient Relationship is further subdivided into chapters according to the following main ethical concerns: The Nature, Rights and Responsibilities of Patient and Physician; Free and Informed Consent; Privacy and Confidentiality; The Child; The Person Living with HIV/AIDS; The Woman during her Reproductive Period; and The Dying Patient.

The Physician Relationship with Colleagues includes discussions on peer relationship and referrals.

The section on Physician Relationship with the Profession, Healthcare Institution and Society deals with issues between the medical profession and the society, research, infection control and pharmaceutical industry.

Each chapter starts with general statements expressing the underlying ethical values in the context of the Philippines in 2017. Specific guidelines regarding how a physician ought to behave are then outlined. This handbook is meant to serve as a practical "tool kit." No attempt to provide in-depth explanations or discussions of the guidelines was made, but references are provided. The "Application" section presents cases with ethical dilemmas outlined in question format.

The first case is analyzed and answers are provided. Reasonable persons may disagree about it being the right reasoning or answer. The subsequent cases are neither analyzed nor answered. They are meant to challenge the readers, to personally reflect and dialogue, and to formulate their own specific responses.

Readers are encouraged to move beyond the guidelines, cases, and questions; and to make this book but a starting point.

Chapter 1

The Physician-Patient Relationship: Nature, Rights and Responsibilities

The physician-patient relationship is a covenant of trust between a healthcare professional with expertise and a promise to serve and a patient in need of the physician's service. It is a mutual agreement between an individual physician, or a managed care organization, or a healthcare facility and the patient.

The imbalance between the physician and the patient and the confidential nature of the encounter underlies the need for the physician to be trustworthy: to always seek the patient's best interest first regardless of the patient's physical, economic, social, religious or other personal characteristics.

Both the physician and the patient have rights and responsibilities which govern the relationship.

Physician's Rights

1. Right to Care for Self – A physician has the right to use resources including time and money to care for the physician's own well- being.[1,2]

2. Right to Autonomy in Practice – A physician has the right to choose the scope, manner, place and hours of practice provided it is in line with the accepted standards of practice.[2,3,4]

3. Right Not to be put in Conflict with other Physicians – A physician has the right to avoid discord and to harmoniously relate with other physicians.[2,3]

4. Right to Receive Just Compensation for Services – A physician has the right to receive a just compensation for professional services rendered. This may be paid by the patient, the patient's family, a contracted health facility, an insurance company or the government.[3,4,5]

5. Right to Respect and Good Name – A physician has the right to be respected by the community and to maintain a good name, untainted by unfair criticism or expectations.[1]

Physician's Responsibilities

1. Duty to Care for Self – A physician has a duty to maintain his/her own physical, mental, emotional and spiritual well-being.[6]

2. Duty to Care for the Sick – A physician, by tradition and professional oath, has a moral obligation to care for the sick. This obligation is collective to the medical profession with each individual physician doing one's share.[4,7,8,9] When circumstances require the specific skills of the ID physician to prevent harm to others (i.e. epidemics), this right to autonomy in practice may be overridden by the responsibility to provide patient care and the principle of non-maleficence.[2,5]

3. Duty to be Trustworthy in Caring for the Patient – A physician's primary commitment should always be to the patient's best interest, whether in preventing or treating illness or in helping the patient cope with illness, disability or death.[4,8,9]

   A physician has a duty to be competent and responsible in providing holistic humane healthcare based on scientific and ethical principles.[9]

   A physician has a duty to tell the patient the truth about the patient's illness, its prognosis and alternative options for care.[8,9]

   A physician has the duty to respect patient privacy and maintain confidentiality.[3,8,9]

   A physician has a duty to acknowledge limitations in one's capacity and competence and to decline responsibilities that he/she is unable to perform skillfully.[2,3,4]

   A physician has a duty to avoid conflicts of interests (COI).[8,9]

4. Duty to Deal with the Patient as a Partner – A physician has a duty to internalize the changing philosophy of physician-patient relationship beyond patient-centered care to patient engagement, even empowerment, and the importance of the patient's experiential knowledge.[6]

   A physician has a duty to make the patient an active member of the patient's own healthcare team.[6]

5. Duty to Effectively Communicate – Effective communication is crucial to a strong physician-patient relationship. A physician has a

duty to openly and honestly communicate with the patient and the patient's family; not misrepresent self in an untruthful or deceptive manner, nor mislead the patient regarding the gravity of the patient's illness or the effectiveness of recommended measures.[8,9]

6. Duty to be a Good Steward in the Use of Resources – A physician has a duty to use resources wisely and make them available equally and justly among patients who need them.[3,4,11]

Patient's Rights

1. Right to Life[8] – Life is sacred and shall be valued. It is the necessary condition for all human good. A patient has a right to life.[1] This is mandated by the Philippine constitution.

2. Right to Good Medical Care[8] – Health is a basic need for the proper development and maintenance of life. To promote one's health, a patient has a right to competent and humane medical care irrespective of the person's age, gender, socio-economic status, religious/political affiliation, decision-making capacity or disease condition.[4,6,8]

3. Right to Self-Determination[8] – A patient has the right to make decisions about one's health (accept or refuse a recommendation regarding what is to be done and the circumstances involved). This is expressed in free and informed consent.[5,6]

4. Right to the Truth[8] – A patient has the right to be informed of the truth regarding his/her health, medical care options, and the conditions of managed care, insurance, employment and similar arrangements. This information belongs to the patient and is needed by the patient to make the right decisions.[5,8,9]

5. Right to Privacy[8] – A patient has the right to keep private information a secret except when the patient consents to have it disclosed, when it is required by law or when it is for the common good.[5,8,9]

   A patient has the right to privacy during the process of history-taking and physical examination.

6. Right to Health Education[8] – A patient has the right to be taught how to keep healthy and how to prevent the spread of disease.[2,9]

7. Right to Respect for Dignity[8]– A patient has the right to be treated with the respect befitting a person with dignity.[1,8]

8. Right to Religious Assistance and Practice[8] – A patient has a right to be assisted in practicing one's religion.[1]

9. Right to Justice – A patient has a right to be charged justly, and to have a fair share of benefits and burdens of the healthcare system.[7,12] A patient has the right to reparation for damage after being hurt, aggrieved or wronged.[9]

Patient Responsibilities

1. Duty to Cooperate – A patient has the duty to cooperate in the management of the patient's condition, including providing all information related to it and complying with doctor's orders to the extent the patient is able.[2,13]

2. Duty to Compensate the Physician – A patient has the duty to justly compensate the physician for service rendered.[2,4]

GUIDELINES

1. Provision of healthcare

A. In emergency situations, healthcare shall be given with no discrimination.[2,8,10] When multiple patients are involved, first consideration shall be given to those who are likely to benefit most (triage).[6,9]

B. In non-emergency situations, healthcare shall be allocated according to a fair transparent process established and made known by the health service facility.[9]

C. If a patient cannot pay for healthcare, the patient shall be referred to a charitable or government institution that provides free care.[9]

2. A physician-patient relationship starts the moment the physician responds to a patient's request (face-to-face, telephone, text message, etc.) by answering a question, examining a part of the patient's body, reviewing a test result or making a recommendation which reflects the physician's professional expertise.[9,10]

3. A private physician (not connected to managed care or government facility), in a non-emergency situation, may refuse to start a professional relationship by not responding to the patient's call or by immediately telling the prospective patient that the physician cannot respond, and that the patient should seek professional help elsewhere.[4,7,9]

Acceptable reasons for refusal are:

A. More competent doctors are available (e.g., a pediatrician asked to deliver a baby).

B. The doctor is not physically able to see the patient (e.g., the physician is leaving the area or about to leave in a few minutes and cannot delay the departure).

C. The patient requests care contrary to the doctor's moral values (e.g., a patient asks for a contraceptive). When institution or government policy allows such care, the physician shall justify refusal by stating the moral value involved and invoke the right to "conscience object."

D. The patient requests care contrary to the standards of medical care and ethical practice or the law.

F. The patient has had or has a present blood or emotional relationship with the physician wherein the connection may affect the physician's clinical judgment.[10]

A physician who refuses to care for a patient shall explain to the patient the reason for the refusal and, to the extent possible, suggest the appropriate alternative action.[3,10] If the reason is a blood or emotional relationship, the physician may advise, translate, accompany, advocate and refer the patient but should still refrain from actually providing professional care. A healthcare institution, managed care organization or government institution may have specific rules regarding refusal to provide care. In an emergency, if no other physician is available, a physician cannot refuse to provide care even if no physician-patient relationship has formally begun.[4,10,14]

4. A physician shall provide competent and humane healthcare.[2,5,9]

A physician shall:

A. Protect life from birth to natural death. All forms of direct killing are prohibited (Refer to Chapter 7: The Dying Patient).

B. Ask for the patient's free and informed consent before any procedure (Refer to Chapter 2: Free and Informed Consent)

C. Communicate the truth about the patient's illness and treatment alternatives to the patient and the patient's family with sensitivity and compassion.[4,7] The physician shall promote patient/family understanding and shall be cognizant

of and respond to barriers including health literacy issues and cultural differences (Refer to Chapter 2: Free and Informed Consent).

D. Keep patient's private information confidential (Refer to Chapter 3: Privacy and Confidentiality).

E. Involve the patient in the patient's healthcare, guide the patient through the consent process, and teach the patient measures to get better.[5,11,14]

F. At no time unnecessarily expose the patient to avoidable environmental elements, torture, abuse, cruelty, disrespectful language, rude manners, sexual harassment, or to circumstances that lead to the patient's loss of control, isolation, embarrassment or humiliation.[4,5]

G. Assist the patient in practicing his religion.[5,15]

H. Consider the patient's financial capability in determining recommendations and the physician's professional fee. The physician shall enable patients to get compensation for harm.[3,5]

I. Maintain the boundaries between professional and personal relationship with the patient.[16]

J. Recognize conflicts of interest and deal with them through avoidance, removal, resolution or public disclosure.[5,6]

5. The physician-patient relationship shall end when one party expresses the desire to end the relationship and the other agrees.[9] This expression can be explicit or implied, as when a patient stops visiting the physician. If continued care is needed, efforts shall be taken to properly endorse the patient to the preferred new doctor to ensure that healthcare is not jeopardized and abandonment not perceived.[8,10] The physician-patient relationship does not automatically end when a patient fails to comply with the physician's orders.

6. The physician shall charge a just amount as compensation for professional services.[9] The amount shall depend on the expertise of the physician, the service provided, the prevailing professional service rates at the place of practice and the capacity of the patient to pay.[4,5,9] A physician shall not profit from non-professional services provided to patients such as selling of medicines or vaccines.[4,7,9]

7. The physician shall communicate with other members of the healthcare team to make each member aware of and agree to the diagnostic, therapeutic, and rehabilitation plans for the patient[5].

APPLICATION

Case 1

MS, 24, a call center employee, telephones her aunt, Dr. AT, an ID physician, to ask for an antibiotic. Since four hours ago, MS has had low fever, a runny nose and a painful throat. Six months ago, MS had similar complaints which progressed to a 2-week illness with chills and fever and a productive cough. She was diagnosed by her private physician to have pneumonia and given 3 different medicines. MS did not improve so she consulted her aunt, Dr. AT, who changed her antibiotic and stopped the other drugs. MS improved after 2 days and recovered after a week. MS does not want a similar event to happen so she asks her aunt, Dr. AT, for an antibiotic now.

Dr. AT has known MS since she was born and is aware of MS' general health condition. She also finds MS reliable in reporting accurately her symptoms and following doctor's orders.

Questions:

1. Should Dr. AT prescribe an antibiotic?

2. Should Dr. AT answer the telephone consultation?

3. Should Dr. AT treat a relative?

Suggested analysis:

1. An antibiotic is prescribed for an infection caused by a micro organism responsive to antibiotics. As described, it is too early to tell if MS' upper respiratory complaints are due to a bacterial infection requiring an antibiotic. Statistically, viral causes are more common.

2. An ethical ID physician shall provide competent care. Dr. AT should know that it is too early to give an antibiotic and not do it. If she gives one, she is incompetent and unethical.

3 Telephone consultations are discouraged. The risk of receiving the wrong information and making decisions based on the wrong information always exists. This is even greater when the one giving the information is a patient with no medical training. MS is a call center employee with no medical training. Although MS may

accurately describe what she feels, essential physical examination findings are absent. How high is the fever? What is the appearance of the throat? Are there enlarged lymph nodes? Without this information, a wrong diagnosis may be arrived at.

At the same time, telephone consultations are often convenient for the patient who is feeling ill and will have to bear the traffic, the waiting, the physical strain and financial burden of going to the doctor's clinic. If the illness is mild, the patient is known to the ID specialist and reliable, the ID physician might take the risk of making a wrong diagnosis and out of compassion treat MS on the phone. Because MS is a close relative it may be difficult for Dr. AT not to treat at all. Dr. AT might advise rest, fluids, antipyretics and possibly an antihistaminic and decongestant. Dr. AT however, should emphasize to MS that MS should see a doctor ASAP if symptoms persist or get worse.

Should a doctor charge the patient for a telephone consultation? In as much as a professional service is provided, a corresponding professional charge is justified. In MS' case, however, being a niece, Dr. AT will probably not charge her, not for ethical reasons but for cultural ones.

3. Doctors should not treat relatives. Their emotional involvement may make them either minimize or magnify the gravity of the illness and its adverse consequences and come to unfortunate decisions. Again, it is difficult to refuse to treat a relative given our Filipino culture. It may be interpreted as not caring. Dr. AT should tell MS that she should not be treating relatives and why (although she already did 6 months ago, and should have told her then that it was not right). She may advise rest and fluids, reassure her it is probably not serious, but insist that MS visit her regular physician if MS does not improve. Dr. AT may even suggest the specific physician MS should go to.

For the same reason of losing clinical objectivity, doctors should also not treat themselves.

Suggested Answers:

1. Dr. AT should be competent and not prescribe an antibiotic.

2. Dr. AT should not respond to telephone consultations.

3. Dr. AT should not treat relatives. Based on cultural norms, Dr. AT may choose or feel "forced" to do so, and if she does, should not charge. She should refer MS to the appropriate physician.

Case 2

To provide time for rest and to care for their own well-being, five ID physicians decided to start a group practice. They manage patients through a decking system. Although each one has specific patients, regular clinic hours and daily rounds, the doctors rotate for night duty. The physician on night duty takes care of all ID calls during the night irrespective of who the attending ID physician is. The five ID physicians are equally competent and their medical orders are usually alike.

Questions:

1. Do the facts of equal competence and duty to care for self justify the night rotation system? What would be to the patient's best interest?

2. Should the patients be informed of this arrangement and give informed consent?

3. What if the Attending ID physician disagrees with what the ID physician on night duty ordered? Should the patient be told?

4. Who will be responsible if an unpleasant event occurred?

5. How is the professional fee determined and divided? Should the patient be told?

6. Should there be a hospital policy regarding such arrangements?

Case 3

An ID physician asks his patients to buy the drugs he prescribes at his wife's drug store.

Questions:

1. Is there a conflict of interest (COI)?

   COI occurs when professional judgment (objectivity) concerning a primary interest tends to be or appears to be unduly influenced (dominated) by a secondary interest. The ID physician's primary interest should be to promote the health of his patients. Secondary interests include earning, learning, research or professional recognition. Would profits from drug sales and financial incentives from pharmaceutical companies affect the ID physician's clinical judgment and prescription choices or appear to affect it? How can this be resolved?

2. Can patients refuse and buy their medicines elsewhere? Should patients be told that the ID physician's wife owns the drug store? Is there an element of coercion? Misrepresentation?

3. What if the ID physician's samples are sold in the drug store? What if the clinic and drug store are beside each other?

Case 4

Patients who are unable to pay their hospital bills stay in the hospital long after orders for their discharge are given. To prevent the unpaid bill from becoming even bigger, some hospitals allow the patients to go home without paying both the hospital bills and physicians' professional fees.

Questions:

1. Do hospital administrators have the right to allow patients to forego the physician's professional fees?

2. Should physician's informed consent be asked first?

2. What should a just hospital policy to deal with such situations consider?

REFERENCES

1. Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

2. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

3. Code of Medical Ethics. American Medical Association; 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.

4. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf.

5. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html.

6. Timbreza F. Bioethical and moral decisions 7th Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

7. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

8. Alora AT. Ethical guidelines for medical practice, 2nd ed. Manila, Philippines: UST Publishing House; 2013.

9. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

10. Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine 2012; 156:73-104.

11. Babor E. Bioethics A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers, 2nd ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

12. Pence G. The elements of bioethics. New York, USA: McGraw-Hill Education; 2007.

13. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

14. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

15. Puchalsky C. The role of spirituality in health care. Baylor University Proceedings 2001;14:352–357.

16. FICE Code of ethics for people working with children and young persons. FICE Bulletin #14, 1998.

Chapter 2

Free and Informed Consent

Every competent person has the right to decide (accept or refuse a recommendation) what will be done to oneself and its circumstances (who, when, where, at what cost) regardless of being terminally ill, pregnant or with dependents.[1,2] This is expressed in free and informed consent.

Free and informed consent is based on respect for a person's dignity. It is rooted in

1. Autonomy: the right of self-determination: to choose according to one's own values and act accordingly, within the limits of humanity and natural law;[3,4]

2. Inviolability of person: to be free to protect one's bodily integrity from unwanted interference;[1,3] and

3. Stewardship: to be responsible for the care of one's own well-being in the pursuit of one's ultimate end.[4,5,6]

Free and informed consent is the process through which a competent person freely and voluntarily gives valid permission for specific procedures in healthcare and research after having received and understood all the information relevant to the decision and weighing it according to one's values.[7]

GUIDELINES

1. Informed consent shall be obtained from every patient and prospective research participant or legitimate substitute/proxy before any procedure (diagnostic, therapeutic, research) is done to the patient/research participant.[8,9,10]

2. For consent to be valid, the consent giver shall have:

   A. Competence or the decisional capacity to receive relevant information, remember, understand, assess, and use it to make a rational decision in line with one's values about what is best for oneself, and to communicate the decision.[11,12]

      Being competent is not necessarily equate to making good decisions. Serious disease may put a patient into a state of helplessness and depression that will affect decision- making. Psychiatric patients shall have special evaluation for competence by a Psychiatrist.[2,6]

B. Correct and sufficient information is given by the consent taker.[11,12]

C. Freedom from dependence, constraint, undue influence, deception or any coercive physical or psychological pressure, control or limitation, by others or outside forces.[6,13]

The ID specialist (physician or researcher) shall not impose the ID specialist's personal values on the patient/participant who may have different beliefs from the ID specialist.

D. Voluntariness: to decide with one's own free will by an act of choice.[4,8]

3. The physician in healthcare delivery and the researcher in research shall be responsible for obtaining the consent.[8,9,10,11]

The consent taker shall not be in a position of authority or any similar position in relation to the consent giver, which may influence the decision-making of the consent giver.[3]

4. The consent taker shall disclose all relevant scientific and moral information (what a reasonable person would need or any essential information desired by the patient/potential participant) necessary for the specific consent giver to make a proper decision.[15] This shall include substantive and accurate information regarding the nature of the intervention, its purpose, the justification for its choice, the person who will perform the procedure, when and where it will be done, expected outcome, benefits, risks/harms/burdens (including costs), alternatives, appropriate course of action should an adverse event occur, and whom to contact for clarifications.[4,6,8]

Information shall be provided using easily comprehensible words and in a manner that is understandable to the specific consent giver.[14] Acceptance and understanding of the information shall be manifested by re-expression of the information in the consent giver's own words.

If the consent giver refuses to receive the information or if knowing the truth may gravely harm the consent giver, information may be withheld.[7,12] (Refer to Chapter 1: Nature, Rights and Responsibilities). In such a case, however, consent is not valid.

The consent giver shall be encouraged to ask questions, discuss, reason and deliberate with others before giving consent.[5]

5. Consent shall be expressed in a signed, dated, and witnessed written consent form.[7,12]

6. Consent evolves, shall be subject to constant re-negotiation and may be withdrawn at any time. A new consent shall be obtained whenever material or substantial changes occur, as when the patient's condition changes, an additional procedure is to be done, or new information is available.[2,3]

7. If a person is unable to give informed consent (e.g., incompetent, immature, too sick), consent shall be given by a substitute decision maker (proxy). The substitute decision-maker may be a spouse, parent, guardian, family member, designated surrogate, and in their absence, attending doctor, hospital authority or court of law.[3,5,6]

   The substitute decision maker shall be a patient advocate and decide according to the patient's previously expressed wishes, or if unknown, according to the patient's best interest.

   In addition to parents' or guardians' consent, partially competent (older child, moderately developmentally challenged) persons shall be involved in decision-making to the greatest extent possible.[8,13] They shall be given information in a manner appropriate to their developmental abilities and shall give assent.[14] Dissent shall be respected unless such dissent is strongly against their best interest (Refer to Chapter 4: The Child).

8. Consent may be presumed or implied:

   A. In an emergency, when an incompetent person has no surrogate available, for therapeutic interventions which the doctor feels are for the patient's best interest (therapeutic privilege), provided there is no indication that the patient would have refused the treatment.[6,15,16,17]

   B. For routine procedures in the delivery of routine healthcare (e.g., blood pressure determination).[6]

9. Consent may be omitted in disasters with many patients, few doctors and limited time. Autonomy may be overridden by utility and beneficence.[8] The time saved by omitting consent may be used in providing care.[3,12,16,17]

   A designated member of the healthcare team (usually the leader) shall make the decision to forgo obtaining informed consent.

10. For as long as the requirements (of consent giver and consent taker) are fulfilled and the correct process is satisfied, refusal to give consent shall be valid[6,15]. The nature of treatment, the opinion of the healthcare provider, or the outcome of the refusal shall not affect the person's right to refuse[12,14].

    In exceptional conditions, when refusal risks severe injury and the proposed intervention is likely to provide immediate significant benefit, the doctor may override refusal to consent provided the refusal is not based on religious reasons.

    Documentation of the reason for refusal to give consent or reason for overriding consent shall be done.

APPLICATION

Case 1

BD is a 23-year-old school teacher who had fever, severe headache, vomiting and diplopia 2 weeks ago. In the provincial hospital blood, CSF examinations, x-rays and a brain CT scan were done. She was given IV medications but did not improve. After 5 days, the family decided to bring BD to Manila.

Admitting diagnosis was meningitis. A lumbar puncture (LP) had an opening pressure (OP) of 300 mmHg. CSF findings supported the impression of TB meningitis. BD was immediately started on anti-TB treatment and IV mannitol. Within 24 hours, BD improved. Her headache which was 10/10 on admission became 6/10, vomiting ceased, fever dropped, and diplopia lessened. On the 3rd hospital day, mannitol dose was reduced. The following day, headache recurred and diplopia worsened. Repeat LP had an OP of 240 mmHg. Mannitol dose was increased. From then on BD progressively improved.

BD suffered from difficult IV insertions throughout her hospital stays. Often it would take the healthcare provider 3 or 4 attempts to find a vein. On the 14th HD, with all of BD's admission complaints relieved, BD had an extremely painful experience with the IV insertion. She became very upset and refused IV attempts.

The doctor explained to BD that stopping IV mannitol risked again increasing the intracranial pressure (as what happened on the 3rd HD) and headache, vomiting and diplopia might recur. More dangerous was the risk of a brain herniation which could be fatal. BD listened, asked no questions but appeared to understand. She complained to her mother of the intolerable pain. BD and her mother discussed the situation and agreed to refuse further IV attempts.

Questions:

1. Is BD's refusal valid and should it be followed?

2. What should the ID physician do?

Suggested Analysis:

1. TB meningitis is an infection characterized by increased intracranial pressure that manifests with headache, vomiting and diplopia. The risk of brain herniation, which can be fatal, exists. LPs and IV mannitol decrease the pressure. LP carries its own risks and is not advised daily. Mannitol can only be given intravenously. The standard treatment for TB meningitis, therefore, is anti-TB treatment and IV mannitol.

   BD refuses IV insertion. Given all the suffering it has caused her, this is understandable. However, it is still difficult to justify.

   - Is BD's refusal valid and should it be honored?

   - Was BD given the correct information regarding the need for IV mannitol?

   Ordinarily, the possibility of a brain herniation is frightening and would make one agree to painful IV insertion. Also, headache, vomiting and diplopia are not easy to bear. It appears that BD was adequately informed and understood these risks but still refuses IV medication.

   - Does BD have the required decisional capacity?

   - Does her illness and emotional state affect her decisional capacity?

   BD appears to have the required decisional capacity. She listened and appeared to understand. She also discussed her concerns with her mother. Because BD is feeling better, the pain of the IV insertion is now magnified; when she was very sick, she had bigger problems, and suffered the pain.

   - Is the decision free and voluntary?

   There is no evidence pointing it to be otherwise. No one has tried to convince BD not to have the IV line. BD's refusal is therefore valid.

- Given it is valid, should it be followed or can it be overruled?

Best interest overrules autonomy. Clearly, in BD's case, her best interest is to continue IV mannitol even if she does not want it. Simplistically, her decision can be overruled.

The difficulty lies on how to implement the overrule. Restraining a conscious 23-year-old woman and "forcing" the IV is cruel and unacceptable. To sedate her may be risky given her CNS disease. BD's cooperation must be obtained. Without it, the overrule is an exercise in futility. Another important consideration is the possible negative emotional and psychological effect the overrule may cause. It may make BD uncooperative, frustrated and depressed. Disregarding her wishes may not be to BD's best interest.

The ID physician should compassionately and patiently explain to BD why he cannot agree to her refusal. He should offer alternatives, such as finding the healthcare provider who can insert IV lines the best or by applying a local anesthetic to the area prior to the procedure. He can explain how the suffering is temporary and how it can be sublimated for the good of others. He can get help from other patients who have similar experiences with painful IV insertions.

If the ID physician is unsuccessful despite all efforts, then BD's refusal has to be honored. She is the best judge of her best interest and has the right to decide. This decision should be documented.

Suggested Answers:

1. Refusal is valid. It cannot be overruled on the basis of BD's best interest. Even if deemed against BD's best interest, BD still has to cooperate and is unlikely to do so.

2. Negotiate with BD so refusal is withdrawn. If refusal persists, honor her wish and document.

Case 2

An ID physician is doing a double-blind randomized UTI research comparing norfloxacin versus a test drug. She invites her patients to be research participants. She tells them that the test drug has been effective and safe but needs further confirmatory studies. If patients agree to be part of the study, they may get either norfloxacin or the test drug for free and she will follow them up for their response. After the study, if they are not well, she will prescribe another medicine to treat them.

Questions:

1. What problems arise when an attending physician is also a researcher? Is there a conflict between his roles as an attending physician who should choose the best drug versus his role as a researcher who should determine which is the best drug?

2. Can patients refuse to be part of the study? How does the authority figure of the doctor affect their decision? How do the cultural traits of "nakakahiya" or "pakikisama" affect decision-making? Does this invalidate the informed consent?

3. Is giving free medicine an undue inducement to join the study? Do the patients believe that by joining the study they will receive better medical care (therapeutic misconception)? Would this invalidate the informed consent?

Case 3

CE is a 6-year-old child admitted with hematochezia. BP was 60/40 mmHg, PR 130 beats/minute and RR 28 breaths/minute. Diagnosis: severe dengue. Blood transfusion is needed to save CE's life. CE's parents refuse to give consent for the blood transfusion. They are Jehovah's witnesses who believe they will go to hell if CE receives blood.

Questions:

1. Is the decision to refuse blood acceptable to the ID physician? Scientifically? Ethically?

2. How is the best interest of CE weighed (temporal vs. eternal life)? If the ID physician does not believe giving blood condemns one to hell, should the ID physician give blood to save CE's life? Can the ID physician use deception to give the blood?

3. Which is the priority consideration: Autonomy (parent's refusal based on religious grounds) or non-maleficence (blood to save CE's life)?

4. Are CE's parents competent to decide? How does the stress and anxiety from having a child in shock affect their decisional capacity? Would it be ethical to override their decision?

5. What are the ethical alternatives?

REFERENCES

1. Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

2. Pence G. The elements of bioethics. New York, USA: McGraw-Hill Education; 2007.

3. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

4. Timbreza F. Bioethical and moral decisions 7th Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

5. Babor E. Bioethics: A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

6. University of Washington. Ethics in Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

7. Beauchamp T, Childress J. Principles of biomedical ethics 5th ed. New York, USA: New York Oxford Press; 2001.

8. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

9. Declaration of Helsinki. Adopted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 as amended in the 64th WMA General Assembly, Fortaleza, Brazil; October 2013.

10. Mitscherlich A, Mielke F. The Nuremberg Code: Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman;1949. pp. xxiii-xxv.

11. Emmanuel E, Wendler D, Grady C. An ethical framework for biomedical research. The Oxford Textbook of Clinical Research Ethics. New York, USA: Oxford University Press; 2008.

12. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

13. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

14. Snyder L. American College of Physicians Ethics Manual 6th Ed. Annals of Internal Medicine; 2012;156:73-104.

15. Pence G. Medical ethics: accounts of ground-breaking cases 7th ed. New York, USA: McGraw-Hill Education; 2015.

16. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

17. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

Chapter 3

Privacy and Confidentiality

Privacy is the right of every person to keep personal aspects secret: to be left alone.[1] Privacy of information, observation and decision refers to information one has not or does not wish to make known to others.

Confidentiality is the obligation of every person not to disclose private aspects of another person.[1] Confidentiality of information refers to information one has confided to another which one does not wish the other to make known. It underpins trust and ensures that a patient divulges all relevant information necessary for appropriate healthcare. It is a professional, legal and ethical obligation.

In the healthcare setting, the patient or the doctor may have information they want to keep secret. Others have the obligation not to disclose it.

The process of observing privacy and confidentiality are largely affected by culture. Where family affiliation is strong, individual secrets are often shared with family members. These guidelines are based on the Philippine setting.

GUIDELINES

1. Private information shall be disclosed with the person's (patient or healthcare provider) consent which specifies:[2,3,4,5]

    A. What is to be told

    B. To whom it should be told

    C. For what reason/s (circumstances)

    D. When it is to be told

2. Private information may be disclosed without the person's consent to prevent greater harm to self or others after alternatives to prevent the said harm are not found, or when required by the law.[3,6,7,8,9]

3. Disclosure of private information (including medical certificates regarding disability or illness) shall:[1,5,10,11]

    A. Be factual

    B. Never be cruel

C. Timely to be useful

D. Dependent on the owner's condition

E. With measures to minimize harm

4. Regarding a physician's illness, the need to disclose the illness to the patient shall be directly proportional to the:[12,13,14]

   A. Risk of the doctor transmitting the disease to the patient

   B. Lack of implementable infection control measures to prevent transmission

   C. Seriousness of the disease

   D. Deleterious effect of the disease on the competence of the doctor to perform the health service required

   E. Risk of the physician to be perceived as betraying the patient's trust;

   and inversely proportional to the chance that informing may harm the patient (cause anxiety or fear).

   Disclosure shall be made before exposure when risk is significant (death, permanent disability, hospitalization or fetal injury). Disclosure may be made only after the significant exposure, when risk is not significant (e.g., mild discomfort).[12]

5. Regarding medical "errors"

   Patients shall be informed of procedural or judgment errors made in the course of care as soon as possible if such information is material to the patient's well-being.[8,9,14] Errors do not necessarily constitute improper, negligent or unethical behavior; but failure to disclose them may.[1,5,9]

   Disclosure of "errors" shall include:

   A. What happened;

   B. What resulted;

   C. What remedy was done; and

   D. What preventive measures will be done to avoid repeating the "error".[1,15]

There shall be no malice, no claiming of incompetence or carelessness, and no speculation. Expression of empathy and apologizing for the "error" is encouraged.

APPLICATION

Case 1

CF, a preschool teacher has cough. Sputum was (+) for acid-fast bacilli. She was started on quadruple anti-TB treatment. After 4 weeks, she is feeling much better and wants to return to work. Repeat sputum smear is negative. CF does *not* want anyone to be told of her PTB and a different diagnosis was written both in her medical certificate and PhilHealth form. She is afraid to be stigmatized.

Questions:

1. Should CF be allowed to return to work?

2. Should CF's request that no one be told of her PTB be followed?

3. What if she refuses to have them told? CF is willing to resign.

Suggested Analysis:

1. As a preschool teacher, CF exposes her students to TB. The children are particularly susceptible because they are young. Before allowing CF to return to teach, the ID physician must first make sure that CF is no longer infectious by doing more than one sputum examination to document AFB negative results. This follows the principle of non-maleficence.

2. CF requests that no one be told of her condition. Based on the principle of privacy and confidentiality, CF has the right to keep her illness private and the doctor has the obligation to keep it a secret. However, these are overridden by the duty to prevent harm. TB is a chronic disease and it is very likely that CF was teaching before she was diagnosed. The possibility that CF may have infected her students exists. Her students should therefore be screened and treated for TB as necessary to protect them from further harm. If there is a way that the parents can be convinced to have their children screened or at least be cleared by their pediatrician without implying that CF had TB, that would be an effective alternative to disclosure. Unfortunately, it may be difficult to do this. If parents cannot be convinced to have their children checked without giving a reason, parents should be informed. Non-maleficence overrides privacy. There should, however, be no blaming or condemning of CF as a source of disease.

CF should also tell her employer. The employer may be able to help disclose the risk to the parents without identifying CF and may coordinate the screening process to reduce costs. The employer might also assign CF to work in a capacity that will neither aggravate her disease nor spread it to others. This will follow non-maleficence for the children and beneficence for CF. The employer may also need to take measures to prevent complaints or litigation from parents.

CF has to be reassured that TB is a curable condition and those who may stigmatize her are misinformed. She should therefore help educate them and may even ask the ID physician to help do the same. But until then, she has to accept that various illnesses may stigmatize in one way or another.

The medical certificate and PhilHealth forms should contain truthful information. Honesty prevails.

3. Even if CF resigns, exposure still occurred. Hence, disclosure is necessary. Her resignation may, however, spare her from facing the children and their parents and avoid the possible embarrassment this may cause. Medical and administrative forms would still have to be filled out accurately and honestly.

   If instead of being a teacher, CF was in an occupation with no close contact to other people especially children (e.g., plumber), it is acceptable not to disclose her illness to others. For as long as she avoids infecting others, disclosing would not lead to any good consequence and is not overridden by non-maleficence.

Suggested Answers:

1. Allow CF to return to work when she is proven to be not infectious.
2. Tell principal and parents of children who were put at risk of CF's TB immediately after CF has been diagnosed. Fill out forms honestly.
3. Despite resignation, inform the parents and the employer.

Case 2

DG is a 48-year old male with a purulent urethral discharge for 3 days after having intercourse with a commercial sex worker. Upon consultation, you tell DG that he should inform his wife and possibly have her treated. DG does not want his wife informed. He claims that there will be dismal consequences to their marriage. He asks you not to tell her.

Questions:

1. Which principle takes precedence: confidentiality or non-maleficence? Will maintaining DG's privacy harm his wife to the extent that confidentiality can be overridden?

2. Who should tell the wife? If DG refuses to do so, does the ID physician have an obligation to disclose? If DG's wife is also a patient of the ID physician, how does this affect the ID physician's responsibility to tell her? If she asks about DG's illness, what should the ID physician say?

3. If DG claims that he has not had intercourse with his wife within the last week (hence, the likelihood of him infecting her is nil), would DG still have to tell her of his infection?

4. If the ID physician is able to cure DG of the gonorrhea before DG has intercourse with his wife, would DG still have to tell her?

Case 3

EH is a 32-year-old bank employee with infectious hepatitis B. He asks you, his ID specialist, to tell no one. His father, a former classmate and presently a practicing surgeon, asks you what his son is suffering from.

Questions:

1. Does confidentiality prevent you from telling EH's father that EH has hepatitis B? How do the circumstances of EH's father being your former classmate and a fellow physician affect the obligation of confidentiality?

2. What alternatives to breaking confidentiality work? Ask father to ask EH? Ask EH permission to tell his father? Find out why EH wants no one to be told and solve the underlying problem/reason?

3. If EH's father, despite being a surgeon, also treats his family including EH, should he know EH's illness?

4. What hospital policy should be created to ensure confidentiality of EH's records?

5. How is confidentiality observed during case discussions in the academic setting?

REFERENCES:

1. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

2. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

3. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

4. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

5. Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine 2012;156:73-104.

6. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

7. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.

8. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

9. Pence G. Medical ethics: accounts of ground-breaking cases 7th ed. New York, USA: McGraw-Hill Education; 2015.

10. Timbreza F. Bioethical and moral decisions 7th ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

11. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

12. Henderson D, Dembry L, Fishman N, et al. SHEA Guideline for management of healthcare workers who are infected with hepatitis b virus, hepatitis c virus, and/or human immunodeficiency virus. Infection Control and Hospital Epidemiology 2010; 31(3):203-232.

13. Johnston L, Conly J. Nosocomial transmission of bloodborne viruses from infected health care workers to patients. Canadian Journal of Infectious Diseases 2003;14(4):147-151.

14. Standards of Care in the Management of the HIV Infected Healthcare Worker. Philippine Society for Microbiology and Infectious Diseases. Philippines; 2017 (ongoing).

15. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

Chapter 4

The Child

The child, at whatever age, is a person with inherent dignity who should not be harmed (non-maleficence), be benefited (beneficence), be respected as a person, and be dealt with fairly (justice).

With growth, a child develops a sense of self and values, imagines a future for one's self, and develops the cognitive skills to reason using complex concepts, to understand illness and death, and to analyze and decide on health issues. Children with a chronic or terminal illness may have experiences that endow them with insight and maturity beyond their years. Their level of development and maturity is an essential consideration in determining what an ID physician should tell, how to tell it and how to involve the child in decision-making.

Children are vulnerable, easily harmed and need protection. They are unlikely to be able to express their choices nor defend them. They may not be able to care for themselves. Although parents usually understand and act in the best interest of their children, they may not always do so. The ID physician should be the child's advocate, always valuing and respecting the child as an individual, always trying to facilitate the child's growth and development, always considering what is of most benefit and least harmful. The ID physician, however, should avoid paternalism, bias (emotional) and conflicts of interests.

The physician-patient relationship when dealing with children is a "triadic" system.[1] The child often depends on adults (parents/guardians) physically, emotionally and financially. The ID physician deals with the child and the child's parents/family. Family-centered ethics respects the relationship of the child to parents and other family members, and considers the responsibilities, benefits and burdens of each.[2]

GUIDELINES

1. Truth-telling

   Children and their parents shall be told the truth even if it is "bad news" or unwanted.[1,3]

   Truth-telling shall be timely (dependent on the listener's readiness to accept the truth), honest, kind and compassionate. Disclosing unpleasant news (an injection, surgery, fatal disease) shall always include hope without exaggerating or providing inappropriate expectations (e.g., promising "*It won't hurt*" or "*You will get well*").[3,4]

Emotions (fear) and feelings (don't like) shall be addressed before discussing problems or analyzing reasons. When offering a choice, especially in a situation of poor prognosis (e.g., extremely premature newborn with multiple abnormalities), careful explanation of possible outcomes (survival, disabilities, pain, suffering, quality of life, resource use and cost of care) of alternative options shall be explained.[5,6]

Both parents and the ID physician shall decide what will be communicated to the young child (less than 12 years old) and who will do it.[7,8] In some cases, such as when communicating with a mature adolescent suffering from an STD, an ID physician may tell the adolescent first then let the adolescent decide what to tell the parents and who will do it.[1]

2. Informed Consent

Informed proxy consent shall be given by the surrogate parents or guardians for all minors.[1,3,7] Assent shall be requested from all children seven years old and above.

The consent giver, whether child or surrogate, shall have:

A. Competence to understand options, weigh them according to one's values, decide, and defend one's choice

B. Adequate information

C. No undue influence affecting freedom (parent pressure or fear)

D. Expressed the decision

E. Consistency in the choice

The child shall be involved in the consent process to foster trust and confidence towards the ID specialist and because the child will live with the outcome of the decision.[1,7] The extent of child involvement shall depend on the child's level of development, experience with illness and treatment, and decision-making skills.[1,7,9]

Infants and preschool children have no significant decision-making skills. A surrogate shall give consent.

Primary school children may participate but have no full decision-making capacity or full understanding of implications; their assent shall be sought; strong and sustained dissent shall be taken seriously.[7,10]

Adolescents vary in their capacity to decide. This shall be determined individually. In cases of dependent adolescents, even if found capable, parents shall decide[7,11]. Their dependence make their parents responsible for them as well as the ones to deal with the consequences of the decision.

Refusing a test or treatment is a child's right and is not necessarily unreasonable. The ID physician shall listen and explore reasons for refusal[10]. The ID physician shall consider the effects of imposing a test or treatment against a child's wishes on the physical well-being, quality of life, self-esteem and dignity of the child[4,7,12]. If such refusal is clearly against the child's best interest, the ID physician shall explain why the refusal cannot be granted and apologize for not being able to fulfill the child's wish[1,10]. At the same time, the child should be encouraged to express her preferences regarding smaller matters, i.e., which side an injection should be given, and this should be followed back to "the ID specialist.

The ID physician shall provide spiritual and psychological support.

A parent faced with the sudden crisis of a child's illness may be in shock, stressed, confused and shall be assisted in focusing on what is best for the child. When a cure is no longer possible; guilt from "causing" the child's death may prevent a parent's agreement to stop treatment. Guilt shall be allayed. Palliative care shall be offered[5,13].

For children, who are not capable of making decisions, seeking the child's best interest is more important than respecting autonomy. As such, a child/parent's decision shall not supersede the ID physician's responsibility as advocate for the child to seek the child's best interest[7,10,13]. The child/parent cannot choose a harmful or unreasonable program of care[9,10]. Decisions that appear inappropriate, shall be looked into to seek motives other than the child's best interest. Others (pastor, bioethics committee) may be involved in deciding what is best for the child[7,10].

A pregnant woman generally is considered the appropriate decision-maker for the fetus she is carrying[2,10]. If her decision, however, is clearly against the best interest of the fetus, the decision has to be clarified, discussed, and reconsidered and possibly submitted to the Ethics Committee[3,4].

3. Privacy and confidentiality

The child no matter what age, shall have to the extent possible, privacy respected and private matters kept confidential[1,3,10,14,15]. Those involved in the decision-making and those significantly

affected by the child's illness (caregivers) shall be informed to the extent needed for them to perform their duties and whenever possible, with the child's permission.[1,10,13]

When matters need involvement of the law, such as in child or substance abuse, the need for disclosure shall be explained to the child, and the law followed.[9,10]

APPLICATION

Case 1

FI, a 10-year-old cancer patient on chemotherapy for the last 6 months, develops pneumonia. He refuses treatment both for cancer and pneumonia but FI's parents want him to have both.

Questions:

1. Is FI's refusal to be respected?

2. What is the ethical action?

Suggested Analysis:

1. Free and informed consent requires:

    A. Competence. Is FI competent to make a decision? Competence means understanding the information, weighing it according to one's values, and deciding and being able to defend the decision. A 10-year-old child may not fully understand the consequences of his decision but would have some experience (treated for 6 months and probably observed other patients while receiving chemotherapy) to know what he likes and what he does not like. This is the competence of his developmental stage. His dissent should be seriously considered.

    B. Possession of relevant accurate information on which to base his decision. There is always the claim that a 10-year-old cannot understand medical information. A 10-year-old is not expected to understand the way an ID physician or an adult understands but he should be able to understand a simplified 10-year-old version of what is wrong, how it might be corrected, why and what to expect. He can be told he has cancer and pneumonia (lung infection) and with medicines he may feel better and breathe easier, but without it he may get worse and even die. Treatment will not be pleasant and may even be painful but other children have received it and got better.

C. Freedom to decide. Parent pressure is a common undue influence that prevents a child from deciding according to the child's wishes. When parents start crying and begging, it is difficult for the child not to be affected. Fear also can make the child decide against the child's better judgment. Since FI's parents want treatment, and FI is able to refuse, FI is probably not giving in to their pressure. His fears have to be allayed.

D. Decision expressed and sustained. Occasions arise when children choose one option then change to another then change again back within the hour. For a decision to be accepted, it should be sustained for at least 24 hours. FI should be told however that if he refuses treatment today, he can change his mind and agree to it tomorrow. Or if he agrees to treatment today, and finds it unbearable, he can stop tomorrow.

E. Power of decision. Assent should be accepted. Dissent should also be accepted unless there is a compelling reason to believe it is against FI's best interest. If FI's cancer is advanced, chemotherapy has not worked, treatment for pneumonia and continuing chemotherapy is difficult to defend as being to FI's best interest. FI's refusal or dissent should be respected. If the cancer is at an early stage and chemotherapy is working, treatment for the pneumonia might not be futile and efforts should be made to convince FI to agree.

2. Approach to the patient

The ID physician and FI's parents should first try to understand FI, clarify what is misunderstood, and allay fears. They should never force FI to follow their decision. This would additionally psychologically harm an already suffering child. At best, they can negotiate, offer to try treatment for 3 days, and if no improvement occurs, stop the treatment. Both parents and the ID physician would need patience to deal with FI and the humility to accept that another's (FI's) decisions is sometimes the better one and should be accepted.

Suggested Answers:

1. Refusal should be accepted if treatment is futile.

   If there is realistic hope for improvement, negotiate for trial of treatment.

2. Understand and support FI.

Case 2

GJ, a16-year old student, has syphilis which needs treatment to get well. As a minor, however, Philippine law requires that parents must be informed and give consent for treatment. GJ refuses to have her parents told even to the extent of refusing treatment if parent notification is required. GJ invokes her right to privacy and the doctor's duty of confidentiality. She also claims her right to decide what is to be done to her and says that physicians cannot be trusted if they tell on their patients to their parents.

GJ lives with her parents and gets an allowance from them. She has some savings which she claims she will use to pay for her treatment.

Questions:

1. How should the ethical principles (non-maleficence, beneficence and autonomy) be weighed against each other and against the law?

2. What is the ethical decision?

3. What benefit can be obtained from telling GJ's parents? Can the physician mention these benefits to convince GJ? How else can the ID physician convince GJ to tell her parents?

4. Which virtue would the ID physician need to treat GJ without her parent's consent? To refuse to treat without parent's consent?

Case 3

HK's mother refuses routine immunization for HK, after having read of children developing complications following vaccination. She believes that vaccination has more risks than benefits.

Questions:

1. Does HK's mother have the correct information on which to base her decision? What should the ID physician tell her? Would her refusal be valid?

2. Should the ID physician insist based on HK's best interest? Should the physician insist based on the physician's public health duty to protect other children?

3. Can an ID physician refuse to care for HK if the mother wants only check-ups and treatment for infection but refuses vaccinations?

4. What can the ID physician do to educate the public regarding vaccinations?

5. Would you advise mandatory vaccination? Which ethical principles need to be considered?

REFERENCES

1. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

2. FICE. Code of ethics for persons working with children and young people. FICE Bulletin No. 14; 1998.

3. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

4. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

5. Timbreza F. Bioethical and moral decisions 7th ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

6. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

7. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

8. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

9. Wiesermann C. Moral equality, bioethics and the child. Switzerland: Springer International Publishing; 2016.

10. Hester DM, Schonfeld T. Guidance for healthcare ethics committees. Cambridge, UK: Cambridge University Press; 2012.

11. Babor E. Bioethics A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

12. Beauchamp T, Childress J. Principles of biomedical ethics 5th ed. New York, USA: New York Oxford Press; 2001.

14. Standards of care in the management of the HIV infected healthcare worker. Philippine Society for Microbiology and Infectious Diseases. Philippines; 2017 (ongoing).

15. Alora AT. Ethical guidelines for medical practice 2nd Ed. Manila, Philippines: UST Publishing House; 2013.

Chapter 5

The Person Living with HIV / AIDS

The person living with HIV/AIDS (PLHIV) is a person who should be treated with respect and dignity.

These guidelines are for all patients (including HIV patients) and are in agreement with PSMID policy, Philippine AIDS Prevention and Control Act of 1998 (R.A. 8504) and the Revised Philippine HIV and AIDS Policy and Program Act of 2012.

GUIDELINES

1. Universal precautions shall be standard of practice by all healthcare providers for all patients and settings.[1,2]

2. The patient shall be provided with competent and humane medical care that is free from unfair discrimination. No ID physician shall refuse to treat a patient who is HIV positive solely because of the patient's HIV status.[3,4,5]

3. The patient shall be counselled regarding HIV: the infection, tests, care for oneself, prevention of transmission of AIDS, including the need for lifestyle modification, management of predisposing and aggravating factors, and recognition of disease manifestations which warrant medical attention. Counselling shall be a continuous process, from first suspicion of the disease to end of life planning.[6,7]

4. Truthful information regarding the patient's health, medical care and treatment options shall be given to the patient as needed/wanted.[5,8]

5. Free and informed consent shall be obtained from the patient prior to any HIV or HIV-related test or therapeutic measure.[1,2,3,9]

   There shall be no routine (i.e., periodic health assessments) or universal (i.e., all employees in a group) testing. A patient's refusal shall be complied with unless the test/therapeutic measure is required by law.[3,10]

6. All private information about the patient shall be kept confidential unless the patient consents, it is required by law, or it is for the common good.[1,3,11] Disclosure, when done, shall be limited to those with a direct need to know and conducted in private areas.[3,7,11] Family members have no right to know, but the advantages of them being told should be explained to the patient in order to help the patient consent.

7. Patients shall be assisted in claims for reparation for damage from being harmed, discriminated against, stigmatized or deprived of healthcare.[3,4,8,11]

8. An ID physician who knows that an identified person may be in clear risk or danger of being infected from the physician's patient with HIV shall take steps to protect such person.[2,12] The ID physician shall try to convince the patient with HIV to inform the identified person.[2,3,4,12] The ID physician shall be sensitive to the difficulties in disclosing one's status to others. The physician shall offer to help and allow some time for the patient to do so. If the patient refuses, the ID physician shall disclose the danger to the person at risk.[2]

9. ID physicians shall support efforts to keep the spread of HIV infection as low as possible.[12] They shall participate in HIV/AIDS public awareness campaigns and be trained to be effective counselors.[4,12]

10. In doing research on PLHIV, the ID physician shall take cognizance that these patients belong to a vulnerable population. Particular care should be taken when choosing them as research participants, asking for informed consent, and to prevent conflicts of interests.[7,13,14]

APPLICATION:

Case 1

IL is a 28-year old male nurse with multiple male sex partners. He complains of weight loss and frequent diarrhea. The ID physician suspects AIDS and recommends an HIV test. IL refuses because of fear from the "stigma" which would arise if he tests positive. He also claims that it is useless to know because there is no curative treatment.

Questions:

1. How is IL's autonomy weighed against the right of IL and his sexual partners not to be harmed (non-maleficence)?

2. What is your ethical obligation? Is there a difference in an ID physician's obligations if HIV is merely suspected compared to when HIV is confirmed?

   Will the obligation change after IL dies? What should the ID physician write in the death certificate?

3. How does the diagnosis of HIV affect IL's work as a nurse? Should he divulge his condition?

4. What is the role of the institution?

5. Would the public refrain from HIV testing and receiving treatment if confidentiality is violated or when disclosure is mandatory?

Suggested Analysis:

1. IL has the right to decide what is to be done to him including remaining in willful ignorance of his HIV status. That is autonomy. For as long as IL understands the benefits and risks of being tested (availability of treatment, protection of sexual partners, stigmatization), weighs it according to his values, and freely chooses, his informed choice is his right.

   IL and his partners also have a right not to be harmed. For IL, without proof of AIDS, treatment will not be available. For IL's partners, without revealing the identity of IL or proof that IL has AIDS, convincing them to go for testing and treatment will be more difficult. This will put them at risk of serious harm from AIDS. Based on non-maleficence, IL should be tested to prevent harming himself and his partners.

   IL can choose autonomy over non-maleficence with regard to his own life. He can decide that stigmatization is more harmful than no treatment and therefore refuse testing. He cannot, however, choose the same for his partners. Provided IL's partners can be convinced to be tested and treated (so that they are not harmed), then IL's autonomy should be respected. If the partners need a confirmed HIV test to be convinced, then non-maleficence will override IL's autonomy and IL should be tested. This is, however, more easily said than done. The need for good counselling, emotional support and encouragement for IL to be tested and to change his high-risk behavior cannot be over-emphasized.

2. If IL continues to refuse, the ID physician should first listen to IL and clarify the extent of and allay his fears: how HIV is an illness and not a punishment, how disclosure is being more common and stigmatization becoming less common. The ID physician should emphasize the benefits of the test even if results are positive: monitoring, free treatment, protection of partners and accuracy of epidemiologic data. He should explain how these benefits outweigh the harms; assure IL of privacy. If IL continues to refuse

without compelling evidence to doubt that IL's refusal is free and informed, the ID physician has no basis to override IL's decision. The ID physician cannot test IL for HIV. The ID physician should, however, tell IL that his partners have to be told. He can offer to help inform the partners. If IL refuses to warn his sexual partners, the ID physician may himself warn them.

Confirmation of HIV status makes the obligation of the ID physician to protect everyone against harm stronger than mere suspicion. The ID physician, however, has to be careful not to make "suspicion" (and not confirmation) an excuse for not protecting others.

After IL dies, the ID physician should tell IL's partner/s that IL probably had AIDS. Non-maleficence overrides confidentiality. Disclosure does not include telling those not affected such as IL's non-partners. If IL had requested that AIDS not be written in his death certificate, weighing the good (accurate epidemiologic data) and harm (stigmatization) of such action favors not writing it. Confidentiality does not end with a patient's death; and overrides beneficence. The ID physician can instead write "Immune Deficiency" only.

3. IL should not stop working if he feels strong enough to do so. IL should practice standard precautions. He should modify his practice to ensure that patients are not put at risk. He should not let his blood or body fluids come in contact with patient's blood or open wounds, and provide nursing care with utmost scrupulousness. Another option is to consider moving to a supervisory or administrative position rather than actual healthcare provision.

   IL can maintain his privacy, since the risk of IL transmitting HIV to his patients is extremely small. Furthermore, with his HIV status not being confirmed, he has nothing to disclose. Once he is confirmed to have HIV, however, he is encouraged to inform the Hospital Infection Prevention and Control Unit (HIPCU) as well as the Hospital HIV/AIDS Core Team (HACT).[11] His healthcare team should not divulge mere suspicion.

4. The institution should have specific policies to deal with such cases following the law. A just and compassionate hospital policy should include voluntary testing, obligatory declaration of HIV status to hospital authorities, strict confidentiality by hospital authorities, and available monitoring and treatment as needed. Measures to prevent the spread of the disease should be installed.

5. Today, a PLHIV is still stigmatized. If one's status is not kept confidential and the person is required to disclose it, the person exposes himself to stigmatization and discrimination. This discourages testing and promotes its unfortunate consequences. Mandatory testing of high-risk individuals singles them out and violates justice which demands equality. It also violates compassion by exposing them to humiliation and stigmatization.

Suggested Answers:

1. Autonomy overrides non-maleficence as long as harm is minimized. Partners should be informed of probable diagnosis and the need for HIV testing. If harm cannot be minimized, then non- maleficence overrides autonomy and IL should be tested and partners informed.

2. The ID physician should counsel IL and try to convince him to be tested and to warn his partners. If AIDS remains only a suspicion, the ID physician may wait until it is confirmed or try other means to convince IL before telling his partner/s. After IL dies, if IL has not already done so, the ID physician should inform sexual partners of the need to be tested and possible treatment. If IL requested privacy, then AIDS need not be written in the death certificate. A more general term can be used, such as "Immune Deficiency."

3. IL can still be encouraged to work but should be guided regarding which activities he can and cannot do so as not to expose others to the disease.

4. The institution should have a just and compassionate policy to deal with such situations.

5. The public would likely refuse testing if confidentiality is not maintained. Mandatory testing will not be obeyed.

Case 2

Dr. OB is a resident in obstetrics in a government hospital. She learns of JM, a person living with HIV, who is scheduled for an elective caesarean section. In order not to be assigned to do the caesarean section, Dr. OB goes on leave.

Questions:

1. As the ID physician in the hospital, the director asks for your recommendation. What advice should you give?

2. What is Dr. OB's obligation to provide the medical care that JM needs? RA 8504?

3. Does Dr. OB have a right to refuse to do the CS? Does refusal violate the professional oath Dr. OB took on becoming a licensed physician – to care for the sick?

4. How do factors such as the availability of other physicians/hospitals and the non-emergent nature of the procedure justify her refusal? Does employment as a government physician carry responsibilities not required of employment in a private one? Are responsibilities different if she was working at a teaching hospital?

5. Should JM be informed of Dr. OB's decision? What if she does not ask? What about other patients?

6. Can the hospital refuse to admit JM? What hospital policies should include when dealing with similar situations?

Case 3

KN, a 22-year-old employee living with AIDS, is admitted with severe pneumonia due to *Pneumocystis jirovecii*. KN has an HMO as a 3rd party payer. Putting on record that KN has HIV will exclude HMO coverage for hospital expenses and KN, unable to pay for his hospital bill, will not be treated. KN requests that the diagnosis of HIV be omitted from the doctor's entries so that he can avail of his HMO benefits.

Questions:

1. How does one balance beneficence (hospitalization benefits and healthcare) and autonomy (patient's request) versus truth disclosure (diagnosis of AIDs on records but loss of funds). Are there other means to help the patient obtain the needed treatment without the wrong-doing? How essential is adding the diagnosis of HIV in KN's record? Would pneumonia suffice?

2. Should there be signs/labels in KN's room or medical records to warn others of AIDS?

3. What should an ethical ID physician's response be? Can there be a "win-win" option? Can there be separate records of KN's private files and HMO claim?

4. Should an advanced directive be suggested? (Refer to Chapter 7: The Dying Patient)

REFERENCES

1. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

2. Ethical issues in the care of PLHIV. Harvard Medical School AIDS Initiatives in Vietnam 2015. Available from: http://slideplayer.com/slide/8942810/

3. Congress of the Philippines. Republic Act 8504 The Philippine AIDS Prevention and Control Act of 1998. Manila, Philippines; 1998.

4. Center for Disease Control and Prevention. Division of HIV/AIDS prevention annual report 2015: putting prevention advances to work. Atlanta, Georgia; 2015.

5. Philippine College of Physicians Code of Ethics. Quezon City, Philippines: 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

6. Center for Disease Control and Prevention. Revised guidelines for HIV counseling, testing, and referral technical expert panel review of CDC HIV counseling, testing, and referral guidelines. Morbidity and Mortality Weekly Report; 2001/50(RR19);1-58

7. South African Medical Association Ethical and Human Rights Guidelines. Available from:https://www.samedical.org/images/attachments/guideline-ethical-human-rights-aspects-on-hiv-aids-2006.pdf.

8. Pence G. The elements of bioethics. New York, USA: McGraw-Hill Education; 2007.

9. Babor E. Bioethics a philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd ed. Quezon City, Philippines; C&E Publishing, Inc.; 2010.

10. Standards of Care in the Management of the HIV Infected Healthcare Worker. Philippine Society for Microbiology and Infectious Diseases. Philippines; 2017 (ongoing)

11. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

12. Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014: Summary for Clinical Providers. 2014. Available at http://stacks.cdc.gov/view/cdc/26063.

13. Declaration of Helsinki. Adopted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 as amended in the 64th WMA General Assembly, Fortaleza, Brazil; October 2013.

14. Mitscherlich A, Mielke F. The Nuremberg Code: Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman;1949. pp. xxiii-xxv.

Chapter 6

The Woman during her Reproductive Period

All life is sacred! It must be respected and protected from all forms of harm from the moment of conception to natural death.

Children shall be borne out of the marital act where life-giving is united to and integrated with love-giving.

GUIDELINES

1. The woman/couple shall receive clarifications regarding their Church's stand on reproduction and new reproductive technologies.[1]

2. The pregnant patient

   A. The ID physician shall always be cognizant of the possibility of pregnancy in the care of a woman in her reproductive years (menarche to menopause), regardless of marital status, and shall undertake efforts to diagnose an existing pregnancy by standard methods as necessary (history, physical examination, pregnancy test).[2]

   B. When managing a pregnant patient, the ID physician shall protect, to the utmost extent possible, the well-being of the fetus, regardless of age of gestation and specific circumstances of the pregnancy (sexual assault, out of wedlock, unwanted, inconvenient).[3,4]

      1) Direct abortion, contraceptives which lead to abortion, delivery before viability, and all forms of direct attack on the fetus shall not be done, even if requested by the mother/couple.[1,5] Testing to detect a disorder shall be allowed if aimed to correct or prevent the disorder but shall not be allowed if aimed to abort the fetus if found defective.[4,6,7]

      2) Diagnostic/therapeutic interventions shall be limited to those known not to harm the fetus either directly (abortion or demise) or indirectly (congenital malformation, post-natal disease).[1,2,6]

      3) If potential for harm of the diagnostic/therapeutic intervention is unknown but possible, either it is avoided, or if the intervention is absolutely necessary, standard measures to minimize harm shall be put in effect.[1,2]

When the therapeutic intervention that is considered essential and critical to maintain the well-being of the pregnant woman is known to harm the fetus, either directly or indirectly, the *principle of double effect* shall apply.[1,4,7]

A. The action must not be wrong, it must be a good or at least a neutral act. It cannot be a direct attack on the fetus.

B. Only the good effect, which is to help the mother, must be intended. The bad effect, which is to harm the fetus, may only be foreseen.

C. The bad effect must not be the means to the good effect.

D. The good effect must outweigh the bad effect that is permitted.

In all cases, the ID physician should get the patient's free and informed consent before any procedure.[8,9]

3. The non-pregnant patient

The ID physician shall be cognizant of the possible effects of diagnostic/therapeutic measures on the reproductive health concerns of the non-pregnant woman and vice versa.

A. For the non-pregnant woman who is not currently desirous of pregnancy, the ID physician shall take appropriate measures so that the diagnostic/therapeutic measures being undertaken do not interfere with whatever fertility control measure the patient is on and vice-versa.[10]

B. For the woman who is trying to achieve pregnancy, the ID physician shall inform her of possible effects of the diagnostic/therapeutic measures on her ability to conceive and vice versa, and get her consent.[9,11]

C. For the woman who is not on any fertility control method, if the diagnostic/therapeutic measure could potentially harm an incidental pregnancy or vice versa, the ID physician shall inform the patient of this possibility and get her consent.[2,11,12]

D. Should the patient/couple request for professional advice regarding fertility control, the ID physician shall refer the patient to the appropriate specialist or, if no one is available, limit recommendations to methods ethically acceptable (e.g., natural family planning methods for Catholics).[10,13]

E. Should the patient/couple request professional advice regarding methods of achieving fertility, the ID physician shall refer the patient to the appropriate specialist or, if no one is available, limit the recommendations to those that are ethically acceptable (e.g., for Catholics, assisted reproduction which involves education, drugs and/or surgery which facilitate safe and successful reproduction while maintaining the pro-creative component of the marital act).[7,10,14]

F. Sterilizing surgery for a proportionate good reason (e.g., cancer) is allowed.[4,7,15]

4. Competing rules and regulations

A. Ethical standards adhered to by the ID physician as contained in these guidelines, shall supersede contradicting hospital and/or government promulgated rules and regulations.

B. The ID physician shall refuse to do unethical diagnostic/ therapeutic interventions on "conscience objection" grounds.[4,16]

C. The ID physician shall not facilitate the refused diagnostic/ therapeutic intervention by a referral to another physician or institution.[7,14]

APPLICATION

Case 1

LO, a 34-year-old female on her 1st trimester of pregnancy, is found to have MDR-TB.

She is worried that the fetus may be affected by her sickness or its treatment and asks for an abortion. She says that she will be unable to care for a "defective" child. If not an abortion, then LO wants no treatment until after delivery. This, according to LO, will prevent the toxic effect of anti-TB drugs on her child and the corresponding risk of an abnormality.

Questions:

1. Should an abortion be allowed?

2. Should LO's treatment refusal be accepted?

Suggested Analysis:

1. Abortion is the direct killing of the child and is forbidden. Even if it could be proven (which is highly unlikely) that the fetus has TB and/or will have congenital defects from RT's treatment, abortion is still the direct killing of an innocent (even if "defective") child and is still not allowed.

2. LO has a right to refuse treatment provided it is a free and informed decision. LO needs to understand that without treatment she and her fetus may die. Hence, it is to their best interest that she gets treated. Waiting until after delivery may be too late.

   LO should not be deceived that the medications are safe. The risk of harm and the evidences regarding the extent and chance the risk should be clarified. LO should also be advised about any misconceptions related to caring for a "defective" child. Her undue anxiety may affect her decision-making. If after understanding the correct information LO still freely refuses treatment, then her refusal should be honored.

   It could be argued that it is to the best interest of LO and the fetus that LO be treated and therefore her refusal be overridden. But it is LO who decides both for herself and the fetus. It is also LO who has to comply with the medication regimen. If in LO's mind, the risks of treatment to her fetus is greater than that of non-treatment and she cannot be convinced otherwise, she will not comply with any treatment the ID physician may prescribe. Overriding her decision would be futile. For better physician-patient relationship, her refusal should be honored.

Suggested Answers:

1. Abortion should not be allowed.

2. Provided LO's refusal has all the elements of free and informed consent – competence to understand and decide, correct information, freedom of decision – LO's decision should be honored.

Case 2

MP, a 27-year-old single female, has severe oral candidiasis. Administering antifungal drugs are indicated. If MP is on contraceptive pills, the drug may reduce the effectiveness of the contraceptives and MP may have an unwanted pregnancy.

Questions:

1. Should the ID physician give the antifungal drug? Should the ID physician presume that, because MP is single, she is neither on contraceptive pills nor sexually active?

2. Should the ID physician tell MP of the anti-contraceptive effect of the antifungal drug? How should it be told without appearing judgmental regarding MP's sexual activities?

3. Is free and informed consent needed?

4. Should MP get an unwanted pregnancy, what is the ID physician's responsibility? Indemnity?

5. Severe oral candidiasis is often seen in AIDs. Should the ID physician test MP for HIV? Will informed consent be needed for the test?

Case 3

NQ, a 32-year-old single woman on her 4th week of gestation, has an intrauterine infection with sepsis. Management requires removal of the infected non-viable fetus, leading to its death. Alternative measures such as broad-spectrum antibiotics without surgery is not standard of care. NQ requests the doctor to not tell anyone that she is pregnant because she fears being ostracized, both for getting pregnant and for killing her unborn child.

Questions:

1. Would the principle of double effect justify the death of the child?

2. Who should be informed of NQ's single status? Of her pregnancy? Of the death of the unborn child? What responsibility do the members of the healthcare team have regarding confidentiality? What harm would upholding confidentiality cause?

3. To what extent should the father of the child be involved?

4. Philippine law requires reporting of infected pregnancies. What is the ethical action of the ID physician given NQ's request for confidentiality?

REFERENCES

1. Babor E. Bioethics a philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

2. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html.

3. Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

4. Kukla R, Wayne K. Pregnancy, birth, and medicine. The Stanford Encyclopedia of Philosophy (Winter 2016 Edition), Edward N. Zalta (ed.) Available from: https:// plato.stanford.edu/archives/win2016/entries/ethics-pregnancy/

5. Catechism of the Catholic Church, No.2270. Available from: http://www.scborromeo. org/ccc/p3s2c2a5htm

6. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

7. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing Inc.; 2015.

8. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

9. Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine; 2012;156:73-104.

10. Gordon, E. 2011. Moral case against contraception 2011. Available at: www.bbc. co.uk/ethics/contraception.

11. Timbreza F. Bioethical and moral decisions 7th ed., Quezon City, Philippines: C&E Publishing, Inc.; 2007.

12. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

13. Evariste H. Family planning by means of contraception: an ethical comparison of different methods of contraception used by couples of Kalingalinga, Mtendere, Kabwata and Kamwala Compounds in Lusaka, Zambia. [Thesis] University of Zambia; 2012. Available from: http://dspace.unza.zm:8080/xmlui/bitstream/ handle/123456789/2529/habiyaremye.pdf?sequence=1.

14. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

15. Oduncu FS, Kimmig R, Hepp H, et al. Cancer in pregnancy: maternal-fetal conflict. Journal of Cancer Research and Clinical Oncology; 2003;129(3):133-46.

16. American College of Obstetrics and Gynecology Committee on Ethics. Sterilization of women, including those with mental disabilities. Ethics in Obstetrics and Gynecology, 2nd ed. USA; Updated 2007.

Chapter 7

The Dying Patient

Death is inevitable; dying is a natural process to be realistically faced with full dignity. The ID physician is often called for an infection in a dying patient. The ID physician should look beyond physical "cure" and effectively address the patient's total needs to help the patient die peacefully.

GUIDELINES

1. Humane care

   The ID physician shall provide humane care which shall be directed from healing to comfort and support. This shall include:[1,2,3,4,5]

   A. Spiritual care from a hospital chaplain or a minister of the patient's religion
   B. Food and hydration
   C. Narcotics and sedatives to reduce pain and suffering
   D. Nursing care
   E. Warmth for infants

2. Life-prolonging measures

   Measures which are futile (will not improve the patient as a whole for a significant period of time and will only prolong the dying process) shall not be offered.[3,5,6]

   Measures which are disproportionate (may be useful, but which, in the values of the patient, have burdens which outweigh benefits) may be refused by the patient.[6,7,8]

   Decisions regarding withholding or withdrawing measures shall be made by the patient or, if incompetent, by the patient's surrogate (family, designated representative) based on accurate information given by the ID physician and weighed according to the values of the patient (free and informed consent).[7,8,9]

   Withholding and withdrawing measures are ethically equal.[8] When in doubt, a measure shall be given. After a limited pre-determined trial time, if found to be apparently futile or disproportionate, the measures may be withdrawn.[5,8]

Certain conditions are required to allow *dysthanasia* (keeping a patient alive with no hope of significant improvement): good reason, the patient is not suffering, the patient consents and when possible, the family agrees.[8]

Good reasons include:

A. To buy time to settle doubt regarding futility (e.g., time-limited trial, second opinion, Bioethics Committee)[8]

B. Compassion (e.g., wait for a loved one, wait for family to accept a child's death)[8]

C. Utility (e.g., wait for proper harvesting of an organ for transplantation, sustaining a non-viable fetus)[8]

A medical junta and family meeting to clarify the patient's condition, the usefulness of various measures, and the prognosis to aid and facilitate decision-making shall be encouraged.

3. The ID physician, if the primary attending physician, shall discuss advance end-of life planning with competent patients. A written directive or living will shall be encouraged. The living will lists the patient's preferences regarding treatment goals and plans specifying what should and should not be done in the event the patient cannot express decisions.[3,7] It shall be given to a family member or attending physician who shall incorporate it in the patient's medical record.

   The patient's preferences may also be made known through the designation of a surrogate (durable power of attorney) who will express these preferences for the patient. These preferences shall, to the fullest extent possible, be complied with.[3,10,11]

4. Organ donation from suitable patients shall be encouraged.[2,5,6,7,12]

5. Discharge from the hospital to allow the patient to die at home amidst loved ones shall be endorsed.[5]

6. The ID specialist shall NOT:

   A. Lie to the patient that the patient will get well.[8]

   B. Project the ID physician's own values about quality of life on the patient.[3,8]

   C. Perform half-hearted resuscitation or "slow codes".[3,5]

D. Hasten (by euthanasia or assisted suicide) nor postpone death (dysthanasia)[3,9]

E. Abandon the patient to suffer alone.[3,4]

F. Provide over treatment or unwanted suffering.[6,7,8]

7. The ID physician shall consider the patient's family's needs before and after the patient's death.[13]

APPLICATION

Case 1

OR is a 48-year-old uncontrolled diabetic with end-stage renal disease on regular dialysis. He also has heart failure secondary to coronary artery disease, hospital- acquired pneumonia and gangrene of his toes. He is referred to the ID physician for management of the pneumonia. OR is conscious, suffering and knows that he is terminally ill. He refuses all usual tests and treatment despite the doctors explaining the consequences (early death). He claims that he has limited funds and would prefer to use it for the education of his children. He requests to die in order to stop "everyone's suffering." OR asks his ID physician to administer large doses of morphine to kill him. When the ID physician refuses, OR then asks for the morphine to self-administer.

Questions:

1. How should OR be treated? Should OR's refusal of tests and treatment be honored?

2. How should the ID physician react to OR's request to die?

3. For what reason can morphine be given?

Suggested Analysis:

1. In determining whether a measure should be given or not, the first determination is if the measure is useful or futile. Will the available tests/treatment for pneumonia significantly improve OR as a whole so that he will be able to live a relatively comfortable life for a reasonable time (useful), or will OR, despite the available tests/treatment for pneumonia, still die soon from the complications of his diabetes (futile)? If tests/treatment are futile, some ethicists feel that these should not be offered at all. Futile measures would harm by adding unnecessary costs, prolonging suffering, and stress

decision-making. Whether offered or not, futile measures need not be given.

If tests/treatment are useful, OR is expected to significantly improve, then the tests/treatment should be offered. It is for OR to decide if its cost (economic, physical and psychological) is worth it. The role of the ID physician is to provide the facts of the illness, its prognosis, and the benefits and burdens of the different measures in a kind and humanistic manner. If according to OR's values, the additional test/treatment is not worth the cost and they are disproportionate, OR has the right to refuse them and they should not be given.

OR has refused all tests/treatment, stating economic reasons and knowing the consequences of his refusal. His decision appears competent, informed and free. It should be respected and complied with. Tests/treatment should be withheld or withdrawn if already given. The refusal and the reason for it should be documented.

OR should be treated with respectful, responsive care. He should be given palliative measures, good nursing care, oxygen, symptomatic anti-pyretics, bronchodilators, pain relievers, fluids and spiritual care. He should be assisted to live his remaining life as fully and comfortably as possible – helped to make his final passage gentle rather than stormy.

2. Most ill patients often request to die not because of a real desire to die but because of the pain, fears, anxiety, sorrow and distress they suffer. These feelings can and should be addressed. The ID physician should find the underlying reason for the request then take measures to relieve pain, to allay fears and anxiety, and to reduce sorrow and distress. Talking to and reassuring OR that his ID physician will help and not abandon him will reduce distress arising from helplessness. Allowing OR some self-control and human dignity (to decide what to accept and refuse) also helps.

   To administer morphine with the intention to kill OR is murder and wrong. That it follows OR's request (respecting patient autonomy) is irrelevant, the ID physician should follow his own conscience. To give morphine for OR to self-administer is physician-assisted suicide. It is cooperating in a wrong-doing and is also wrong. Morphine given with the intention to kill whether administered directly by the doctor or indirectly by OR himself is unethical.

3. Morphine, however, may be given to relieve pain or suffering. Following the principle of double effect (Refer to Chapter 6: The Woman during her Reproductive Years), morphine given for that reason is acceptable even if doses may hasten death.

Note:

As described, OR was referred to the ID physician for treatment of the pneumonia. Ordinarily, the ID physician should limit his care to that. The main attending physician should deal with the circumstances of dying. In this case however, OR has involved the ID physician in his refusal of tests/treatment and his request to die. In such a situation, the ID physician and main attending physician should work together to help OR.

Suggested Answers:

1. Agree with OR's refusal of tests/treatment. Provide OR with humane palliative end-of-life care that helps him toward a peaceful death.

2. Do not kill OR whether by euthanasia or physician-assisted suicide.

3. Give morphine to relieve distress and pain but not to cause death.

Case 2

PS is a 58-year-old executive with pancreatic carcinoma and liver metastasis. He is in considerable pain and needs strong pain relievers, sometimes narcotics. PS develops sepsis and is referred to the ID physician for management. Both the ID physician and family members recognize futility and agree to withhold tests/treatment, but PS during his lucid periods wants "everything done to save his life" and has the financial resources for "everything to be done". He wants to survive until new discoveries save him.

Questions:

1. Should sepsis be treated with expensive broad-spectrum antibiotics? How do considerations of futility, proportionality, and just use of resources come into play?

2. What does "everything be done to save his life" mean? Since financial resources are available, should PS be administered futile alternatives for a pre-determined period of time to convince and console him that everything that could be done was done and then stop when he agrees?

   If medical resources (ventilator, ICU bed, etc.) are limited, can the fact that PS can pay justify their use?

3. When, if at all, should PS be told that science has nothing more to offer? If so, who should do it? How will hope be preserved?

4. When and how should the ID physician move away from science and lead the patient to prayer and God? How can the ID physician help PS face his crisis and make the best of it?

5. What is the use of a medical junta and family meeting?

Case 3

QT is a 14-year-old boy who suffered a massive intracerebral bleed and other injuries following a motorcycle accident. He is unconscious but kept alive with vasopressors, repeated dialysis and a respirator. On the 4th HD, he develops fever and chills and is referred to the ID physician. His family wants "everything done".

Questions:

1. How can the doctor explain to the family that "everything" that is helpful to QT – nursing care, fluids, nutrition and oxygen – will be done/provided and that other measures which will not help him will not be provided?

2. What is the role of the ID physician? Should the ID physician pray with the family? Can measures to keep QT alive until his parents accept their loss be allowed? If yes, to what extent and for how long?

REFERENCES

1. Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

2. Pence G. The elements of bioethics. New York, USA: McGraw-Hill Education; 2007.

3. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html.

4. Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. Departments of Psychiatry and Medicine, Duke University Medical Center. Southern Medical Association 2004; 97(12):1194-1199.

5. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

6. Timbreza F. Bioethical and moral decisions 7th ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

7. Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine 2012;156:73-104.

8. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

9. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

10. Babor E. Bioethics A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd Ed. Quezon City, Philippines: C and E Publishing Inc.; 2010.

11. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

12. Pence G. Medical ethics: accounts of ground-breaking cases 7th ed. New York, USA: McGraw-Hill Education; 2015.

13. American Board of Internal Medicine. Caring for the dying: identification and promotion of physician competency. Reprint of Educational Resource Document and Personal Narratives. Philadelphia, USA; 1998.

Chapter 8

The ID Physician-Colleague and other Healthcare Providers Relationship

The Hippocratic oath states: "*My colleagues will be my brothers*."[1]

Healthcare is a team effort characterized by mutual respect, cooperation and communication. The ID physician works with other physicians (consultants, fellows, residents, trainees), the nurse, the medical technologist, the radiologist, the pharmacist, the pharmaceutical company and the patient's personal healthcare giver.

GUIDELINES

In Relation to Colleagues:

1. An ID physician shall act with proper respect towards colleagues[2,3]. The ID physician shall NOT:

   A. Criticize another's professional management during social and similar non-scientific gatherings.[2,4]

   B. Use other physicians as means: exploit them or make them agents, with commissions for referrals[3,5].

   C. Compete with them through solicitation of patients by unfair advertising or low professional fees.[3,5]

2. An ID physician shall support colleagues.[2,3,6]

   When part of a healthcare team, the ID physician shall cooperate in good faith additively rather than competitively, giving proper regard to the primary attending physician.[2]

   If conflicts in patient care arise, the ID physician shall confer with the other physicians and try to arrive at an agreement.[6] If unsuccessful, the ID physician shall offer to withdraw, provided no harm or abandonment occurs.[7]

   Seniors shall share expertise unselfishly: guide, be good role models, and avoid leading juniors astray; juniors shall appreciate the skills and experience of their seniors[4,5,6,8]. Both shall acknowledge the help they receive from the other.

An ID physician shall treat an ill colleague with professional courtesy (no charge).[3,5,7]

An ID physician shall "cover" for an absent colleague: care for the absentee's patients with the same dedication as the ID physician gives his own (Refer to Chapter 9, Referrals).

3. An ID physician shall immediately address a colleague's behavior which diminishes the colleague's capacity to practice.[2,3,7,9]

   If an error occurs in the delivery of healthcare, an ID physician, if part of the patient's medical team, shall intervene to correct the harm done to the patient. Whether part of the health team or not, the ID physician shall offer private fraternal help and corrective advice to the colleague.[4,6,7,9]

   An ID physician shall report with absolute honesty repeated errors, professional misconduct and malpractice including fraud, incompetence and abandonment of a colleague to the corresponding institution, local medical society (e.g., Philippine Medical Association, Professional Regulation Commission, etc.), legal authorities in hierarchical order but refrain from any publicity of the matter.[2,3,5,6,8]

   An ID physician shall monitor an impaired colleague's medical competence in relation to allowing the impaired colleague to practice. In cases when the ID physician is the attending physician of the colleague, monitoring a colleague is likely not to be objective (conflict of interests) and should be avoided.[5]

   An ID physician shall not cooperate in any wrong-doing of a colleague.[4,6]

In Relation to Other Members of the Healthcare Team

1. An ID physician shall be part of a healthcare team and respect and support its other members.[2,3,4,6,10]

2. An ID physician may call the attention of a member to perceived errors in the provision of care but shall never criticize the other in public or in a rude manner.[4,5]

APPLICATION

Case 1

RU consults you because of recurrent fever, cough and right upper quadrant abdominal pain for the last two months. He has seen his private physician 4 times and was each time prescribed different antibiotics and cough suppressants. There was no improvement. After examining RU you suspect a liver abscess and ask for an ultrasound of the liver and gall bladder. Results demonstrate the abscess and you start treatment. RU asks you if his physician was negligent in not asking for an ultrasound earlier and if this delayed treatment made him worse. He is thinking of complaining to the PMA and even suing his physician.

Questions:

1. Was RU's previous physician negligent?
2. What should you do for RU?
3. How should RU's question be answered?
4. How should you respond to RU's plan of complaining to the PMA or suing his doctor?
5. Presuming you are aware of her physician's repeated incompetence, what should you tell RU? What should you do?

Suggested Analysis:

1. Negligence. It appears that an ultrasound should have been done. Why RU's doctor did not do it is difficult to judge as you were not there then and cannot read the doctor's mind. Retrospect thinking is always easy but not necessarily right. For as long as the initial physician interviewed RU, examined him, explained options and treated him, there is little basis to say that he was negligent. There may have been an error of judgment but this is not negligence.
2. Since you have now confirmed the liver abscess you should treat RU for it.
3. RU can be answered: "I was not there and cannot judge. An ultrasound was indicated when I saw you but may or may not have been indicated earlier." There should be no disparaging of the previous doctor by saying the doctor was negligent or incompetent or could have done better.

4. Every patient has a right to redress for harm done by his physician. This includes correction of and compensation for the harm from error or delay in treatment. By treating RU, you are correcting the damage done. Compensation, however, may not be forthcoming and doctors rarely offer it. As such, patients sometimes resort to complaining to the PMA or courts of law. As an ethical ID physician, you should encourage RU to first ensure that his complaint is justified, then to speak privately with his doctor. You may even offer to help him. You should discourage RU from making the matter public.

   If RU sues his first doctor and you are summoned to appear in court, you should explain that you did not attend to the patient at the onset so what you know about the case is hearsay and you cannot make a judgment. You should limit yourself to general statements about liver abscess based on your readings and experience.

5. Presuming you are aware of his doctor's repeated incompetence, it is not your role to tell RU about it. You should talk to the doctor about it and if incompetence persists, inform the proper authorities.

Suggested Answers:

1. You cannot be sure if the previous doctor was negligent.

2. Treat RU's abscess.

3. "I don't know as I was not there at the time."

4. Encourage RU to make sure his complaint is justified then talk to the doctor. Try to avoid going public (PMA, courts of law). If summoned to court, state that your knowledge of the case is hearsay and stick to generalities.

5. Do not talk to RU about it. Counsel and advice the physician. If it does not work, report to proper authorities.

Case 2

SV, an ID physician is attending an international conference in Oregon, USA. While away, he asks a resident to "cover" for him. This means the resident will manage SV's patients.

Questions:

1. How does attending an international conference justify leaving patients?

2. Should a resident "cover" for a physician/consultant? Will a resident provide the same service a physician/consultant gives? Same competence? Is there deception? What will the patients be told? Will they be asked for informed consent? How will the patients be charged? Resident/physician/consultant rate?

3. With available communication (text messages, phone calls), the resident can easily consult with the physician. Will this justify the arrangement of leaving the patient to the resident?

4. If an accident occurs or if a patient is not satisfied, how will accountability be assigned? Resident/physician/consultant?

Case 3

An order you made to administer vitamin K was not followed by the nurse, TW, because "the patient's blood potassium level was high and vitamin K was not needed." TW presumed that vitamin K and potassium (elemental symbol: K) were the same. For TW, high potassium level meant administration of vitamin K was unnecessary and possibly harmful. Fortunately, you made early rounds, picked up the error, and corrected it. No obvious harm resulted.

Questions:

1. Was TW incompetent? Should her good intentions excuse her incorrect and wrong action?

2. Does TW's error need correction?

3. What should be done to TW? Who should discipline her if at all?

4. Under what conditions, if any, should a nurse overrule a doctor's order? Presuming TW was right about the harm the injection would do, what should she have done as a nurse?

5. How can mutual respect and support manifest in events like this?

6. Should the patient be told that her medicine was delayed and why? How? If she does not ask? If the patient is not told but learns about it later, is the risk of harm from loss of trust in the healthcare service worth not telling her before she finds out? How does transparency

versus deceit come into play?

7. If significant harm occurred, should the patient be told why the harm occurred?

8. How should the healthcare provider and institution be protected against liability?

REFERENCES

1. Post S, editor. Encyclopedia of bioethics 3rd ed. New York, USA: Macmillan Reference. USA; 2004.

2. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

3. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

4. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html.

5. Snyder L. American College of Physicians Ethics Manual 6th Ed. Annals of Internal Medicine 2012;156:73-104.

6. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.

7. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

8. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

9. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing Inc.; 2015.

10. Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

Chapter 9

Referrals

Referrals provide patients with the best available professional healthcare. Infectious disease physicians are often called when infections do not respond to initial treatment, when secondary infections occur in immunocompromised patients (diabetes, cancer, transplant, etc.) or when infections are severe.

Good communication and goodwill between the referring attending physician (AMD) and the ID physician are vital to the referral process.

GUIDELINES

1. Both the patient and the AMD shall agree to the referral to an ID physician, its purpose (evaluation, procedure, co-management or transfer), nature, and expected outcome.[1,2]

2. The AMD shall communicate the request for a referral to the ID physician, its purpose, and make available to the latter all relevant information about the patient.[1,3,4]

3. If the ID physician cannot or refuses to see the patient, he/she shall immediately inform the AMD so that alternative options can be considered.[2,3]

4. If the ID physician accepts the referral, the ID physician shall see the patient as soon as possible (immediately in emergency situations and within 24 hours in non-emergency situations).[1,5] An assistant (fellow or resident) may initially see the patient and report to the ID physician. The ID physician may give a preliminary answer based on the assistant's report but shall still personally see the patient as soon as possible. If the ID physician cannot see the patient personally and immediately, then he/she should inform the AMD.

5. If the referral is for:

    A. Evaluation

    The ID physician shall evaluate the patient then communicate the assessment to the AMD.[2,5,6] The ID physician may add suggestions regarding management. The ID physician shall not directly communicate his/her evaluation to the patient or the patient's family/representative; the AMD shall do so. If the patient insistently inquires about the ID physician's evaluation, the ID physician shall communicate

the evaluation first to the AMD and ask the permission of the latter to communicate it to the patient in the AMD's behalf.[1,5] The main responsibility for patient care lies on the attending physician.

B. Procedure

The ID physician shall explain to the patient what will be done, discuss the rationale of the procedure and the expected outcome, obtain free and informed consent, perform the procedure, and communicate to the AMD the results of the procedure.[1,2,5,6] The ID physician shall not directly communicate the results or its significance to the patient, patient's family or patient's representative; the AMD shall do so. If the patient insistently inquires about the ID physician's findings from the procedure, the ID physician shall communicate the results first to the AMD and ask the permission of the latter to communicate it to the patient on the AMD's behalf. The main responsibility for patient care lies on the attending physician.

C. Co-management

The ID physician shall treat the patient as the ID physician's own.[2] The ID physician shall communicate with the AMD plans and, whenever possible, get the latter's approval before implementing them.[2,5,7] The ID physician shall refrain from changing orders made by the AMD without first discussing the matter with the latter and getting the AMD's approval.[7] The ID physician shall refrain from treating any condition of the patient which is not within the ID physician's specialty.[6] Instead, the ID physician shall refer it to the AMD or may suggest a referral to another specialty. The ID physician shall not make the new referral or, without being asked, name the doctor to whom the referral shall be made.

In a life-threatening emergency, if the AMD is not available, the ID physician shall treat the patient even without the AMD's approval.[2,4,7] The ID physician shall inform the AMD about the management made to the patient during the AMD's absence as soon as possible[7].

If the ID physician has to leave the patient, the ID physician shall inform the AMD and, if requested by the AMD, make arrangements for the ID physician's substitute who shall be approved by both the AMD and the patient. The first ID physician shall inform the replacing ID physician of all relevant data regarding the patient.

If the AMD and ID physician cannot agree on the management, despite attempts to do so, the ID physician shall explain to the patient, in a diplomatic manner, their difficulties, without maligning the competence of the AMD, and, with the AMD and patient's approval, withdraw from managing the patient.[1,4,6,7] If the patient insists on retaining the ID physician, then the patient, the AMD and the ID physician shall meet and decide the best approach.

D. Transfer

The ID physician shall take over the management of the patient.

6. Once the purpose of the referral is fulfilled, the ID physician shall end his/her service and submit a separate professional fee. This end of service shall be made known to the AMD and the patient.[2,7]

7. Follow-up care, consultation or re-admission for the same or a new complaint, shall be to the AMD unless delegated by the AMD to the ID physician.[7] If the ID physician feels that the ID physician's service is still needed, the ID physician can tell the AMD and offer to do the follow-up care.

8. The ID physician shall not give referral commissions or fee splits to doctors or healthcare providers who refer patients to him/her.[1,2,4,7,8]

APPLICATION

Case 1

UK, a lupus patient under the care of a rheumatologist, is referred to you, an ID physician for management of TB. You see her as an out-patient, initiate quadruple anti-TB treatment and tell UK to go back to her rheumatologist for follow-up care.

Questions

1. Who should provide follow-up care?

2. What if UK prefers to transfer to you? She claims she has limited funds and cannot afford two physicians. How can you help UK?

3. How can you maintain a good physician-physician relationship?

Suggested Analysis:

1. UK is referred for management of TB. Since management of TB is for 6 months, you may ask UK to return to you for TB treatment follow-up. You should not, however, treat the lupus. An alternative is that you start anti-TB treatment then endorse follow-up to the rheumatologist who, if she does not feel comfortable doing it, may ask you to do the follow-up.

2. If UK expresses a preference for your care, you should clearly and firmly explain to her that she was referred to you for TB and you have started treatment. Let her know that lupus is not within your expertise and that the rheumatologist is in a better position to treat it. It is unethical for you to treat a condition which is not within your expertise. Even if UK insists, you should not agree. At best, both you and the rheumatologist should treat her. And, if you believe UK really lacks funds and want to help her, you can treat her for free, teach her how to get free anti-TB medicines from government institutions, prescribe equally effective and safe but cheaper preparations, give her your samples, identify pharmacies that sell drugs at lower prices, refer her to charitable institutions and inform the rheumatologist of UK's predicament. "Pirating" patients (transferring UK to your service without the AMD's permission) is unethical.

3. The good physician-physician relationship requires honest communication and support between physicians. You should talk to the rheumatologist about UK, explain how you want to help her, and work together towards UK's best interest. At the same time, you should not force and definitely not shame the rheumatologist into
   not charging UK.

Suggested Answers:

1. The rheumatologist should perform follow-up care with the option to call you as needed.

2. Explain why UK should not transfer to you and refuse to accept her. Find ways to help UK spend less.

3. Talk and support each other.

Case 2

VY is referred to you, an ID physician, by a Family Medicine physician for co-management because of persistent diarrhea. A number of broad-spectrum antibiotics had been given and are still being given. You feel that these antibiotics are unnecessary and may be the cause of the current diarrhea. You discontinue the antibiotics and VY improves. Both VY and VY's family ask what was wrong with VY.

Questions:

1. Should you have asked the permission of the family physician before discontinuing his ordered antibiotics? Or at least informed him before discontinuing it?

2. What should you tell VY/VY's family? Should you include your suspicion that the antibiotics given by the family physician contributed to the persistence of diarrhea?

3. How should you deal with the family physician? Should you tell him about the adverse effects of antibiotics? Or should you ignore the family physician?

4. VY's brother who is coughing is being treated by the same family physician for TB. VY claims that he is not improving and brings him to you without a referral from the family physician. What should you do?"

Case 3

In her first trimester of pregnancy, VZ is referred to you, an ID physician, by her obstetrician for evaluation of her two-week fever. After interviewing and examining VZ, your impression is typhoid fever and you want to do blood cultures, admit VZ and start treatment. Both VZ and her family are eager to be admitted and start treatment. VZ informs you that she is a healthcare management card holder and requests that you refer her to a doctor in that healthcare management group so that she will get free treatment benefits. She explains that you will still make all the medical decisions for her care and the healthcare management doctor will only sign the required forms.

Questions:

1. What should you tell VZ?

2. Should you proceed with the blood cultures? Are these laboratory tests part of your evaluation or do they need permission from the obstetrician?

3. Should you admit and start treatment without informing VZ's obstetrician?

4. If you admit VZ, under whose service should she be?

5. If VZ's obstetrician has left town to attend an international conference, how does this change the manner you should deal with VZ?

6. Should you agree to refer VZ to the doctor in the healthcare management group? Is making a referral for securing financial benefits justifiable? Should it be yours or the obstetrician's decision?

REFERENCES

1. Alora AT. Ethical guidelines for medical practice 2nd Ed. Manila, Philippines: UST Publishing House; 2013.

2. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

3. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

4. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.

5. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

6. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

7. Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine 2012;156:73-104.

8. Anyanwu EB, Harrison A, Onohwakpor E. The practice of medical referral: ethical concerns. American Journal of Public Health Research 2015; 3(1):31-35.

Chapter 10

The ID Physician-Medical Professional/Society Relationship

The ID physician is a member of the medical profession. As such, the ID physician is required to have specialized knowledge that requires continuous study, maintain high standards of achievement and conduct, and have a service – rather than a profit – orientation.

The ID physician is a member of society often looked up to as one who can be trusted and deserving of special privileges (e.g., no car coding). As such, the ID physician should be worthy of this trust, never abuse privileges, and always model good behavior.

GUIDELINES

In Relation to the Medical Profession

1. An ID physician shall uphold the dignity and honor of the profession; maintain its high standards by:[1,2,3]

    A. Updating one's competencies.

    B. Teaching and serving as a role model for colleagues.

    C. Accepting the profession's career approval, supervision, counselling and discipline.

    D. Being an active member of the Philippine Medical Association (PMA) and Philippine Society for Microbiology and Infectious Diseases (PSMID) or Pediatric Infectious Disease Society of the Philippines (PIDSP).

2. An ID physician shall not be party to and shall oppose killing, torture, unusual punishments and other abuses of the human person.[1,4,5,6] An ID physician shall not be used as an instrument by any institution to weaken the physical, mental or spiritual resistance of a human being.[4,7,8]

In Relation to Society

1. An ID physician shall be a good citizen.[1,2]

    A. Grateful to society for the physician's education.

    B. Respect the laws.

C. Support educational programs, aid creation of policies, and participate in activities that contribute to the promotion, maintenance and restoration of health and prevention of disease.[3]

D. Work towards an equitable healthcare system.[6]

E. Assist government in the administration of justice as expert witness: limiting testimony to matters he has knowledge of and experience in.[3,5,9]

2. An ID physician shall use resources wisely, making them available justly.[10,11] Resource allocation decision shall be based on likelihood and duration of benefit, urgency of need, and amount of resource required for successful treatment.[6,12] It shall not be based on ability to pay, contribution to society, perceived obstacles to treatment, contribution of patient to his condition and past use of resources.[13,14]

3. In an epidemic or public calamity, the ID physician shall attend to victims, alert public on the dangers, and enforce measures for prevention and cure.[3,5,9]

4. An ID physician shall deal with social and environmental causes of disease.[6,9,12]

5. An ID physician shall contribute to new knowledge: perform scientifically and ethically sound research serving the good of man.[1,2,3]

APPLICATION

Case 1

XA, a 28-year-old female has an acute uncomplicated urinary tract infection. She asks you to use her mother's name in your prescription for her so that she could avail of the senior citizen's discount of her mother. She claims it is her mother who will pay, anyway, and that other doctors do it. She also asks to be confined and have a complete executive check-up to be able to use her health benefits.

Questions:

1. Should you agree to XA's requests?

2. What is the relevance of the mother paying? Of other doctors doing it?

3. How should you react to the request for a senior citizen prescription? To the executive check-up?

Suggested Analysis:

1. Writing a prescription for a non-senior citizen under the name of a senior citizen is dishonest. It cheats the government and the public. Funds may be depleted and the privileges stopped. More importantly, it promotes the habit of dishonesty both in the patient and the physician. This lowers the standards of the profession and eventually leads to loss of trust in the physician and the medical profession.

   An executive check-up has an indication: pre-employment, senior citizen, risky life style, family pre-disposition, annual check-up for an executive, etc. Does XA fit into any of these categories? Would you have recommended an executive check-up if XA had not asked for it? If the answer is yes, then it should be done. If the answer is no, then it should not. Using a hospital bed, laboratory reagents and hospital services unnecessarily is a waste of resources and may deprive others who need them more. Whether it is a health benefit or not and who specifically pays for it is irrelevant. It is unjust and unethical.

2. The fact that the mother will pay has no relevance. The law says the mother should be the patient and not the payor.

   The fact that other doctors do it has no relevance. One should do what is right; not what others do. The profession should, in fact, discipline those other doctors who behave dishonestly.

3. You should clearly and firmly tell XA that writing a senior citizen prescription for a non-senior and having an unnecessary executive check-up is wrong and you will not participate in the wrong-doing.

Suggested answers:

1. Do not agree to write a senior citizen's prescription for a non-senior. Do not unnecessarily admit a patient for an executive check-up.

2. Who pays and what others do have no relevance to what you should do. You should do what is right.

3. Explain why it is wrong and that you will not do it. Find other ways to help XA save money.

Case 2

YB is a competent surgeon with asymptomatic chronic infectious hepatitis on treatment. He applies to be an active consultant in a private hospital where you are the ID physician.

Questions:

1. Should YB be accepted? Is surgical competence enough justification to expose patients to the risk of harm from the hepatitis? Which should take priority, the right of YB to practice or the right of patients not to be put at risk of harm?

2. If accepted, what measures should be undertaken to reduce the risk of harm? What is your role as the ID physician of the hospital? What about the right of patients to receive competent healthcare?

3. Should potential patients be informed of YB's hepatitis status and asked for consent? If YB accidentally cuts himself during surgery and contaminates the operative field and possibly the patient, should the patient be told? What else should be done? Who would be accountable if the patient develops hepatitis? YB? The infection control committee? The hospital?

4. If the patient sues and as an ID physician you are summoned as expert witness, what should you do?

5. What should hospital policies on how to deal with infected healthcare providers include? Should medical/surgical procedures be stratified based on the levels of risk of healthcare transmission be used as a basis to restrict YB's practice? Should YB be required to have an ID physician take care of him and monitor his status?

Case 3

ZC is a 62-year-old ID physician who became a diplomate 20 years ago. ZC has many patients and is satisfied with his practice and its earnings. ZC does not attend scientific meetings or post-graduate ID courses. He depends on pharmaceutical industry literature for his updates. If sponsored to a convention, he participates more in the social events than in the learning activities then posts his certificates of attendance in his clinic.

Questions

1. Is using pharmaceutical industry literature sufficient to update an ID physician's expertise?

2. How can ZC be convinced to behave as a professional should? What kind of role-model is ZC to the younger colleagues?

3. Should the PSMID or PIDSP require evidence of scientific update to maintain diplomate status? Should it discipline its members? How?

REFERENCES

1. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

2. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

3. Snyder L. American College of Physicians Ethics Manual 6th Ed. Annals of Internal Medicine 2012;156:73-104.

4. Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

5. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

6. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

7. Timbreza F. Bioethical and moral decisions 7th Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

8. Puchalsky C. The role of spirituality in health care. Baylor University Proceedings. 2001;14:352–357.

9. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics

10. Babor E. Bioethics A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

11. Beauchamp T, Childress J. Principles of biomedical ethics 5th ed. New York, USA: New York Oxford Press; 2001.

12. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

13. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

14. Pence G. Medical ethics: accounts of ground-breaking cases 7th Ed. New York, USA: McGraw-Hill Education; 2015.

Chapter 11

The Infectious Diseases Physician and Research

The ID physician has a duty to contribute to knowledge by doing research. It is also the ID physician's duty when doing research to promote and safeguard the life, health, well-being and rights of participants involved in the research.[1] This responsibility can never be transferred to the research participant even if he/she gives informed consent.[1]

Scientific and ethical research has advanced the delivery of healthcare and allayed illness and suffering. Unscientific and/or unethical research has wasted resources, abused participants and betrayed public trust.

Responsibility for the ethical soundness of a research project falls on all those involved: investigator, participants, ethics review committee, healthcare professionals who refer or recruit participants, institution, sponsor and the government. The main responsibility rests on the investigator and the Research Ethics Committee (REC).

This policy is in line with the Declaration of Helsinki as revised in 2013 and the Philippine National Ethical Guidelines as revised in 2012.

GUIDELINES

1. The primary motive of research shall be for the good of man: his/her health and well-being.[1,2,3,4,5] It shall be conducted only if the importance of the objective outweighs the risks and burdens to the research participants.[1]

2. Scientific soundness is an absolute pre-requisite for ethical soundness: bad science is bad ethics.[1,2,6,7]

    A. Objectives shall be relevant.[3]

    B. The presence of a "knowledge gap" shall be established with proof but insufficient evidence of the concept to be tested.[1,8]

    C. The method shall be adequate to achieve the objectives and feasible under the circumstances the research is to be done.[1,8]

    D. Outcomes shall be clear.[6,9]

    E. The measurement tool shall be valid.[4]

F. Statistics shall be appropriate to assess findings.[4]

G. Accurate and truthful results shall be reported.[1,6,8]

H. Correct conclusions shall be made.[4]

D. Doable recommendations shall be given.[4,8]

J. The design and performance of the study shall be clearly described and justified in the research protocol.[1]

3. Research shall follow universally accepted ethical principles.[2,5]

A. Non-maleficence

1. Harm/wrong shall be unavoidable, minimal and proportionate to the benefit foreseen and humanitarian aim of study.[1,3]

2. Risk shall be assessed before initiation of the study and safeguards including "stop rules" shall be in place.[4,7,8,9]

3. Long-term monitoring of the participant's health and well-being shall be done beyond the research period with needed interventions provided.[7,8]

4. Inclusion criteria which wrong or harm participants shall not be allowed.[3]

5. Key persons to contact and how to contact them to request information or clarification, and to report untoward events shall be clearly identified and made known.[7,9]

6. New and incidental findings shall be immediately disclosed to participants.[6,9,10]

7. Confidentiality of participant's personal information shall be maintained.[1,4,6,7,9,10]

8. Therapeutic misconception and unfounded optimism shall be avoided.[6,7]

9. Vulnerable groups shall receive specific protection.[1,5]

10. The environment shall be protected.[1,7]

B. Beneficence

1. Participants shall leave the research better than when they joined: healthier, more knowledgeable or with more resources.[1]

2. There shall be a favorable benefit/risk ratio for participants.[1,3,10]

3. After a drug trial, the drug shown to be better (the control or experimental) shall be offered to the group who received the lesser form.[1,7]

4. The community from which participants were chosen shall improve: influx of knowledge/expertise/resources, availability and accessibility of proven better drugs/ devices/practice.[4,8]

C. Respect for person

1. Free and informed consent shall be continuously obtained from all participants from recruitment to publication and re-asked as new information is available.[1,3,4,5,6,9]

2. Participants shall be treated politely.

D. Justice

1. Existing inequalities shall not be exacerbated.[5]

2. Eligibility of researcher, participant and assignment shall be primarily based on the research objectives.[1]

3. The vulnerable (those who cannot refuse) shall be protected and made participants only for studies of direct relevance and benefit to them.[1]

4. Groups often underrepresented in medical research shall be provided appropriate access to participation.[1]

5. Participants shall receive free standard healthcare.[4,9]

6. The best available drug shall be used as control.[1]

7. There shall be timely disclosure of true results initially to the scientific community.[4,8,9]

8. If later published in media, misinterpretation or unjustified extrapolation shall be avoided, and if found, corrected.[1,6,8,10]

9. Compensation to researcher and participant shall be fair: neither exploitive nor coercive[2,5,6].

10. Appropriate treatment and compensation for participants harmed as a result of joining the research shall be ensured[1,5].

11. There shall be no "finder's" or recruitment fee[6,11].

4. The researcher shall have the capacity (education, training and qualifications) to do the research and be trustworthy to protect the participants and avoid conflicts of interests[1,3,8,9]. The attending physicians shall not be researchers[1,9]. Their role as attending physicians would be in conflict with their role as researchers[5].

5. There shall be a collaborative partnership with the community in which research is conducted[4].

   A. To determine if the research is acceptable and responsive to their health problems.

   B. To ensure fair distribution of benefits from rthe esearch outcome.

6. The protocol shall be reviewed and approved in a transparent process by an independent research ethics committee (REC) prior to the initiation of the study. It shall be monitored by the committee during the study. After the study, the committee shall receive a final report containing a summary of the study's findings, conclusions and recommendations[1,7,8,9,10].

7. The protocol shall be registered in the national health research registry[1,9].

8. Physicians who refer their patients to participate in a research shall monitor their participation to ensure that scientific and ethical standards are met[10].

9. Innovative treatments (unconventional dosage, non-approved indications) may be given with the primary purpose of benefiting the individual patient provided there is sufficient evidence that it may work and the patient gives free and informed consent[1,10,11]. If used for more than one patient, a research study shall be planned.

APPLICATION

Case 1

A double blind measles vaccine trial involves exposing healthy children to measles with the experimental group vaccinated and the control group not vaccinated.

Questions:

1. Under what conditions may children be research participants?
2. What harm can children participants be exposed to?
3. How will they be protected against harm/wrong?
4. Should exposed non-participants also be protected?
5. What benefits will the children get?
6. How should the information be given to the parents in obtaining free and informed consent?
7. What is the role of the parents and the child in giving consent?

Suggested analysis:

1. Children should not be research participants for studies where adults can be participants. This is because children are developing and more prone to be damaged by unknown drugs and because they cannot give free and informed consent. In order to justify using children as research participants, the study must be relevant to children, must be carried out only on children (cannot be done on adults), must cause minimal or no harm, and parents and their children must give consent and assent, respectively.

   Measles is a disease found commonly during childhood. It can be dangerous to the child. A vaccine against it is thus relevant to children. The study can only be done on children because children's reactions are different from adults; and children are the target population for the vaccine. Measures to protect them from harm should be included in the protocol: aseptic technique, close monitoring and immediate management of adverse reactions. Parents should give their consent and children should give assent.

2. To intentionally expose a healthy child to disease is harming him/her and violates the principle of non-maleficence. To be acceptable, harm has to be unavoidable, minimal and proportionate to the benefit the study may result in. In this trial, pain from an injection is unavoidable because the vaccine has to be injected, but harm from exposure is not unavoidable since the exposure can be avoided if not participating in the trial. Harm is not minimal: since measles may become a serious condition. Harm might not be proportionate: since there are vaccines available now to protect the child and the additional benefit of a new vaccine is not clear.

Sacrificing the children today to protect future generations of children is insufficient basis to expose the children to harm. Since the harm is avoidable, more than minimal and disproportionate, it cannot justify the trial. This does not mean that there can never be new studies on measles vaccine. It means that new studies would have to show additional, maybe extra-ordinary measures to protect the children and a considerable positive benefit/harm ratio should be established. Control should be the best available vaccine.

3. To protect the children against harm, they should not be made participants of this study. If reasons are given to involve them – such as the experimental vaccine is much safer or cheaper than what is available and will be given to the population at prices they can afford
   -- then safeguards must be in place such as strict inclusion criteria of healthy children who can be properly monitored, a competent healthcare giver to recognize early signs of measles and administer prompt appropriate treatment, and stop rules if unacceptable adverse effects occur.

4. Those not participating in the study but in close contact with the participants (hence, exposed), such as siblings, roommates, caregivers and room cleaners must be protected. Exposure must be minimized (isolation techniques and infection control precautions). Monitoring should be in place for early diagnosis and adequate treatment. They should also be asked to give free and informed consent.

5. During the study, all participants should receive standard healthcare. After the study, whichever is found better (the control or experimental vaccine) should be offered to the group who received the less effective form provided it may still do some good. In addition, some other means to benefit all participants should be given like free multivitamins, or free healthcare or free health education which they would ordinarily not be entitled to.

6. Disclosure of information to parents when asking consent should be in a manner that will make the parents understand the risk they are exposing their children to and the possible benefits, plus the right to withdraw at any time. There should be no coercion. Parents should be given a clear explanation to avoid therapeutic misconception (parents believing that by joining the research their children will receive better healthcare) and the attending pediatrician should not be the one to request patients to join the study.

7. Parents should give consent (permission), and the child, assent. If the child refuses, then she cannot be a research participant.

Suggested Answers:

1. The study must be relevant to children, must be carried out only on children, must cause minimal or no harm, and parents must give consent and the child, assent.

2. Minimal, unavoidable, proportionate harm.

3. Do not make them participants, or have safeguards in place.

4. Exposure should be minimized, safeguards in place, and informed consent obtained.

5. Free standard healthcare and some compensation, such as health education.

6. Complete understandable disclosure of benefits and risks, right to refuse at any time, and freedom from coercion. The attending physician should not ask for consent.

7. Parents should give consent and the child should give assent.

Case 2

You are offered to participate in a double-blind randomized study for the prevention of recurrent UTI, which compares a new antimicrobial drug with a placebo given for at least 3 months (Phase III).

Questions:

1. Is recurrent UTI a priority concern in the Philippines and should it be accepted as a subject of study?

2. What elements of ethical research should you be particularly concerned about? What is the significance of prolonged antimicrobial intake? How will collateral damage be monitored? What is the potential limitation of taking prophylactic drugs for 3 months? What advice should you give participants at the end of the trial? How can respect for person and justice be applied?

3. Should you as the attending physician agree to also be the researcher? How will you manage the dichotomy of your two roles as attending physician who should choose the best drug for your patients and as a researcher who should determine if a particular drug is good or not? How can you use a drug which you know may or may not work when you should choose the best for the patient?

How should you resolve the potential conflict between scientific and therapeutic goals? In addition, as the attending physician, how will you ask consent from your patients? Would it not entail coercion?

4. When is the use of a placebo justified?

5. How can you ensure the availability of the tested drug for the average Filipino, if proven effective?

Case 3

A resident is doing a retrospective study to determine the prevalence of pulmonary tuberculosis and its common clinical manifestations though a chart review of patients admitted in the charity wards for the last 5 years.

Questions:

1. What is the value of this research? Is there a knowledge gap that needs to be filled for the good of man or are present studies regarding the prevalence of TB and its common manifestations sufficient?

2. How will privacy and confidentiality be observed? How can charts be anonymized and participants de-identified?

3. How will participants benefit? Can participants be met and rewarded for joining the research?

4. How will informed consent from participants be obtained?

5. Is selection of charts of only charity patients unjust?

6. How can the researcher manifest trustworthiness?

REFERENCES

1. Declaration of Helsinki. Adopted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 as amended in the 64th WMA General Assembly, Fortaleza, Brazil, October 2013.

2. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

3. Mitscherlich A, Mielke F. The Nuremberg Code: Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman;1949. pp. xxiii-xxv.

4. Emmanuel E, Wendler D, Grady C. An ethical framework for biomedical research. The Oxford Textbook of Clinical Research Ethics. New York, USA: Oxford University Press.; 2008.

5. Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

6. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

7. Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

8. Williams J. World Medical Association medical ethics manual 3rd ed. United Kingdom; 2015.

9. National ethical guidelines for health research. Philippine Health Research Ethics Board Ad Hoc Committee for the Revision of Guidelines. Philippines; 2011. Available from: http://www.ethics.healthresearch.ph/index.php/phoca-downloads/category/4-neg

10. Snyder L. American College of Physicians Ethics Manual 6th Ed. Annals of Internal Medicine. 2012;156:73-104.

11. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics

Chapter 12

The ID Physician and Infection Control

The public trusts that the ID physician, because of the physician's special expertise, will protect the public from infectious diseases. This is done by providing competent healthcare, participating in health education, cooperating in public health programs, and joining infection control committees of institutions. It is the ID physician's obligation to meet this trust.

GUIDELINES

1. The ID physician shall protect patients and public from disease.

    A. Prevent healthcare providers who are infectious from working under conditions wherein their infection may spread.[1,2,3,4]

    B. Promote the observation of standard and transmission-based precautions.[5,6,7]

    C. Educate other healthcare givers and the public about infections and their control.[1,2,7]

2. The ID physician shall do one's best to provide healthcare to infected patients even if at the self-risk of infection.[1,9]

3. The ID physician shall be actively involved in the infection control program of the hospital.[1,6,10]

    A. Be familiar with the rationales and techniques of infection control.

    B. Possess basic skills in epidemiology, surveillance and statistical analysis.

    C. Establish policy to control infection.

    D. Resolve conflicts of interests between infection control duties and private practice/hospital income.

4. The ID physician shall participate in national surveys regarding infection.[2,3,6,10]

5. The ID physician shall be actively involved in antibiotic stewardship programs.[11]

APPLICATION

Case 1

AD was admitted into a regular ward with fever. On the 3rd hospital day, she manifests the rash of chickenpox. Two weeks later, 2 nurses and 3 patients in the same ward also develop chickenpox.

Questions:

1. Should AD have been admitted to the regular ward?
2. As head of infection control:
   A. What is your responsibility to the exposed patients? nurses?
   B. Whom should you inform regarding the break in infection control measures? What good would this do?
3. Should immunization of nurses be part of the hospital policy?

Suggested Analysis:

1. At the time of admission, the admitting physician may not have suspected that AD had chickenpox. Early manifestations are non-specific and admission of febrile patients to a regular ward is common in the Philippines where isolation facilities are not easily available. However, an infection should have been suspected and accepted measures to prevent spread (i.e. proper distance between beds, hand-washing, etc.) implemented. Exposed patients in the ward should have been protected. This follows the principle of non-maleficence.

2. A. The exposed patients and healthcare providers in the ward should be informed of their exposure risk and advised how to recognize signs of chickenpox and prevent its spread. Quarantine, to the extent feasible, and monitoring by the healthcare professionals are encouraged. This follows non-maleficence and beneficence.

   B. The hospital authorities should be informed by the head of infection control. This will prepare them for any complaint, allow them to implement measures to protect the exposed, and review their policies, which allowed such exposure to happen. Should sanctions be given, then it is an unavoidable consequence.

3. Part of infection control is creation of policies that will improve the

resistance of healthcare workers and protect them from infection. The ID physician should advise routine adult immunization to be included in the hospital infection control policy.

Suggested Answers:

1. AD may have been admitted to the regular ward but hygienic measures should have been implemented.

2. A. Exposed patients should be informed of their risk and advised quarantine and monitoring.

   B. The head of infection control should inform hospital authorities to help them prepare for complaints and prevent similar occurrences.

3. Recommend immunization of all non-immunized healthcare providers against chickenpox and other recommended adult immunizations.

Case 2

You are the ID physician in a tertiary hospital with a 400-bed capacity. A memo from the hospital director prohibits admission of patients suspected with the Middle East Respiratory Syndrome coronavirus (MERS-CoV) infection. BE, 42, an EENT specialist of the hospital is referred to you for a "systemic viral infection". You suspect MERS-CoV.

Questions:

1. What should you do to BE? What if BE refuses transfer to a DOH-designated MERS-CoV hospital? What relevance does the fact that BE is an EENT specialist of the same hospital have to your decision? Is there a conflict of interest? Should you quarantine BE at home? How would autonomy and non-maleficence be applied? In general, the least restrictive means which the patient will voluntarily cooperate with are recommended because these respect the patient best. How is this applied to BE?

2. Who should you inform of his suspected MERS-CoV infection? BE, the referring physician, or the hospital authorities?

3. If the media inquires, what benefit/harm would disclosing to the media the MERS-CoV suspect in your hospital do to BE? the Hospital? Yourself? Should you, as head of Infection Control handle the media or should you defer it to the medical director?

Case 3

As head of the Infection Control Committee, you are aware of international guidelines to reduce infection in your hospital. Unfortunately, budget is limited and you have limited disposable gloves and masks, gowns and even soap and paper towels.

***Questions*:**

1. What efforts can you take to reduce infection?
2. Is there a basic minimum without which all efforts are futile?
3. Should you resign if administration is unable to meet your needs or should you do the best you can under the circumstances? Would participating in a deficient infection control program be equivalent to cooperating in a wrong-doing by the hospital administrators?
4. Should infected patients be classified based on biologic factors of the disease (virulence and mode of transmission) in selecting the infectious control measures? Would this be just?

REFERENCES

1. Snyder L. American College of Physicians Ethics Manual 6th Ed. Annals of Internal Medicine 2012;156:73-104.
2. Code of Medical Ethics. American Medical Association, adopted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.
3. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf
1. Silva M, Ludwick R. Ethics column: "What would you do? ethics and infection control" Online Journal of Issues in Nursing 2006;12(1). doi: 10.3912/OJIN. Vol12No01EthCol01.
2. Siegel JD, Rhinehart E, Jackson M, et al. Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings. USA; 2007. Available from: http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf.
3. Bennet J, Dolin R, Blaser M. Mandell, Douglas, and Bennett's Principles and practice of infectious diseases 8th ed. Philadelphia, USA: Elsevier Saunders; 2015.
4. McIvor J. The ethics of infectious disease control: lessons from the ebola outbreak

and an ethical framework [MA Thesis]. Kelburn, New Zealand: Victorian University of Wellington; 2016 [cited 2017 Jan 25]. Available from: http://researcharchive.vuw.ac.nz/xmlui/bitstream/handle/10063/5308/thesis.pdf?sequence=1

8. Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html.

9. Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGraw-Hill Education; 2015.

10. McKibben L, Horan T, Tokars J, et al. Guidance on public reporting of healthcare-associated infections: recommendations of the Healthcare Infection Control Practices Advisory Committee. American Journal of Infection Control 2005; 33(4):217-226.

11. Barlam T, Cosgrove S, Abbo L, et al. Implementing an antibiotic stewardship program: guidelines by the Infectious Diseases Society of America and the Society for Healthcare and Epidemiology of America. Clinical Infectious Diseases 2016;62(10):e51-e77.

Chapter 13

The ID Physician-Pharmaceutical Industry Relationship

The physician-pharmaceutical industry relationship should be one of mutual support and benefit with the common goal of improving healthcare[1].

These guidelines are in line with the Mexico City Principles for Voluntary Codes of Business Ethics in the Biopharmaceutical Sector and its implementing guidelines (DOH AO 2015-0053.)

GUIDELINES

1. No activity shall interfere with the independence of the ID physician in practicing Medicine.[1,2,3]

2. All activities shall be transparent, fair to both parties, and done in good taste befitting the medical profession.[2,3,4,5]

3. All promotional information (written and oral) provided by the pharmaceutical industry and accepted by the ID physician shall be:

    A. Truthful and substantiated with updated scientific data and references.[1,2,3,4]

    B. Balanced between benefits and risks.[2,3,4]

    C. Befitting the medical profession.[2,4]

4. Gifts from the pharmaceutical company or its representatives to practicing ID physicians shall:

    A. Not be primarily for entertainment or recreation (e.g., theater tickets, sporting events).[1,2,4]

    B. Directly provide either patient benefit or doctor education.[1,4]

    C. Be of modest value (₱300 or less).[1,2,4]

5. Donations to institutions shall be either directly related to patient care or doctor education.[2,4,5]

6. Continuing Medical Education Activities

    Meetings organized by medical professional associations or health institutions may receive pharmaceutical company support provided:

A. The scientific program shall be independently organized by and the speakers chosen by the hosting organization.[5]

B. More time and money are devoted to the scientific activity than to entertainment and hospitality.[1,2,4]

C. Speakers will disclose all conflicts of interest, present truthful balanced information, use generic rather than brand names and not endorse/promote any specific product.[2,3]

7. Support for individual ID physician's attendance in conventions/ conferences shall:

A. Have the subject matter of the event directly related to the practice of infectious diseases.[1,5]

B. Not require any obligation to prescribe/endorse company product.[1,3,4,5]

C. Be limited to financing the ID physician and not any accompanying guest.[1,2,4]

D. Require that the ID physician share what has been learned either by participating in echo seminars or writing published articles.[2]

E. Not be based on number of prescriptions (past, present, or future) of the company's product/s.[2,4,5]

F. Require the sponsored ID physician to accept only one sponsor for a particular activity and only one sponsorship per year from a specific company.

8. Sponsorship for ID fellowship training shall:

A. Be limited to fellows' monthly stipend and attendance to conferences.[2,4]

B. Not involve the fellow in any research initiated by the sponsoring company or lecture on company products during fellowship period.[1,4]

9. The ID physician shall not endorse/promote specific pharmaceutical products or brands.[1,2,3,5] If invited to speak at scientific meetings, whether organized by the pharmaceutical company or a private institution, the ID physician shall ensure that words and visual aides do not endorse or appear to endorse a specific company or its products.[3,5]

10. The ID physician shall not solicit donations from pharmaceutical companies not related to patient care or medical education (e.g., charity patients, medical missions).[2,3,5]

APPLICATION

Case 1

As an ID physician, you are offered sponsorship to attend the PSMID Convention by Pharmaceutical Company X. Its products include a number of antimicrobials you frequently prescribe.

Questions:

1. Is the pharmaceutical industry sponsorship good or bad?

2. What important concerns should you consider in deciding to accept/ refuse the offer?

Suggested Analysis:

1. In itself, the pharmaceutical industry sponsorship is not bad. It helps some doctors avail of the benefits conventions offer. At the same time, sponsorships risk harming physicians by eroding their character: making them dependent on the pharmaceutical industry for their learning which should be their own responsibility; brand loyalty develops non-pharmacologic-based prescription habits, and tempts physicians to prescribe according to pharmaceutical industry rather than the patient's best interests. Without paying for the event, physicians give less value to the scientific learning and spend more time using it as a means for socializing.

2. Although it is tempting to accept all offers and rationalize that it is a freebie physicians deserve, a physician should think about why he was chosen to be sponsored. Has he done work for the company (e.g., like give lectures, be a consultant, or do research) which deserves this sponsorship? If "work for the company" means prescriptions written whether prior to or after the sponsorship, then the sponsorship is unjustified. A physician

should prescribe the best drug for his patient irrespective of the company that made it. It is part of his duty; and to accept a sponsorship in exchange of prescriptions is unethical.

***Suggested Answers*:**

1. The pharmaceutical industry sponsorship is not intrinsically bad in itself but bad in the way it is used.

2. Why was I chosen? What is in it for me? For the pharmaceutical company? Am I expected to "repay the favor"? How?

Case 2

Your Section of Infectious Diseases needs support for a planning and team-building event.

Questions:

1. How does a team building event directly relate to patient care or physician education?

2. What and how can pharmaceutical companies help? Can it dovetail the event to a conference it organizes and invite the same people? How should expenses be shared?

3. What responsibility will the section have to the pharmaceutical company?

Case 3

You received a Mandell Infectious Disease book from a pharmaceutical company for use as reference in your section. They now ask you to give 6 lectures on sepsis and mention their antibiotic which you are already using and find effective and safe. They provide you with data and PowerPoint slides on their product.

Questions:

1. Was it appropriate to accept the book?

2. How should you respond to their request for lectures from you which include mentioning their antibiotic using their slides?

   How does giving lectures fit into your obligation as a physician to help other physicians update their knowledge?

Will content of slides prepared by the company be truthful and unbiased? Will it emphasize the positive and minimize the negative aspects of their product or emphasize the benefits of their product without mentioning the benefits of alternatives? Will it bear the logo of the company? Can it be interpreted by the audience to be an endorsement of the company's product/s? Would it be better for you to prepare your own slides?

What should you disclose at the beginning of the lecture? The book donation? Should you receive an honorarium for the lecture?

REFERENCES

1. Code of Practice. Pharmaceutical and Healthcare Association of the Philippines. Philippines; 2015.

2. Philippines. Department of Health. Office of the Secretary A.O.2015-0053: Implementing guidelines on the promotion and marketing of prescription pharmaceutical products and medical devices. Manila, Philippines; 2015.

3. Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics

4. The Mexico City principles for voluntary codes of business ethics in the biopharmaceutical sector. Asia Pacific Economic Cooperation. USA; 2011.

5. Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

REFERENCES

Alora AT. Ethical guidelines for medical practice 2nd ed. Manila, Philippines: UST Publishing House; 2013.

Alora AT. 100 Most frequently asked bioethics questions. Quezon City, Philippines: C&E Publishing, Inc.; 2015.

American Board of Internal Medicine. Caring for the dying: identification and promotion of physician competency: Reprint of Educational Resource Document and Personal Narratives. Philadelphia, USA; 1998.

American College of Obstetricians and Gynecologists Code of Professional Ethics. Washington: 2011. Available from: https://www.acog.org/-/media/Departments/National-Officer-Nominations-Process/ACOGcode.pdf?dmc=1&ts=20160831T2231251501

American College of Obstetrics and Gynecology Committee on Ethics. Sterilization of women, including those with mental disabilities. Ethics in Obstetrics and Gynecology, 2nd ed. USA; Updated 2007.

Anyanwu EB, Harrison A, Onohwakpor E. The practice of medical referral: ethical concerns. American Journal of Public Health Research 2015;3(1):31-35.

Babor E. Bioethics A philosophical journey and a critical analysis into the life sciences: a guide to healthcare providers 2nd ed. Quezon City, Philippines: C&E Publishing, Inc.; 2010.

Barlam T, Cosgrove S, Abbo L, et al. Implementing an antibiotic stewardship program: guidelines by the Infectious Diseases Society of America and the Society for Healthcare and Epidemiology of America. Clinical Infectious Diseases. 2016;62(10):e51-e77.

Beauchamp T, Childress J. Principles of biomedical ethics 5th ed. New York, USA: New York Oxford Press; 2001.

Bennet J, Dolin R, Blaser M. Mandell, Douglas, and Bennett's Principles and practice of infectious diseases 8th Ed. Philadelphia, USA: Elsevier Saunders; 2015.

Catechism of the Catholic Church, No 2270. Available from: http://www.scborromeo.org/ccc/p3s2c2a5htm.

Centers for Disease Control and Prevention. Division of HIV/AIDS prevention annual report 2015: putting prevention advances to work. Atlanta, Georgia; 2015.

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014: Summary for Clinical Providers. 2014. Available from: http://stacks.cdc.gov/view/cdc/26063.

Centers for Disease Control and Prevention. Revised guidelines for HIV counseling, testing, and referral technical expert panel review of CDC HIV counseling, testing, and referral guidelines. Morbidity and Mortality Weekly Report; 2001/50(RR19);1-58.

Code of Medical Ethics. American Medical Association, adapted 2016. Available from: https://www.ama-assn.org/about-us/code-medical-ethics.

Code of Ethics of the Philippine Medical Association. Quezon City, Philippines; 2008. Available from: https://www.philippinemedicalassociation.org/downloads/pma-codes/FINAL-PMA-CODEOFETHICS2008.pdf

Code of Practice. Pharmaceutical and Healthcare Association of the Philippines. Philippines; 2015. Available from: http://www.phap.org.ph/files/downloadables/56_1.pdf

Congress of the Philippines. Republic Act 8504 The Philippine AIDS Prevention and Control Act of 1998. Manila, Philippines; 1998.

Declaration of Helsinki. Adapted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 as amended in the 64th WMA General Assembly, Fortaleza, Brazil, October 2013.

Emmanuel E, Wendler D, Grady C. An ethical framework for biomedical research. The Oxford Textbook of Clinical Research Ethics. New York, USA: Oxford University Press.; 2008.

Ethical issues in the care of PLHIV. Harvard Medical School AIDS Initiatives in Vietnam 2015. Available from: http://slideplayer.com/slide/8942810/

Ethics in Medicine. University of Washington Medicine. Washington, USA; 2013. Available from: http://depts.washington.edu/bioethx/topics/physpt.html

Evariste H. Family planning by means of contraception: an ethical comparison of different methods of contraception used by couples of Kalingalinga, Mtendere, Kabwata and Kamwala Compounds in Lusaka, Zambia. [Thesis] University of Zambia; 2012 Available from: http://dspace.unza.zm:8080/xmlui/bitstream/handle/123456789/2529/habiyaremye.pdf?sequence=1

FICE Code of Ethics for Persons working with Children and Young People. FICE Bulletin #14, 1998.

Gordon E. Moral case against contraception 2011. Available from: www.bbc.co.uk/ethics/contraception

Henderson D, Dembry L, Fishman N, et al. SHEA Guideline for management of healthcare workers who are infected with hepatitis b virus, hepatitis c virus, and/or human immunodeficiency virus. Infection Control and Hospital Epidemiology 2010; 31(3):203-232

Hester DM, Schonfeld T. Guidance for healthcare ethics committees. Cambridge, UK: Cambridge University Press; 2012

Johnston L, Conly J. Nosocomial transmission of bloodborne viruses from infected health care workers to patients. Canadian Journal of Infectious Diseases 2003;14(4):147-151.

Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. Departments of Psychiatry and Medicine, Duke University Medical Center. Southern Medical Association 2004; 97(12):1194-1199.

Kukla R, Wayne K. Pregnancy, birth, and medicine. The Stanford Encyclopedia of Philosophy (Winter 2016 Edition), Edward N. Zalta (ed.) Available from: https://plato. stanford.edu/archives/win2016/entries/ethics-pregnancy/

Levine C. Taking sides: clashing views on bioethical issues 13th ed. New York, USA: McGraw-Hill Education; 2010.

McKibben L, Horan T, Tokars J, et al. Guidance on public reporting of healthcare-associated infections: recommendations of the Healthcare Infection Control Practices Advisory Committee. American Journal of Infection Control 2005; 33(4):217-226.

McIvor J. The ethics of infectious disease control: lessons from the ebola outbreak and an ethical framework [MA Thesis]. Kelburn, New Zealand: Victorian University of Wellington; 2016 [cited 2017 Jan 25]. Available from: http://researcharchive.vuw.ac.nz/xmlui/bitstream/ handle/10063/5308/thesis.pdf?sequence=1

Mitscherlich A, Mielke F. The Nuremberg Code: Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman;1949. pp. xxiii-xxv.

National ethical guidelines for health research. Philippine Health Research Ethics Board Ad Hoc Committee for the Revision of Guidelines. Philippines; 2011. Available from: http://www.ethics.healthresearch.ph/index.php/phoca-downloads/ category/4-neg

Oduncu FS, Kimmig R, Hepp H, et al. Cancer in pregnancy: maternal-fetal conflict. Journal of Cancer Research and Clinical Oncology 2003;129(3):133-46.

Pence G. Medical ethics: accounts of ground-breaking cases 7th ed. New York, USA: McGraw-Hill Education; 2015.

Pence G. The elements of bioethics. New York, USA: McGraw-Hill Education; 2007.

Philippine College of Physicians Code of Ethics. Quezon City, Philippines; 2009. Available from: http://www.pcp.org.ph/committee-on-ethics/386-code-of-ethics.

Philippine Obstetrical and Gynecological Society (Foundation) Inc. Ethical Guidelines in Obstetrical and Gynecological Practice, Medical Education and research, November 2011

Philippines. Department of Health. Office of the Secretary A.O.2015-0053: Implementing guidelines on the promotion and marketing of prescription pharmaceutical products and medical devices. Manila, Philippines; 2015.

Post S, editor. Encyclopedia of bioethics 3rd Ed. New York, USA: Macmillan Reference USA; 2004.

Puchalsky C. The role of spirituality in health care. Baylor University Proceedings 2001; 14:352–357.

Report of the APEC Life Sciences Innovation Forum Planning Group Meeting. Moscow, Russia; 2012.

Siegel JD, Rhinehart E, Jackson M, et al. Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings. USA; 2007. Available from: http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

Silva M, Ludwick R. Ethics column: "What would you do? ethics and infection control" Online Journal of Issues in Nursing 2006;12(1). DOI: 10.3912/OJIN.Vol12No01EthCol01

Snyder L. American College of Physicians Ethics Manual 6th ed. Annals of Internal Medicine 2012;156:73-104.

South African Medical Association Ethical and Human Rights Guidelines. Available from: https://www.samedical.org/images/attachments/guideline-ethical-human- rights-aspects-on-hiv-aids-2006.pdf

Standards and Operational Guidance for Ethics Review of Health-Related Research with Human Participants. World Health Organization 2011.

Standards of Care in the Management of the HIV Infected Healthcare Worker. Philippine Society for Microbiology and Infectious Diseases. Philippines; 2017 (ongoing).

The Mexico City principles for voluntary codes of business ethics in the biopharmaceutical sector. Asia Pacific Economic Cooperation. USA; 2011.

Timbreza F. Bioethical and moral decisions 7th Ed. Quezon City, Philippines: C&E Publishing, Inc.; 2007.

Toy E, Raine S, Cochrane T. Case files medical ethics and professionalism. New York, USA: McGrawHill Education; 2015.

Universal Declaration of Human Rights. United Nations; 2015. Available from: http://www.un.org/en/universal-declaration-human-rights/

Wiesermann C. Moral equality, bioethics and the child. Switzerland: Springer International Publishing; 2016.

Williams J. World Medical Association medical ethics manual 3rd Ed. United Kingdom; 2015.