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The Ethical Challenge of Conflicts of Interest in Healthcare

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THE ETHICAL CHALLENGE OF CONFLICTS OF INTEREST IN HEALTHCARE

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ABSTRACT

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Dissertation supervised by Professor Gerard Magill

Conflicts of interest are prevalent across all walks of society, and unfortunately, the healthcare industry is not immune to these impediments. Conflicts of interest arise when the objective of upholding a patients' interest collide with the physicians' secondary goals and is mostly but not always related to monetary gain.

To avoid conflict of interest, it is advisable for medical practitioners to weigh the pros and cons that their actions would inflict. Medical practices whose benefits outweigh the associated risks are ethically upright hence avoid conflict of interest.

Each section proposes solutions for the conflicts of interest encountered at the disparate healthcare settings and contexts, and thus the dissertation's immense contribution to the field. For instance, the study proved normative methods to be key to ethical decision making in healthcare as they establish rules, procedures, and regulations necessary to achieve informed

consent. Moreover, they ensure the patient's full autonomy as it puts them in a comprehensive position that they can voluntarily make their own decisions. This could comprise the most needed solutions in healthcare to ensure patient autonomy and informed consent hence solve the issue of conflict of interest in this context. The dissertation further illustrates how the importance of patient-physician relationship and involvement of family members in meaningful decision making can result in no conflicts of interest. The use of abortion and euthanasia as case studies availed meaningful statistics that are of significant impact in healthcare. These eye-openers raised important debates on the government involvement in such issues and how the current policies are only making the situation worse. In order to make certain legislation effective, the dissertation proved the need for gaining people's consent in passing laws that affect them, and thus its contribution to society.

The dissertation also elucidates the role of the government in shaping the moral fabric of the society hence its need to be involved in addressing conflict of interest issues in society. On the professional context, the dissertation emphasizes the need to prioritize the code of ethics as a guideline to prevent conflict of interest and proves how they benefit all stakeholders involved. The dissertation notes some proven finding to solutions to conflict of interest and commitment, such as higher reimbursements and payment for every service and highlights the need for policymakers to intervene. Finally, the analysis of organizational conflicts of interest sheds light on the importance of establishing a HEC as a strategy for countering conflicts of interest at the organizational level. Furthermore, the dissertation's propositions on of the effective solutions to curb conflict of interest, especially regarding data privacy and confidentiality are widely applicable in both healthcare and other fields. Some of these entail data de-identification, reduction of patient-related variables, instilling strict regulations, continuous auditing,

transparency, and adoption of user access controls and management system.

DEDICATION

To my Family..

ACKNOWLEDGMENT

I would like to express my deepest gratitude to Dr. Gerard Magill, My Dissertation advisor and life teacher. Thank you for your support, effort, and patience through the years.

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Chapter 1: Introduction:

This work explores the ethical challenge of Conflicts of Interest in the field of healthcare. Conflicts of Interest can be widespread, covering clinical, professional, and organizational arenas. This dissertation examines the ethical challenge of Conflicts of Interest in these diverse areas of healthcare.

The analysis begins by explaining how the complex realities connected with patient consent present the context that engenders potential Conflicts of Interest for healthcare service providers. After considering this context, the dissertation discusses Conflicts of Interest in clinical, professional, and organizational settings. Naturally, because these settings overlap, in the discussion there is some duplication of Conflicts of Interest from these varying perspectives. However, these categories provide a helpful template to address the varying Conflicts that can arise.

The discussion of clinical Conflicts of Interest focuses on patient consent related to respect for life, especially in the euthanasia and abortion debates. The next section describes the professional Conflicts of Interest regarding the relationship between professional ethics and codes of ethics and the connection between Conflicts of Commitment and Conflicts of Interest. Then the dissertation considers organizational Conflicts of Interests related to the concepts of moral agency, ethical programs, and complicity. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contributes to the discussion over Conflicts of Interest, connecting confidential data protection with the dissertation's analysis. The purpose of the analysis is to identify and resolve the main ethical challenges regarding Conflicts of Interest in healthcare, from related clinical, professional, organizational perspectives, and cybersecurity measures. The approach is to use the main topics in each chapter to identify and resolve the

Conflict of Interest challenges that arise.

Respecting Patient Consent: Context of Conflicts of Interest:

This chapter considers how patient consent presents the clinical context that engenders Conflicts of Interest in health care. The chapter is organized to raise the pivotal topics that help to identify and resolve Conflicts of Interest. The analysis discusses the relation between autonomy and consent, as illustrated in surgery, and the connection between dementia and dependency, as highlighted in decisions about treatment, to highlight the ethical challenge of accompanying Conflicts of Interests.

Autonomy and Consent:

Conflicts of Interest arise when healthcare providers fail to respect patient autonomy by not obtaining consent from their patients. The normative principles underlying autonomy and consent help to identify and resolve Conflicts of Interest that can arise.

Normative Principles:

Autonomy denotes self-determination and self-rule, and the concept is normatively significant. Specifically, autonomy is central to moral responsibility because it means that an autonomy-based demand should be respected. Respect for autonomy in healthcare places limits within the patient-physician relationship. The most critical constraint associated with the respect for autonomy is informed consent. The principle provides that "a patient should not receive medical treatment of any sort unless she is well-informed enough as to the treatment nature and effect to be able to make an informed decision about it."[1] In other words, the patient must provide consent to treatment, based on the information the physician provides. Dworkin explains this critical point by explaining that "the requirement for informed consent is necessitated as part and parcel of a more basic imperative to respect patient autonomy."[2] In other words, a physician

can encounter ethical challenges around Conflict of Interest if patient autonomy and consent are not properly honored.

Consent (Illustrated in Surgery):

The relationship between patient autonomy and consent can raise significant challenges for a clinician.[3] That is, autonomy and consent can intrude into the provider-patient relationship, and hence inhibit the ability of healthcare providers to act in a fiduciary manner,[4] especially regarding the complexities that arise in the medical field.[5] There is a need for more ethical attention to Conflict of Interests that arise because of the failure by physicians regarding respect for patient autonomy and informed consent.[6] In the purview of healthcare, personal autonomy denotes "the right of patients to make decisions about their medical care without physicians trying to influence them" in an inappropriate manner.[7] Respect for patient autonomy permits doctors to educate patients but it prohibits them from making decisions on behalf of patients without patient or surrogate consent. Because of the Conflicts of Interest that can arise around the ethical principle of autonomy, there is a crucial need for "the inclusion of respect for autonomy as a key concern in biomedical ethics."[8] Where patient autonomy and consent are properly safeguarded, patients possess the appropriate ability to make informed decisions regarding their choice of healthcare interventions or those that they do not wish to receive.

The moral intention of respecting patient autonomy and informed consent are pivotal.[9] The reason is to guarantee that the treatment that physicians offer attains the desired end and that the patient chooses.[10] In fact, the ultimate objective of focusing on autonomy and informed consent is moving the moral template of making decisions from physician-centered models to patient-centered approaches.[11] This is especially evident in the realm of surgery where informed consent respects the autonomy of the patients and provides a process for the signing of consent

documents.[12] Markedly, this process continues until the specific patient brings it to an end. Those who conduct surgical procedures must prioritize patient interests by respect for their personal autonomy and consent.[13]

Without recognizing this duty towards their patients, surgeons can encounter Conflicts of Interest. In surgery, there can be many ways that can undermine patient autonomy and informed consent, including the ability of the patient to comprehend the surgeon's use of the disclosed information, and "the demands placed on physicians and how well surgeons satiate the minimal standards for disclosure."[14]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services to establish strict regulations and evaluation policies toward patients' confidential data protection and storage. This Act was divided into two parts to meet the requirements of cyber security so that the U.S. Department of Health and Human Services published two papers: the Standards for Privacy of Individually Identifiable Health Information and the Electronic Protected Health Information. Both of them were referring the security of patients' private information; thus, the first regulation paper sets national security measures on all types of data, while, the second one targets information which is held in electronic form. Nevertheless, these two parts of the Act are the only existing standards for data protection and cover the whole spectrum of healthcare services, operations, and activities.

Furthermore, the HIPAA also defines the Code of Ethics for all-levels medical staff as well as obliges them to conduct their duties and responsibilities concerning the patients' right for the confidence. Noteworthy, the HIPAA enforcement intersects all levels of medical institutions' organization so that, it can be suggested that each type of Conflicts of Interests are intersected

with this primary data protection law.

Dementia and Dependency:

Just as the connection between autonomy and consent sheds light on potential challenges regarding Conflicts of Interest, the connection between patient dementia and dependency further highlights these challenges for clinicians during disease management and treatment decisions.

Autonomy & Disease Management:

Dementia refers to an assortment of ailments that engender a steady reduction in thinking ability and remembrance.[15] Typically, dementia significantly affects the daily functioning of an individual. Other symptoms associated with individuals who have dementia are diminished motivation, language difficulties, and emotional problems. Because dementia has debilitating effects on the sufferer, it results in dependence on medical professionals. Not surprisingly, the dependency that arises from dementia can lead to potential Conflicts of Interest in healthcare. Smebye et al. emphasize that the process of providing health care services to individuals living with dementia raises ethical quandaries pertaining to how to strike a balance between autonomy, well-being, and safety.[16] The reason is that persons with dementia may heavily depend on clinicians to maintain their autonomy and align their lives with the patient's stipulated values.[17] For that reason, Conflicts of Interest may arise when doctors do not fully respect the autonomy of dementia patients, as can occur for example when the desire of physicians to avert harm (non-maleficence) conflicts with patient autonomy.[18] To respect the autonomy and dependency of individuals living with dementia, clinicians must address patient vulnerabilities during disease management.[19] To avoid Conflicts of Interest between professional caregivers and persons with dementia, there is a need for healthcare providers to exhibit attentiveness, competence, responsibility, as well as responsiveness.[20] This process of combining autonomy and dependency

during disease management "demands continuous involvement and decision-making,"[21] failure of which can lead to Conflicts of Interest in healthcare.

Autonomy and dependency interact on a sliding scale that impacts how medical professionals interact with patients.[22] Applebaum argues that "dependencies as such do not conflict with autonomy if individuals still maintain a sufficiently adequate range of identification to sustain their personal sense of integrity and worth."[23] In this regard, Smebye et al. suggest that the autonomy of an individual living with dementia remains in tension with the obligation of physicians to prevent the occurrence of harm (maleficence) due to the responsibility of the professional during disease management; the independence of the individual with dementia is in tension with the caregiver's duty of beneficence; to continually uphold patient autonomy, patients living with dementia must depend on health care providers during their disease management.[24] That is why professionals must be very attentive to the potential Conflicts of Interest that might arise.

Decisions about Treatment:

When making treatment decisions for individuals living with dementia, physicians must respect patient autonomy as a critical element of human dignity, recognizing that dementia increases over time. According to Jan Killeen, "individuals with dementia have a lifetime's experience of making decisions for themselves; however, dementia is a progressive condition which gradually erodes their capacity to make some or all decisions in their own interests."[25] As dementia progresses in disease management, Conflicts of Interest may arise between physicians and the patients, family members, or friends of the patient during treatment decisions. Killeen posits that "family members, partners, and friends have the complex task of moving between supporting the person to make their own decisions, to making decisions together, and, when

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necessary, using the powers granted to them, to act as substitute decision-makers."[26] Notably, Conflicts of Interest may arise when other individuals (such as family) make treatment decisions on behalf of the person with dementia that the physicians feel lacks beneficence, may cause harm to the patient (maleficence), and interferes with the physician's duty of care.

In sum, this chapter discusses the normative principles that delimit autonomy and consent as illustrated during surgical procedures. It also examines the nexus between autonomy and disease management in persons with dementia to identify and resolve Conflicts of Interest that arise. The main Conflicts of Interest arising from the failure to obtain proper consent from patients when undertaking surgical procedures, from the abrogation of patient autonomy during disease management, and from the tensions between dementia patients' representatives and physicians while making treatment decisions. To resolve these Conflicts of Interest, healthcare organizations should devise an approach that deals with the above issues regarding the patient-physician relationship during surgery and treatment of individuals with dementia. Having described patient consent as the basic context for understanding how Conflicts of Interest can arise in healthcare, the subsequent chapters explore such Conflicts in clinical, professional, and organizational settings.

Clinical Conflicts of Interest:

This chapter discusses Clinical Conflicts of Interest in healthcare. While there can be an abundance of these clinical scenarios, the chapter centers upon pivotal life and death issues of abortion and euthanasia to indicate where Conflicts of Interest arise and how they should be resolved.

Abortion:

The chapter focuses on typical Conflicts of Interest that can arise by reflecting the tension

between dignity and pluralism, and the tension between consent and financial incentives.

Human Dignity and Pluralism:

Scholars associate the ethical debate over abortion with the tension between human dignity and pluralism.[27] That tension can create Conflicts of Interest in healthcare. The conservative stance advocates for the legal prohibition of abortion because it contravenes the rights of the unborn child, while the progressive stance argues for the legalization of abortion because it supports rights of women.

The main ethical arguments against abortion explain that the embryo possesses human dignity (and thus it is entitled to human rights), that abortion is not permissible because it does not show respect for life because of undermining human dignity, and that abortion undercuts human dignity because it disregards the sanctity of human life.

In the stance against abortion, the Abortion Act of 1967 in Great Britain construes women as patients who are in the process of seeking medical care, rather than as individuals seeking abortion services. That is, "women are vulnerable subjects in need of assistance to make responsible decisions."[28] However, the opposition argument claims that abortion abrogates human dignity because it creates conflicts between the right of women to autonomy and the embryo's life,[29] arguing for the end of the prioritization of women's dignity over the embryo.[30] From this perspective, abortion is opposed because it disregards the life of the fetus by placing it at the whims of the medical professional.[31] In particular, human dignity is the lens through which the claim of the woman to independence and the interest in the life of the fetus are best construed.[32] This stance allows for the reconciliation and simultaneous protection of the bodily integrity and autonomy of the woman and the life and dignity of the fetus.[33]

In contrast, the pro-choice stance argues that abortion should be permitted in many cases

of problematic pregnancies. The philosophical underpinnings of this position are that the fetus lacks a moral value since it should not yet be construed as a person, that abortion is morally permissible due to many different circumstances, and that the responsible employment of abortifacients.[34]

According to Lopez, abortion ought to be ethically legitimate in circumstances where "the mother does not want the child, the father does not want the child, the mother will possibly die from giving birth, and the pregnancy is the result of rape."[35] A mother's choice to abort may be founded on the grounds that the mother is aware that the child possesses mental or physical abnormalities, she is addicted to drugs such as alcohol, or she is overly insecure and immature.[36] Nonetheless, proponents of abortion advocate for reasonableness in the process of orchestrating it.[37] Furthermore, physicians should adhere to codes of ethics and thus offer the best advice to women considering an abortion.[38] The tension of these differing positions can raise potential Conflicts of Interest in healthcare when physicians either inappropriately assist or hinder women from seeking an abortion. On the one hand, for conservatives who consider abortion unethical because it contravenes human dignity, clinicians may impose undue pressure on a woman to avoid an abortion, accommodating their own beliefs about abortion rather than serving the patient. On the other hand, for those who seek to uphold the rights of the mother, they may impose undue pressure on a woman to undertake an abortion, again accommodating their own beliefs about abortion rather than serving the patient.

Consent and Finance:

This tension between pro-life and pro-choice camps, with their accompanying propensity for Conflicts of Interest, is accompanied by another terrain that raises potential Conflicts of Interest, the landscape of financial interests. According to Sawicki, "the legal norms of informed

consent during abortion often deviate from moral norms since they make neutrality, objectivity, and impartiality impossible and unwarranted."[39] This focus on the legality or legal norms may be inappropriately connected with financial interests that accrue from providing abortion services. Jones et al. state that many patients undertaking abortion come from financially disadvantaged backgrounds, "yet most pay several hundred dollars out of pocket for abortion services."[40] This can be an example of a potential Conflict of Interest where providers accrue significant financial gain, especially from poor patients who can least afford the services. This Conflict of Interest contravenes the physician-patient relationship. This scenario of potential Conflicts of Interest can arise when consent to an abortion (in the context of significant financial gains to the provider) highlights the lack of private and public health insurance coverage of abortion-related services. Assisted Death:

Just as occurs with abortion, Conflicts of Interest arise in the clinical scenario of assisted death in a variety of ways. The chapter focuses on typical Conflicts of Interest that arise based on different types of death-bringing services and the tension between rights, law, and religion. Death, Dying, and Types of Assisted Death:

Death denotes "the cessation of all biological functions that sustain human beings."[41] It results in different phenomena such as disease, senescence, euthanasia, and suicide.[42] The purview of medicine that is concerned with death and dying is palliative care.[43] Healthcare professionals in palliative care have the ethical duty of prioritizing the interests of patients even on their death beds.[44] In focusing on assisted death, it is vital to fully understand concepts such as the autonomy of choice, alleviation of pain, and peaceable death.[45] While some scholars argue that death should occur naturally, others claim that assisted death is ethically allowable under certain circumstances.[46] This debate over assisted death can lead to Conflicts of Interest in

healthcare.

Euthanasia denotes the intention to undertake "the process of hastening the death of a patient to prevent further sufferings, which portends philosophical, legal, religious, and political dimensions."[47] One form of hastening death is euthanasia, of which there are different types: voluntary, involuntary, non-voluntary, active, and passive.[48] Other terms related to assisted death are "withdrawing life-sustaining treatment, physician-assisted suicide, and medical futility."[49] There are significant complexity and confusion about terms in this debate. For example, for some, voluntary euthanasia is construed as a sort of assisted suicide that occurs with the consent of the patient.[50] In other words, it is conducted where the patient expresses a wish to die and therefore allows another person to provide euthanasia.

In contrast, during involuntary euthanasia, the health care provider does not obtain the consent of the patient, who is competent to express his willingness to die.[51] Non-voluntary euthanasia takes place when a doctor facilitates the death of a patient who is incompetent to make a decision, for instance, comatose or mentally incompetent patients and babies born with grievous congenital abnormalities.[52] Active euthanasia is performed by individuals, for example, by injection with a lethal drug, while passive euthanasia is that which emanates from the failure to do something (an act of omission).[53] Passive euthanasia can involve forgoing life-sustaining treatment coupled with the intention to kill.

Moreover, physician-assisted suicide occurs when the doctor provides a mechanism by which patients can end their lives. In withdrawing or withholding life-sustaining treatment, the medical expert should consider patient benefit, patient or family wishes, and treatment futility.[54] Hence, depending on the type of euthanasia performed, informed consent may or may not be involved. Each of these complex scenarios can lead to potential Conflicts of Interest for the

physician or provider in healthcare, such as saving on hospital costs for treatment or avoiding lengthy care of a dying patient that is burdensome for the provider.

Opponents of euthanasia argue that the practice should be banned because it encourages the elimination rather than treatment of the vulnerable. This involves an ethically wrong intention, it contravenes the traditional function of medicine, it promotes the commercialization of health care services for a nefarious practice, it abrogates accepted principles of medical ethics, and it is contrary to health care policy where public funds should be spent on providing palliative care to terminally ill patients, rather than killing them.

Both stances, supporting and opposing euthanasia, can lead to Conflicts of Interest for professionals in healthcare. On the one hand, proponents of euthanasia support the practice of assisted death as a measure of last resort.[55] They contend that physicians should conduct themselves in deference to the sick person's right to die with dignity and to the recognition that assisted death can encourage organ donation and transplantation, can minimize the caregiver's burden, can reduce needless suffering and pain, and can provide psychological reassurance to dying patients.[56] Despite this context, some argue that health care institutions should discourage euthanasia because it may engender Conflicts of Interests. These conflicts can deal with having financial incentives or with avoiding the burden of providing services.[57] On the other hand, opponents of euthanasia also can be faced with potential Conflicts of Interest, such as when their personal beliefs interfere with providing legal service for assisted death that is requested by a patient. These potential Conflicts of Interest need to engage the tension between rights, law, and religion.

Rights, Law, and Religion:

Examining the relation between rights, law, and religion requires a complex discussion

on assisted death. First, rights highlight the crucial role not only of the patient but also of the family. In other words, the family plays a critical role in decision-making about assisted death,[58] and therefore Conflicts of Interest may arise between physicians, families, and patients where there is a request for euthanasia.[59] The reason is that the patient may either support the request for euthanasia or adamantly oppose it based on the right to life.[60] There are multiple roles for the family when a request for euthanasia occurs, including the following:

- The family can initiate a request to assist a patient in dying without knowledge of the particular individual's actual wishes.[61] This may give rise to clinical Conflicts of Interest due to the failure to consider his autonomy and right to life.

- The family can remind the concerned physician of a previous euthanasia request and expect the request to be carried out when the medical condition of the patient deteriorates. Again, clinical Conflicts of Interest may arise due to the disregard for patient autonomy and rights.

- The family may oppose euthanasia, even when the patient has made a death request.[62] Clinical Conflicts of Interest may arise from the failure to respect the patient's autonomy and perceived right to die.

- The family may report euthanasia to the authority in fulfillment of the law. The failure by the physician to respect the patient may engender clinical Conflicts of Interest, particularly where the doctor provides medically futile treatment without informed consent by the patient or their legitimate representatives.

These issues yield ethically problematic situations for patients, families, and providers.[63] For instance, clinical Conflicts of Interest may result from differences in opinion between the physician and family concerning particular aspects of euthanasia, including manipulation,

cooperation, and confrontation.[64]

Second, because euthanasia concerns the fundamental rights to life and death, the law must play a vital role in regulating the practice.[65] The most pertinent role regarding assisted death that law plays is enacting regulation to either legalize or prohibit the practice in healthcare organizations.[66] For instance, in the 1980s, the United States passed the *Baby Doe Legislation* to withhold federal funds from healthcare organizations that withheld life-saving and life-sustaining treatment to newborns based on the expectation of serious mental and physical abnormalities.[67] Also, the government can enact laws, policies, and regulations that attempt to address clinical Conflicts of Interest that may arise between families, patients, and physicians during euthanasia.[68] This is because the government can shape the moral fabric of the society, which involves whether assisted death is permissible or not.[69]

Third, the role of religion regarding assisted death is twofold: challenging the practice and opposing voluntary euthanasia laws,[70] presenting approaches to ethics that address assisted death.[71] Religion typically explains that voluntary euthanasia engages the debate over rights to life and death.[72] Religion can provide a distinctive moral compass for ethically-responsible behavior in society regarding assisted death.[73]

To summarize, this chapter discusses the pivotal life issues of abortion and assisted death to indicate and resolve clinical Conflicts of Interest that can arise. It explores the nexuses between human dignity and pluralism and consent and financial incentives in abortion. And it explores types of assisted death with accompanying issues related to rights, law, and religion. These clinical issues can engender professional Conflicts of Interest, and these conflicts must be resolved via a balance between professional obligations, legal requirements, and patient interests, as discussed in the next chapter.

Professional Conflicts of Interest:

The previous chapters discuss Conflicts of Interest that can arise with regard to patient consent and in clinical contexts such as with abortion and assisted death. This chapter explores Conflicts of Interest that arise more broadly for professionals in healthcare. The chapter centers on professional ethics and codes of ethics and the distinction between Conflicts of Interest and Conflicts of Commitment.

Professional Ethics and Codes of Ethics:

Conflicts of Interest may arise from the tension between codes of ethics and professional leadership and the tension between moral culture and decision making.

Codes & Professional Leadership:

There is an intricate connection between the codes of ethics and professional leadership.[74] Codes of ethics provide ethical benchmarks that regulate professional leadership in healthcare organizations.[75] That is, codes of ethics delineate values, principles, and standards that guide professional leadership in healthcare.[76] Cathy Flite and Laurinda Harman highlight the reciprocity between professional values medical codes of ethics.[77]

Codes of ethics inform the professional practice of healthcare leaders because it strengths decision-making processes and assists in resolving ethical problems that arise in their interactions with patients. Professional Conflicts of Interest are a prominent example of these problems.[78]

Health care providers are often confronted with convoluted concerns in their daily practice, which they can only address by the application of the code of ethics.[79] In particular, the code of ethics provides fundamental guidelines for medical professionals as they endeavor to prioritize patients' interests by delivering high-quality care.[80]

Because of the intricate connection between codes of ethics and professional leadership in healthcare, the failure to observe the tenets encapsulated in the codes may engender professional Conflicts of Interest. Specifically, codes of ethics regulate the physician-patient relationship to ensure the professional leadership leads to the prioritization of patients' interest. For that reason, disregarding codes of ethics may interfere with physician-patient relationship and therefore engender serious professional Conflicts of Interest.

Moreover, codes of ethics inform professional ethics which encompass the organizational and personal standards of behavior that clinicians exhibit.[81] In the field of healthcare, professional ethics comprise the principles that tend to govern professional leadership.[82] The code of ethics is the primary source of professional ethics which outlines the ethical principles that regulate healthcare professionals.[83] Typically, the code of ethics for healthcare comprise the following ethical principles: trustworthiness, honesty, accountability, avoidance of Conflicts of Interest, adherence to the law, and respect for others.[84] Professional codes of conduct depend on the above professional ethical principles as the basis for prescribing required behavior standards for healthcare professionals.[85] They anticipate that adherence to professional ethics to avert Conflicts of Interest between clinicians and patients in the provision of high-quality care.[86]

The intention of codes of ethics and professional ethics is to afford guidelines for the standards for suitable behavior in healthcare settings.[87] They benefit the public (patients), health care professionals, the healthcare profession, and healthcare organizations.[88] They facilitate professional leadership to avert professional Conflicts of Interest that may cripple the traditional purpose of medicine of providing a supporting model for decision-making. And they "provide a common understanding and acceptable practice which builds collegiality and allows for fairer disciplinary procedures."[89]

Assuming the core notion of the Medical Code of Ethics, it can be stated that in term of the leadership and ethical behavior, clinicians are also responsible for maintaining primary duties, defined by the HIPAA regulations. From this perspective, it is worth to mention that medical staff is supposed to notify patients which data is recorded or might be recorded during the treatment process, and how this data will be used within the medical institution. Moreover, clinicians should get authorization from patients and legal agreement to collect their data to ensure that any further realization of private information will be done with patients' allowance. Returning to the ethical behavior and the Code of Ethics, it is worth to mention that medical staff takes responsibility to protect patients' data from unauthorized access, as it is stated in the HIPAA regulations. Beyond, as medical leadership is related to policy and law development within the facility, the HIPAA policies allow clinicians to create specific prohibitions to secure confidential data.

In summary, there an intricate nexus between codes of ethics, professional ethics, and professional leadership in healthcare contexts. This connection can help to highlight potential Conflicts of Interest when medical personnel exhibit unprofessional leadership for failing to observe professional practice delineated in the code of ethics. This reciprocity (that is, codes of ethics inform professional ethics, and professional ethics inform professional leadership) helps to identify and resolve professional Conflicts of Interest in healthcare.

Moral Culture and Decision-Making:

Codes of ethics significantly influence the moral culture of healthcare organizations. Consequently, moral culture influences decision-making by clinicians as they relate to patients and others served. In other words, the moral culture of a healthcare organization determines how well clinicians engage in ethical decision-making. Bruning and Baghurst emphasize that

"Healthcare change occurs rapidly and increases tension and mistrust between payers, providers, and patients, which may consequently create constant Conflicts of Interests."[90] The lack of ethical decision-making creates serious Conflicts of Interest in healthcare contexts. Therefore, the "application of ethical standards to decision-making improves trust and minimizes the occurrence of Conflicts of Interests between physicians and patients."[91] The moral culture of a healthcare organization impels medical professionals to make ethical decisions regarding patients and thus minimizes the incidence of professional Conflicts of Interest.

According to Donnellan, suitable moral culture results in ethical decision making and ethical behavior, which "results in better patient care, a more committed and satisfied staff, more efficient care delivery, and increased market share."[92] In addition, the moral culture of a healthcare organization provides a comprehensive view of the function of ethical programs, which allow medical professionals to cultivate an efficient, well-sustained ethical culture. Consequently, it transforms the healthcare organization into an ethical organization with "integrated and shared ethical values and practices, an effective ethics infrastructure, ongoing ethics education for staff at every level, ethical and morally courageous leaders, and a culture that is consistent with the organization's values."[93] Such an organization provides effective avenues for ethical decision-making, and thus they help to identify and resolve professional Conflicts of Interest between doctors and clients. However, when there is a lack of moral culture, physicians do not have a robust ethical decision-making context to address Conflicts of Interest. This translates to poor decision-making, and consequently, non-resolved Conflicts of Interest between physicians and patients.

Conflicts of Interest and Conflicts of Commitment:

Having discussed the crucial connection between professional ethics and codes of ethics

for understanding how to identify and resolve Conflicts of Interest as a function of professional leadership and organizational culture, the following discussion explains the distinction between Conflicts of Interest and Conflicts of Commitment.

Conflicts of Interest:

In healthcare, Conflicts of Interest denote competition between personal interests and the professional interests and judgments of physicians.[94] Specifically, these conflicts take place when the central objective of upholding the interests of the patients collides with the healthcare provider's secondary goals, particularly the need for personal gain.[95] Conflicts of Interest may stem from the need to augment revenues of healthcare institutions from vending healthcare services as well as products.[96] Notably, healthcare organizations expect physicians to maintain appropriate affiliations with patients by avoiding Conflicts of Interest.[97] This is because Conflicts of Interest inhibit the traditional role of medicine, augment problematic claims against health care organizations, and above all undermine the moral status of the profession.

Conflicts of Commitment:

Conflicts of Commitment occur whenever professional, personal, financial or commercial activities or interests outside healthcare organizations have the capacity of interfering with the ability of physicians to fully satiate their mandate.[98] They include compromises of the professional judgment of the concerned experts, and they result in doctors inappropriately gaining at the expense of the patient and the healthcare organization.[99] To avoid Conflicts of Commitment, medical professionals must avoid engagements that can either influence or appear to interfere with objective and independent judgment in patient-related decisions or interactions.[100] Moreover, they should circumvent these conflicts by avoiding the use of a health care organization's resources for non-organizational or personal purposes.[101] In other words, they

should not participate in extraneous business interests, professional organizations, or public service that may culminate in conflicts related to allocation of energies or time, or concern their professional loyalty to specific healthcare organizations.[102]

In sum, this chapter discusses professional Conflicts of Interest in healthcare. The analysis suggests that the relationship between codes of ethics and professional leadership, moral culture and decision making can help to identify and resolve Conflicts of Interest and Conflicts of Commitment. Healthcare organizations can effectively address Conflicts of Interest through codes of ethics and professional leadership. Also, creating a moral culture that facilitates ethical decision-making is necessary for ensuring that physicians prioritize patients' interests before personal gain. Professional Conflicts of Interest arise in many different setting, and a sound organizational culture can help to identify and resolve them. This awareness of organizational culture leads to a more extensive discussion of Organizational Conflicts of Interest in the next chapter.

Organizational Conflicts of Interest:

This chapter discusses organizational Conflicts of Interest. It centers on the nexus between moral agency and ethics programs and as well as conflicts in data sharing to explain how to identify and resolve organizational Conflicts of Interest.

Moral Agency and Ethical Programs:

Conflicts of Interest may arise from the tension between organizational moral agency and complicity and the failure to observe the standards encapsulated by organizational ethical programs in healthcare. Each is discussed in turn.

Moral Agency and Complicity:

In legal terms, organizations are individual entities with moral duties to enhance the

welfare and well-being of individuals in the society.[103] Notably, moral agency derives from healthcare organizations' norms, ethics, and expectations, elements that delineate its social responsibilities.[104] In reality, healthcare organizations are moral agents that are guided by strong moral cultures so that they can fulfill their responsibilities to the society.[105]

The concept of moral complicity in medical ethics captures the notion that "a person can do wrong by being associated, in some way, with the wrongdoing of other individuals or of a collective he or she is part of."[106] However, this understanding of complicity may be too broad to provide practical moral guidance.[107] Because healthcare organizations are moral agents, they are privy to the causal and non-causal conceptions of moral complicity.[108] The tension between organizational moral agency and complicity creates provider-initiated Conflicts of Interest,[109] involving collective action, collective wrongdoing, moral taint, and moral responsibility.[110]

The moral agency of an organization is inseparable from the behavior of individuals in the organization.[111] Through individual behavior, healthcare organizations may participate in immoral conduct that can affect society.[112] To assess organizational complicity, people should analyze to determine different levels of involvement.[113] It is necessary for workers in healthcare organizations to create a sustainable culture that promotes moral agency in their collective efforts.[114]

In this way, they will be able to reduce the incidence of Conflicts of Interest between physicians and their clients. To avoid these Conflicts of Interest, ethics programs seek to train personnel about moral complicity.

Organizational Ethics Programs:

The role of organizational ethics programs in healthcare is to enlighten the behavior of employees and ensure that they act in patients' or clients' best interests.[115] Moreover, they

inform good moral conduct and avoid moral complicity within healthcare organizations.[116] The

Health Ethics Committee guides the formulation and implementation of these programs.[117] The

ethics programs pertinent to healthcare organizations comprise the principles, norms, and

standards that govern the behavior of physicians as well as their decision-making.[118] The

structure and shape the moral environment of healthcare organizations, and they guide ethical

behavior. In this way, they impel physicians to act responsibly within their confines.[119] In

particular, they anticipate Conflicts of Interest that may arise from the physician-patient

relationship and curb them.[120] Organizational ethical programs anticipate potential Conflicts of

Interest and complicity and devise norms and standards to govern the provider-patient

relationship. The proper integration of organizational ethics programs into healthcare fosters

sound moral agency.[121] These programs build a strong moral culture that helps to identify and

resolve provider-patient Conflicts of Interest as moral complicities that hamper the ethos of

medicine.[122] One of the most common examples of Conflicts of Interest that arise in the context

of organizational moral agency deals with Conflicts of Interest regarding data sharing.

Conflicts in Data Sharing:

Organizational Conflicts of Interest may arise from the distribution, privacy,

confidentiality, and misuse of data by physicians or health care officers in healthcare settings.

Background & Benefits:

A contemporary trend in medicine involves teams of care providers from different

healthcare organizations providing healthcare services to patients. This necessitates cross-

organizational data sharing, creating an ethical concern about inter-related healthcare

organizations. Some scholars emphasize that "quality of care can be put at risk when patients are

transferred from one organization to another; hence, the need for cross-organizational data

sharing."[123] Hence, data sharing is critical to ensuring quality care even when physicians from different healthcare organizations treat the same patient. In addition, data sharing is critical because it enables healthcare organizations to minimize readmissions, circumvent medication errors, and diminish replicate testing. These benefits underline the need for healthcare information exchange to ensure the delivery of high-quality care services. Despite these benefits, other scholars note that "the need for protecting patient privacy is sometimes an inhibitor to providing Information and Communication Technologies' solutions to facilitate data sharing."[124] This means that data sharing presents a critical context for identifying and resolving related Conflicts of Interest in health care, especially regarding privacy and confidentiality.

Privacy & Misuse:

Organizational Conflicts of Interest may arise from a breach of privacy, confidentiality, and misuse of shared data. Some explain that "interoperable organizations are utterly reluctant to collaborate on patient information due to fear of breach of personal health information."[125] In such cases, all medical institutions are to implement and correspond to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 so that data privacy and patient's confidential information are under not only legal protection, bit also secured due to the national standards in software and hardware. The implementation of the HIPAA into healthcare organizations' body will reduce or, even, prevent any inconvenient situations with data flow streams and private security. Interoperable healthcare organizations fear that patient health information may be used or the privacy or confidentiality of patients breached, thereby resulting in serious Conflicts of Interest. Also, the confidential information of patients may fall into the wrong hands during distribution and thus instigate grave Conflicts of Interest between physicians and patients or healthcare organizations and patients. Conflicts of Interest may also arise from

the misuse of patients' personal data by other health care officers or physicians. In summary, data sharing raises serious confidentiality, privacy, misuse, and distribution issues that establish a crucial context for identifying and resolvingg Conflicts of Interest that may significantly harm the reputation of the relevant healthcare organizations.

In sum, this chapter discusses organizational Conflicts of Interest. Understanding organizational moral agency and recognizing the value of ethics programs create an enlightened context to identify and resolve organizational Conflicts of Interest. Healthcare organizations should foster moral cultures such as via organizational ethics programs to develop awareness about organizational Conflicts of Interest. The emerging expansion of data sharing presents a particularly complex problem for Conflicts of Interest in healthcare. Healthcare organizations must address data sharing by using technologies that strictly adhere to state privacy and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations regarding patient information. By doing so, Organizational Conflicts of Interest can be effectively identified and resolved as a hallmark of an excellent organizational moral culture.

Conclusion:

This dissertation discusses the ethical challenge of Conflicts of Interest in healthcare. The purpose is not to present a new way of addressing Conflicts of Interest – there is an abundance of literature on doing so that is the remit of legal compliance departments in healthcare organizations. This is not a study on legal compliance but a dissertation on bioethics. Hence, the purpose is to highlight the range and variety of Conflicts of Interests in healthcare as a distinctive ethical challenge. The approach of the dissertation has been to discuss pivotal ethics topics in healthcare that help to identify and resolve pervasive Conflicts of Interest. That is, by understanding each topic from a balanced ethical perspective, Conflicts of Interest can be

identified and resolved. The ethics discussion of each topic achieves two related goals: the ethics discussion of the selected topic sheds light on what can be construed as a Conflict of Interest, thereby clarifying the extent of the problem of these conflicts; and the resolution of the conflicts requires respecting the nuanced ethical perspectives raised around the selected topic. The ethics topics are organized across the chapters, beginning with patient consent as the basic context for understanding the problem of Conflicts of Interest, followed by a discussion in subsequent chapters of clinical, professional, and Organizational Conflicts of Interest. The outcome of the analysis is to emphasize that understanding the nuanced ethical debate around the selected topics is the most constructive way to identify and resolve Conflicts of Interest in healthcare.

Notes:

[1] Dworkin, Gerald. "Autonomy and Informed Consent." In *Ethical Health Care*, eds. Patrician Illingworth and Wendy Parmet, (Upper Saddle River, NJ: Pearson Prentice-Hall, Volume Three: Appendices (Studies on the Foundations of Informed Consent). Washington, D.C.: The Commission; (1982): 63-81.

[2] Dworkin, Gerald. "Autonomy and Informed Consent." In *Ethical Health Care*, eds. Patrician Illingworth and Wendy Parmet,. Volume Three: Appendices (Studies on the Foundations of Informed Consent). Washington, D.C.: The Commission; (1982): 63-81.

[3] Jagsi, Reshma. "Conflicts of interest and the physician-patient relationship in the era of direct-to-patient advertising." *Journal of Clinical Oncology* 25.7 (2007): 902-905.

[4] McGregor, Joan. "Consent and Autonomy." In *is it Rape?* (London: Routledge, 2017), 113-148. MbyRes in Philosoph.

[5] O'Neill, Onora. "Some limits of informed consent." *Journal of medical ethics* 29.(2003): 4-7.

[6] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, Issue 5,v (1994): 323–325.

[7] Entwistle, Vikki A., Stacy M. Carter, Alan Cribb, and Kirsten McCaffery. "Supporting patient autonomy: the importance of clinician-patient relationships." *Journal of general internal medicine*, Volume 25, Issue 7, (2010): 741–745

[8] Entwistle, Vikki A., Stacy M. Carter, Alan Cribb, and Kirsten McCaffery. "Supporting patient autonomy: the importance of clinician-patient relationships." *Journal of general internal medicine*, Volume 25, Issue 7, (2010): 741–745

[9] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic

Publishers, Volume 6, <u>Issue 5</u>,v (1994): 323–325

[10] Hall, Daniel E., Allan V. Prochazka, and Aaron S. Fink. "Informed consent for clinical treatment." *Canadian Medical Association Journal* 184 (5) (2012): 533-540; DOI: https://doi.org/10.1503/cmaj.11212

[11] Woodward, Beverly. "Confidentiality, consent and autonomy in the physician-patient relationship." *Health Care Analysis* 9.3, Volume 9, <u>Issue 3</u>, (2001): 337–351

[12] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, <u>Issue 5</u>,v (1994): 660-661.

[13] Hall, Daniel E., Allan V. Prochazka, and Aaron S. Fink. "Informed consent for clinical treatment." *Canadian Medical Association Journal* 534, 184 (5) (2012): 533-540.

[14] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, <u>Issue 5</u>,v (1994): 12

[15] Forbes, Dorothy, Emily J. Thiessen, Catherine M. Blake, Scott C. Forbes, and Sean Forbes. "Exercise programs for people with dementia." *Cochrane Database Syst Rev* 12.0 (2013). http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD006489.pub4/full.

[16] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21.

[17] Crisp, Roger. "Medical negligence, assault, informed consent, and autonomy." *Journal of Law and Society* 17.1 (1990): 77-89.

[18] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21.

[19] Crisp, Roger. "Medical negligence, assault, informed consent, and autonomy." *Journal of Law and Society* Vol. 17, No. 1, Legal and Moral Dilemmas in Modern Medicine (Spring, 1990): 77-89

[20] Sulmasy, Daniel P. "Informed consent without autonomy." *Fordham Urb. LJ* 30 (2002): 207.

[21] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21.<u>https://dx.doi.org/10.1186%2Fs12913-015-1217-1</u>.

[22] Sulmasy, Daniel P. "Informed consent without autonomy." *Fordham Urb. LJ* 30 (2002): 207.

[23] Appelbaum, Paul S. "Assessment of patients' competence to consent to treatment." *New England Journal of Medicine* 357.18 (Nov 2007): 1834-1840
DOI: 10.1056/NEJMcp07404

[24] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21. https://dx.doi.org/10.1186%2Fs12913-015-1217-1.

[25] Killeen, Jan. "Dementia autonomy and decision-making: Putting principles into practice." *Edinburgh: Alzheimer Scotland* (2012): 1-28.

[26] Killeen, Jan. "Dementia Autonomy and Decision-Making: Putting Principles into Practice." *Edinburgh: Alzheimer Scotland* (2012): 1-28.

[27] Nussbaum, Martha, and Rosalind Dixon. "Abortion, dignity, and a capabilities

approach." *Feminist Constitutionalism: Global Perspectives* (December 1, 2013): 4.

[28] Halliday, S. "Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life." *Contemporary Issues in Law* 13.4 (2016): 287-322. ISSN 1357-0374

[29] Gelman, Sheldon. "Life and Liberty: Their Original Meaning, Historical Antecedents, and Current Significance in the Debate over Abortion Rights." *Minn. L.* (1993): 586.

[30] Halliday, S. "Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life." Contemporary Issues in Law, 13.4 (2016): 287-322. ISSN 1357-0374

[31] Kaposy, Chris. "Two stalemates in the philosophical debate about abortion and why they cannot be resolved using analogical arguments." *Bioethics* 26.2 (2012): 84-92.

[32] Gelman, Sheldon. "Life and Liberty: Their Original Meaning, Historical Antecedents, and Current Significance in the Debate over Abortion Rights." *Minn. L. Rev.* 78 (1993): 588.

[33] Kaposy, Chris. "Two stalemates in the philosophical debate about abortion and why they cannot be resolved using analogical arguments." *Bioethics* 26.2 (2012): 84-92.

[34] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[35] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[36] Yardi, Sarita, and Danah Boyd. "Dynamic debates: An analysis of group polarization over time on Twitter." *Bulletin of Science, Technology & Society* 30.5 (2010): 316-327.

[37] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[38] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[39] Sawicki, Nadia N. "The Abortion Informed Consent Debate: Lighter, Less Heat." *Cornell JL & Pub. Poly* 21 (2011): 19.

[40] Jones, Rachel K., Ushma D. Upadhyay, and Tracy A. Weitz. "At what cost? Payment for abortion care by US women." *Women's Health Issues* Volume 23, Issue 3, (2013): e173-e178.

[41] Green-Pedersen, Christoffer. "The conflict of conflicts in comparative perspective: Euthanasia as a political issue in Denmark, Belgium, and the Netherlands." *Comparative politics* (2007): 273-291.

[42] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[43] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[44] Van der Lee, Marije L., Johanna G. van der Bom, Nikkie B. Swarte, A. Peter M. Heintz, Alexander de Graeff, and Jan van den Bout. "Euthanasia and depression: a prospective cohort study among terminally ill cancer patients." *Journal of Clinical Oncology* 23.27 (2005): 6607-6612.

[45] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[46] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[46] Van der Lee, Marije L., Johanna G. van der Bom, Nikkie B. Swarte, A. Peter M. Heintz, Alexander de Graeff, and Jan van den Bout. "Euthanasia and depression: a prospective cohort study among terminally ill cancer patients," *JCO* 23, no. 27 (2005): 6607-6612.

[47] Chao, D. V. K., N. Y. Chan, and W. Y. Chan. "Euthanasia revisited." *Family Practice*,

Volume 19, Issue 2, (2002): 128–134

[48] Chapple, Alison, S. Ziebland, A. McPherson, and A. Herxheimer. "What people close to death say about euthanasia and assisted suicide: a qualitative study." *Journal of Medical Ethics* 32.12 (2006): 706-710.

[49] Chao, D. V. K., N. Y. Chan, and W. Y. Chan. "Euthanasia revisited." *Family practice* 19.2 (2002): 128-134.

[50] Chapple, Alison, S. Ziebland, A. McPherson, and A. Herxheimer. "What people close to death say about euthanasia and assisted suicide: a qualitative study." *Journal of Medical Ethics* 32.12 (2006): 706-710.

[51] De Boer, Marike E., Cees MPM Hertogh, Rose-Marie Dröes, Cees Jonker, and Jan A. Eefsting. "Advance directives in dementia: issues of validity and effectiveness." *International Psychogeriatrics* 22.2 (2010): 201-208.

[52] Schneider, Carl E. "Rights discourse and neonatal euthanasia." *California Law Review* 76.1 (1988): 151-176.

[53] Pellegrino, Edmund D. "Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship." *J. Contemp. Health L. & Poly* 10 (1994): 47.

[54] Pellegrino, Edmund D. "Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship." *J. Contemp. Health L. & Poly* 10 (1994): 50.

[55] Schneider, Carl E. "Rights discourse and neonatal euthanasia." *California Law Review* 76.1 (1988): 151-176.

[56] Strinic, Visnja. "Arguments in Support and Against Euthanasia." *British Journal Of Medicine And Medical Research* 9.7 (2015): 1-12.

[57] Strinic, Visnja. "Arguments in Support and Against Euthanasia." *British Journal Of Medicine And Medical Research* 9.7 (2015): 1-12.

[58] Kimsma, Geritt K., and Evert van Leeuwen. "The role of the family in euthanasia decision making." *HEC Forum*. Vol. 19. No. 4. Springer Netherlands, (2007): 365-376.

[59] Kimsma, Geritt K., and Evert van Leeuwen. "The role of the family in euthanasia decision making." *HEC Forum*. Vol. 19. No. 4. Springer Netherlands, (2007): 365-376.

[60] Fraser, Sharon I., and James W. Walters. "Death-whose decision? Euthanasia and the terminally ill." *Journal of Medical Ethics* 26.2 (2000): 121-125.

[61] Fraser, Sharon I., and James W. Walters. "Death-whose decision? Euthanasia and the terminally ill." *Journal of Medical Ethics* 26.2 (2000): 121-125.

[62] Goel, Vaibhav. "Euthanasia A dignified end of life!." *International NGO Journal* 3.12 (2008): 224-231.

[63] Goel, Vaibhav. "Euthanasia A dignified end of life!." *International NGO Journal* 3.12 (2008): 224-231.

[64] Van der Maas, Paul J., Johannes JM Van Delden, Loes Pijnenborg, and Caspar WN Looman. "Euthanasia and other medical decisions concerning the end of life." *The Lancet* 338.8768 (1991): 669-674.

[65] "Should the Government be involved in Patients' End-of-Life Decision." ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[66] Churchill, Larry R., and N. M. King. "Physician-assisted suicide, euthanasia, or withdrawal of treatment." *BMJ: British Medical Journal* 315.7101 (1997): 137.

[67] "Should the Government be involved in Patients' End-of-Life Decision," ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[68] Churchill, Larry R., and N. M. King. "Physician-assisted suicide, euthanasia, or withdrawal of

treatment." *BMJ: British Medical Journal* 315.7101 (1997): 140.

[69] "Should the Government be involved in Patients' End-of-Life Decision," ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[70] Nitschke, Philip. "The Role of Religion in Assisted Suicide and Voluntary Euthanasia Laws," *The New York Times,* accessed April 10, 2012. https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/the-role-of-religion-in-assisted-suicide-and-voluntary-euthanasia-laws.

[71] Nitschke, Philip. "The Role of Religion in Assisted Suicide and Voluntary Euthanasia Laws," *The New York Times,* accessed April 10, 2012. https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/the-role-of-religion-in-assisted-suicide-and-voluntary-euthanasia-laws.

[72] Olukunle, O.A. "Religion and Euthanasia." *Orita: Ibadan Journal of Religious Studies* 16, no. 1 (2008): 54.

[73] Olukunle, O.A. "Religion and Euthanasia." *Orita: Ibadan Journal of Religious Studies* 16, no. 1 (2008): 61.

[74] Lere, John C., and Bruce R. Gaumnitz. "The impact of codes of ethics on decision making: Some insights from information economics." *Journal of Business Ethics* 48.4 (2003): 365-379.

[75] Lere, John C., and Bruce R. Gaumnitz. "The impact of codes of ethics on decision making: Some insights from information economics." *Journal of Business Ethics* 48.4 (2003): 365-379.

[76] Noddings, Nel. *Caring: A relational approach to ethics and moral education*. (Oakland: University of California Press, 2013), 78.

[77] Flite, Cathy A., and Laurinda B. Harman. "Code of ethics: principles for ethical leadership." *Perspectives in Health Information Management/AHIMA, American Health Information Management Association* 10.Winter (2013): 1-11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3544144/.

[78] Noddings, Nel. *Caring: A relational approach to ethics and moral education*. (Oakland: University of California Press, 2013), 81.

[79] Zahedi, F., Sanjari, M., Aala, M., Peymani, M., Aramesh, K., Parsapour, A., Maddah, S.B., Cheraghi, M.A., Mirzabeigi, G.H., Larijani, B. and Dastgerdi, M.V. "The code of ethics for nurses." *Iranian journal of public health* 42.Supple1 (2013): 1.

[80] Zahedi, F., Sanjari, M., Aala, M., Peymani, M., Aramesh, K., Parsapour, A., Maddah, S.B., Cheraghi, M.A., Mirzabeigi, G.H., Larijani, B. and Dastgerdi, M.V. "The code of ethics for nurses." *Iranian journal of public health* 42.Supple1 (2013): 3.

[81] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority*,* accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[82] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority*,* accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[83] Slomka, Jacquelyn, Beth Quill, Mary Desvignes-Kendrick, and Linda E. Lloyd. "Professionalism and ethics in the public health curriculum." *Public health reports* 123.2_suppl (2008): 27-35.

[84] Kangasniemi, Mari, Piiku Pakkanen, and Anne Korhonen. "Professional ethics in nursing: an integrative review." *Journal of advanced nursing* 71.8 (2015): 1744-1757.

[85] Kangasniemi, Mari, Piiku Pakkanen, and Anne Korhonen. "Professional ethics in nursing: an integrative review." *Journal of advanced nursing* 71.8 (2015): 1744-1757.

[86] Dehghani, Ali, Leila Mosalanejad, and Nahid Dehghan-Nayeri. "Factors affecting professional ethics in nursing practice in Iran: a qualitative study." *BMC medical ethics* 16.1 (2015): 61.

[87] Dehghani, Ali, Leila Mosalanejad, and Nahid Dehghan-Nayeri. "Factors affecting professional ethics in nursing practice in Iran: a qualitative study." *BMC medical ethics* 16.1 (2015): 65.

[88] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority, accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[89] Memarian, Robabeh, Mahvash Salsali, Zohreh Vanaki, Fazlolah Ahmadi, and Ebrahim Hajizadeh. "Professional ethics as an important factor in clinical competency in nursing." *Nursing Ethics* 14.2 (2007): 203-214.

[90] Bruning, Paul, and Timothy Baghurst. "Improving Ethical Decision Making in Health Care Leadership." *Bus Eco J* 4 (2013): e101.

[91] Bruning, Paul, and Timothy Baghurst. "Improving Ethical Decision Making in Health Care Leadership." *Bus Eco J* 4 (2013): e101.

[92] Donnellan Jr, John J. "A moral compass for management decision making: a healthcare CEO's reflections." *Frontiers of health services management* 30.1 (2013): 14-26.

[93] Donnellan Jr, John J. "A moral compass for management decision making: a healthcare CEO's reflections." *Frontiers of health services management* 30.1 (2013): 14-26.

[94] de Brantes, Francois and Conway, Patrick H. "Patient-Provider Conflict: The Perfect Environment," NEJM Catalyst, accessed March 17, 2018. https://catalyst.nejm.org/videos/patient-provider-conflict-perfect-environment/.

[95] de Brantes, Francois and Conway, Patrick H. "Patient-Provider Conflict: The Perfect Environment," NEJM Catalyst, accessed March 17, 2018. https://catalyst.nejm.org/videos/patient-provider-conflict-perfect-environment/.

[96] Benaiche, Lionel, and Maxime Lassalle. "Conflicts of Interest and Healthcare." *Les Tribunes de la santé* 2 (2013): 29-48.

[97] Eccles, Martin P., Jeremy M. Grimshaw, Paul Shekelle, Holger J. Schünemann, and Steven Woolf. "Developing clinical practice guidelines: target audiences, identifying topics for guidelines, guideline group composition and functioning and conflicts of interest." *Implementation Science* 7.1 (2012): 60.

[98] Kälvemark, Sofia, Anna T. Höglund, Mats G. Hansson, Peter Westerholm, and Bengt Arnetz. "Living with conflicts-ethical dilemmas and moral distress in the health care system." *Social science & medicine* 58. 6 (2004): 1075-1084.

[99] Benaiche, Lionel, and Maxime Lassalle. "Conflicts of Interest and Healthcare." *Les Tribunes de la santé* 2 (2013): 29-48.

[100] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295. 4 (2006): 429-433.

[101] Marc A. Rodwin. *Conflicts of Interest and the Future of Medicine: The US, France, and Japan*. Vol. 392 (Oxford: Oxford University Press, 2011), 78.

[102] Patricia Backlar. "Managed Mental Health Care: Conflicts of Interest in the Provider/Client Relationship. « *Community Mental Health Journal* 32, no. 2 (1996): 102.

[103] Gini, A. R., and David Ozar. "Appendix 1: Patricia H. Werhane's Publications." *The Moral Imagination of Patricia Werhane: A Festschrift* 47 (2018): 94.

[104] Gini, A. R., and David Ozar. "Appendix 1: Patricia H. Werhane's Publications." *The Moral Imagination of Patricia Werhane: A Festschrift* 47 (2018): 95.

[105] Pellegrino, Edmund D. "Societal duty and moral complicity: the physician's dilemma of divided loyalty." *International journal of law and psychiatry* (1993): 373.

[106] Johnson, Craig E. *Organizational ethics: A practical approach*. (Thousand Oaks, CA: SAGE

Publications Inc., 2015), 211.

[107] Orr, Robert D. "The role of moral complicity in issues of conscience." *The American Journal of Bioethics* 7.12 (2007): 23-24.

[108] Orr, Robert D. "The role of moral complicity in issues of conscience." *The American Journal of Bioethics* 7.12 (2007): 23-24.

[109] Pellegrino, Edmund D. "Societal duty and moral complicity: the physician's dilemma of divided loyalty." *International journal of law and psychiatry* (1993): 373.

[110] Devolder, Katrien, and John Harris. "Compromise and moral complicity in the embryonic stem cell debate." In *Philosophical Reflections on Medical Ethics*. (London: Palgrave Macmillan, 2005), 88-108.

[111] Boyle, Philip J., et al. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (San Francisco: John Wiley & Sons, 2001), 33

[112] Boyle, Philip J., et al. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (San Francisco: John Wiley & Sons, 2001), 33

[113] Boyle, Philip J., Edwin R. DuBose, Stephen J. Ellingson, David E. Guinn, and David B. McCurdy. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (San Francisco: John Wiley & Sons, 2001), 123

[114] Musto, Lynn C., Patricia A. Rodney, and Rebecca Vanderheide. "Toward interventions to address moral distress: Navigating structure and agency." *nursing ethics* 22.1 (2015): 91-102.

[115] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1458.

[116] Masters, Kathleen. *Role Development in Professional Nursing Practice* (Burlington: Jones & Bartlett Publishers, 2015), 165.

[117] Dyer, Kirsti A. "Ethical challenges of medicine and health on the Internet: a review." *Journal of Medical Internet Research* 3.2 (2001). https://dx.doi.org/10.2196%2Fjmir.3.2.e23.

[118] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1461.

[119] Dyer, Kirsti A. "Ethical challenges of medicine and health on the Internet: a review." *Journal of Medical Internet Research* 3.2 (2011). https://dx.doi.org/10.2196%2Fjmir.3.2.e23.

[120] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1461.

[121] Candy, Val. "Integrated Ethics Programs in the Healthcare Industry." *American Journal of Health Sciences* 5.1 (2014): 5.

[122] Candy, Val. "Integrated Ethics Programs in the Healthcare Industry." *American Journal of Health Sciences* 5.1 (2014): 5.

[123] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425-432.

[124] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425-432.

[125] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425-432.

Chapter 2: Respecting Patient Consent: Context of Conflicts of Interest

This chapter considers how patient consent presents the clinical context that engenders Conflicts of Interest in health care. The chapter is organized to raise the pivotal topics that help to identify and resolve Conflicts of Interest. The analysis discusses the relation between autonomy and consent, as illustrated in surgery, and the connection between dementia and dependency, as highlighted in decisions about treatment, to highlight the ethical challenge of accompanying Conflicts of Interests.

2.a) Autonomy and Consent:

Conflicts of Interest arise when healthcare providers fail to respect patient autonomy by not obtaining consent from their patients. The normative principles underlying autonomy and consent help to identify and resolve Conflicts of Interest that can arise.

2.a.i) Normative Principles:

Autonomy denotes self-determination and self-rule, and the concept is normatively significant. Specifically, autonomy is central to moral responsibility because it means that an autonomy-based demand should be respected. Respect for autonomy in healthcare places limits within the patient-physician relationship. The most critical constraint associated with the respect for autonomy is informed consent. The principle provides that "a patient should not receive medical treatment of any sort unless she is well-informed enough as to the treatment nature and effect to be able to make an informed decision about it."[1] In other words, the patient must provide consent to treatment, based on the information the physician provides. Dworkin explains this critical point by explaining that "the requirement for informed consent is necessitated as part and parcel of a more basic imperative to respect patient autonomy."[2] In other words, a physician can encounter ethical challenges around Conflict of Interest if patient autonomy and consent are

not properly honored.

There are also principles that allow patients to make their decisions with respect to the medical interventions they receive and those they are not willing to undergo. The principle helps patients have the feeling that they are under the control of their lives rather than being controlled. Due to the feeling, they increase the patient participation in the decision-making process of the health institutions. Additionally, it contributes to the patients feeling comfortable in their daily activities. The autonomy and freedom of decision- making involves the choices that are made intentionally and with enough or substantial understanding and freedom from those in control.[3] Through the freedom of patients to make crucial decisions that might lead to a great change in their lives, they have the right to decline to surgeries they do not consider beneficial to their lives. Additionally, they can agree on surgery to be performed if they consider it beneficial to their lives.[4] The practice helps in protecting the patients from unwanted interventions, which helps in resolving any Conflict of Interest that might rise.

The process is also imperative to the understanding of the patients by physicians. In making the perfect decisions, the physicians should also offer guidance to the patients. The guidance includes telling the patients of the importance and consequences of different surgeries.[5] However, the guidance from the medics should not lead a patient to make a specific decision. It should only help the patient understand the situation and the procedures involved in the intervention. Through the understanding, it creates a good environment for the patient to make the right decision willingly.[6] The practice helps in improving and developing of potential autonomy-enhancing decision aids. The appreciation of autonomy in medical decision-making in surgery not only prevent Conflict of Interest but it also helps in ensuring medical ethics in the health cares' and respect of patients.

There is also the question of confidentiality, fidelity, privacy, and honesty when it comes to autonomy.[7] In some instances, honesty is questionable in that the physician may hold some information to the patient that might be crucial to the patient. Some physicians withhold the information as it may have grave consequences to the patient. In this case, withholding of information is against the ethical practices that suggest that the patient must know all the details about the surgery that can help in making an informed decision. There is also fear that the autonomy of decision making of patients may have negative implications. It can also distract physicians from conducting their practice efficiently.[8] For instance, in a situation where the patient feels that the surgery cannot be performed, it might risk their lives if there is no another option other than the surgery. In this case, the freedom of the patient to choose jeopardizes the work of the physicians.

Autonomy also risks the life of the patient in circumstances where the patient fears making the wrong choice to avoid being blamed for the consequences. The patient may not be protected in such situations, as some physicians may feel that the patient is competent enough to make their decisions. Due to this feeling from the medics, they insist that the patient should choose thereby making the patients feel abandoned.[9] The abandonment of the patients denies them a suitable environment to make rational decisions. The abandonment of the patient is against the health care ethics and should be punishable by law. The lack of protection thus leads to deterioration of health care ethical practices about decision-making in surgery.[10] Additionally, due to the major focus on decision making of the patients, it may lead to neglect of other situations that need attention leading to greater problems[11]. Due to this fact, the clinicians affect the confidence of the patients in making the right decisions. The lack of confidence of the patients is due to the accumulation of pressure on the issue of making decisions. Although it is

highly ethical to allow patients to make decisions about their lives, Conflict of Interest on the issue of decisions making has been a great challenge to the developing countries. The challenges are due to the paternalistic attitudes in the patient-physician relationship.

1) Beneficence and Non-maleficence:

Beneficence and non-maleficence are very important aspects of the medical ethics. The two practices ensure doctors practice ethics in the health care and to the patients. Beneficence refers to the methods or practices that focus on removing harm in an effort of benefiting others.[12] Non-maleficence, on the other hand, refers to the practices that focus on not doing harm. The two aspects exist due to the risks, effects, benefits, and complications involved in the treatment of patients thereby leading to doctors weighing the benefits against the risks. Beneficence plays a key role in improving morality in the medical field.[13] The actions taken in this case are aimed at preventing or removing harm and improving the situation of others. The practice expects the physicians to refrain from causing harm and at the same time help their patients.

Ethics have gone a step ahead to differentiate between obligatory and ideal beneficence.[14] In respect to ethics, helping the patients is an obligation of the doctors. On the other hand, ideal beneficence involves the acts of generosity with the aim of benefiting others in all occasions. It is the expectation of the patients that physicians exercise obligatory beneficent. For this reason, the doctors are expected to prevent and remove harms from the patients. Secondly, in order to avoid Conflict of Interest, physicians should always weigh and balance the benefits against the risks involved with their actions.[15] The practices in this category involve the vaccination of the population against certain diseases or outbreaks and encouraging patients to stop smoking and start living a positive life. It may also involve the education of the public on sexually transmitted diseases and AIDs prevention. The obligatory practices in case of a surgery involve the advising

of the patients on the benefits and danger of the surgery.[16] It also involves the understanding of the patient and guiding them through the path of rational decision-making in helping the patients improve their lives. The physicians in the occasion of surgery are expected to ensure confidentiality and honesty.[17] Exercising of these actions is both obligatory and ethical to the practitioners and helps in rescuing others from harm. However, it is not mandatory for the practitioners to exercise ideal beneficent.[18]

Some of the ideal beneficent may include the helping of disabled persons and rescuing individuals who are in danger such as helping a drowning person. In the case of ideal beneficence, the physicians should protect the rights of the patients and those of their family[19]. The rights may include cautioning the family against negative views of the patient. The doctor may also engage the family and the patient on the right health practices that they should engage and the type of foods that is healthy to the situation.

Non-maleficence is paramount to the outcome of the physicians' actions. In the case of non-maleficence, the doctors should avoid at all costs refrain from ineffective treatments or act with malice. In refraining from offering ineffective practices, ethics suggest that the benefits of the practices should outweigh the burden or the consequences.[20] Practices that have more benefits than risks prevent the patients from harm thus meeting the expectations of ethics and patients of avoiding Conflict of Interest. According to non-maleficence, the physicians should communicate the benefits and threats to the patients. In providing this communication to the patients, it helps in making of rational decisions in surgery.[21] In the balancing of the benefits and risks of the surgery, the doctors are in a better position of preventing harm to the patients. For this reason, the benefits and harms are important factors that influence the ethical decision-making of the patients in surgery. Certain practices, in this case, are considered to be against the

principle of non-maleficence. Such practice includes the delay of surgery that might cause harm to the patient.[22] Due to this, the physicians should be very clear with the patients in informing them about the benefits and consequences of the surgery. At the same time, they should give the patient a time limit to make decisions ensuring they do not delay the process. Through the balancing of the benefits and effects of the surgery, the exercise helps the doctors in protecting the patient's interests.[23] However, the principles of non- maleficence are not clearly defined. Due to this, it is difficult to identify the main ways in which the physicians can refrain from causing harm to the patients.

A situation that can best describe the situation is a child born with Trisomy 18 that is a genetic disorder. The disorder is incompatible with life and, in this case; the physicians must weigh the benefits and disadvantages of the solution to ensure the survival of the child. The treatment should reduce harm to the baby and prevent cases of futile treatment.[24] In providing intervention to the baby, the doctors should take into consideration the wish and will of the family. Therefore, beneficence and non-maleficence play a major role in reducing and prevention of Conflict of Interest and medical errors.[25]

2) Professional-Patient Relationship:

A professional providing clinical services and an individual in need of care commit to a relationship that necessitates, among other things, honesty, conjoint respect, trust, and confidentiality. In the process, the aspect of sharing information freely limits cases of intimidation, undue influence, or disdain. Appropriate relationship allows a patient to provide accurate information required for effective care in addition to informing the professional competence to offer matching treatment to restore health condition of a patient. In the modern world, a team of care providers joins efforts to provide care to a patient, especially with the new

setting of acute-care hospital. Nonetheless, the final relationship multiplication does not influence individual character in relation to collaboration between a patient and health care providers.

For Conflict of Interest prevention, a healthy physician-patient relationship is vital and remains the cornerstone of health care.[26] The relationship is fundamental to the therapeutic process and should be dependent on trust. Trust is paramount in here since it involves processes that have many personal details such as the gathering of data, diagnosis, patient activation, and patient support. The trust established between different patients and physicians contribute to the number of patients that return to the organization since professional-patient relationship determines the patient satisfaction.[27] The professionals can establish a trustworthy relationship with their patients in various ways. Firstly, the professionals should ensure an open and trustworthy discussion with their patients. Being open with the patient makes them comfortable and can easily open up to their challenges.[28] Trust in this case helps the patients in achieving their goals, which is resolving the challenges and emotional problems they may be facing. In accomplishing this, it should be done in an ethical and professional manner. The trust that the physician creates with the patient highly determines the success of the therapy. If in any case, the patient feels that there is no trust in the conversation, they will withhold information that is critical to solving the problem.

The professionals in solving the challenges and problems faced by the patients should practice the following. First, the professional should be empathetic, and his focus should be to the patient and show objectivity. By being empathetic, the patients felt understood and respected that contributes to the patient's cooperation with the physician.[29] Apart from showing empathy towards the patient, the physician should balance their emotions. In balancing the emotions, the

professionals should not pity or agree with irrational behaviors of the patient. For the professionals to understand the patients, they should focus on the patient in that they listen carefully to the things that they experience for them to come up with the best solution. Through listening, the patient will develop trust with the doctor or counselor that will be imperative in developing a suitable therapy plan.[30] In listening to the patient's history, the physician in charge should then develop an objective according to the needs of the patient. They should then communicate the objectives to the patient. The communication is vital in helping the patient develop hope in that their problem is being resolved. Additionally, the objective will indicate to the patient that the professional is paying attention to them thereby developing trust with the physician.[31]

Another factor that the physicians should portray is unconditional positive regard in the therapy by showing preparedness, patience and flexibility, and lack of coddling.[32] Showing positive regard by giving positive remarks on what the patients share helps them open up and gives the patients the feeling that they are not being judged.[33] The counselor or physician should review previous sessions to understand the patient or go through research on search problems to help in coming up with the best solution. Going through previous sessions of the patient helps in understanding the individuals thus helping the physician on preparedness. If the patients feel that the professional is not prepared, they might fail to trust the physician thereby withholding critical information.[34] On top of this, the physician should be patient and flexible enough to adjust to the pace of the patient. The patients also tend to be slow or have less trust in physicians who seem to be coddling them that is being overprotective. The action will tend to be a pretense, and the patient will not trust the professional[35]. Most importantly, the relationship should be professional in that the physician distinguishes the difference between being friendly and being in friendship

by only asking the relevant questions. Being friendly is ethical and can greatly contribute to the success of the therapy.

An additional factor, which may contribute to the trustworthy in the professional-patient relationship, is the indication of non-biases, confidentiality, and honesty.[36] Non-biased counselors, in this case, should not have stereotyping characteristics but should listen to each patient carefully and give their individual opinion. In giving any treatment, the physicians should seek the consent of the patients, and this will contribute to the patients believing in the professional since they show respect by asking the opinion of the patient. It is also imperative to uphold the confidentiality of each patient. Sharing of patients' information with other patients will reduce the trust between the patient and the physician.[37] The reduction in trust will influence the outcome of the therapy negatively. For this reason, it is important for the physicians to keep the personal information of each patient confidential. The sharing of the confidential information of the patients does not only reduce trust, but it is also against the medical ethics. The outcome of the therapy also contributes to future therapies, as positive results will indicate competence of the physician increasing the trust of the patients with the counselor.[38]

2.a.ii) Consent (Illustrated in Surgery):

The relationship between patient autonomy and consent can raise significant challenges for a clinician.[39] That is, autonomy and consent can intrude into the provider-patient relationship, and hence inhibit the ability of healthcare providers to act in a fiduciary manner,[40] especially regarding the complexities that arise in the medical field.[41] There is a need for more ethical attention to Conflict of Interests that arise because of the failure by physicians regarding respect for patient autonomy and informed consent.[42] In the purview of healthcare, personal autonomy denotes "the right of patients to make decisions about their medical care without physicians

trying to influence them" in an inappropriate manner.[43] Respect for patient autonomy permits

doctors to educate patients but it prohibits them from making decisions on behalf of patients

without patient or surrogate consent. Because of the Conflicts of Interest that can arise around

the ethical principle of autonomy, there is a crucial need for "the inclusion of respect for

autonomy as a key concern in biomedical ethics."[44] Where patient autonomy and consent are

properly safeguarded, patients possess the appropriate ability to make informed decisions

regarding their choice of healthcare interventions or those that they do not wish to receive.

The moral intention of respecting patient autonomy and informed consent are pivotal.[45]

The reason is to guarantee that the treatment that physicians offer attains the desired end and that

the patient chooses.[46] In fact, the ultimate objective of focusing on autonomy and informed

consent is moving the moral template of making decisions from physician-centered models to

patient-centered approaches.[47] This is especially evident in the realm of surgery where informed

consent respects the autonomy of the patients and provides a process for the signing of consent

documents.[48] Markedly, this process continues until the specific patient brings it to an end. Those

who conduct surgical procedures must prioritize patient interests by respect for their personal

autonomy and consent.[49]

Without recognizing this duty towards their patients, surgeons can encounter Conflicts of

Interest. In surgery, there can be many ways that can undermine patient autonomy and informed

consent, including the ability of the patient to comprehend the surgeon's use of the disclosed

information, and "the demands placed on physicians and how well surgeons satiate the minimal

standards for disclosure."[50]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the

Secretary of the U.S. Department of Health and Human Services to establish strict regulations

and evaluation policies toward patients' confidential data protection and storage. This Act was divided into two parts to meet the requirements of cyber security so that the U.S. Department of Health and Human Services published two papers: the Standards for Privacy of Individually Identifiable Health Information and the Electronic Protected Health Information. Both of them were referring the security of patients' private information; thus, the first regulation paper sets national security measures on all types of data, while, the second one targets information which is held in electronic form. Nevertheless, these two parts of the Act are the only existing standards for data protection and cover the whole spectrum of healthcare services, operations, and activities.

Furthermore, the HIPAA also defines the Code of Ethics for all-levels medical staff as well as obliges them to conduct their duties and responsibilities concerning the patients' right for the confidence. Noteworthy, the HIPAA enforcement intersects all levels of medical institutions' organization so that, it can be suggested that each type of Conflicts of Interests are intersected with this primary data protection law.

Patient autonomy is imperative to the principle of professional medical ethics and decision making in surgery. In respect to this, patients should have the right to make their decisions while physicians should provide the right environment for them to do so.[51] In creating a suitable environment for patients' decision-making, the physicians should act in the best interest of the patients. In this case, physicians show respect to the dignity and diversity of all patients and treating them equally in all aspects without discrimination.[52] Physicians, in this case, should accommodate people with difficulties or challenges in accessing the health care. In ensuring efficiency in the health care, respect for autonomy is vital in biomedical ethics.

1) Capacity for Autonomous Choice:

In this case, the ability to make an independent judgment about a medical condition should be pegged on the law and an individual's capability to understand the ensuing dynamics[53]. The exercise involves the assessing of the patient's mental capacity. It is the requirement of the law to grant patients their wish when proving that they are mentally stable. Even if the patient refuses to take the medication, it is their decision and the physicians should not coerce the patient into accepting their treatment.[54] In respecting the law in this aspect, the law insists that the patient should be in a position to reason, hold appropriate values and goals, understand the information given, and communicate their choice. If the individual is in a position of doing this, then they are mentally stable, and their choices should be respected.

It is also evident that the capacities keep changing over time.[55] Due to this, it is important for the physicians to evaluate the patients at different times. In this case, the law states that the mental capacity may be present to a greater or lesser extent while legal competence cannot be present to a greater of lesser extent.[56] In case there is a contention on treatment between the doctors and the patient or patient's family, the courts should determine the right of the individual. The courts decide whether the person in contention has the mental capacity and whether they have the legal competence of making such decisions.[57] In deciding, the decision of the courts stands in that situation. However, in some instances, the gravity of the decision in contention increases the legal competence. In this case, when the seriousness of the decision is high, the capacity increases. For instance, if someone requires a blood transfusion and he or she cannot decide independently, the doctors should make their decisions. If the situation was life threatening and the patient did not have sufficient capacity to refuse the treatment, the doctor's decision should be respected.[58]

On the other hand, even if the circumstance is life threatening and the patient chooses to decline or refuse the treatment their choice should be respected. The law also states that the physicians should not confuse the mental capacity of the individual with the gravity of the situation. Despite the gravity of the circumstance, the will of the patient should always be respected despite the consequences.[59] Additionally, to acting in the best interest of the patient, it is a legal requirement for the doctors to act towards the wish of the person.[60] In respect to this, the physicians should be in a position of balancing the autonomy and well-being of the individuals. The professionals should, therefore, act with the understanding of the situation at hand, which they cannot control. In this case, the physicians balance the extent of autonomy the individual has and the extent to which they should respect the autonomy. In whichever case, the more capacity the individual has, the more likely the professionals will respect their decision.[61] Due to this, the legal competence increases as the seriousness of the situation increases. The nature of the law, in this case, leaves room for making errors as the patients may not make the right or rational decisions.

2) Disclosure:

Disclosure of information should be based on the rules of confidentiality and the need to avoid harm on the parties involved.[62] Many processes take place in the surgical rooms. There is the need for the patient to understand the things that take place since it directly affects their lives[63]. Since the actions affect the patients directly, it is important for the practitioners to let the patient understand the procedures and consequences of the surgery. The understanding will help the individual in making a rational decision.[64] When the patients accept the surgical processes to take place, the question of whether they should know all the procedures that took place arises, and that might create Conflicts of Interest. There is the argument that the details should be

withheld from the patient for their care and safety.[65] Physicians, in this case, act as the educators to the individuals. Given this argument, they should be the ones making decisions on what to disclose to the patients for their best interest. It is clear that patients do not have sufficient knowledge on medicine. Due to their limited knowledge, it is almost impossible for a patient to give informed consent regarding medicine.[66] Despite this understanding, it is the obligation of the physician to disclose to the patient the details of the process. It is also morally right to enlighten the individuals with the necessary details on the processes taking place in their bodies.

The disclosure of information reduces the risk of patients raising doubts with the professional's actions.[67] Due to the necessity of the patient to understand the details of the procedures, the physicians should maintain a balance between too much and too little information. They should not give unnecessary information to the patient or withhold important details. The identification of the right information to give to the patients shows that the physician is competent. The competence of the physician adds credibility to their practice thus establishing trust and confidence among the patients.[68]

According to the legal concept of informed consent, individuals of the age of major have the right to know and determine the activities that are done to their body. In a case where a physician is performing operations on a patient without their consent, the professionals are violating the patient's legal rights and may be charged for medical malpractice.[69] The physician in charge may also face the consequences such as removal from the provider's list or loss of the provider's privileges. In avoiding the wrath of the law of informed consent, it is proper for the practitioners to disclose enough information to the patient. Disclosure of enough information contributes to the patients making informed decisions.[70] The law does not indicate the amount of information that the physician should disclose to the individual. However, traditional courts held

that the physicians should disclose the information to the patients based on their community disclosure standards. Where the community and the individuals came from, could determine the level of information that the person could handle depending on their age. For this reason, the physician should use their wisdom in identifying the amount of information to disclose.[71] In disclosing the information, the practitioner should ensure that the information does not hurt the stability or emotions of the patient.[72]

Interference with the emotions of the patient may lead to making an irrational decision that might have deleterious implications on the health of the individuals. In disclosing the information, the practitioners should also consider the age of the person and their reasoning capacities for them to understand the amount of information they can handle. In the recent past, they have discovered that the traditional disclosure standards do not work in the patient's best interests, as the professionals withhold much information. The withholding of information prevents the patients from making informed decisions. Additionally, the withholding of information helped in the protection of the doctors. Since the patients have limited information on the procedures and operations of the physicians, it reduced accountability on the physicians. The physicians limited the information that would make the patient reject the option thus leaving the patients to make the decision thus escaping accountability.

Currently, the law abolishes the use of traditional disclosure methods and states that the physicians should disclose the information that they consider reasonable. However, the statement may raise the question on the information that might be considered reasonable. Due to this, the laws goes ahead to indicate that any information that risks the life of the patient is reasonable. On top of this, the physicians should also disclose the information that might lead to the patient changing their decision. In disclosing this kind of information, Conflict of Interest will be

avoided and the practice will be fair and ethical.[73]

Other disclosures include any details that might have an effect on personal or economic interests and can influence judgment or decision of the patient. It is also a legal requirement for the physicians to disclose all diagnostic tests that might rule out the possibility of the condition thus leading to the change of decision of the patient. Apart from disclosing the information that the physicians find reasonable, it is also vital for the physicians to disclose to the patient's information that would be reasonable in the position of the patient.[74] In respect to this, if a doctor leaves a surgical material in the patient's body, they should reveal these details to the patient. They should also disclose the condition of the patient after the treatment.[75] The disclosure will allow the patients to analyze the condition and make an informed decision. In completion of the surgery, the physician should disclose to the patient the risks involved. Most importantly, it is crucial for the professionals to disclose to the patients the things that might happen it the surgery or treatment is not undertaken.[76] The courts also suggest that the physicians are expected to disclose their experience with the practice if the patient insists on knowing the details. In giving these details, it allows the physicians to take the necessary precautions in improving their health and avoiding the risks. In disclosing the information, the physicians were restricted on the amount of information they should disclose to the patients. For instance, it is medically unethical for the practitioners to disclose the life expectancy of the patients. The argument on this fact was that the statistical analysis does not relate or reflect the individual's future.

Although it is necessary to disclose the reasonable information, it is incorrect and unethical for the doctors to disclose to the patients the risks of the procedure if done incorrectly. In disclosing the information to the patients, it is a requirement that the physicians record the informed consent of the patient. The recording of the informed consent applies in two different

situations. First, the recording should take place if the individual is unconscious or is not in a position to consent. The process is necessary if the benefit of performing the treatment outweighs the potential harm involved in the process.[77] Secondly, it is improper for the physicians to disclose to the patients if doing so would risk the life of the patient. Such risks to the patient may include psychological or emotional effect. In observing, the details as indicated above, both parties will be in a position of avoiding harm.

In the components of informed consent, understanding and voluntariness play a major role. Valuing one's role as a client/patient or physician leads to an intentional and structured process that acknowledges consent.[78] Consent, in this case, refers to the physician involving the patient in making decisions about the health care. The involvement happens due to the patient's ethical and legal rights to dictate whatever transpires to their body. In the process of involving the patients, the physicians should disclose the relevant information to the patients voluntarily. In disclosing the information to the patient, the individual is offered an opportunity to be informed in the acquisition of knowledge about their health. In making an informed decision, it involves various concepts such as nature of the decision, evaluation of the patients' understanding, and rational options to the suggested intervention.

Other elements in the process of discussion include the possible risks, benefits and uncertainties, and the acceptance of the intervention or treatment by the patient.[79] In assessing the elements, it helps the patients in making a valid consent. The process will also help both the patient and the physician in understanding the nature of the decision. In understanding the nature of the decision, the patient will identify and understand the consequences of the decision. The patient will be in a position of basing their decision on the proposed alternatives by the physicians.[80] The physician providing the various alternatives gives the patient an opportunity of

weighing the alternatives and consenting to the most beneficial alternative to their health.

Besides, the alternatives give the individual a chance to assess the risks and benefits of the

alternative to their health and the implications of the different alternatives. The patient

assessment of the different alternatives also gives the physicians an opportunity to assess the

understanding of the patient. In understanding the patient, the practitioners will be in a better

position of guiding the individual and identifying the relevant information that they should

disclose. The understanding of the patient by the physician and disclosure of the relevant

information and alternatives should allow the patients to accept or reject the treatment

voluntarily.[81]

In making either of the decision of accepting or rejecting the intervention, the patients

should be considered of sober mind.[82] In proving the mental ability of the patients to be in the

expected condition, they should make the necessary decision voluntarily. In the recent past, cases

of coercion have greatly intensified in medical institutions. In these situations, the patients

considering, their pain while seeking treatment, feel powerless and vulnerable in the process of

making the decisions. The feeling may be due to various reasons that may include lack of

disclosure of enough information or intimidation from the physicians. For this reason, the

patients cannot consent willingly, which is against the medical ethical practices. To avoid ethical

issues, it is important for the physicians to engage in positive exercises that encourage the

patients to make decisions voluntarily without any intimidation or coercion.[83]

The process can only be successful if the professionals make it clear to the individuals the

seriousness of the decision as opposed to the normal signing of forms. Identifying and

understanding the gravity of the decisions will encourage the individuals to take their time in

analyzing the different benefits and implications of the decisions. In making the signing or

consenting of the persons to the decision, it will appear as an invitation to the patient to make a crucial decision in the health care and not a formal procedure conducted on a daily basis directing the patient where to sign.[84] Some decisions made in the medical institutions can be barely understood by reading of the forms. It is, therefore, the obligation of the doctors to make the patient understand the different processes in the decision-making. The physicians can contribute to the process through explaining to the patients the gravity of each step without leading the individual to a certain decision.[85] In this case, the physician should offer a recommendation to the problem and provide their reasoning in reaching to the recommendation.

On the other hand, they should also offer to reason on the other alternatives and their reasons of not going for the alternatives. In so doing, it will help the individuals in fully understanding the implications involved in every alternative. The physicians in explaining their reasoning to the patients should do it in a layperson's terms and language despite their educational levels. The language will contribute to the higher understanding of the information by the patients. Additionally, it will help in the equitable treatment of the patients in the different situations. In understanding the implications, it will foster confidence in the patients in making the decisions. In developing confidence and the sufficient understanding of the alternatives, the patients will consent to the specific decision willingly thereby adding a voice to the care that they receive.[86] Due to the understanding of the different concepts, the patients will make the decisions without the feeling of inferiority. The patient will also feel free in asking the questions that will lead them to agree to the best alternative in their opinion. For instance, drawing blood from a patient who has given blood previously will depend on the decision. Even if the patient is willingly donating the blood, it is ethical to explain the procedure that will be used in drawing the blood. The explanation will prevent any disagreements or lack of satisfaction to any of the

parties. If the patient dislikes the method used in drawing the blood, it will be an opportunity for the medics to improvise another way of performing the same task.

In ensuring understanding and voluntary contribution of the patient, the physician should give sufficient information. In giving the relevant details to the individuals, the doctors should take different approaches that will ensure compliance with the ethical practices.[87] Such approaches will comprise a rational physician, patient and subjective standard. The three approaches to disclosure of the information play a major role in ensuring understanding of the information and voluntary making of decisions. With the reasonable standards of the physician, the responsible practitioner should evaluate the interventions that a typical physician would take. In assessing the interventions of a typical practitioner, the doctor will be in a position of understanding the information that should be disclosed. In reasoning in the steps of a typical practitioner, it will ensure that the physician does not reveal information that might cause danger to the patient. Although the approach in most instances has been used in determining the appropriate information to disclose, some researchers have had arguments against the method. The researchers argue that the method is a massive Conflict of Interest because it takes the interest of the physicians into consideration rather than the interest of the patient.[88] Given the nature of the technique, it is said that the approach is inconsistent with the goals of reaching an informed consent.

Another concept that the physician may take into consideration is the rational patient standard. With this standard, the professional should analyze the details a typical patient would have interest. The analysis will help in giving the most appropriate or necessary information a typical patient would need to make an informed decision. The approach is very common since it represents the patient's interests. The final approach that the doctors consider is the subjective

standard. The method requires the physician to make an analysis of the patient and understand the details they would need to understand and make an informed decision.[89] The method is challenging since it requires the professional each patient that they encounter. However, the approach is the most efficient since each individual has different interests and preferences. In understanding each patient, it means that the health providers will be treating each patient according to their needs thus creating a better avenue for the patients to understand the basics needed to make an informed decision.[90] Additionally, it will help the individuals in making a voluntary decision.

3) Applying HCE Principles in Decision-Making in Surgery:

Health care ethics (HCE) principles play a major role in the decision-making in surgery.[91] The principles will enhance patient comprehension and autonomy. The principles act as a guideline to the physicians in conducting their practice and making decisions during surgery. The principles that help in the achievement of the different obligations in health care ethics include autonomy, justice beneficence, and non-maleficence. The four principles are very important in ensuring safety and care of the patients while allowing the understanding of the patients. It also helps in increasing the freedom of the patients in making decisions in surgery.[92] Autonomy, in this case, offers the patient the right to have full control of their body. In this case, the physician only prescribes and advice the patient on the necessary treatments and that helps to reduce the chances of having conflict of interest. Upon recommendation, the patient is fully in control of the treatment that they prefer or consider best for their health. In the recent past, there have been upsurges in diseases that require surgical operations.[93] For this reason, the patients have the power to decide whether an operation should be conducted on their bodies or not.

The physicians, on the other hand, have no option but to accept the decision of the

patients. The decision not to perform a surgery does not depend on the gravity of the situation but preference of the individual.[94] At times, some physicians have attempted to manipulate the principle in coercing the patients to take the decision they do not consider best for their health. Beneficence is another principle that has greatly contributed to the comprehension and autonomy of the patients. With the principle, the physicians should undertake all the surgical processes with the aim of benefiting the patient in all situations.[95] In ensuring that the physicians have the patient's best interest at hand, they should increase their skills and knowledge in surgical operations. The skills should be in the current procedures that will ensure the physicians are in a position of reducing harm to the patients. The increase in surgical errors such as leaving of materials in the body is due to incompetencies of the physicians. In ensuring the benefit of other in the surgical rooms, it will lead to an understanding of the patients and encouraging patients to be autonomous in making decisions.[96]

Another principle that resolves Conflict of Interest and brings more impact to the health care ethics is non-maleficence. The principle involves the avoidance of causing harm to individuals. In respect to this, the physicians should ensure that they do not make decisions that might lead to the causal of harm to the community and individuals. In prevention of harm to the people, it gives the practitioners the opportunity to interact with the community. The exercise helps in understanding the patients better and making the best decisions. The decision of performing surgery to an individual should also consider other people in the society. The other people that might be affected in this case include the family of the patient[97] Due to the implications that might take; it is important to seek the decision of the patient that gives the individual the full power in the direction of the surgery. The other principle of consideration, in this case, includes justice. According to this principle, the processes involved should be fair to

both parties.[98] The surgical processes, in this case, should consider all the parties involved and their take on the decision. The consideration of the patients in the decision-making gives them the opportunity to dictate their lives. The principle requires that the physicians should ensure equal distribution of resources. In the different surgical departments, the resources should be distributed equally in that no department should face difficulties in serving its patients. The equitable distribution of resources will lead to patients finding a wide area to make their decisions from thus improving on their autonomy.

4) Applying Informed Consent to Decision-Making in Surgery:

The application of informed consent in the medical field especially surgery has had a great impact on the field. Informed consent serves ethical, administrative and legal roles. The application of informed consent to the making of a decision in surgery is both important and challenging for the issue of Conflict of Interest. Firstly, informed consent is a situation where the physician and the patient engage in a conversation about the treatment to be used and its benefits and dangers or risks.[99] The patient should then make their decisions on the treatment that they prefer or decline to all the options provided by the health provider. Similarly, the performance of surgery on a patient should involve the engagement of the practitioner and the patient on the processes involved. In discussing the steps or approaches used in the surgical process, its benefits and implications will serve as an ethical practice. Allowing the patient to make their decision regarding the recommendations provided is a medical ethic.[100] It gives the patient the moral right to decide on whether to engage in the surgery or decline. The practice further binds the doctor to the ethical practice of making it an obligation to disclose the information to the patients and help them consent in a rational manner. Through the dialogue, the patient can understand better the expectation of the surgery before and after. Understanding the implications is ethical, and this

will help the individuals in making informed decisions.

Informed consent serves an administrative role.[101] The physician acts as the administrator of the process of surgery. The physician is responsible for analyzing the situation affecting the patient. In analyzing the situation, the practitioner has to inform the patient of the problem and give the necessary recommendations. As any other administrator, the doctors are in a position of deciding the amount of information that they should reveal to the patients. They use different approaches like any other administrator such as the mental capability of the patients and the understanding of the individual.[102] As an administrator, the physician has to guide the patient in the different steps of surgery in ensuring that they do not mislead the persons. The physician, therefore, plays the role of an administrator in controlling the patients.

It is also the obligation of the Administrator in this case, who is the physician to ensure that the decisions or recommendations given protect the participants' rights. The same way the doctors protect the patient, and the society is the same administrators control their organizations in ensuring they do not cause social harm.[103] The practice also serves the legal role. It is the expectation of the law that the physicians act to the best interest of the patient. In binding the physician with this law, it plays the role of the legal aspect. Any action that is not to the best interest of the patient is taken as a violation of the law and thus significantly plays its legal part. Additionally, the law also expects the physician to reveal the relevant information to the patients. It further indicates that non-compliance with this law bounds the physician responsible for violation of patient's rights. Apart from this, it goes ahead to identify the extent to which the physicians should disclose the information. The law also insists on the exceptions of the law that clearly indicates that application of informed consent serves a legal role in the practice of medicine.

From the above discussion, the decision of the patients regarding surgery must be governed by the set standards for surgery consent. The patients must be well informed and allowed to make their decision voluntarily without any coercion. Also, it is also clear that in the case of experiments, the researchers are supposed to reveal every detail concerning the experiment. The ideal way of doing that is by avoidance of providing partial information or deceiving the participant. As a result, the values of the health industry are reinforced since the doctors are accountable to every decision they make. Moreover, from the above discussion, it is clear that despite the fact that the health professionals have the capacity and are well knowledgeable in the medical field, for every decision that requires consent from the patients, the role of the decision-making process is left to the patient themselves.

Conclusively, it is evident that normative methods to ethical decision-making are integral in healthcare ethics since they establish procedures, rules, and regulations that should be applied to determine informed consent. Most importantly, the normative methods are very crucial in ensuring the autonomy of the patients and their ability to make decisions. With the use of normative principles in decision-making, the patients are in a position of understanding and voluntarily making their decisions. It is an improvement in the health care industry in ensuring the physicians perform their job efficiently. Components of informed consent, on the other hand, help the patients in making informed decisions and ensuring legal understanding of the individuals in having a say in their lives. It also encourages the individuals to make informative decisions that will positively affect their lives. Besides, it ensures that the disclosure of the relevant information by the professionals play a critical role in ensuring understanding and the voluntary making of decisions by the patients. In improving the health of the patients, the principles lead to the reduction of Conflict of Interest in the making of decisions. The

informative consent also gives the patient the power of understanding of the surgical procedures and their benefits and implications. With the physicians helping the individuals understand the medical processes taking place in their bodies, they encourage and increases medical ethics in the health care. Finally, decision making in surgery and the application of the health care ethics helps in the eradication of doubts and improvement of professional-patient relationship. The consideration of the above laws in health care ethics is paramount in the application and decision-making.

2.b) Dementia and Dependency:

Just as the connection between autonomy and consent sheds light on potential challenges regarding Conflicts of Interest, the connection between patient dementia and dependency further highlights these challenges for clinicians during disease management and treatment decisions. Care ethics relates to the standards of moral decisions and professional practice. Nurses are accountable to the patients for their actions and policies. In this case, it is essential for them to have a sound acknowledgment of legal and ethical issues in the role of autonomy for dementia patients. The autonomy of the victims is supplemented by beneficence regulations that allow nurses in the interest of the patient with the aim of preventing potential harms. Moreover, the care ethics allows the professional responsibilities of the nurses to become legal on the occasion of the breach of the policies during practice. There is a significant need for providing autonomy for the dementia patients. Close to this aspect, the care ethics fosters the creation of various research ethics agencies and clinical ethic bodies to offer significant support for autonomy for the patients.

The ever-changing health values, society, and behavioral aspects lead to the fact that the care ethics incorporates the moral elements for the clinical sector and respond effectively to

elderly care, especially in promoting autonomy. In the end-stages of dementia, it is significant that, in spite of the best care, treatment, and attention, the individual is undergoing the best care at the end of his/her life. The patient's autonomy is important. Thus, the ethics care ensures that the ill is made to feel more comfortable and rationale. The final dementia stages can last from several days to a couple of years depending on the type of condition and patient situation. Within this period, the ethics care guides the nurses on the way to promote autonomy for the patients to control and monitor the symptoms and pain, including short breath, nausea, or constipation. Even with the experience, nurses are likely to find the final stages of the patient's life unequally challenging. The practices of care to the elderly patients are linked with complex ethical decisions. For instance, the elderly who have dementia require significant support from palliative care to home health monitoring since individuals with last-stage dementia, particularly the elderly people, remain underserved with clinical services in spite of the substantial evidence that this disease is fatal.

Consequently, the use of healthcare ethics can help to formulate safe and moral practices for the necessary care that the patients deserve. Thus, proper adherence to care standards helps in avoiding Conflict of Interest between the caregiver and the care-receiver. This chapter focuses on elderly care and how ethics care can be used to formulate recommendations on how to promote autonomy for patients with advanced dementia. The chapter begins by reviewing the prognosis and clinical guides since they are the principal constraints to clinical care. The proceeding section examines the moral decision-making support in the management of dementia. It is essential to make use of ethics care to build a strong relationship with the patient to avoid the utilization of undesirable and intrusive interventions such as tube feeding. The management strategies for dementia complications include sleep problems, behavioral issues, and pain

minimization. If addressing these problems is adequate, they are likely to eliminate Conflict of Interest and enhance the quality of life. This Chapter aims to help the elderly patients throughout the process of health care as the effective end-of-life care vital for providing peace, respect, and dignity to the patient.

Care ethics entails the moral significance of the fundamental elements of relationships and dependencies in human life. The implication is that the standards of care consist of a linkage between various parties and that the connections work towards improving the welfare of the recipients. From a normative angle, care ethics works to maintain these associations by contextualizing and promoting the well-being of both the caregiver and care-receiver. Care involves understanding the needs and the world of others and oneself. The concept builds on the aspects of caring for the needy and vulnerable in the society. Besides, it is inspired by the realization of self and the memory of being cared. The concept is increasingly gaining ground in the healthcare sector.[104] Similarly, there is also a significant growth in medical aspects, such as research, healthcare education, and administration. These changes require ethical guidance since unethical practices pose grave risks to the whole system. Thus, this study attempts to focus on management of advanced dementia among the elderly patients and ethical challenges in the care process.

Healthcare is one of the sectors that are significantly affected by ethical changes due to its impact on the central domains of human life. The key consideration in bioethics is that it addresses issues relating to healthcare ethics.[105] The concept comprises of the approaches that rationalize the moral conflicts that are acceptable in certain circumstances, and which, by extension, may require special consideration in instances of integration with other values.[106] Various ethical theories may be used in such situations. For example, consequentialism looks at

the expected outcomes after the implementation of given intervention, such as happiness. The

deontology model, on its part, emphasizes intentions or duties. In this case, caregivers and

receivers are expected to perform certain duties, including the duty not to lie to maintain moral

ethics.[107] Furthermore, it is important to consider the interests of the beneficiaries and the

caregivers when deciding the approach necessary for contemplation in this relationship.

Bioethics applies in diverse situations, and its scope has been expanding.[108] The concept touches

on extensive areas in healthcare circles and influences the decisions made within the sector. In

this paper, there is an exploration of the application of care ethics in the context of healthcare,

which is separated into various sections and subsections. The first section investigates on ethics

of care and the management of dementia patients, whereas the other sections recognize the

importance of palliative care as part of the management process and divergent views that might

pose Conflict of Interest ethical issues. The discussion ends with a conclusion and

recommendations on the contributions of care ethics to bioethics. Dementia patients require

autonomy, standard professional conduct, and moral judgment. In relations to this issue, care

ethics provides solutions for nurses on how to carry out basic care management problems for the

patients.

2.b.i) Autonomy & Disease Management:

Typically, dementia has debilitating effects on the sufferer, it results in dependence on

medical professionals. Not surprisingly, the dependency that arises from dementia can lead to

potential Conflicts of Interest in healthcare. Smebye et al. emphasize that the process of

providing health care services to individuals living with dementia raises ethical quandaries

pertaining to how to strike a balance between autonomy, well-being, and safety.[109] The reason is

that persons with dementia may heavily depend on clinicians to maintain their autonomy and

align their lives with the patient's stipulated values.[110] For that reason, Conflicts of Interest may arise when doctors do not fully respect the autonomy of dementia patients, as can occur for example when the desire of physicians to avert harm (non-maleficence) conflicts with patient autonomy.[111] To respect the autonomy and dependency of individuals living with dementia, clinicians must address patient vulnerabilities during disease management.[112] To avoid Conflicts of Interest between professional caregivers and persons with dementia, there is a need for healthcare providers to exhibit attentiveness, competence, responsibility, as well as responsiveness.[113] This process of combining autonomy and dependency during disease management "demands continuous involvement and decision-making,"[114] failure of which can lead to Conflicts of Interest in healthcare.

Autonomy and dependency interact on a sliding scale that impacts how medical professionals interact with patients.[115] Applebaum argues that "dependencies as such do not conflict with autonomy if individuals still maintain a sufficiently adequate range of identification to sustain their personal sense of integrity and worth."[116] In this regard, Smebye et al. suggest that the autonomy of an individual living with dementia remains in tension with the obligation of physicians to prevent the occurrence of harm (maleficence) due to the responsibility of the professional during disease management; the independence of the individual with dementia is in tension with the caregiver's duty of beneficence; to continually uphold patient autonomy, patients living with dementia must depend on health care providers during their disease management.[117] That is why professionals must be very attentive to the potential Conflicts of Interest that might arise.

Ethical issues are increasingly becoming a concern in the contemporary healthcare sector. Care providers are often confronted with these is when attempting to offer efficient services to

their clients. Healthcare workers have a moral encompass but they often face difficult times in making ethical decisions, which are so complex and ultimately result in ethical dilemmas. The latter is the main consequence that negatively affects caregivers and care receivers in an effective decision-making process. Besides, an advanced dementia disorder is difficult situation to resolve without facing ethical challenges. Sometimes the problems are insurmountable that it becomes a problem since it might not be clear whether the caregiver is making the right or wrong decision.

Today, in the healthcare system, the ethical approaches to care have become the critical components affecting care providers when they are delivering their services within certain required standards. For people with dementia, an ethical for care is the pathway that is used to plan their future and to make their life easier.[118] The ethical approaches to care are helpful to the healthcare staffs, the patient, and the family members related to the patients diagnosed with the different type of diseases. Today, many healthcare providers use complementary and descriptive ethical approaches. These strategies are considerate to both the healthcare and the individual seeking services.[119] In any case where the clinicians use a different type of approach to addresses treatments that are associated with Conflict of Interest ethical issues, making a timely and advanced diagnosis is an important practice for patients with fatal illnesses.

However, the growing number of people diagnosed with dementia is intensifying the ethical issues within the healthcare system. Most of the ethical approaches that the healthcare organizations are using for patients with dementia are normative and complementary.[120] These approaches examine what is considered right or good during the treatment of patients with advanced dementia conditions. Additionally, some of the approaches that the clinicians use when making decisions on dementia patients are descriptive. These strategies primarily focus on examining the belief of the people and the way they act without reference to standards.[121]

Despite this, the philosophy of clinical care for elderly dementia patients does not overlook ethical principles. Furthermore, there have been several attempts by bioethicists to approach ethical issues from different ways by focusing on main principles, which contribute to ethical dilemmas when there is a conflict of providing care services to dementia patients.

1) Ethical Principles:

The ethical principle of beneficence requires the caregivers to do the right thing that only benefits the patient. Healthcare practice has a moral basis of concern with beneficence when an elderly dementia patient is receiving treatment services. It imposes two tasks, which includes avoiding harm and maximizing the possible benefits while minimizing the potential harm.[122] The study indicates that beneficence requires physicians to act in the best interest of their patient to promote their welfare efficiently.[123] Adequate care and consideration of patient welfare imply competent healthcare providers. The principle of beneficence aims to do good to patients, thus care providers should make the right decisions that benefit seniors with advanced dementia illness.[124] Therefore, health care workers should be kind and generous to their patients.

One of the fundamental principles of bioethics is the act of doing good and being generous or kind to others.[125] Nurses should embrace and incorporate the principle of beneficence when making ethical decisions of providing care to elderly people with dementia disorder. In most cases, when seniors with dementia need medical attention, family members usually step in to offer decision-making, especially in the life-threatening emergency case.[126] For example, the patient might need surgery, and the family members can help nurses to make an informed decision before the consent of the sick. In this case, beneficence trumps autonomy since the elderly patient cannot make a decision. Thus, the concept conflicts with autonomy specifically when the best interests of patients clash with the health care assessment needs.[127]

The ethical principle of autonomy is an effective approach that focuses on the free will and accord. It is all about the right to offer valid information or make an informed consent. In this case, dementia patients deserve respect and dignity when receiving treatment. The latter may incorporate self-worth and individual agency, which is likely to call for matters of privacy.[128] Autonomy is one of the ethical aspects in the health care sector.[129] Nurses provide medical services and therapies that are based on personal decision-making in most states. These countries have legally protected patient rights. Thus, any intervention in the provision of medical services to dementia patients must take into consideration the valid consent.[130] However, this principle can create Conflicts of Interest if the elderly dementia patient demands the caregivers to do something that they consider dangerous. The patient's autonomy wishes may come into conflict with the concern of the care providers to be beneficence of preventing harm.

As a result, bioethicists have recognized respect as one of the core principles in the field of bioethics. The ethics require nurses to respect the right to self-determination of elderly dementia patients when providing healthcare services. In addition, they should respect their autonomy even if the sick decides not to follow the advice of the health caregivers. Though this principle at times poses a significant challenge to the health caregivers, respect for autonomy is vital in defining the physician-patient relationship.[131] Traditionally, care providers played significant roles that would primarily define the best cause of action when offering medical treatment. However, as times goes by, the transformation in the healthcare sector and increased technology has changed care provision. Currently, patient decision making is considered as long as it does not conflicts with the ethical issues in the healthcare profession.

Personal decision-making is one of the chief ethical concerns in healthcare settings. The provision of medical services involves many procedures and therapies even in the less-developed

nations. Most nursing and medical training programs comprise discussions and seminars concerning the legally protected rights of patients.[132] Therefore, any intervention in the provision of services must encompass a valid consent authorizing the professionals to act.[133] The benefits, burdens, and risks attached to a particular response give an individual the necessary capacity to make decisions. As a result, people should not be pressured, manipulated, or coerced to make decisions. The three components of the consent process may be compromised or obstructed by the nature and symptoms of illness.[134] In instances where patients decline this element of consent, health workers often ignore it. Moreover, healthcare providers should determine when permission has been rejected and whether or not it has been given by a sound-minded person to circumvent the violation of ethical standards.[135]

Before consent can be termed as valid, it is important to determine whether the patient has the mental capacity to make a concrete decision. The decision-making process is especially important to persons with a mental health condition. Their conditions may influence the decisions they take. In such a situation, it is vital to ensure that the patient understands the whole process they go through and is aware of the consequences of undergoing or missing a particular medical therapy.[136] However, different clinicians may have varying capacities to follow the right procedure. Besides, their assessments on a patient's ability to make sound decisions may differ. Thus, the kind of indulgence on consent is limited from the side of healthcare providers. Importantly, court rulings and legislations have concluded that a patient with mental health problems can still have the capacity of consenting or declining a recommended therapy.[137]

There is a possibility of involving a substitute in instances where a patient is not in a position to act decisively. However, this may still be damaging and traumatic to the therapeutic process, especially if the treatment is administered against the will of the patient.[138] Before

deciding on the necessity of an intervention, it is important to ensure that prior wishes and interests of the patients are met through the proposed intervention.[139] The alternative decision-maker must also be aware of the type of medication administered and its potential consequences.

One of the key implications of substitute decision-making is that a patient's personal information is availed to third parties. The substitutability element raises issues of ethical concerns on the rights to confidentiality and privacy of health information. It is important to bear in mind that various regulations and statutes have been put in place to protect patients' right to privacy.[140] As a result, clinicians and other health professionals have a duty to keep this information as confidential as possible. The consequences of exposing private information to the public may be dire, including the impairment of social relationships and loss of employment.[141] For instance, a health insurer who accesses critical patient information may decide not to offer coverage. Therefore, healthcare organizations and clinicians need to be proactive in instituting practices that safeguard the safety of patients.[142]

2) Medicare Guidelines:

Research reveals that dementia is one of the major causes of deaths among the seniors in many states.[143] However, Medicare services play significant roles towards the reduction of this disorder among this age category. Medicare is a federal healthcare insurance program for older adults above 65 years who are under social security retirement benefits.[144] The package is highly beneficial to patients with advanced dementia since it covers both the inpatient and medical fees for dementia patients. Though this program is helpful to elderly people, there are effective guidelines that one should follow to benefit from the federal government health care services. The federal government demands that people affected by dementia to have access to rehabilitation therapies, neuro-diagnostic testing, psychotherapy, and medical management. The

policy offers a greater opportunity for seniors and caregivers who offer therapy services.

Currently, the Medicare caters for the medical services for the elderly undergoing cognitive assessment and care planning process. Nevertheless, one should be an eligible citizen of the state to qualify for the federal government services. Most importantly, Medicare not only caters for the needs of people above 65 years of age but also individuals with less than 65 years old and is still receiving social security disability benefits. Regardless who receives social benefits, every citizen should apply for Medicare services three months early before reaching the retirement age.

Dementia is one of the challenging and biggest concerns for many people getting older. However, the terminal condition is persistent with chronic illness concerning the geriatric problem. Thus, the eventual terminal nature is the foundation for predicting the future issues of dementia and offering effective control measures. There has been a significant attempt from various scholars to determine the actual cause of this condition and the measures but there is still a wide gap in the literature about the situation.[145] The true cause of dementia has not been well established but evolving research indicates that dementia patients can reduce risk related aspects to this condition through effective lifestyle changes. Most of the dementia diseases such as Alzheimer are inevitably progressive and can eventually lead to death. However, effective palliative care, management, or control measures are essential to the process of recovery. To offer effective management or control measures, it is important first to understand the major causes of dementia.

Dementia condition is a common neuro-system condition where the patients suffer from problems such as memory damage, cognition, and behavior. If the illness progresses, the diagnosed individual is likely to rely on the help from his or her family members or even

becomes disable since the condition affects the body system. As time goes, dementia patients are extremely weakened to an extent the illness becomes life threatening. About 35.6 million people have dementia, and healthcare researchers project its prevalence to double in the future. It is safe to say that the condition has healthcare needs that are comparable with other fatal illnesses such as cancer, heart failure, asthma, and arthritis.

Although there is no clear cause of dementia, evolving researches indicate that it results from brain injury and gradual behavior change. The most common cause of dementia disorder is the degeneration of brain cells, which poses a serious health threat to the patient.[146] Dementia affects seniors and the disease is linked with the aging process. The changes mostly occur due to the build-up of abnormal proteins in the brain, which may lead to the damage of the organ and result in the decline of mental capability. The brain injury can also lead to physical disabilities to the victim.

Dementia diseases are diverse, and the most common cause is the Alzheimer's, commonly termed as AD. The major cause of AD is the loss of the brain cells.[147] The condition affects the cerebral cortex, a gray matter that covers the brain. The issue is of particular importance in thought processing functions and memory retrieval. Thus, its destruction can cause a serious loss of memory and affect the neurotransmitter chemical that controls the brain. Once this problem occurs, the patient is likely to experience a dementia condition. Though most of the brain damage cases can be a permanent problem, loss of memory issues as a result of depression or vitamin deficiencies can be managed or treated.

3) Managing Dementia:

Control measures of dementia depend on the main cause of the disease and ethical guidelines in the healthcare. Nonetheless, effective management can lead to better results.

Besides, observing standard professional behaviors when performing basic care management can enable the healthcare providers to reduce ethical challenges. In the case of managing dementia disorder among the elderly people, it is necessary first understand the ethical challenges of Conflict of Interest that might arise when dealing with them. In the past years, there have been various studies on effective understanding of the pathophysiology of dementia. In turn, the researches have changed the management process beginning from the conservative, symptomatic, biologically to a medical specific one.[148] Thus, the management of dementia is characteristic of the behavioral disturbances, environmental manipulation, and counseling in relation to safety issues.

The first step to dementia management is a diagnosis process aimed at determining the type of the disorder. While carrying this process, it is important to bear in mind that the decline in one or more cognitive domains can lead to loss of memory. Therefore, conducting diagnosis will help physicians to understand the type of dementia condition present. Moreover, early diagnosis of dementia is necessary for a better management and accurate prognosis.[149] Besides, apparent symptomatic treatment can enable nurses to determine patients who are likely to suffer from Lewy bodies that might become severe or life-threatening. [150]Thus, diagnosis is an effective and first step towards understanding the type of dementia disorder to manage.

Press and Michael claim that dementia patients are unable to make effective management decisions.[151] Thus, management and safety issues are necessary aspects of providing to people suffering from the condition. Different safety-related concerns to dementia arise when the disorder progresses. Thus, addressing these issues on time can prevent further consequences. Management of safety issues, including decision-making and financial capacity among other allied issues are critical aspects of controlling dementia. The decision management capability

approach requires that any treatment that comprises cognition may be linked with reduced capacity.[152] In other words, the possibility of the reduced capacity of dementia is related to the severity of cognitive impairment. Among the dementia patients who are at the mild stage of this disorder, verbal memory and reasoning are the core aspects that explain the capacity measures to consent. Similarly, measures to individual awareness of his/her memory issues also correlate with their decision-making capacity.

The environmental modification is also an effective step towards reducing the likely stressors that can cause agitation among dementia patients.[153] Most importantly, dealing with dementia is not an easy task since this disorder can cause aggression, confusion, and other complicated issues for the patients. Aggression is commonly caused by either physical discomfort or environmental factors.[154] In this case, altering the environment can be among the effective management of dementia behaviors. Researchers have also recommended the use of patient-centered approaches to effective feeding process and this should be part of the normal care of advanced dementia patients.[155] It also advocates the improvement of oral feeding method by changing the environment to reduce potential stressors that affect dementia patients.

Palliative care has recently become an effective process towards managing dementia. Fortunately, regarding the advanced stage of this condition and behavioral complications, a body of research is evolving to guide symptomatic management of the situation in hospitals.[156] The expertise plays the critical role in palliative care for advanced dementia patients, close to the end of life. The study indicates that clinicians have recently realized that palliative care is the best approach for managing and supporting people with dementia condition, particularly for treating advanced dementia patients.[157] Physicians use this approach as an effective method for enhancing the quality of life for dementia patients. Thus, they initiate treatment measures by

prevention means and pain relief of patients through treatment of physical and psychosocial problems. Furthermore, physicians are likely to reduce dementia symptoms in terminal stages in case doctors offer palliative care services in a timely manner.[158] [159]However, it is important for physicians to take the ethical challenges of Conflict of Interest into considerations when providing palliative care services.

Palliative care clusters principlism is an approach of ethical decision-making focusing on moral principles. In other words, it allows doctors to treat dementia patient under common ground of self-sufficiency, benevolence, and justice.[160] In this context, the treatment decisions through palliative care are made with respect to the patients' choice and self-determination. For example, palliative care allows patients to choose what medical treatments they need over the one they do not need. Hence, this makes the healthcare staffs respect the right of the patients, which is perceived as an ethical framework.[161] As palliative care approach is promoting the aspect of doing the best thing (beneficence), this makes the approach cluster moral structure and the nurses treat dementia patients in the best way possible.[162] The strategy is ethical since it requires clinicians to carry out their duties in a way that will show justice and fairness. It is entirely ethical when dementia patients receive care services in a fair way, especially when they are being given care resources appropriately.[163] Finally, palliative care approach is based on the communication between the healthcare provider and the patient with dementia. In essence, it is within the ethical communication framework where clinicians understand the values of the patients with dementia and make a decision on concerning treatment procedures.[164] The communication values make palliative care approach compatible to care services, as clinicians understand the different opinions about whether an individual with dementia illness should receive treatment services immediately or being cared for later.[165] Consequently, this shows how

ethical doctors and nurses treating dementia patients are since the treatment decisions are based on referral opinions, and the patients' perspectives.

2.b.ii) Decisions about Treatment:

When making treatment decisions for individuals living with dementia, physicians must respect patient autonomy as a critical element of human dignity, recognizing that dementia increases over time. According to Jan Killeen, "individuals with dementia have a lifetime's experience of making decisions for themselves; however, dementia is a progressive condition which gradually erodes their capacity to make some or all decisions in their own interests."[166] As dementia progresses in disease management, Conflicts of Interest may arise between physicians and the patients, family members, or friends of the patient during treatment decisions. Killeen posits that "family members, partners, and friends have the complex task of moving between supporting the person to make their own decisions, to making decisions together, and, when necessary, using the powers granted to them, to act as substitute decision-makers."[167] Notably, Conflicts of Interest may arise when other individuals (such as family) make treatment decisions on behalf of the person with dementia that the physicians feel lacks beneficence, may cause harm to the patient (maleficence), and interferes with the physician's duty of care.

Medicare decision-making process is effective in the healthcare treatment plan. Nurses, patient, family members, and other stakeholders play a significant role in ethical decision-making process.[168] The main duty of caregivers and physicians is to restore the health of the patients, relieve pain, and enhance the quality of life.[169] Though diverse range of Medicare decisions exists, it is advisable to consider ethical issues before making health care choice for dementia patients.

One of the Medicare services that can help ease the pain for people suffering from

dementia is adequate analgesia or palliative care. The two plans are effective services that can

help care providers to ease the pain on their clients. Dementia is a terminal disease and the

treatment should focus on improving the quality of patients and ease of pain. [170] The patient

should be the baseline of this approach as this will allow the medical professionals to remain

inclusive when implementing a treatment plan. The family members should also be present

during the treatment process to offer the patient comfort.[171] In this case, incorporating palliative

care approach in homes of the elderly people diagnosed with the fatal disorder is necessary.[172]

When elderly dementia patients at home receive palliative care, clinicians not only ease the pain

but also increase the knowledge and confidence with people receiving care.[173] Therefore, the

main aim of Medicare services is to ease pain and offer the highest level of comfort to the

patient.

Discontinuity from life-sustaining treatment is also another aspect of Medicare decisions.

Making decisions involving patients with terminally ill diseases is complex for Medicare

providers. It can also be challenging for those involved in care provision. The end-of-life

decision-making capacity is not easy because of varied views from the healthcare

stakeholders.[174] Though the decision making of withdrawing is mostly made by the close family

members, the views of the patient have serious implications. Making decisions involving patients

with terminal conditions can be difficult for medical practitioners and other people involved in

the caregiving. Such complexities emanate from the fact that the different players such as

relatives, surrogates, physicians, and other caregivers may have different opinions on how to end

the life of a patient.[175] The decisions made are often guided by the views of the patient and close

family members on the meaning of life and the dying processes, both of which pose several

implications, including the eminent danger of death.[176] In such scenario, patients face different

fears, such as losing their worth in the course of life. Some patients prefer not to know about their illness and may not be willing to share any information concerning the eminent death.

The principal duty of physicians and other medical practitioners is to improve the life of their patients. This call involves minimizing suffering, curing, and consequently prolonging the life of the patient.[177] At times, medical personnel face the dilemma of ending an individual's life or continuing to provide care even at the face of death. The argument by most healthcare providers is that their role is to provide medical services and ensure the wellbeing of patients.[178] Thus, shortening the life of a patient is not only illegal, but also goes against professional ethics in the line of duty. Medical practitioners owe the patients a duty of care but not the responsibility to end their lives.[179] Afraid of breaching or contradicting code of ethics that guide their profession, caregivers often avoid a scenario where they have to make the decision of terminating the life of a patient.[180] Most medical practitioners often continue giving care even when they are convinced that their life is ending. In cases where end-of-life decisions have to be made, ethics committees are involved to avoid legal actions.

In an attempt to prolong life, medical practitioners often subject patients to immense pain and agony. Many caregivers are hesitant to provide factual information to patients, more so when they know that the chances of survival are minimal or nil.[181] However, failure to provide verbal communication does not imply that the patient is incapable of reading or understanding the information being passed.[182] The continued silence has the potential of sending negative information concerning the well-being of the patients. The fear that comes with non-communication sends unpleasant signals that could worsen the patient's condition.[183]

Sometimes, when a patient reaches advanced dementia and they do not have hope, nurses and family members have to reach a concise agreement of terminating the treatment. One way of

doing so is by the discontinuation of the patient from life-sustaining machines. Decisions of discontinuity from life-sustaining equipment based on costs are also rarely made when doctors have fully utilized healthcare resources and there is no hope of finding the cure for a terminally ill patient.[184] Though this might be justifiable to a small extent, Conflict of Interest might arise between the family members and Medicare providers.

Discontinuing life-sustaining treatment is quite challenging. Nurses need to make ethical and sound informed decisions when making decisions about discontinuity of treatment. Life-sustaining treatment can only be beneficial if it benefits the patient with dementia condition. However, it cannot be beneficial if it causes pain to the patient and family. It can also be seen as burdensome if prolonging life without benefit distracts the quality of life of a person and affects others. Difficult in decision-making might arise when discontinuing the treatment. Withdrawing life-sustaining treatment is morally justifiable in some circumstances.[185] Before making any decision on treatment, it is imperative to involve family members. The family doctor should also be free to offer advice to the family and patient is struggling with decision-making capacity. However, it is morally justifiable to discontinue life-sustaining treatment in case the patient fully understands the consequences of his/her decision and/or the treatment no longer benefits the patient.

Another problem pertinent to end-of-life decision-making processes revolves around who should render the verdict. Various players are involved in the caregiving process. A resolution on the health and the welfare of the patient should be based on a consultative platform. Medical practitioners cannot make the decisions alone. They require the input of family members and other players to make an integrative decision.[186] However, the decision-making process in the end-of-life phase should be centered on the patient. The theory of deontology puts the needs or

the wishes of the patient first. Therefore, emphasis should be placed on the patient's wellbeing. Nevertheless, in certain cases, the patient cannot be trusted to make sound decisions. In such instances, a proxy can make the decision on behalf of the patient.[187]

1) Diverging Views on the Appropriate Treatment:

The need for appropriate management and treatment of dementia raises ethical concerning questions. As the population continues to have elderly persons, the number of people with dementia also rises. Decisions on the treatment for this aging people are often made without the capacity to include the dementia patients in the advanced stage.[188] Most of the aging people with dementia lack the capacity to make their own decisions. In such situations, relatives, and family members or at times the physicians can make effective decisions on suitable treatment on the patient behalf. However, different people may have their own perceptions towards the suitable treatment to offer dementia patients; thus contributing to the ethical dilemma. Such ethical dilemmas might arise because of divergent opinions from varied people including the surrogates, family members, care providers, doctors and advance directives. The views might be conflicting and ultimately contributing to ethical issues.

2) Patient vs. Physician:

Advanced dementia is a complex condition that might pose Conflict of Interest issue among the patients and physicians especially when making treatment decisions. Patients at times are alert and conversant but their decisions on proper medication seem questionable. Patients are assumed to be competent when it comes to decision making on the suitable treatment. For example, the decision-making capacity to withdraw the life-sustaining support may be morally justifiable in case the patient understands the clinical information given to him/her. It can also be justifiable if the patient appreciates the situation and communicates well.

Additionally, physicians have the significant role of ensuring that they deliver the best services to the patients. Divergent views might arise on the kind of treatment but physicians should use their knowledge and skills to make an informed consent. The study indicates that ethics of care should have the value-loaded content form in which the standard guidelines are applied to assess the treatment outcome. Therefore, even though diverging issues might arise between patients and physicians concerning the care, it imperative to follow the value-loaded content. The care involves the values and norms that can be advanced to generate the best outcomes. In this case, the foundational view on the patient is value-loaded and has a normative content.

The question of who should terminate human life brings Conflict of Interest issues among healthcare practitioners. Physicians are frequently torn between taking care of a dying person or concentrating on the welfare of individuals whose life can be saved. Death is not an instant occurrence but a gradual process that involves instances of pain and suffering.[189] Death can be as a result of various factors, including physical conditions and other forms of illnesses. Due to the pain incurred during the dying process, many people are concerned about the welfare of the patient and, thus, tend to suffer with them. In the end of their lives, most patients receive health care which is mostly provided without a clear objective of what they want, their hopes, as well as their wishes.[190] While caregivers are well versed with the technical skills required, they are often confused by the particular needs to fulfill.[191]

In the recent past, there has been a paradigm shift in the capacity and capability of health caregivers to provide treatment and meet the expected end results. Diseases that were untreatable in the 20th century can be well addressed in the 21st century, a sign of the advancement that has been achieved in this sector. With technological milestones such as artificial breathers and organ

transplants, physicians have been able to prolong the life of patients and improve their quality of life. Consequently, the focus of medicine has shifted from caring for the suffering and those in the dying stages to curing illnesses.

3) Family vs. Physician:

The family is the immediate and primary caregiver of patients with dementia. Surrogates and relatives should also be involved in the decision-making process to ensure that the best interests of each player are met. Proxies and family members need to be consulted since end-of-life decisions affect the life of their loved one. Physicians together with other healthcare professionals have a distinct responsibility to offer professional advice on the patient's health status.[192] On its part, the ethics committee should play a part in the mediation process to make sure the best decision is arrived at and that the medical professionals do not carry the burden of an ethics violation. The final objective is to guarantee that the decisions made are for the best interests of the patient and are completed in accordance with the varied perspectives of those involved.[193] The decision-making process is, therefore, a shared responsibility that should take into account diverse views.

Family members play critical roles in ensuring that the patient receives appropriate treatment. Family members often strive to ensure that the patient takes medication and follows all the guidelines provided. Both the family and physician strive to meet the health care needs of their loved ones.[194] Thus, they may make a decision on the treatment that might be conflicting with the ethical professional standards of the physicians. For example, the family can choose the use of tube feeding or hand feeding as the suitable method of care for patients with advanced dementia illness. A research study conducted by the American Geriatrics Society reveal that when feeding problems arise, feeding tubes are not effective for elderly patients with advance

dementia. [195]In this case, careful hand feeding is recommendable because this method has shown to be of great significance in the past few decades since tube feeding is risk.

In addition, tube feeding can lead death and are liked with agitation and greater use of chemical restraints. Though tube feeding is a medical therapy, family members have the right to make the decision by either declining or accepting this care provision.[196] Nonetheless, it is the role of all members including nurses and family members to express the wishes of the patient in regard to tube feeding.[197] Hence, they can incorporate these wishes in the care plan. Thus, health care sector can promote ethical decision-making by making an informed decision and honoring the right of the patients.

4) Medical Ethics vs. the Society:

The medical ethics have principles and guidelines that govern the society at a whole. Medical ethics are founded on the contemporary bioethics and the theoretical school of thought.[198] Deontologists use the rule-based model that follows the work of Emmanuel Kant's principle of utilitarianism.[199] The utilitarianism theory judges the actions of an individual based on their consequences.[200] Thus, Kantian may argue on the issue of suitable treatment of dementia patients based on the consequences. Utilitarianism theory takes into considerations the greatest happiness for many people in the society other than an individual interest. Therefore, medical ethics may also take into considerations the happiness of many people in the society by suitable care to patients in the society.

Medical code of ethics has evolved overtime for many decades. The society did not have a say in medical ethics in the past few years.[201] However, medical ethics have now started involving the public more than ever. Physicians involve in decisions making of shortening the life of the patient especially when someone is suffering from a terminal illness.[202] Nonetheless,

the society is currently more involved in the decision-making process of suitable medications to the patient than ever.[203] The society evaluates the burden and the needs of the society as a whole before making the informed decisions. [204]Particularly, among the dementia patients, ethical considerations on proper medication are imperative. Thus, both the society and medical ethics play critical roles towards treatment decision making.

Laws and regulations dictate the delivery of services in the healthcare sector. However, a common concern arising from issues related to ethics is that the society makes use of power for its collective interests to the detriment of the minority or individual interests.[205] Healthcare decisions are often based on the social norms governing acceptable behaviors as well as responses where social expulsion, surgical interventions, and even death dictate the practice.[206] Different personalities have a role to play in ensuring that rules and regulations are observed by the respective players. This section captures the various aspects of the legal stipulation.

Divergent views between the members of the family can also have a serious ethical implication on the suitable treatment of dementia patients. Ethical challenges of Conflict of Interest might arise in the case of members disagree on the kind of treatment to give the patient. The divergent view among family members can be explained by using personalist ethics. Personalist is a form of ethical thinking that has some normative human nature approach.[207] From the personalism theory perspective, good healthcare providers have an opportunity to map the philosophical and theological health management perspectives.[208] Therefore, ethical decisions regarding suitable treatment can be based on the personal view of the member of the family. In this case, nurses and care providers might find it complex to make the moral judgment on the suitable medical treatment.

Although elderly dementia patients demand autonomy, ethical principles tend to conflict;

thus posing moral dilemma in the health care sector. However, bioethicists have made considerable efforts of tackling these issues from divergent ways by focusing on different principles. Some of these principles include beneficence and autonomy, which both pose ethical dilemmas when providing care services. Beneficence requires the caregivers to do the right thing while autonomy focuses on the free will and accord.[209] Dementia is one of the challenging and biggest concerns for many people getting older. The most common cause of dementia is the degeneration of brain cells and this creates a serious health threat to the patient.

Control measures of dementia depend on ethical guidelines in the healthcare. One of the first steps towards dementia management is an effective diagnosis process. The altering or modifying the environment can be also an effective approach towards reducing the likely stressors to dementia patients. Palliative care has become the significant process for managing dementia.[210] Nevertheless, both nurses, patient, family members and other stakeholders in the care system play a considerable role in ethical decision-making process. One of the Medicare services that can help ease the pain for dementia patients is adequate analgesia or palliative care. Discontinuity from life-sustaining treatment is a critical service. Making decisions involving patients with terminally ill diseases is problematic. Thus, there is a need for appropriate management and treatment of dementia raises ethical concerning questions.

Bioethics stipulates the importance of this ethical consideration in the event of treatment and ensures that each party is fully aware of the ethical issues surrounding the decision-making process. Within healthcare circles, ethical standards are highly vital as they determine the kind of service offered to patients.[211] They guide and direct individuals towards ensuring smooth operation aimed at safeguarding the welfare of all the parties involved in the care process. Overall, ethics safeguard the rights of the patient, and those of the caregiver.[212] Therefore, it is

recommendable for healthcare providers to take ethical issues into considerations seriously when providing care to patients with terminal illness. Dementia is a challenging disorder; thus it requires careful ethical analysis when making treatment decisions.[213]

Successful medical care providers should collaborate with patients and physicians. Their corporation should have an active role in the treatment and disease management process. Competent patients can make autonomous decisions to control and direct their health care.[214] Physicians likewise should also encourage dementia patients to raise questions or concerns. Physicians should allow the family and patients to participate in meaningful decision-making about the healthcare treatment. Patients should also understand the ethical standards as this will help them to make effective decisions. Lastly, patients, care providers and the physicians should work together towards overcoming ethical challenges and ultimately realize their intended goal in the society.

From this discussion, it is apparent that palliative care approach is a well-established method that doctors and clinicians are using to initiate care services for people with dementia. By far most, palliative care is an essential method that healthcare organization can use to enhance bioethics issues. Thus, to deal with problems of patients values and identity, healthcare and policymakers should make an effort of implementing palliative care programs, as this will make the doctors maximize the freedom of the patients, enhance monitoring, and minimize the risks that are associated with fatal illnesses such dementia.

2.c) Conclusion:

In conclusion, this chapter discusses the normative principles that delimit autonomy and consent as illustrated during surgical procedures. It also examines the nexus between autonomy and disease management in persons with dementia to identify and resolve Conflicts of Interest

that arise. The main Conflicts of Interest arising from the failure to obtain proper consent from

patients when undertaking surgical procedures, from the abrogation of patient autonomy during

disease management, and from the tensions between dementia patients' representatives and

physicians while making treatment decisions. To resolve these Conflicts of Interest, healthcare

organizations should devise an approach that deals with the above issues regarding the patient-

physician relationship during surgery and treatment of individuals with dementia. Having

described patient consent as the basic context for understanding how Conflicts of Interest can

arise in healthcare, the subsequent chapters explore such Conflicts in clinical, professional, and

organizational settings.

Notes:

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[1] Dworkin, Gerald. "Autonomy and Informed Consent." In *Ethical Health Care*, eds. Patrician Illingworth and Wendy Parmet, Volume Three: Appendices Studies on the Foundations of Informed Consent (Washington, D.C.: The Commission; 1982 Oct), 63-81.
[2] Dworkin, Gerald. "Autonomy and Informed Consent." In *Ethical Health Care*, eds. Patrician Illingworth and Wendy Parmet. Volume Three: Appendices Studies on the Foundations of Informed Consent (Washington, D.C.: The Commission; 1982 Oct), 63-81.
[3] Jonsen, Albert R. *A short history of medical ethics*. (Oxford University Press, 2000), 226-233.
[4] Gill, Robin. *Health care and Christian ethics*. Vol. 26. (Cambridge University Press, 2006), 42-50.
[5] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 47-62.
[6] Gill, Robin. *Health care and Christian ethics*. Vol. 26. (Cambridge University Press, 2006), 25-22.
[7] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 5-14.
[8] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 1-12.
[9] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 8-17.
[10] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 22-29.
[11] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 15-19.
[12] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford

University Press, USA, 2001), 13-18.

[13] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 35-37.

[14] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 1-12.

[15] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 28-32.

[16] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 54-62.

[17] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 20-27.

[18] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton DC: Georgetown University Press, 2010), 22-34.

[19] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton DC: Georgetown University Press, 2010), 42-54.

[20] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 18-32.

[21] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 27-32.

[22] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 23-28.

[23] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 14-20.

[24] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton DC: Georgetown University Press, 2010), 26-28.

[25] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 1-11.

[26] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 22-29.

[27] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 34-42.

[28] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 28-33.

[29] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 34-40.

[30] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton DC: Georgetown University Press, 2013), 49-56.

[31] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 293-297.

[32] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton DC: Georgetown University Press, 2013), 52-59

[33] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton DC: Georgetown University Press, 2013), 62-57.

[34] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 3-11.

[35] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 11-13.

[36] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton DC: Georgetown University Press, 2013), 80-83.

[37] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton DC: Georgetown University Press, 2013), 74-78.

[38] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 32-36.

[39] Jagsi, Reshma. "Conflicts of interest and the physician-patient relationship in the era of direct-to-patient advertising." *Journal of Clinical Oncology* 25.7 (2007): 902-905.

[40] McGregor, Joan. "Consent and Autonomy." In *is it Rape?* (London: Routledge, 2017), 113-148. MbyRes in Philosoph.

[41] O'Neill, Onora. "Some limits of informed consent." *Journal of medical ethics* 29. (2003): 4-7.

[42] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, Issue 5, (1994): 323–325.

[43] Entwistle, Vikki A., Stacy M. Carter, Alan Cribb, and Kirsten McCaffery. "Supporting patient autonomy: the importance of clinician-patient relationships." *Journal of general internal medicine*, Volume 25, Issue 7, (2010): 741–745.

[44] Entwistle, Vikki A., Stacy M. Carter, Alan Cribb, and Kirsten McCaffery. "Supporting patient autonomy: the importance of clinician-patient relationships." *Journal of general internal medicine*, Volume 25, Issue 7, (2010): 741–745.

[45] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, Issue 5, (1994): 323–325.

[46] Hall, Daniel E., Allan V. Prochazka, and Aaron S. Fink. "Informed consent for clinical treatment." *Canadian Medical Association Journal*, 184 (5) (2012): 533-540; DOI: https://doi.org/10.1503/cmaj.112120

[47] Woodward, Beverly. "Confidentiality, consent and autonomy in the physician-patient relationship." *Health Care Analysis* 9.3, Volume 9, Issue 3, (2001): 337–351.

[48] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, Issue 5,v (1994): 660-661.

[49] Hall, Daniel E., Allan V. Prochazka, and Aaron S. Fink. "Informed consent for clinical treatment." *Canadian Medical Association Journal* 184 (5) (2012): 533-540.

[50] Wear, Stephen, and Jonathan D. Moreno. "Informed consent: patient autonomy and physician beneficence within clinical medicine." *HEC Forum*. Vol. 6. No. 5. Kluwer Academic Publishers, Volume 6, Issue 5,v (1994): 12.

[51] Jonsen, Albert R. *A short history of medical ethics*. (Oxford University Press, 2000), 196-200.

[52] Jonsen, Albert R. *A short history of medical ethics*. (Oxford University Press, 2000), 125-137.

[53] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 81-82.

[54] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 28-33.

[55] Jonsen, Albert R. *The birth of bioethics*.(Oxford University Press, 2003), 290-301.

[56] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 3-11.

[57] Jonsen, Albert R. *A short history of medical ethics*. (Oxford University Press, 2000), 298-300.

[58] Jonsen, Albert R. *A short history of medical ethics*. (Oxford University Press, 2000), 1-6.

[59] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 88-90.

[60] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 18-23.

[61] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 290-294.

[62] Gill, Robin. *Health care and Christian ethics*. Vol. 26. (Cambridge University Press, 2006), 1-15.

[63] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 313-315.

[64] Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*. (Oxford University Press, USA, 2006), 72-77.

[65] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 295-304.

[66] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 5-17.

[67] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 32-49.

[68] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 13-19.

[69] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 32-41.

[70] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 30-35.

[71] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 139-145.

[72] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 109-114.

[73] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 115-117.

[74] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 122-126.

[75] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 37-40.

[76] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 40-44.

[77] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 28-38.

[78] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 47-48.

[79] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 56-59.

[80] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 73-75.

[81] Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: a comparative analysis*. (Gorgetown University Press, 2003), 22-30.

[82] Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: a comparative analysis*. (Gorgetown University Press, 2003), 36-40.

[83] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care*

ethics. (Washignton, DC: Georgetown University Press, 2013), 116-122.

[84] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 144-158.

[85] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 115-118.

[86] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 104-111.

[87] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 183-201.

[88] Jonsen, Albert R. *The birth of bioethics*.(Oxford University Press, 2003), 13-19.

[89] Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: a comparative analysis.* (Gorgetown University Press, 2003), 36-40.

[90] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 109-111.

[91] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 151-160.

[92] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 170-175.

[93] Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: a comparative analysis*. (Gorgetown University Press, 2003), 1-8.

[94] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 141-145.

[95] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 33-35.

[96] Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: a comparative analysis*. (Gorgetown University Press, 2003), 1-5.

[97] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 150-155.

[98] Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. (Oxford University Press, USA, 2001), 22-29.

[99] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 25-27.

[100] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 131-135.

[101] Jonsen, Albert R. *The birth of bioethics*. (Oxford University Press, 2003), 23-30.

[102] Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*. (Washignton, DC: Georgetown University Press, 2013), 215-219.

[103] Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. (Washignton, DC: Georgetown University Press, 2010), 102-123.

[104] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 185.

[105] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 43.

[106] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 24.

[107] Vanlaere, Linus, and Chris Gastmans. "A Personalist Approach to Care Ethics." *Nursing Ethics*,18, no. 2 (2011): 163.

[108] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York:

Routledge, 1993), 24.

[109] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21.

[110] Crisp, Roger. "Medical negligence, assault, informed consent, and autonomy." *Journal of Law and Society* 17.1 (1990): 78.

[111] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21.

[112] Crisp, Roger. "Medical negligence, assault, informed consent, and autonomy." *Journal of Law and Society* Vol. 17, No. 1, Legal and Moral Dilemmas in Modern Medicine (Spring, 1990): 77-89.

[113] Sulmasy, Daniel P. "Informed consent without autonomy." *Fordham Urb. LJ* 30 (2002): 207.

[114] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research 16.1* (2015): 21. https://dx.doi.org/10.1186%2Fs12913-015-1217-1.

[115] Sulmasy, Daniel P. "Informed consent without autonomy." *Fordham Urb. LJ* 30 (2002): 207.

[116] Appelbaum, Paul S. "Assessment of patients' competence to consent to treatment." *New England Journal of Medicine* 357.18 (Nov 2007): 1834-1840. DOI: 10.1056/NEJMcp07404.

[117] Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study." *BMC health services research* 16.1 (2015): 21 https://dx.doi.org/10.1186%2Fs12913-015-1217-1.

[118] Dementia Ethical Issues, "What is an ethical approach to care." Accessed April, 2017. https://nuffieldbioethics.org/wp-content/uploads/Dementia-Chapter-3-What-is-an-ethical-approach-to-care.pdf,.

[119] Hughes Julia and Jill Common. "Ethical issues in caring for patients with dementia." *Nursing Standard 29, no. 49* (2015): 45.

[120] Whitehouse, Peter. "Ethical issues in dementia." *Dialogues Clin Neurosci 2* no 2, (2000): 164.

[121] Whitehouse, Peter. "Ethical issues in dementia." *Dialogues Clin Neurosci 2* no 2, (2000): 164.

[122] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 270.

[123] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 270.

[124] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 244.

[125] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 375.

[126] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and*

Emerging Issues, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 79.

[127] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 188.

[128] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 46.

[129] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 47.

[130] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 188.

[131] Mitchell, Susan L. et al., "Advanced Dementia: State of the Art and Priorities for the Next Decade." *Annals of Internal Medicine* 156, no. 1 (2012): 45.

[132] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 123.

[133] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 46.

[134] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 47.

[135] Edwards, Steven D. "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 190.

[136] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 31.

[137] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 31.

[138] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 31.

[139] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 48.

[140] Edwards, Steven D. "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 191.

[141] Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. (Oxford: Radcliffe Pub, 2009), 123.

[142] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 31.

[143] Mitchell, Susan L. et al., "Advanced Dementia: State of the Art and Priorities for the Next Decade," *Annals of Internal Medicine* 156, no. 1 (2012): 47.

[144] Purtilo, Ruth B. and Henk ten Have, eds. *Ethical Foundations of Palliative Care for Alzheimer Disease*. (Baltimore: Johns Hopkins University Press, 2004), 48.

[145] Groenhout, Ruth, E. *Connected Lives: Human Nature and an Ethics of Care*. (New York: Rowan and Littlefield, 2004), 91.

[146] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[147] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[148] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

http://www.uptodate.com/contents/treatment-of-dementia

[149] Press, Daniel, and Michael Alexander. "Management of Neuropsychiatric Symptoms of Dementia." *UpToDate* (2014). http://www.uptodate.com/contents/management-of-neuropsychiatric-symptoms-of-dementia.

[150] Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. (Oxford: Radcliffe Pub, 2009), 116.

[151] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[152] Press, Daniel, and Michael Alexander. "Safety and Societal Issues Related to Dementia."*UpToDate* (2014). http://www.uptodate.com/contents/safety-and-societal-issues-related-to-dementia.

[153] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[154] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[155] American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1590.

[156] Purtilo, Ruth B. and Henk ten Have, eds. *Ethical Foundations of Palliative Care for Alzheimer Disease*. (Baltimore: Johns Hopkins University Press, 2004), 89.

[157] Purtilo, Ruth B. and Henk ten Have, eds. *Ethical Foundations of Palliative Care for Alzheimer Disease*. (Baltimore: Johns Hopkins University Press, 2004), 90.

[158] Mohanti, Bidhu K. "Ethics in palliative care." *Indian journal of palliative care 15*, no. 2 (2009): 90.

[159] Mitchell, Susan L. "Palliative Care of Patients with Advanced Dementia." *UpToDate* (2014). http://www.uptodate.com/contents/palliative-care-of-patients-with-advanced-dementia.

[160] Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. (Oxford: Radcliffe Pub, 2009), 114.

[161] Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. (Oxford: Radcliffe Pub, 2009), 115.

[162] Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. (Oxford: Radcliffe Pub, 2009), 121.

[163] Mohanti, Bidhu K. "Ethics in palliative care." *Indian journal of palliative care 15*, no. 2 (2009): 92.

[164] Woods, Simon. Death's Dominion: Ethics at the End of Life. (Maidenhead: Open Univ. Press, 2007), 102.

[165] Ashby, Michael and Brian Stoffell. "Artificial hydration and alimentation at the end of life: a reply to Craig." *Journal of medical ethics* 21, no. 3 (1995): 135-140.

[166] Killeen, Jan. "Dementia autonomy and decision-making: Putting principles into practice." *Edinburgh: Alzheimer Scotland* (2012): 1-28.

[167] Killeen, Jan. "Dementia Autonomy and Decision-Making: Putting Principles into Practice." *Edinburgh: Alzheimer Scotland* (2012): 1-28.

[168] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 79.

[169] Purtilo, Ruth B. and Henk ten Henk, eds. *Ethical Foundations of Palliative Care for Alzheimer Disease* (Baltimore: Johns Hopkins University Press, 2004), 49.

[170] Mohanti, Bidhu K. "Ethics in palliative care." Indian journal of palliative care 15, no. 2 (2009): 91.

[171] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 190.

[172] Tronto, Joan C. Moral Boundaries. *A Political Argument for an Ethic of Care*. (New York: Routledge, 1993), 87.

[173] Mitchell, Susan L. "Palliative Care of Patients with Advanced Dementia." *UpToDate* (2014). http://www.uptodate.com/contents/palliative-care-of-patients-with-advanced-dementia.

[174] Press, Daniel, and Michael Alexander. "Safety and Societal Issues Related to Dementia."*UpToDate* (2014). http://www.uptodate.com/contents/safety-and-societal-issues-related-to-dementia.

[175] Held, Virginia, *The Ethics of Care. Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 25

[176] Held, Virginia, *The Ethics of Care. Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 25.

[177] Tronto, Joan C., *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 45.

[178] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 188.

[179] Tronto, Joan C., *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 45.

[180] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 26.

[181] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 27.

[182] Tronto, Joan C., *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 45.

[183]Tronto, Joan C., *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 48.

[184] Janssens, Louis. "Artificial Insemination: Ethical Considerations." *Louvain Studies,* 8, no. 1 (1980): 11.

[185] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 78.

[186] Held, Virginia, *The Ethics of Care. Personal: Political, and Global* (Oxford: Oxford University Press, 2006), 33

[187] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 190.

[188] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 221.

[189] Edwards, Steven D. . "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 189.

[190] Woods, Simon. *Death's Dominion: Ethics at the End of Life*. (Maidenhead: Open Univ. Press, 2007), 78.

[191] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 27.

[192] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York:

Routledge, 1993), 36.

[193] Tronto, Joan C. *Moral Boundaries. A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 47

[194] Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).

[195] American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1591.

[196] American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1591.

[197] American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1592.

[198] American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1590.

[199] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin (London: SAGE Publications Ltd, 2011), 124.

[200] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 39.

[201] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 47.

[202] Woods, Simon. Death's Dominion: Ethics at the End of Life. (Maidenhead: Open Univ. Press, 2007), 104.

[203] Edwards, Steven D. , "Is There a Distinctive Care Ethics?". *Nursing Ethics* 18, no. 2 (2011): 185.

[204] Vanlaere, Linus, and Chris Gastmans. "A Personalist Approach to Care Ethics." *Nursing Ethics,* 18, no. 2 (2011): 167.

[205] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 47.

[206] Held, Virginia, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006), 29.

[207] Selling, Joseph. "Is a Personalist Ethic Necessarily Anthropocentric?" *Ethical Perspectives,* 6, no. 1 (1999): 62.

[208] Vanlaere, Linus, and Chris Gastmans. "A Personalist Approach to Care Ethics." *Nursing Ethics*, 18, no. 2 (2011): 162.

[209] Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, (London: SAGE Publications Ltd, 2011), 41.

[210] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 46.

[211] Vanlaere, Linus, and Chris Gastmans. "A Personalist Approach to Care Ethics." *Nursing Ethics,* 18, no. 2 (2011): 167.

[212] Tronto, Joan C. *Moral Boundaries: A Political Argument for an Ethic of Care* (New York:

Routledge, 1993), 46.

[213] Edwards, Steven D. "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011): 187.

[214] Edwards, Steven D. "Is There a Distinctive Care Ethics?". *Nursing Ethics* 18, no. 2 (2011): 186.

Chapter 3: Clinical Conflicts of Interest:

This chapter discusses Clinical Conflicts of Interest in healthcare. While there can be an abundance of these clinical scenarios, the chapter centers upon pivotal life and death issues of abortion and euthanasia to indicate where Conflicts of Interest arise and how they should be resolved.

3.a) Abortion:

The chapter focuses on typical Conflicts of Interest that can arise by reflecting the tension between dignity and pluralism, and the tension between consent and financial incentives. The issue of abortion has turned into a controversial debate amongst the scholars and other interested parties across the globe. While the opponents of the contentious issue argue against the act, with assertions that it is against the societal morals and values, some support the move by emphasizing that women deserve the right to make decisions concerning their pregnancies. As such, the involved parties strive to attain public support as well as try to seek legal justification for their claims.

More often, the supporters of abortion incline towards creating the 'abortion rights' chorus, thus making the majority to believe that the action is moral and justifiable. Despite their strive, the anti-abortion campaign supporters, on the other hand, assert that the killing of the fetus as well as risking of the life of the child bearer are among the burning issues that make them differ from the opinions of their counterparts.

Abortion, the majority of individuals who undergoes it claim capitalize it on moral grounds, indeed violates the medical regulations and societal values. As the wrangles intensify, the issue has turned political with the legalization taking effect in some nations, while other opposing to abortion creating tough anti-abortion laws, to bar its people from practicing in doing

the act.

Regardless of the squabbles from the two sides, the core subject that emerges is whether abortion promotes or violates the values and ethics that define the human dignity and rights. It, therefore, raises the issue, is abortion morally defensible in the light of universal codes? The paper seeks to analyze and elaborate on abortion and its impact on human decorum and Rights. Again, this chapter will base various potential sources of Conflict of Interest surrounding abortion, such as the cultural diversity and pluralism, the national policies regarding the issues together with the consent of the society. Further, the analysis will weigh the risks involved in undertaking the abortion as well as the legal measures for and against the subject.

3.a.i) Human Dignity & Pluralism:

Scholars associate the ethical debate over abortion with the tension between human dignity and pluralism.[1] That tension can create Conflicts of Interest in healthcare. The conservative stance advocates for the legal prohibition of abortion because it contravenes the rights of the unborn child, while the progressive stance argues for the legalization of abortion because it supports rights of women.

The main ethical arguments against abortion explain that the embryo possesses human dignity (and thus it is entitled to human rights), that abortion is not permissible because it does not show respect for life because of undermining human dignity, and that abortion undercuts human dignity because it disregards the sanctity of human life.

In the stance against abortion, the Abortion Act of 1967 in Great Britain construes women as patients who are in the process of seeking medical care, rather than as individuals seeking abortion services. That is, "women are vulnerable subjects in need of assistance to make responsible decisions."[2] However, the opposition argument claims that abortion abrogates human

dignity because it creates conflicts between the right of women to autonomy and the embryo's life,[3] arguing for the end of the prioritization of women's dignity over the embryo.[4] From this perspective, abortion is opposed because it disregards the life of the fetus by placing it at the whims of the medical professional.[5] In particular, human dignity is the lens through which the claim of the woman to independence and the interest in the life of the fetus are best construed.[6] This stance allows for the reconciliation and simultaneous protection of the bodily integrity and autonomy of the woman and the life and dignity of the fetus.[7]

In contrast, the pro-choice stance argues that abortion should be permitted in many cases of problematic pregnancies. The philosophical underpinnings of this position are that the fetus lacks a moral value since it should not yet be construed as a person, that abortion is morally permissible due to many different circumstances, and that the responsible employment of abortifacients.[8]

According to Lopez, abortion ought to be ethically legitimate in circumstances where "the mother does not want the child, the father does not want the child, the mother will possibly die from giving birth, and the pregnancy is the result of rape."[9] A mother's choice to abort may be founded on the grounds that the mother is aware that the child possesses mental or physical abnormalities, she is addicted to drugs such as alcohol, or she is overly insecure and immature.[10] Nonetheless, proponents of abortion advocate for reasonableness in the process of orchestrating it.[11] Furthermore, physicians should adhere to codes of ethics and thus offer the best advice to women considering an abortion.[12]

The tension of these differing positions can raise potential Conflicts of Interest in healthcare when physicians either inappropriately assist or hinder women from seeking an abortion. On the one hand, for conservatives who consider abortion unethical because it

contravenes human dignity, clinicians may impose undue pressure on a woman to avoid an abortion, accommodating their own beliefs about abortion rather than serving the patient. On the other hand, for those who seek to uphold the rights of the mother, they may impose undue pressure on a woman to undertake an abortion, again accommodating their own beliefs about abortion rather than serving the patient.

1) The UNESCO 2005 Human Rights Declaration:

The United Nations Educational, Scientific, and Cultural Organization converged together in October 2005 and developed crucial regulations that would defend and uphold the human dignity.[13] The adoption of the UNESCO UDBHR declaration by this international body indeed provided a strong position that individuals and societies could capitalize on in the event of deciding on crucial matters regarding the general welfare of humanity.[14] During the Convention, the UNESCO emphasized on 'human dignity 'as the epicenter of the common discussion, and it is apparent that the term encompassed event the human nature in the prenatal state.[15] The human dignity as defined by the UDBHR matches with the Universal Declaration of Human Rights since they both support the need for the society to consider the human interest first before undertaking any scientific oriented action or experimentation, more so when handling the bioethics.[16] However, some arguments emerge on whether the unborn fetus should acquire the same moral status as that of the born child, or the adult being.[17]

Nonetheless, it is evident considering the UDBHR declaration that the concept of human dignity applies to all persons regardless of their status, hence the need for the society to observe their right at all times. Prior the enactment of the UDBHR, the modern scientific developments had brought the argument about the issue of human dignity into a sharper focal point, the factor that made the harmony to become indefinable.[18] As such, the October 2005 UNESCO

conference developed the UDHBR regulations to dilute such controversies and let the world understand that even the unborn being deserve the right for survival and the society requires to observe their dignity at all.[19]

2) The Occurrence of Dignity in the Declaration and Its Significance to Abortion:

In the UDHBR declaration, the term 'dignity' occurs at averagely nine times and in all cases, the word implies 'the life of humanity' or the general human life. In other cases, the word dignity also refers to individuals.[20] Further, it is apparent that the term human dignity also appears in the declaration in about six times, with an implication to the values and ethical aspects of humanity. In general, it is quite apparent that despite the existing variance, in the way the UDBHR uses the term, which the word signifies humans or people in the society regardless of their statuses.[21] In Recital 3 of the UDHBR declaration article, for instance, an elaboration that the human dignity comes first when recognizing the ethical factors that emerge from the advance in scientific technology, implies to all humanity rights from the time of conception to the period of adulthood.[22] Another crucial area that human dignity features in the declaration is in Article 2 (c) of the Declaration, which emphasizes that the crucial aim of the development of such regulations is to promote the value of human dignity as well as uphold the human rights.[23]

Further, the article emphasizes that to uphold human dignity and observance of human rights entails respecting and guiding the life of human beings, with the inclusion of unborn. Nevertheless, the conflict has also intensified since the development of the UDHBR regulations, with most individuals arguing that such regulations does not accurately define whether the regulations include the pre-natal beings.[24] Furthermore, it is due to these arguments that the majority of these individuals acclaim that abortion only affects the pre-natal beings, which in this case have not developed the status as people; hence, the idea of human dignity does not apply to

them. Contrary to the opinions of such individuals, the article UDHBR Declaration elaborates more on the issue, in Article 10, whereby it clarifies that all humans have a right to equity, justice and equality regardless of their status. As such, the human dignity should apply even to the individuals not born yet but have undergone the conception stage since they are still humans. Other that observing the human dignity, the human rights, and fundamental freedoms also applies in all humanities.[25] As such, the termination of human life, regardless of one's state of being is indeed the promotion of human prejudice, hence a crime as well as the disrespect of human life.

Additionally, the critique also elaborates on the role of culture in human life and its significance. In article 12, there is a strong emphasis on the respect of cultural diversity and pluralism, if the cultures do not infringe upon the human dignity. It is apparent from the article that some cultural practices or even the scientific ones should play a vital role, but they should not come before the interests of individuals regarding their lives.[26] Abortion, for instance, is controversial amongst various cultures in the modern society.

However, the grand analysis indicates that the act (abortion) generates more harm than good to both the bearer and the fetus.[27] In most cases, the crude methods that some individuals apply are indeed painful and risky to human existence. Besides, the act is against the human ethics and rights in the sense that it involves the termination of the life of an individual, who in this case has a right to survive.[28] Further, supplementary clarity emerges in article 28 of the UDHBR declaration. In this section, it is apparent that the society should deny any act that is against the human rights directives. In other worlds, any act that fails to keep the human dignity and obese the human rights should not feature in the society.[29]

3) Abortion in Regards to the UDHBR Declaration:

In contrast with the UDHBR Directives, the abortion act attains the alleged reimbursement by killing the innocent fetus. Sometimes, it by accident causes the fatality of the female carrying the child. As such, this is contrary to the requisites of the above declaration. The declaration emphasizes on the upholding of human dignity together with the observance of human rights, which includes the avoidance of termination of individual's lives, regardless of their statuses. Individuals, in this regard, include all human beings right from the conception status.[30] Various individuals tend to differ in determining the point where life begins in humanity, with most of the individuals arguing that life begins at birth. However, the truth is that human life begins right from the period of conception; hence, the abortion act is just like murder, hence violating the human ethics and rights. Various scholars affirm that abortion is just like the direct defiance of the commonly accepted idea of the sanctity of human life, as well as an act, which prejudices the life of the unborn individuals through termination.

Furthermore, the UDHBR affirms that human dignity encompasses avoiding exposing the human beings into risky situation likely to cause harm of terminate lives. Again, there are rare civilized societies that will allow an individual to harm or kills another, and go scot-free. Since abortion is about the termination of the life of a fetus, the situation can easily link to murder, as well as an act that entails brutal punitive measures against the offenders.[31] World statistics indicate that about 34% of the women aged between 24 and 36 prefer abortion as the remedy towards dealing with unwanted pregnancies as well as other factors. Such individuals come up with numerous arguments to defend their decisions. Some of them argue that the abortion process is medically safe when conducted with the experts, not caring about the infringement of the rights of the unborn.[32] Some emphasize that some situations under which conception take

effect such as rape or incest can paint a long term psychological disturbances, hence the need to terminate the pregnancy to create way towards the recovering process. However, this move is unethical and considers as a Conflict of Interest challenge since it involves destroying the innocent lives at the expense of other offenders.

Moreover, it is apparent that human lives reserve protection as well as need to exist with independence and freedom without any alternation whatsoever. It is also ideal to note that other individuals have utilized the scientific concepts to claim that the unborn baby lacks independence entity, since it depends on the placenta of the mother.[33] In this case, they argue that the termination of such fetus in that state does not violate the human ethics and rights. On the contrary to such arguments, it is apparent that young fetus feed and moves while in the womb without the influence of the mother, thereby an indication that they survive on their own, hence regarded as potential human beings. Terminating their lives is tantamount to violating their ethic and rights, just like killing a born baby or an adult. Further, such violation features among those prohibited by the UNESCO UDHBR Declarations.[34]

Other than taking away the life of a fetus, it is apparent that the process of abortion is quite risky. In most cases, the process causes long-term health complications to the mother and may even cause death as well. Statistics indicate that about 47000 of the mothers die in the process of undertaking unsafe abortion annually, and the World Health Organization considers the process as one of the easiest preventable causes of maternal mortality in the globe.[35] In the US alone, about 0.6 per 100.000 of legal, safe abortion ended in health complications and deaths respectively occurred.[36] Considering the above data, it is therefore, apparent that such acts go against the International Human rights as well as violates the ethics and the human dignity of various individuals in the society. Again, this act goes against the directives of the UDHBR, due

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to the causing of the unnecessary pain on the patient.[37]

It is vivid that abortion goes against the alleged remuneration by ending the life of the prenatal child as well as goes against the regulations UNESCO UDHBR declaration. It is, therefore necessary for the societies and families to campaign against the act, as well as encourage various individuals to condemn the act, since it prejudices the human dignity and violates the human right in general.[38] The pro-life individuals, those that are in support of the move against abortion always struggle to elaborate the necessity to avoid such behaviors but the pro-choice individuals, that are not against the act, have remained adamant, the reason for the emergence of such Conflict of Interest.[39] Regardless of the opinions from both sides, it is vivid that the demerits of abortion surpass the merits, hence the need for the society to create stern measures against the offenders.[40] However, some situations in the society can lead to abortion. Studies indicate that the act is legalized in the event that it threatens to kill the life of the bearer. In such a situation, thorough scrutiny ought to take effect to determine the possibility alternatives that can enable the operation to save both the baby and the fetus. In other words, there must be a forcing factor and should be approved by the qualified physicians before the process commences.[41] In general, the abortion move should not feature in humanity since it goes against the UNESCO UDHBR declaration as well as goes against the Global human rights.

4) Abortion and its Perils:

The act of abortion can be very risky, more so the medical abortions. Actually, the opinions about tailored medicine likens to making a bet at a discotheque. More often, the outcome might not be victorious to the extent of causing harm, or even death. Statistics indicate that the medical abortions that take effect in the first nine weeks into pregnancy are less risky or rarely lead to complications.[42] However, the abortion after nine weeks is quite risky and requires

experienced professionals to undertake such processes.[43] According to 2014 UNESCO statistics, about 13% of women across the globe lose their lives due to medical and other forms of abortion. These and other statistics from medical scholars testify that the act of abortion carries intrinsic risks to women and girls, regardless of the reputation of the clinic where the action takes effect.[44]

As the society experiences the rapid increase of health-conscious issues, abortion serves among the major health threats that the society should prohibit.[45] Various well-documented researches together with the reports from the peer-review journals indicate that the risk of abortion is quite vast than even miscarriage and birth in that it contributes to massive deaths as well as causes severe health challenges of the individuals that undertake the act.

In most cases, the medical complications, as well as the health risks involved with abortion tend to undermine the false information that features from the abortion, industries together with the information emerging from the supporters of the issue.[46] Most arguments in support of the abortion move assert that the society should consider both sides before deciding on the issue, that is whether to safe or sustain the life of the mother or develop concern about the rights of the unborn baby.[47]

More often, some individuals in the society argue that the risks of birth are quite higher than the risk of abortion, not knowing that even if the mother survives in the event of abortion, she is likely to develop more health complications than the later.[48] However, the truth is that his regulation of abortion by the society creates more benefits, as well as saves the lives of both the child and the mother. This is contrary to the situations where most women die because of abortion, with some developing some enormous medical complications the situation that they could have avoided through birth.[49]

Research indicates that the risk of fatal anaphylaxis with penicillin is quite higher in that

it causes death at the rate of two in every 50 users of the same. Other medical abortions that most

individuals trust but are all equally risky include the use of the mifepristone and misoprostol,

thus yielding to more health complications on the involved parties. A good example is in Europe

whereby about 1.6 million women have utilized the medications mentioned to terminate their

pregnancies in the past one year.[50]

However, the outcome has turned disastrous, with the majority of these reporting some

complication or tending frequent medical cares. Worse still, some women and girls involved in

the practice face numerous complications in delivered or even become barren. Further, the

scientific information indicates that very serious complication outcomes from medical abortions

arise compared to the birth process, which is normally safe and healthier to both the mother and

the born child.[51]

Using other forms of treatments, more so the use of the antibiotics while undertaking

abortion is riskier and can cause significant arm. Unfortunately, most of the women and the girls

alike prefer to undertake abortion, not forgetting that the move is indeed risky and affects the

future conceptions. Worse still, some individuals argue that the expenses of giving birth to a

child are indeed higher, whereby they range between $3000 and $27000 in the United States

alone.[52] However, this is not true considering the cost of medication that one is likely to incur in

the process of developing health complications in the event of abortion.

It is also apparent that some individuals happen to acquire their pregnancies through

other ways that are not society supported for instance in the event of rape or incest cases.[53] In

such a situation, the majority tend to ignore the medical risks to undergo the abortion process,

with an argument that the move will cover the committed atrocities and dispel the necessary

stress. In the event, such individuals tend to regret later after facing some complication, the

factor that makes them suffer more and even face death.

5) Risks of Abortion:

It was clear in the earlier arguments that the act of abortion violates the human ethics as well as deprives the humans their right to survive among other demerits. Therefore, the abortion process completely alters the life of humanity and leads them towards a painful life filed with long-term physical, spiritual and physiological torture.[54] Again, he process itself is indeed risky, the factor that makes its prohibition a right alternative. Various risks arise in the process of undertaking the act of abortion. Immediately after the abortion, some immediate and undisputed risks emerge, thereby making the life of an individual more miserable and most irritating. Among the immediate risks, include the blood clots, the injury that takes place on the cervix, excessive hemorrhage together with the possibility of the occurrence of incomplete abortions, which cause excessive pain.[55]

Medical experts also assert that the process of abortion can easily cause cardiac arrest together with the renal failure. In the event of such occurrences, an individual can easily die or face other body consequences that can turn very painful. In some situations, some individuals undertaking the act of abortion have experienced respiratory arrest, sudden shock together with the possibly of metabolic disorders, the factor that turns into a life threat.[56] It is apparent that such situations arise due to abortion, hence an indication that the abortion process is indeed very dangerous and life threatening. Again, statistics indicates that about 13% of the women undergoing the abortion process die due to unsafe abortion complications.[57]

Other than the immediate effects, the abortion process also creates permanent effects on individuals. These consequences occur in the form of physical and psychological and they encompass, the consequent preterm birth experiences in women, the occurrence of placenta

previa leading to excessive bleeding, severe mental health setbacks together with the possibility of frequent miscarriages.[58] In other cases, individuals involved with abortion may acquire breast cancer because of the depravity of defensive outcome of an initial full-term conception. Considering these risks, it is indeed quite risky for an individual to prefer abortion to the normal childbirth process.[59]

Another risk that arises due to the abortion process is the possibility of the occurrence of the pre-term birth in the consequent pregnancies. To elaborate, the pre-term birth is a condition whereby a woman gives birth to a child in an earlier period than the projected nine months. In most cases, this duration ranges at about three or more weeks earlier than the stipulated period. Various scholars and other peer reviewed articles have associated the induced abortions with the preterm births (PTB), the factor that has revealed that the two issues relate.[60] According to John Throp, the preterm births tops on the global chats as the major causes of infant mortality, with the death figures as a result of it reaching about 4 million in a year.

The western countries such as UK and US are the most hit regions due to the rampant abortions practiced due to the flexibility on the issue of abortion.[61] Other than causing deaths, the preterm birth children become underweight during the birth process, the factor that makes them to suffer from numerous medical complications or even meet their early death.

Statistics also indicate that such children suffer from developmental problems such as the cerebral palsy, vision deformities, and mental and chronic health issues among others. Some can even suffer from cognitive destruction together with the underdevelopment of sensory organs within their bodies, the condition that is quite painful to the parent and the child. Worse still, parents that undergo preterm births utilize more income to enable the child revive and reach the level of attaining independence and self-reliance.

In the US, the estimated value serving as hospital costs for the preterm births is about $ 1.5 million.[62] The higher costs is due to the long-term overstay in these medication facilities an act meat to allow the child grow in special machines, for them to compensate the three weeks of early birth.

The development of placenta previa in the coming pregnancies amongst the mothers that underwent the induced abortion is another risk associated with the issue. The medical experts define Placenta Previa as an impediment that arises during the pregnancy period whereby the placenta partly or absolutely envelops the cervix, thereby causing relentless flow of blood before or in the process of giving birth.[63] More often, this occurrence is quite dangerous to both the mother and the baby, since the excessive loss of blood can lead to death on the side of the mother.

On the side of the child, the consumption of fecal matter will cause blockages, thereby complicating the breathing process. In some cases, the child may suffocate and die. Other dangers include the utilization of the emergency cesarean, to induce the early deliveries as a way of stopping the excessive loss of blood in the event of delivery.[64] It is apparent that this process may also arise due to the infections that a woman gets in the event of abortion. Statistics indicate that about 2% of the women that experiences the Placenta Previa had underwent the abortion process. The condition is quite tedious and requires more finance, as well as threatens the life of the child together with that of the mother.[65] .As such, this repercussion that emerges due to abortion process cannot occur in the event that individuals avoid the move for abortion but rather capitalize on other secure ways such as giving birth.

Finally, the issue of abortion leads to psychological risks such as depression, anxiety and suicide, thus causing havoc in both the mother and those that care after her. Various researches

have indicated that most women and girls alike suffer from mental problems after conducting the act of abortion.[66] Some studies have also indicated that about 70% of the women that aborted their first pregnancies ended up developing a serious depression in their entire lives. In most cases, most women become guilty of their decisions hence end up developing strong psychological effect that later on impact the normal functioning of their routine lives.[67] Other findings also indicate that about 13% of the marital predicaments arise directly associate with the act of abortion. In such a case, it is apparent that most of the parents, more so the women that undertake the act of abortion face some challenges such as the societal discrimination, the factor that makes them resort into alcoholism or even commit suicide.[68] This statement matches with the empirical data, which asserts that about 30% of the women that undertake the act of abortion develop suicidal ideation, with 40 percent of them attempting the same. There exist other more risks of the act, but the important point is that abortion possesses a major conflict of interest that threatens the human dignity and it is against the human rights, hence not ideal.

3.a.ii) Consent and Finance:

This tension between pro-life and pro-choice camps, with their accompanying propensity for Conflicts of Interest, is accompanied by another terrain that raises potential Conflicts of Interest, the landscape of financial interests. According to Sawicki, "the legal norms of informed consent during abortion often deviate from moral norms since they make neutrality, objectivity, and impartiality impossible and unwarranted."[69] This focus on the legality or legal norms may be inappropriately connected with financial interests that accrue from providing abortion services. Jones et al. state that many patients undertaking abortion come from financially disadvantaged backgrounds, "yet most pay several hundred dollars out of pocket for abortion services."[70] This

can be an example of a potential Conflict of Interest where providers accrue significant financial gain, especially from poor patients who can least afford the services. This Conflict of Interest contravenes the physician-patient relationship. This scenario of potential Conflicts of Interest can arise when consent to an abortion (in the context of significant financial gains to the provider) highlights the lack of private and public health insurance coverage of abortion-related services.

1) Abortion as a Nationwide or Local Strategy:

The issue of abortion has become an issue of controversy amongst various states and regions across the globe. More often, various countries and international bodies develops such regulations as means of securing the lives of their people as well as ensuring that some societal rights are effective and favor the human dignity at all times.[71] In the actual sense, various states across the globe have received the mandate under the international human rights to protect the health status of their citizens. Actually, the enhancement of communal interests is typically among the major goals of governments in the event of serving their citizens. However, in some cases, this common benefit guiding principle goes against personal approval.[72]

Despite the reality that some health-related guidelines and regulations associated with the fortification of human rights, others take the wrong direction more so when they criminalize, forbid and control admittance to essential health services. A good example owes to the laws that prohibit abortion and other issues such as the conception capacity, in the name of life protection by the governments and societies are against the human ethics and rights. More often, the doctors and the involved parties may take a drastic decision aimed at saving lives, but fear to undertake the act, due to the fear associated with the punitive measures by the government.[73] In such a situation the governments and societies should ensure that, such bioethics seeks consent of the patient. In most cases, some patients fall victims of endangered health, as well as the deprival of

the individual rights to decide on the right course for one's health.

More often, an assortment of cases happens whereby the administration takes the illegalization or justification pronouncement without informing the parents or the folks that feel the direct impact of the issue.[74] As such, the prohibition of abortion can encourage the majority to search for insecure abortion methods, which will ultimately impinge on their prospect lives. On the other hand, the justification of abortion is prone to cause much damage in the event of poor administration strategies. Eventually, the majority of the people will hold close the abortion and accept it as a substitute so solve their crisis after participating in the unprotected sex.[75] Due to such, the approval of the parents together with the application of human ethics and rights will play a big role when deciding the right move that will apply and win support from the majority. As a rule, the argument concerning abortion is an infinite subject likely to cause incongruity amid the cohorts as well as the opponents to the issue. It is evident that any pronouncement by various governments is likely to gratify several individuals and displease the rest of the proportion.[76]

Again, It is obvious that the government and societies capitalize on the international human rights to develop some regulations that protects the health status of their citizens, with the core issues triggering the formation of such rules including the maternal and prenatal health, drugs among other issues.[77] Other than utilizing the measure like the national insurance plans, disease prevention plan and the generation of state funds to facilitate care to the citizens, other measures that the government utilizes includes the development of laws and regulations that outline the punitive measures that results in the event of breaking such policies and measures.[78] Actually, the implementation of such regulations serve effective since they ensure that all its members adhere to the regulations as a means of adapting a good path towards improving their

health status. However, some regulations and measures developed by the government may create danger to the health of its citizens, thus making some to practice some acts secretly, with the exposure to more harm.[79]

More often, many regulations come with punitive measures such as fines, the withdrawals of operating licenses as well as the criminalization of actions such as rape, abortion or incest. In reality, the government formulates and implements such regulations with the intent of correcting the behaviors of some individuals as well as guides them towards the rehabilitation processes as well as creating lasting solutions to the victims. It is true that the majority of the government created health regulations and policies work best in improving the welfare of people as well as uphold the human rights.[80] More often, some like those associated with rehabilitation as well as those that create punitive measure on issues such as excessive drug consumption, have declined such acts and made of individuals to turn around and adopt constructive lives.[81]

On the other hand, some, such as the illegalization or legalization of abortion contravene basic human rights, hence the need for the consent before criminalizing or prohibiting such issues.[82] In most societies, some conflicts have emerged due to the development of some regulations and policies, which differ, with different opinions of individuals. Among the nations such as Ireland, they have developed polices that criminalize the act of abortion.

According to this nation, their regulations, which affirm that life begins right from conception tend to defend and uphold the life of the embryo and the fetus, but tend to neglect the dangers facing the mother, in this case the woman carrying the pregnancy.[83] In the United States a controversial debate has merged amongst the citizens with some groups supporting abortion while other opposing towards the act. The public division over abortion arises from clashing agendas on individual freedom, the right to religious or moral convictions engulfing the

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perception that life commences at conception or not during the birth period.[84] In general, about 40% of the Americans support abortion terming that it gives an individual the freedom to make choice on whether to carry the pregnancy or terminate it. On the other hand, about 53% of the Americans believe that abortion is ethically wrong. In such situations, it becomes quite complicated for the government or society to formulate polices that give guidance on the issue. Within the US, the intensity of the Conflict of Interest has led to the emergence of two dominant groups namely the pro-life groups, which are against the abortion and the pro-choice groups, which accredit the legalization of abortion.[85]

Other than the public conflict, the political conflict is also another factor that arises because of abortion. Actually, the abortion issue concerns the personal private rights. More often, most nations, with the inclusion of the US and the UK, develop a political conflict with two questions evolving. Among the questions is whether the women reserve the right to carry on with abortion, considering that they are the carriers of the fetus.[86] Again, another question that brings about controversy includes the question whether the unborn child has the right to claim the rights of its own.

In some nations, human rights only apply to born but negates the fetus and the embryo. Nonetheless, those nations that believe that life begins at conception affirm that the unborn child should enjoy the same right with their born child. Still, what irritates most is the reality that some nations develop some policies without the consent of the individuals involved. In such case, the move is indeed unethical and it prejudices the human rights.

In America, the legalization of abortion has indeed caused some moral divide, with the pro-life supporters asserting that abortion is just like murder and the government should not legalize it.[87] However, the pro-choice groups assert that abortion should be an individual

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decision and should undergo the legalization process.[88] Further, some individuals argue that the legalization of abortion will welcome the save methods of undertaking the process as well as an ideal way of reserving the women with the right to control their bodies. However, the argument by the supporters of abortion has deviated from the right path, which dictates the observance of moral and ethical rights to both the child and the mother. Such direction is about observing the social ethics as well as matching with the universal direction about the issue.[89] In general, the government should focus on developing the flexible regulations that could indeed match with the expectations of the majority in the society.

2) Lack of consent unethical:

Lack of consent, more so during the process of formulating abortion policy by the government and societies is indeed unethical and potential source for Conflict of Interest Challenges. Moreover, the UNESCO statements oblige that folks articulate their assent prior to every medical process. Under such grounds, the governments and societies have no mandate to formulate and implement policies regarding the crucial issues such as abortion, since they require the intervention of the individuals or the affected victims.[90] When the government passes an abortion act with an intention to control the growing population, it negates the role and consents of the society, more so the parents. This is self-defeating because the universal aim is attained, but the outcome violates the individual interests. Statistics indicate that several countries have criminalized the act of abortion to some degree. Nevertheless, the regulations by such countries do not apply in the event of healthy regulation as a triggering factor in abortion. Other nations, more so those that operate under the influence of religion and other cultural backgrounds, allow the termination of the pregnancy arising due to rape, incest as wells as due to fetal malformation.[91]

Various cases arise whereby the government takes the illegalization or legalization decision without informing the parents or the individuals whom the issue affects directly.[92] More often, the illegalization of abortion can inspire individuals to seek unsafe abortion paths, which will eventually affect their future lives. On the other hand, the legalization of abortion is likely to cause more harm if not well administered.[93] In this process, more individuals will embrace the act of abortion and take it as an alternative after the involvement of the unprotected sex. Under these circumstances, the consent of the parents together with the application of moral and ethical issues will play a big role in making the right decision concerning the move for abortion.[94]

In general, the Conflict of Interest surrounding abortion is an endless issue that is likely to cause more disagreement amongst the supporters as well as the opponents of the issue. It is apparent that any decision taken by the governments is likely to please some and displease the rest of the percentage. [95]

Considering the much harm created by the issues, most individuals and societies have remained flexible when handling the issue. In this respect, the issue of abortion is partialy legalized in some nations while the rest of the nations have legalized the issue. Conversely, seeking the consent in the event of formulating such regulations and policies will serve effective in the event of developing the policies that can meet the societal demands as well as serve the interest of the majority.[96] Above all, the move by the governments and the societies to develop the ideal regulations and policies should encompass the ethical and human rights as well as uphold the human dignity at all times.

3) Abortion for financial Benefits:

Despite the intensive debate that opposes or supports the acts of abortion, some issues emerging indicates that some people support the matter for the monetary gain purposes. Health

practitioners with an objective to generate income sometimes engage themselves in abortion; the act create Conflict of Interest challenges, which is against ethically, accepted medical practices.[97]

Further research indicates that the private medical facilities make more money from the abortion industry, with an average doctor getting the income of about $2 million in a single year.[98] More often, such individuals emerge into the market with claims to offer sex education, while others claiming that they are offering family planning services. Additional research indicates that such practitioners ignore the human dignity and fail to uphold the human right of the fetus. In most cases, the government contributes much to these cruel activities by finding the efforts of these practitioners, the factor that gives them the upper hand to exploit the taxpayer's money.[99]

Further information indicates that some of the medical practitioners apply the deceptive counseling approaches to convince the women and girls alike to embrace the move for abortion, the factor that makes the majority to fall into their dirty trap. Same case apply in other developed countries such as the UK and Germany, with the abortion cases reaching about 36 and 42 percent respectively in a single year. More often, the minority fall victim of abortion, with the dominant races more so the whites minimizing the abortion cases in America.[100] However, it is not obvious that all the medical practitioners crave for money as a benefit from abortion. Some medical institutions live alone the abortion mills, prefer abortion as the last alternative to save the life of the mother, after other alternatives have failed. It is apparent that such practitioners adhere to the ethic and human rights in the event of undertaking these services. Another point that proves that such individuals are genuine is the fact that they charge less money compared to the private medical facilities the factor that makes them appear genuine.[101]

Finally, various governments and societies have developed tough legal regulations and

measures to control the conduction of abortion by medical practitioners for monetary gains. In the US for instance, it is clear that any medical practitioner that appears to conduct the abortion for the purposes of monetary gains is likely to face a prison term of 5 years as well as pay the fine of up to $5000.[102] Other nations also embrace the same policies, therefore an indication that nations and societies are facing such crimes with focus and are ensuring that the medical practitioners adhere to human ethics at all times. Despite the challenge arising in the process of fighting for the human rights by various societies, it is apparent that the core objective of most societies is to ensure that the human interest comes first and other issues follow afterwards.[103]

4) Effects of abortion for money:

Various effects arise in the event of doctors and other medical practitioners conducting abortion for monetary gains. The damaging element when the practitioners conduct abortion in return for money is that that the act will trigger more crimes, but ignore the morality aspect. In the actual sense, abortion should not feature whatsoever, since it involves the taking away of the life of an individual.[104] Various individuals, more so those that oppose against the issue assert that life begins at conception, and by killing the fetus of a baby, one violates its human dignity and rights.[105] The urge by the majority of medical practitioners to conduct abortion for the purposes of getting money in return, can make various individuals to develop trick information that could make more women and girls to embrace abortion. [106]

Again, the attraction for money is likely to trick the non-experts into the abortion industry, the factor that can cause danger to the individuals involved in the process.[107] In such situation, the mortality rate will go higher due to the increase in deaths caused by non- experts. UNESCO report 2014 indicates that about 13% of females die out of insecure abortion conducted by non experts.[108] Another disadvantage is that the move will deprive the citizens a lot

of money, the factor that is likely to cause poverty and the misuse of the taxpayer funds. More often, the doctors are likely to deceive individuals as well as give them the misleading counseling approaches, with an intention of extracting money from them. [109]

Finally, the act of abortion in return for money can also make some individuals see the move as a routine by the majority, provided that they have money.[110] This could eventually lead several pregnancies arising from carelessness and unprotected sexes, generating further into more abortions. Eventually, the morality and the upholding of the human dignity will decline from the society.[111] The massive loss of lives followed by minimal control of the situation shall be the outcome.

In summary, the act of abortion is indeed unethical and it violates the human dignity. As such, the act violates the human ethics and goes against the human dignity requirements. By encouraging abortion, the society will violate the rights of the fetus as well as threaten the lives of the mother.[112] Furthermore, the issue of abortion causes numerous long-term health complications that will affect the mother as well as tamper with the consequent pregnancies. It is also apparent that the legalization of abortion tempts the medical practitioners hence making them to conduct the services for the purposes of medical gains.

However, the issue of abortion can only feature in compromising situations, more so in the event that the patient faces the health danger.[113] In such a case, the government should develop stern measures and regulations that will govern the decision made by the doctors and other medical practitioners concerning the matter.[114] Other than setting the tough measures, the governments and other governing societies should create stern measures aimed at holding the face practitioner back, as a way of reducing the unnecessary deaths caused by such individuals.[115]

Finally, an ideal strategy should arise to monitor the abortion process, with an intention of ensuring that, only the licensed faculties undertake the process of abortion and that no individual charges extra fee against the expected amount during the undertaking of the process. In doing so, the society will succeed in fighting and controlling the unethical abortion.

3.b) Assisted Death:

Just as occurs with abortion, Conflicts of Interest arise in the clinical scenario of assisted death in a variety of ways. The chapter focuses on typical Conflicts of Interest that arise based on different types of death-bringing services and the tension between rights, law, and religion.

3.b.i) Death, Dying & Types of Assisted Death:

Death denotes "the cessation of all biological functions that sustain human beings."[116] It results in different phenomena such as disease, senescence, euthanasia, and suicide.[117] The purview of medicine that is concerned with death and dying is palliative care.[118] Healthcare professionals in palliative care have the ethical duty of prioritizing the interests of patients even on their death beds.[119] In focusing on assisted death, it is vital to fully understand concepts such as the autonomy of choice, alleviation of pain, and peaceable death.[120] While some scholars argue that death should occur naturally, others claim that assisted death is ethically allowable under certain circumstances.[121] This debate over assisted death can lead to Conflicts of Interest in healthcare.

Euthanasia denotes the intention to undertake "the process of hastening the death of a patient to prevent further sufferings, which portends philosophical, legal, religious, and political dimensions."[122] One form of hastening death is euthanasia, of which there are different types: voluntary, involuntary, non-voluntary, active, and passive.[123] Other terms related to assisted death are "withdrawing life-sustaining treatment, physician-assisted suicide, and medical

futility."[124] There are significant complexity and confusion about terms in this debate. For example, for some, voluntary euthanasia is construed as a sort of assisted suicide that occurs with the consent of the patient.[125] In other words, it is conducted where the patient expresses a wish to die and therefore allows another person to provide euthanasia.

In contrast, during involuntary euthanasia, the health care provider does not obtain the consent of the patient, who is competent to express his willingness to die.[126] Non-voluntary euthanasia takes place when a doctor facilitates the death of a patient who is incompetent to make a decision, for instance, comatose or mentally incompetent patients and babies born with grievous congenital abnormalities.[127] Active euthanasia is performed by individuals, for example, by injection with a lethal drug, while passive euthanasia is that which emanates from the failure to do something (an act of omission).[128] Passive euthanasia can involve forgoing life-sustaining treatment coupled with the intention to kill.

Moreover, physician-assisted suicide occurs when the doctor provides a mechanism by which patients can end their lives. In withdrawing or withholding life-sustaining treatment, the medical expert should consider patient benefit, patient or family wishes, and treatment futility.[129] Hence, depending on the type of euthanasia performed, informed consent may or may not be involved. Each of these complex scenarios can lead to potential Conflicts of Interest for the physician or provider in healthcare, such as saving on hospital costs for treatment or avoiding lengthy care of a dying patient that is burdensome for the provider.

Opponents of euthanasia argue that the practice should be banned because it encourages the elimination rather than treatment of the vulnerable. This involves an ethically wrong intention, it contravenes the traditional function of medicine, it promotes the commercialization of health care services for a nefarious practice, it abrogates accepted principles of medical ethics,

and it is contrary to health care policy where public funds should be spent on providing palliative care to terminally ill patients, rather than killing them.

Both stances, supporting and opposing euthanasia, can lead to Conflicts of Interest for professionals in healthcare. On the one hand, proponents of euthanasia support the practice of assisted death as a measure of last resort.[130] They contend that physicians should conduct themselves in deference to the sick person's right to die with dignity and to the recognition that assisted death can encourage organ donation and transplantation, can minimize the caregiver's burden, can reduce needless suffering and pain, and can provide psychological reassurance to dying patients.[131] Despite this context, some argue that health care institutions should discourage euthanasia because it may engender Conflicts of Interests. These conflicts can deal with having financial incentives or with avoiding the burden of providing services.[132] On the other hand, opponents of euthanasia also can be faced with potential Conflicts of Interest, such as when their personal beliefs interfere with providing legal service for assisted death that is requested by a patient. These potential Conflicts of Interest need to engage the tension between rights, law, and religion.

Cultural inclinations affect the way dying and death is perceived around the world. For example, in the quest to find meaning in and understand life, human beings identify with several religions. Each of these religions has a significant effect on the attitude and comprehension of death among the individuals who partake in the specific beliefs. Further, various practices define a culture. These practices influence the way death is treated as a sequence in life. Hence, ethically, these issues influence the way death is viewed considering aspects such as taboos, which are used in the judgment of things such as the manner of death, which could have resulted from suicide.

Presently even with all these variations concerning death, inventions have been developed to prevent it, prolong or even end the life of an individual based on proven factors. Many decisions concerning the life of a person are founded on the primary goal of availing a means to improve the health and quality of life of an individual.

The persistence and incidence of incurable diseases, which have led to pain and suffering among the affected individuals has swayed the opinion of medical practitioners concerning the best decision for a patient. Some say that a patient should not be left to suffer and measures should be taken to relief the patient from all the misery. Some of these measures may include death. Others oppose such measures based on philosophical and ethical facts and factors. Advances in the medical field along with the continued lack of cures for chronic ailments such as cancer, which cause immense pain to the sufferers has led to a huge debate concerning the decisions to end the lives of affected people through physician assisted suicide and euthanasia. Literally, euthanasia implies having a "good death."[133] However, a number of definitions do exist. On the one hand, euthanasia is described as the deliberate killing of an individual by a doctor using medication after the person makes a competent and voluntary request.[134]

It is also said to be an intervention that is deliberate and, which is conducted with the sole aim of ending the life of a person as a relief measure from their enormous suffering.[135] The European Association of Palliative Care (EAPC) defines it as the act of purposely aiding an individual to commit suicide through the provision of self-administered medicine upon their competent and voluntary wish.[136] Further, people who support euthanasia are of the opinion that it is a means used by clinicians to hasten the dying process of a terminally ill person.[137] Hence, a careful assessment of these definitions implies that for an act to be termed as euthanasia, it has to be formally requested competently, and the doctor must only provide the

prerequisite drugs upon this voluntary wish because of the ethical deliberations associated with the intervention.

On the other hand, physician assisted suicide (PAS) is termed as the action by a doctor of providing a fatal drug overdose, which the patient self-administers as a means of committing suicide.[138] Additionally, it is defined as the act of self-administering with a substance, which is deadly as advised by a medic.[139] Thus, PAS seems to incline towards assisted suicide just as the name suggests. Currently, some countries such as Luxembourg, Belgium, and Netherlands along with Washington and Oregon states in America allow these practices.[140] Nonetheless, in other nations, the debate concerning the acceptability of these acts is continuing.

However, it is important to note that a recent research conducted among individuals suffering from chronic and advanced illnesses on the wish to die noted that around 3 to 20 % and 11 to 55 % of the patients had a persistent and transient desire to die respectively.[141] Subsequently, in life, death is the final stage. Logically, death should take place in a natural manner. Nonetheless, a patient may feel the need to end their life because of the suffering and pain they are experiencing.

Normally, in such an instance, a ready medical intervention to cure their condition is non-existent, which means that the only option is death. Hence, euthanasia and PAS should only be lawful if a patient has the physical and mental capacity to decide whether their life should be terminated. Arriving at this conclusion has been done through several sections and subsections. They include the kinds of euthanasia, its categories, issues concerning this procedure, opinions for and against the practice, the practicalities of dying, and the regulatory aspects about euthanasia around the world.

Before delving further into euthanasia and PAS, it is important to consider the concepts

behind suffering. There is a general agreement among health experts that the nature of suffering to a large extent similar among numerous patients who are under medication. The fact is that if a patient fails to respond positively to treatment, they are subject to suffer in the end.[142] Further, prolonged hospitalization is associated with increased suffering because it is a suggestion that the treatment is taking time to work or is not working as expected. Subsequently, physicians have to decide whether to continue with the treatment, change, or stop it all together with the aim of relieving the suffering experienced by the patients.[143] There are cases where the origin of the pain is known.

However, because of unavoidable aspects, the pain increases or is unmanageable. Thus, there is a supposition among experts that many instances of suffering experienced by patients who are under treatment are not just physical but also psychological bearing in mind the physiology of pain. Hence, the pain is linked to all the hindrances, which have the ability of destabilizing the stability of the psychological and social aspects of the patient.[144] Subsequently, in such an instances, the provided medication functions minimally in alleviating the pain. Furthermore, the health specialist is mandated with the role of making informed and evidence backed resolutions on the best way forward with an aim of doing away with or decreasing the suffering experienced by a patient.

Medically, the challenge is the complexity of predetermining a case whereby a treatment or intervention will fail to work as expected leading to unbearable suffering. Thus, by the time the pain is identified as chronic, the patient will be desperate to get a quick and adequate remedy, which will assist in freeing them from the suffering.

Consequently, the choice of ending their life is considered. By the time this contemplation is considered, it means that the doctors and patients agree there is no other option

left to solve the problem. It causes the patient to be psychologically distressed, which increases their suffering and leads them to contemplate acts such as suicide. Ethically, allowing a patient to commit suicide is wrong because it involves crude methods of ending life.

Hence, instead of allowing individuals to kill themselves in a crude way, the medical expert has a role to play in sustaining the dignity of life of the patient. Compassion is critical in helping a physician in the determination of how a patient can end their life, if they so wish, because there is no other way to eliminate their suffering.

Health specialists are bound by the duty of availing respectful and compassionate health care.[145] The interpretation of the degree of compassionate care varies among health institutions and professionals, which means that in many cases, compassion plays a role in influencing the decision to end the life of a sick individual even though this is not a primary or desired objective in medicine. Further, it is ascertained that there are health care providers who undertake their roles with compassion even if it is an intuitive aspect.[146] Essentially, even if compassion in the medical field is right in its own way, there are challenges in differentiating it from sympathy and empathy as well as comprehending it.

However, regardless of these issues, it is clearly indicated that these decisions are bound by various Conflict of Interest, it is agreed that the medics are influenced by compassion in the way they respond to ensure the decrease of pain and suffering in patients. Subsequently, it is noted that in dire settings, Conflict of Interest arise when doctors have to choose between ending the life of a patient and leaving them to suffer.[147] Many of them select the former option because they perceive it as the only means to end the unending pain experienced by the patient. Fundamentally, this is the most compassionate way of ending the suffering. However, there are people who oppose this view because as earlier indicated; the aim of medicine is not to end the

life of an individual.

However, it is up to the doctor to examine and understand the health state of the patient. Doing so aids in determining the next cause of action depending on the prevailing situation.

Unfortunately, even if compassionate care is intended to save life, the reality is that there are arguments supporting the use of medical interventions to end lives because some conditions cause immense suffering, which has no solution. These medical solutions, which induce death include euthanasia and PAS as explained earlier.

1) Types of Assisted Death:

If an individual wanted to induce death, the person would seek for the means to achieve their wish. Consequently, euthanasia has grown to elicit various Conflicts of Interest because doctors and nurses are faced with ethical considerations when carrying out the procedure. Hence, in light of the above definitions and the wish, determining the types of euthanasia, which a person can use, is important. Largely, euthanasia is classified into two categories that include voluntary and involuntary as well as passive and active groups.[148]

Involuntary euthanasia is explained as the mode of dying, which is conducted against the will of the patient or they have not asked for it to be done.[149] Hence, it lacks any moral grounds to defend it.[150] Voluntary euthanasia means that the affected person has agreed or requested to undergo the necessary procedure to end their life.[151] Thus, the most important point about this category of euthanasia concerns the choice or will of the patient to die.

Active euthanasia concerns a solution that is more active in that the goal is to cause the demise of the particular individual.[152] Hence, a physician offers an intervention that leads to the death of the person.[153] Passive euthanasia implies that there is the deliberate action of withdrawing or withholding the necessary medications with the aim of causing death. Thus, in

this case, a patient is left to die.[154] Hence, medically, it is important to differentiate the two because in some instances it is acceptable withdraw drugs and permit an individual to pass. Nevertheless, it is unacceptable to decide directly that a certain act should be taken with the aim of killing the affected person.[155]

There are instances when a person is so ill that they cannot make a rational choice regarding whether they want to live or die.[156] Moreover, there is an assumption that if they are asked whether they want to die or not, their decision would be the former. In addition, the assessment of the condition could indicate that they will die soon and their current situation is plagued by misery, suffering, and pain.[157] Besides, it could be that their lives are profoundly affected, different, and there is no solution to reverse the situation.[158] Consequently, the decision by physicians is taken to end their lives because they are unable to decide for themselves.[159] In such cases, ending their lives can entail been placed under unceasing sedation or having medicine and fluids withdrawn until such a time that they are declared dead.[160]

An example of such a case is the Liverpool Care Pathway, which involves drug and fluid withdrawal and sedation to induce death.[161] It is important to consider sedation to gain more understanding regarding the issues associated with the various kinds of euthanasia. One form of sedation is called palliative sedation. Palliative sedation, also known as terminal sedation was established 26 years ago.[162] Because of its increased application, moral and ethical considerations have emerged. It is associated with euthanasia by some researchers. Nonetheless, it is differentiated through the assertion that it is a means to deal with unending pain during death.[163]

Medically, there are diseases whereby in spite of the quality of palliative care or the existing mode of treatment, their symptoms cannot be contained. Consequently, health

professionals have no choice but to use palliative sedation to free them from these unending symptoms.[164] Besides, palliative sedation is applied because it stops unendurable pain by minimizing the conscious state of an individual as much as possible. Hence, it provides distinct ethical inferences, which lead health practitioners to define it as being morally correct because it is a type of treatment, which helps in the management of conditions that have no remedy. Morally, hospitals apply the autonomy standard while using palliative sedation.

The argument is that if a patient lacks the capability to rationally make a medical determination concerning their condition, under the law, an auxiliary individual can be relied upon as the decision maker.[165] Thus, the assigned person makes decisions on behalf of the sick individual. In addition, this intervention is vindicated through bioethical standards and the law, which makes it ethically right. Besides, if the individual is a relative, the case is considered as a multi-disciplinary one because it is founded on different regulations and guidelines.[166]

Hence, ethical norms justify palliative sedation as provided in interventions such as the Liverpool Care Pathway, which make it morally correct. Moreover, it provides health care professionals with a means to solve the prevailing health situation because they lack a way to assist the patient, which is their moral and professional duty.

Furthermore, if palliative sedation is used for individuals diagnosed with incurable or prolonged conditions, there is the double effect doctrine. The doctrine is used as an ethical safeguard. The principles of this doctrine mean that terminal sedation is allowed. It is permitted because it gives the relatives as well as the patient to sanction the final mode of treatment.[167] It is so because the goal of palliative sedation is to balance and control the pain while resulting in the least adverse effects that may harmfully affect the life of the individual as well as causing their family to suffer.[168]

Besides, the evidence obtained from research in the medical field illustrates that the double effect doctrine forms a substantial basis for palliative care. Moreover, it backs palliative sedation.[169] Nonetheless, the doctrine asserts that palliative sedation has to morally unbiased. Hence, this notion of ethical impartiality ensures that this form of sedation, as an intervention, functions under the guidelines and regulations of morally upright health care culture and organization.

Furthermore, doctrine of double effect shows that terminal sedation must yield a positive effect not only on the patient but also on their close ones. It also reveals that medical care professionals must not have a perception of bad scenarios as a way to demonstrate that the method is ethically wrong for terminally ill individuals. Besides, the approach has to be applied in a way that the benefits outweigh the negative repercussions.[170] Hence, these assertions illustrate that palliative sedation is considerate of the outcomes, which is vital in all medical interventions. Moreover, terminal sedation stabilizes the impact on the sick individual, the patient and the physician along with the medical specialists.

Additionally, there is the issue of guilt because people who take part in assisted suicide or euthanasia are subject to emotional and mental contemplations, which leads to guilt.[171] Hence, in the case of PAS, there is an emotional remainder in spite of the fact whether the concerned individual is convinced that it was the right thing to do. Despite bearing the burden of making the decision on whether to end the life of a person or not and following the set procedures, it is only human to consider the fact that one has aided in the killing of another individual leading to guilt[172]. Subsequently, this can lead to guilt. Indirectly, guilt may result when an individual who is associated with the affected person experiences emotional remorse after death.[173] May be, they think that more could have been done to prolong the life of the dead individual leading to guilt.

2) Arguments for the Administration of Euthanasia Based on Rights:

Human beings are born with the gift to choose good and bad, which makes euthanasia a critical and delicate aspect of life.[174] Hence, many patients suffering from chronic diseases and other life-incapacitating situations that have no existing solutions are faced with the dilemma concerning the merits and demerits of living. For instance, they are left to judge if it is right for their families to continue bearing the burden arising from their predicament.[175] Subsequently, it is up to these patients to determine if they want to continue living with their current situation or end it in accordance as a relief to their close ones. Subsequently, one of the rights endowed upon such individuals is that to live and die as per their personal perception.[176]

Upholding the right to die for such a person is tantamount to sustaining human dignity because it alleviates the personal and unwanted suffering on the individual.[177] Moreover, it is a sign of respecting the obligation to safeguard the mental and physical wellbeing of the family associated with the person.[178] Moreover, death is a natural occurrence even if it is based on a personal decision to induce it.[179]

Besides, because of its natural facet, a specific clause in international or national laws permitting the right to die is not needed. Further, death is considered a private issue in the life of an individual and no one has the leeway to prevent it if it is harmless to the society and it provides an avenue to a dignified life.[180] A dignified life equals a worthy life, which means the right to a well-intentioned death.[181] Dignity during death is not simply about the mode of dying but the manner in which it occurs.[182] Hence, the right to die upholds dignity in the life of the affected individual.[183] Furthermore, the right to die through euthanasia eliminates unlawful deeds such as homicide or suicide, which emanate from desperation in times of suffering.[184]

3) Arguments for the Administration of Euthanasia Based on Practical Issues:

In some cases, whereby a person is suffering from a chronic ailment, a certified medical professional may have notified the family and the patient that eventually death will occur. Accordingly, it is important to consider the burden experienced by the family and relatives of the patient who have to incur emotional, financial, social, mental, and physical strain in a bid to provide palliative care.[185]

Hence, instead of letting them to experience these negative health and non-health issues, it is prudent to respect the wish to end life because in the end, even after everything is said and done, it is medically proven that the patient will die. It is demonstrated through research findings that there are fears concerning getting health care that is of poor quality because the economic strain on a family is huge.[186] Hence, instead of letting an individual to experience a long and painful death process because the family cannot afford to cater for quality care, euthanasia is important in relieving such stress.[187] In the end, it frees the family from financial strain and the individual from all the unnecessary suffering.

Besides, despite medical advances, there are cases whereby death is unavoidable as explained above.[188] In such cases, researchers stipulate that if there is anything, which can be done to free the patient from the suffering and pain, it is prudent to do so than let the individual suffer. Subsequently, it is assumed that the benefits of euthanasia in such instances outweigh the harm. Moreover, if the circumstances indicate that even after intense quality care the condition cannot be alleviated, symptoms reduced to the most minimum levels, and the end outcome is death, it is only rational to induce death.[189] If it is collectively agreed that there is the need to do away with the continued suffering of a patient.

Medical specialists in charge of the affected individual can apply active euthanasia

because it will stop the chronic pain experienced by the patient.[190] Besides, if the scenario implies that the condition is terminal and the doctor in charge see it wise to end the life of the patient, the health professional should be described as person who is only supporting the decision to end the suffering through death because there is no other option. However, it is vital to note that under euthanasia practice, it is the patient who holds the moral ground to sanction their death because the terminal condition compels the medical specialist to induce death through medications, which will cause slow death.[191]

Hence, it is clear that even though euthanasia is associated with moral demerits, somehow, undertaking it illustrates some ethical reflections as the doctor halts unbearable pain and suffering through scientifically proven interventions, which are legally allowed. Thus, it can be argued that in such an event, it is justifiable and ethical to apply euthanasia because it will eliminate the extreme suffering and uphold the dignity of life as no one is born to suffer.[192] Moreover, the fact that there are no reasonable ways of recuperating coupled with the wish of the patient to die makes euthanasia sensible.

4) Arguments against the Administration of Euthanasia:

The Conflict of Interest entailed by euthanasia has attracted various participants; among them the media, politicians, medical professionals, patient groups, the wider public, and what has come to be known as the 'right to die' movement.[193] The different parties to the discussion hardly share a convergent viewpoint. For instance, the right to die movement has insisted on the sole viewpoint that patients have the right to decide when to end their own lives (albeit through legally permitted methods) while religious leaders tend to take a firm, conservative viewpoint against this proposal (it is worthwhile to note that this has moved from just a proposal into law in some jurisdictions).[194]

Humanity has for long derived its values from religion. It is therefore evident why the debate on euthanasia has been driven by religious and moral values. Accordingly, the values instilled in humanity through generations have been derived from what is considered as sacred.[195] The religious basis for the argument for sanctity of life is that it is not the role of humans to determine which or when an individual should die; this is viewed as the special preserve of the creator. The only common ground among the set of arguments supporting the possibility of a human being taking another's life is when one's own life is perceived to be in considerable danger.[196]

The religious views to the issue of euthanasia are shaped by values defined centuries ago, and in real sense, it fails to conform to the modern day reality. This is especially true considering the increased clamor for personal autonomy, a wave that has come about as the result of landmark judgments that have compromised on the principle of sanctity of life.[197]

Rabiu and Sugand bring up an interesting angle to the argument for sanctity of life, asserting that increase in knowledge (which is believed to be the reason there has been numerous inventions of technology and equipment that help in prolonging life) has been lost in the agitation for a patient's ability to decide if they want to allow euthanasia upon themselves.[198] To prove the unethicality of euthanasia, Jewell notes that it does not make sense that medical practitioners strive to keep an individual alive (which is the basic constituent of their duty) and they can still be tasked with taking away the lives of patients.[199]

A guiding factor to the whole debate on sanctity of life is the definition of the phrase itself, since it is against this definition that a critique can be founded. Importantly, there is a perceived ambiguity in the meaning of sanctity of life, and academicians agree that the phrase is yet to gain a harmonized definition.[200] More so, some researchers insist that the term does not

have a rightful definition but just perceived meanings implied by the agenda the proponents try to advance.[201]

In the argument for the abolition of the death sentence, both sides to the debate agree that execution serves as a 'total deterrent' to the possibility of the same person repeating the crime or involving themselves in any crime in future (because they are dead anyway).[202] Pro-euthanasia researchers have argued that the mistake with the principle of sanctity of life is its perceived 'totality' in criminalizing the act.[203] [204] Without this 'totality' outlook, the argument gives the proponents some leeway to undertake the act. Capping the argument for the superiority of the principle of sanctity of life, Singh paints a clearer picture of euthanasia as simply 'mercy killing', disambiguating the lengthy and confusing arguments raised to dispute the act as just a form of killing.[205]

5) Ethical Arguments:

Despite extensive research and writing on euthanasia, one viewpoint has not been fully exhausted in the discussion (a discussion that hopefully informs the direction that the debate on euthanasia takes) – the ethics of the act. The ethical background to the act is adversely quoted across all arguments for and against this phenomenon. The argument for the unethicality of euthanasia can be contrasted to that of committing abortion, which has also been relatively prevalent in current times. The similarity here is because in some way, the law permits the killing of a fetus if it poses a threat to the life of the mother, as much as it allows physicians to end the life of a 'terminally ill' patient with their consent.

From a moral perspective, it is indeed loathsome and unethical that the individual has to terminate another's life; despite the law providing for the same. However, it is also argued that allowing euthanasia could somehow lessen the number of suicides experienced today.[206] The

worrying aspect of allowing voluntary euthanasia at whatever degree will likely pave the way for infiltration of involuntary euthanasia.[207]

Additionally, the increased autonomy that is sought after could be detrimental especially where the patient is unwilling to listen to the qualified opinion of a medical practitioner – in cases where the patient is extremely enthralled by their condition but the practitioner feels the situation does not warrant euthanasia. This simply implies autonomy for the sick; that is, a process that allows them a chance to decide what to happen to them at a critical phase in their treatment.[208] [209] While proponents of euthanasia could argue that this can be taken care of by enforcing strict regulation, it is highly unlikely that such good intentions could be entirely fruitful.[210] [211] It is this inefficiency in the enforcement that makes for weak case for the proponents of euthanasia, and actively damages the chance that regulation can be used to weaken the ethics' debate.

Undoubtedly, it is rarely possible to discuss euthanasia while omitting physician-assisted suicide. However, as shown in the definition, euthanasia is intended to end the suffering of a patient. It basically points to the need for immediacy. This often also highlights the apathy, which governments have shown towards it while mostly allowing physician assisted suicide. For instance, within the U.S. states that allow mercy killing (used as a broader term encompassing both practices) none allows euthanasia. This shows that the legalization of euthanasia is still a longer distance towards acceptance, and this should form a suitable point for the discussion on perceived ethicality of the practice.

While several arguments can be raised for and against the practice based on this unfolding dimension, it is easy to see that the immediacy of euthanasia creates a rather negative perception – in more specific terms, it can be termed as 'murder'. This outlook, despite looking

like a more subjective way to view the act, is confirmed by a pro-euthanasia writer, Goel, who states that euthanasia is the 'intentional killing by active action or by omission of a person whose role is to oversee the good care of the intended victim'.[212] This goes to show the real ethical issue behind euthanasia – killing of persons – and this is considered both illegal (under most circumstances) and unethical. Arguments in support of the act have to be strong and focused, bearing in themselves the real outlook of the suffering that those who need the service are going through.

The next point of focus in this argument is why at all it is necessary to consider ways to circumvent around an issue that imposes such serious Conflict of Interest and ethical questions, as why not wait for the course of nature to lead to the death of a sick person instead of someone deciding it should be ended. In essence, several diseases and conditions are not treatable, and this means that individuals who suffer from them have no chances of survival (unless, luckily, some natural mechanism wipes out their condition). This leads to extreme desperation, and for the sick, any moment of pain only serves to remind them how much a burden they have become to their caregivers and families.

The most urgent thing (in the absence of the possibility of healing) then becomes passing on, and this may further be aggravated by the perceived amount of pain being felt by a patient. At this point, there is a general feeling of helplessness and a great desire to see the patient's pain subside, whatever the means this can be achieved. Admittedly, the whole scenario points to death, the reason why euthanasia becomes a viable option despite the ethical challenges that come with its execution.

The entire discussion, though non-exhaustive, shows that it is time that society begins to learn how to live with one of the loathed deeds, euthanasia. As time goes by, it is becoming

necessary to make conclusive decisions regarding the future of all categories of patients. For the

purpose of this research, these can, be classified as easily healable, healable, unhealable but

manageable, and unhealable and unmanageable. The initial three categories do not pose a great

challenge to the operations of a physician; however, the unhealable and unmanageable category

of cases is open to 'mercy killing', and it is important that proper categorization is made to avoid

confusion (such as vague definitions and improper justifications) that would be detrimental to the

support for euthanasia. This point is reinforced by the fact that the act has failed to marshal

adequate support (and hence shed the tag of unethicality) because of the negative perceptions it

has borne, and a positive image is only possible if the perception is altered.

3.b.ii) Rights, Law & Religion:

Examining the relation between rights, law, and religion requires a complex discussion

on assisted death. First, rights highlight the crucial role not only of the patient but also of the

family. In other words, the family plays a critical role in decision-making about assisted death,[213]

and therefore Conflicts of Interest may arise between physicians, families, and patients where

there is a request for euthanasia.[214] The reason is that the patient may either support the request

for euthanasia or adamantly oppose it based on the right to life.[215] There are multiple roles for the

family when a request for euthanasia occurs, including the following:

    a. The family can initiate a request to assist a patient in dying without knowledge of the

    particular individual's actual wishes.[216] This may give rise to clinical Conflicts of Interest

    due to the failure to consider his autonomy and right to life.

    b. The family can remind the concerned physician of a previous euthanasia request and

    expect the request to be carried out when the medical condition of the patient

    deteriorates. Again, clinical Conflicts of Interest may arise due to the disregard for patient

autonomy and rights.

c. The family may oppose euthanasia, even when the patient has made a death request.[217] Clinical Conflicts of Interest may arise from the failure to respect the patient's autonomy and perceived right to die.

d. The family may report euthanasia to the authority in fulfillment of the law. The failure by the physician to respect the patient may engender clinical Conflicts of Interest, particularly where the doctor provides medically futile treatment without informed consent by the patient or their legitimate representatives.

These issues yield ethically problematic situations for patients, families, and providers.[218] For instance, clinical Conflicts of Interest may result from differences in opinion between the physician and family concerning particular aspects of euthanasia, including manipulation, cooperation, and confrontation.[219]

Second, because euthanasia concerns the fundamental rights to life and death, the law must play a vital role in regulating the practice.[220] The most pertinent role regarding assisted death that law plays is enacting regulation to either legalize or prohibit the practice in healthcare organizations.[221]

For instance, in the 1980s, the United States passed the *Baby Doe Legislation* to withhold federal funds from healthcare organizations that withheld life-saving and life-sustaining treatment to newborns based on the expectation of serious mental and physical abnormalities.[222] Also, the government can enact laws, policies, and regulations that attempt to address clinical Conflicts of Interest that may arise between families, patients, and physicians during euthanasia.[223] This is because the government can shape the moral fabric of the society, which involves whether assisted death is permissible or not.[224]

Third, the role of religion regarding assisted death is twofold: challenging the practice and opposing voluntary euthanasia laws,[225] presenting approaches to ethics that address assisted death.[226] Religion typically explains that voluntary euthanasia engages the debate over rights to life and death.[227] Religion can provide a distinctive moral compass for ethically-responsible behavior in society regarding assisted death.[228]

1) Definition of a Good Death:

It is important that people die with dignity.[229] Chronic diseases increase dependence, financial limitation, among other negative impacts, hence reinforce a poor self-image and indignity.[230] Examining some of the oldest texts on euthanasia, Joseph notes that the act is simply a way of saving terminally sick or handicapped people the agony of having to endure excessive suffering for the rest of their lives.[231] The definition of a good death is easily derived through a logical interpretation of the persons and situations surrounding the cases that persuade crusaders to seek for better conditions for the dying. Noting that only a very small fraction of patients express the will to die at a critical stage in their ailment, Cohen-Almagor states that some of the people who seek the aesthesia service are people at an advanced stage of their ailment (feeling they have no chance of making it back to a healthy status), those ailing and at an advanced age, and those whose autonomy is safely guaranteed.[232] These facts point to a unified definition of the term 'good death' as outlined under the context of euthanasia.

Put summarily, good death is a situation where the individual is assisted to both approach their last moments (perhaps following a serious illness) in a more dignified manner, such that they do not have to undergo indignity and traumatizing moments.[233][234] Clearly, such a scenario paves way for the involvement of euthanasia in the decision for a dignified end to life. To highlight the intensity of a physician hastened death, Chao et al. state that the first thing to do

when a patient asks for assistance to 'die' is to establish why they see that as the last option, so that the physician can adequately advise them on the possibilities of living a more dignified life.[235]

In accordance with the note by Chao et al. (above), the physician's assessment then becomes a matter of classification of the patient's condition and sickness as per the pre-stated categorizations. Where a patient falls under the unhealable and unmanageable category, the physician therefore has a duty to advise the patient and their kin that indeed euthanasia is the next best option to consider, bearing the fact that excruciating suffering is the only foreseeable eventuality. Such a person is undoubtedly destined for a painful and undignified death. The process of death, according to Chao, begins with the very events that culminate in the actual occurrence.

Therefore, managing the entire process becomes the best way to ensure that the patient dies dignifiedly. Importantly, ensuring that every step of the process is meaningfully painless or treated to the best capabilities there is. It is this lengthy context of the death process upon which patient treatment should be understood, similarly considering that the process of care is partly the same that inevitably leads to the deaths of patients. More so, with the popularization of euthanasia as a means to create a dignified death for patients the process is now open to being triggered by the physician as instructed by the patient or their kin where conditions are properly justified.

While undertaking a qualitative study to understand what practitioners perceive as 'good death', Silva et al. came up with a framework that promotes comfort as the central tenet, with other tenets being relief of discomfort, correct body positioning and maintenance of health, and psychosocial support for the patient.[236] [237] [238] A more comprehensive definition of the term, as

provided above states that quality of death denotes the meeting of individual's desired way of dying; which is, intrinsically, a painless and least uncomfortable occasion.[239] Based on these definitions (which principally present the instances that enumerate comfortable death), there arises a set of events that may precede what can be referred to as good death.

These include instances where the patient is living under experimental medication that has not shown any signs of improving their health; meaning that their foreseeable future does not present any tangible source of hope, and when the patient is seen to be 'overburdened' by living under heavy medication for an undefined period of time.[240] This means that good death for the terminally sick is almost inconceivable unless the physicians intervene to ensure that the suffering is ended in the only way possible at some point. In a broader perspective, a good death is practicable in situations where the intervention not only relieves the patient of their suffering through 'mercy killing' but also ensuring that they do not experience pain while undergoing the process. This is a complex issue that involves active administration of medication to the extent of alleviating pain until such a time that death occurs. The same would not apply for a patient whose condition does not warrant such severe means of intervention.

2) Assisted Death Laws:

There are several notions regarding the laws on euthanasia. The pro-sanctity-of-life debate is indeed supportive of the argument that euthanasia is a means to take the life of a person, an act prohibited in international law. In fact, as earlier noted, governments and their corresponding societies are moving away from every form of 'murder/ killing' where such is not necessitated by a situation of imminent danger to the life of one or a group of individuals. This debate tends to criminalize euthanasia in totality.

However, euthanasia is also regarded as a way of ensuring that an individual has a

dignified death – one that they would approve of.[241] A review of some of the countries in which

the debate on euthanasia has been going on reveals varying degrees of awareness, preparedness,

implementation, and legislation altogether. Only six countries have fully legalized euthanasia

(Canada, Colombia, Netherlands, Belgium, Luxembourg, and Switzerland) with few states in the

U.S. also joining this group.[242]

In the U.K., where the practice is illegal (albeit the fact that a 2010 attempt to pass a law

allowing the act failed by a huge margin, showing huge disapproval), there is a general feeling

that allowing euthanasia in law would affect the Hippocratic oath whose leading tenet is not to

harm patients.[243] The Netherlands has distinguished itself as one of the leading destinations for

safe practicing of euthanasia. A review of the trail of laws that paved way for the enactment of

pro-euthanasia laws shows that the country indeed rose to overcome strict laws that prohibited

the act.

The Dutch Penal Code criminalized the act, and Article 293 provided that any person

who takes another's life at their request was punishable by up to 12 years imprisonment.[244]

Underscoring the erroneous notions of German medical students that Germany criminalizes

physician assisted death, Anneser et al. brings to light the fact that German law is not inclined to

punish those who enforce physician assisted suicide.[245]

The Australian Medical Association does not regard administration of painkillers to

suppress the secondary symptoms of an ailment as unethical or unlawful. In fact, this is

considered 'good practice'.[246] This means that according to the AMA, a physician who

administers the wrong dose believing it is the correct one (meant to prolong the life of a patient)

cannot be held liable for any consequences therein that seem to hasten death. The Australian

Human Rights Commission further states that under the common law that Australia looks to,

refusal to take medicine by a mentally competent individual is allowed, even when such may lead to death. Interestingly, Belgium has a law allowing euthanasia but prohibiting physician assisted suicide.[247]

Japan's approach to the question of euthanasia is relatively conservative, and the Japanese law does not have express laws allowing euthanasia. However, recent developments have shown recognition for death with dignity, which is viewed as the start of the journey towards reforming the healthcare system to allow for euthanasia and physician assisted suicide.[248] India is seen to be actively engaged in a positive review of its laws on euthanasia, with the Indian Supreme Court providing guidelines for the consideration for the process. The guidelines state that every applicant will receive a hearing by a bench that will determine their suitability.[249]

In this case, it is clear that the court bestowed upon itself the role of regulating any cases of euthanasia. There are obviously a number of similarities to the various provisions for euthanasia and physician assisted killing. Some of these include, as can be deduced from the preceding discussion in this subsection, the stringent ways to regulate the way patients request and get approval for the same. Importantly, there must be the exercise of due diligence, such that the process is not undertaken too soon to the extent that there is not enough time to review and classify the request. This is an important and desirable commonality since it is the primary means for regulation.

Obvious differences appear in the regulation processes across jurisdictions, including who handles the process of approval. For instance, while the process of physician assisted killing is left to the doctors, family, hospital administration in the U.S., in India it is the preserve of the court of law to ensure that the process happens with utmost clarity and justification. This Indian

model appears to be subject to very strict regulation, unlike the Netherlands' one that has, by distinction, been in existence for a much longer period of time. This shows that, possibly, the severity of regulation diminishes as community becomes more used to the act, and similarly as acceptability increases.

There is no harmonized approach to the U.S. approach to euthanasia, which is the result of different states having unique laws on the matter. However, the U.S. Supreme Court, in two distinct cases in 1997 held that it regards the distinction between killing and letting die as a matter of rationality rather than a systemized, comprehensive approach.[250] The state of Oregon was the first to formulate and implement laws on physician assisted killing, this coming way back in 1994 although actual implementation began three years later due to prolonged judicial processes.[251]

Oregon's law on physician assisted death governs the situations under which a patient can make a request for assisted death, and when the request can be honored. The state's law stipulates that the patient must have been determined to be suffering from a condition that limits their total life expectancy to just six or less months since the time of the request, and that they must be legally seen as fit to make independent decisions. Furthermore, the patient must make the request twice within a period spanning at least two weeks, and that the decision has to be communicated to the kin besides the patient signing a letter declaring their intention in the company of two witnesses.[252] Several other states have attempted to legislate on the topic; however, only four more states have succeeded in making relevant legislation (however, the laws in all five states criminalize euthanasia while permitting physician assisted killing).[253] Fraser and Walter highlight the legal dilemma for the United States as seeking a balance between personal autonomy and the values system that seems to criminalize end of life medicine.[254]

Because of the increased personal autonomy, there has been a tendency to legislate and rule in favor of the same in most situations that present contradictions between basic human rights and traditional laws. This kind of autonomy seeks to ensure that the dignity of the individual is upheld, such that their right to life is prioritized. An example is the ongoing judicial reforms in the U.S. and elsewhere to eradicate capital punishment (including the death sentence).[255] The right of the individual U.S. citizens to make their own independent decisions is guaranteed in the 14th amendment to the constitution.[256]

This means that, despite several state legislatures having failed to enact laws that guarantee the right to decide when to let a patient die at their own will, the two rulings alluded to above offer state parliaments an easy route for successfully making pro-euthanasia laws. Despite the slow progress towards the path to fully legalizing euthanasia, there is gradual progress in this direction.[257] One such indicators, is the favorable legislations made in the five states of Oregon, Montana, California, Vermont and Washington.

A careful consideration of the arguments for and against euthanasia has revealed that the decision to end life is not in the hands of a physician or a law enforcement officer. Primarily, the decision to die is based on personal circumstances and judgment. Most of these scenarios as noted in the research arise from chronic diseases. Essentially, the supportive agents such as doctors and family associated with such cases can only advise and provide the necessary information based on evidence based assessments to refute or support a request to die. Moreover, the dignity of life and the practicalities of dying indicate that continued suffering while the endpoint is death is irrational.

Further, countries around the globe are taking steps directed towards legalization of assisted suicide while other such as Belgium and Netherlands have adopted it legally.

Subsequently, research suggests that in the next half a century, more and more countries will have legalized euthanasia and PAS, albeit based on different arguments and principles because of the different prevailing settings such as culture and beliefs. Hence, it is justifiable to conclude that euthanasia and PAS should be permitted but only if the patient has the physical and mental capacity to decide whether to die.

3) Religious determination on when death occurs:

Speaking of euthanasia will inevitably have to deal with the concept of incurability. When one can confidently say that a patient is incurable? There is always a possibility of medical errors, including an unfavorable diagnosis. Besides, the concept of incurability is highly dependent on the means and features currently available to the medical system.

Euthanasia as a problem exists only for those who recognize the humanistic principle of the absolute value of the person and his/her life, in relations between individuals, which by the nature of personal relationships and social position just wish each other good. If the relationships between people are full of hatred and disbelief, then euthanasia will be out of the question because it gives a possibility of committing purposeful evil[258].

The internal stress of euthanasia situation (a situation of moral choice when one needs to make a decision about euthanasia) is that it is regarded as a continuation and concrete expression of humane, moral and respect to those who are helped to die. It is seen as an exceptional case where the principle of humanism manages to approve in its positive meaning through the apparent retreat from it[259].

Judging formally, deliberate killing of the innocent is always a moral evil. Consequently, euthanasia is a moral evil. Supporters of euthanasia can appeal to the fact that the above-stated conclusion implies a distinction between justified and unjustified killings[260]. If some kind of

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killing is justified, why not justify voluntary euthanasia, at least under certain circumstances?

Generally speaking, the religious approach to euthanasia is characterized by the unique solution of the problem. Life, no matter how difficult it may be, is given to people by some above forces, and can only be taken away from a person by these same forces[261].

At the same time, religions could agree with the altruistic argument towards euthanasia. An argument based on the Conflict of Interests between the patients' wellbeing and their desires to alleviate the burden of loved ones. But as a rule, this desire is determined not so much by the fact that the man himself wants it, but that he must do so as with a thought of caring for the family he lobes. This argument is closely linked to the principle of the right to die with dignity. As it was mentioned above, Buddhism agrees that every human lives in community, and therefore shares responsibility for all his actions[262]. By caring about others we can also consider that a person wants to release the burden he puts on his relatives by his disease.

However, this would not still be acceptable in Islam. The value attributed to human life is too high, as well as family responsibility for its older/diseased family members is too high, too. Since Allah is a creator and a real owner of all lives, he and only he can make decisions about when a human can die. "We ordained for the Children of Israel that if any one slew a person - unless it be for murder or for spreading mischief in the land - it would be as if he slew the whole people: and if any one saved a life, it would be as if he saved the life of the whole people"[263]; "Do not kill yourselves, for verily Allah has been to you most merciful"[264]; "....take not life which Allah has made sacred"[265]. That said, from this it can be inferred that Islam does not have major dilemmas applied to the issue of euthanasia. Its position is rather strong and ultimate.

4) Roles in end of life discourse:

In many ways, while remaining an ethical issue, euthanasia imposes another source of

Conflict, that is the socio - economic functioning of state. In this sense, the problem of euthanasia arises when people are devalued in the eyes of society and the state as a whole, when they are deprived of elementary attention. If a state provides its citizens (regardless of their health status and age) with the proper way of life (housing, pension, social protection), then the number of people willing to commit a suicide would probably be much less[266]. Many people prefer to die than to beg and suffer. The role of state in solving this problem is to create conditions for the terminally ill (like hospices etc.).

Another role of the state in end of life discourse is creation of legislation, bound by laws and regulations to regulate the controversial issues related to euthanasia[267]. While both doctors and philosophers discuss this problem, many governments tend to take an observational position. The question is not whether the refusal is contrary to the human right to die. Here, the ethical dilemma is whether a state ban for euthanasia contradicts to the basic human rights, including the right to death in dignity. Most of the states exploit lives of their fellow citizens for political reasons (war, extreme working conditions, the fight against natural disasters, epidemics), but at the same time deny the people from taking charge of their future and personal life[268].

Legal definition of euthanasia is the most debated and controversial topic. The approaches vary from country to country. It should be stated that the problem of euthanasia has not found its solution in international conventions. For example, the European Convention on Human Rights and Fundamental Freedoms, adopted on 4 November 1950 and entered into force on 3 September 1953 is silent on this topic[269]. The materials of the European Commission on Human Rights note that neither the Convention nor the case law on the application of the article address the question of the admissibility of suicide from a legal point of view. Questions such as whether the right to life includes the duty to live and whether an individual can deny this right

are open.

In accordance with the Venice Declaration of the terminal state, adopted by the 35th World Medical Assembly (WMA) in October 1983, the doctor must, whenever possible, facilitate the patient's suffering, always guided by the interests of the latter. However, the refusal of treatment, according to the Declaration of 1983, does not exempt the physician from the obligation to help the dying patient by assigning drugs to alleviate the suffering[270]. In October 1987, 39th World Medical Association in Madrid adopted the Declaration on Euthanasia[271]. The text of the document states "Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness"[272].

Therefore, the World Medical Association Declaration of Venice and Madrid allow passive form of euthanasia: a doctor does nothing to prolong the life of a patient, and applies only painkillers[273]. It adheres to a principle legislator Oregon, the only state in the US, where a medical doctor is permitted to assist a patient to die[274].

Talking about country cases, in the Netherlands, legalization on euthanasia was carried out in stages. For example, in April 1994, the Dutch Parliament adopted an instruction allowed to hold it with some restrictions. And on April 10, 2001 the Dutch Parliament approved a law exempting medical doctors who help patients lose their lives from legal responsibility[275]. Thus, we see that the legislature is slowly moving towards the legalization of euthanasia. Totally allowing euthanasia is inhibited by ambiguous public opinion. It should be clear that no general legislature can cover all special cases. Decisions made by medical doctors cannot be replaced by the legal ones[276]. This is especially true concerning the human life.

Four years later, euthanasia was legally allowed in Belgium, freeing doctors from criminal liability for the conduct of such procedure. By adopting such law, the Belgian government has established a Standing Committee to oversee the euthanasia[277]. The last country to legalize voluntary renunciation of human life is Luxembourg. An interesting position on this issue is held by the Swiss legislators, where euthanasia is de-jure forbidden, but in fact allowed, as the legislation mentions that aid in the implementation of the suicide is not against the law. With the same purpose the citizens of other countries come here, because it is the only country in Europe and in the world where euthanasia is not prohibited for foreigners[278].

There are some limitations to legislation, still. For example, in Canada, the right to euthanasia can only be exercised by its citizens and only mentally healthy people over 18 years. And it is not just people who wanted to say goodbye to life, and only suffering from incurable diseases or injury, from which death inevitably comes[279].

Decision about euthanasia must definitely be one of the most difficult decisions which are made within family. From one side, all the loving relatives would hardly bare seeing someone they love suffering and experiencing pain. As evidence and practice show, when a critical situation comes, families tend to spend all their savings so as to trade an opportunity to prolong the life of their loved ones, as well as to relieve the pain they are experiencing[280]. However, death via euthanasia, in its passive or active form, would always be the last possible consideration. Families might also feel hard if they have to make euthanasia decision (especially, when it comes to the states when they are those making decision due to inability of the diseased person to make it). Euthanasia is still a kill, and even knowing that the death would anyway come would be hard to admit that it was made after decision of yours[281].

At the same time, among family concerns financial interests should also be considered.

This is often the case, despite the fact that the evidence on this topic is rather limited. Consequently, euthanasia might be an easy way to get money from the dying patient. The issue of financial interests of all the parties involved in decision-making should be considered before the final decision is made[282].

5) Issues to be addressed:

Euthanasia advocates call it an "act of mercy" and "freedom from suffering." They say that life cannot be considered good when it consists only of physical and mental torture with no hope of relief; if human existence is supported by sophisticated technology, life ceases to be a desirable goal[283]. Among the arguments in favor of euthanasia mentioned and economic aspect: the money spent on the maintenance of life of terminally ill can be spent on the treatment of those who still have hope for the healing. Finally, one of the main arguments in favor of euthanasia is that a person has a right to make decisions about his life[284].

Euthanasia expressed by representatives of all the world religions. Their main argument is that only God gives life to human and only he can take it. The intentional termination of the life of religion is considered murder or suicide. The physician should not assume the function of God[285].

Secular opponents of "right to die" talk about the absolute value of human life: it is in any form better than the absence of all life; it is good even if converted into a continuous suffering, people in a vegetative state, too have a right to live. Those who oppose euthanasia are also talking about the possible abuses by family and doctors: one person may wish to kill another one due to inheritance; the other can thus save the budget[286]. Opponents of euthanasia point out that the termination of life is unnatural for doctors. If the "right to die" will be legalized, there would be a risk that doctors would lose the incentive to search for new drugs and treatments.

Other than that, opponents of euthanasia tend to believe that a person can live in dignity even on the final stages of illness. This simply requires quality care. Also it is necessary to distinguish between the desire to get rid of the pain and a wish to die. With the right approach – especially with well-chosen anesthesia, the availability of morphine on the same day, a person might voluntary stop insisting on euthanasia[287].

Admissibility of euthanasia might also be associated with a significant aging of the population, with an increase in the number of disabled elderly, content, care and treatment which involves a series of economic and social problems. The logical conclusion of the recognition of the social acceptability of euthanasia is defective. Particularly acute, this problem arises with respect to the newborn[288].

The economic and social bases of forced euthanasia is added and the genetic factor, the threat of "biological degeneracy". In contrast to all these forms and types of euthanasia, the application of which is still far from social recognition, forced euthanasia has already appeared on the level of practice[289].

Arguments of physicians opposing euthanasia are based on medical practice. Medicine knows facts of spontaneous treatment of cancer. Although such cases are rare, the possibility to exclude them in each individual situation is impossible. Secondly, the practice of military doctors indicates a person's ability to adapt to life despite a disability (amputation of the feet, hands). Adaptation and new quality of life, as a rule, lead most of them to negative evaluation of their previous requests to doctors to accelerate their death. Thirdly, the acceptance of death as a kind of medical treatment (pain and suffering) can be a powerful obstacle to the development of medical knowledge, the development of which is constantly stimulated by the fight against the death[290].

6) Remedies to bioethics in Assisted Death dilemma:

Medical ethics and medicine as a whole have changed since the time of Hippocrates. Now a lot of attention is paid to the development of palliative medicine. Numerous programs maintaining the quality of life of patients with incurable conditions are being designed, which will help them people to live up to their natural end, without experiencing terrible suffering[291].

At the same time, not all the suffering can be alleviated and released. It is true that the bottom line is very thin, but we should always keep in mind that none of the people should invade the personal life, and should make the decisions on which type of pain can be bearable and which cannot. Consequently, it is recommended that euthanasia is not banned, and the corresponding legislation allowing euthanasia is enforced, following the example of the countries which have this legislation already[292].

A patient must be an adult person or legally sui juris underage; A patient at the time of euthanasia request should be sui juris; The decision to euthanize must be made voluntarily, without any external pressure, after the receipt of accurate and relevant information about the disease, palliative care, etc. If a person is unable to present a request for euthanasia in a written form, then they select the trustee who shall not have any interest (often financial) in the patient's death[293].

7) Regarding the condition of a patient:

It should be medically hopeless condition where a person goes through unbearable physical or psychological suffering that cannot be eased sufficiently.

Euthanasia should only be allowed for adults or legally sui juris underage (the latter can only be established by the court); Euthanasia should be the last possible decision and all the other options should be previously considered. Psychiatric patients who are declared legally incapable,

should not be allowed to ask for euthanasia. This applies to all: for example, to those who are institutionalized voluntarily or those who regularly visit a psychiatrist, psychologist or psychotherapist, and can probably formulate a valid request for euthanasia. But it is believed that even these patients at the time of the request may be in a state of "brain fog". In addition, mental disorders cannot serve as a ground for euthanasia[294].

In case of dementia or Alzheimer's, euthanasia should not be made a possible option. However, there is currently a legislative initiative in some countries that offers euthanasia for patients with damaged brain function[295].

Medical doctor and family can only make a decision on the termination of treatment, but not about the introduction of a lethal dose of the drug. Also, family cannot prohibit euthanasia[296]. In practice, physician cannot directly recommend euthanasia, but patient's behavior may suggest such an option (for example, a patient is not aware of the fact that euthanasia can be legal or is afraid to say it out loud)[297].

Insurance companies should not refuse payment of life insurance (as opposed to suicide), since the law should define euthanasia as a natural death; Similar care must be preceded by unbearable suffering from an incurable disease, or being in an irreversible coma; the main and only motive for the doctor should be the patient`s cessation of suffering. In this context, the patient's death is the only way to end suffering, and so is only possible for the dying. Physician should choose for your patient the most painless and humane way to end this life[298]. The right to be in charge of life is an inalienable human right; accordingly, the person entitled to dispose this right, sell it, and realize this right in the most extreme cases. Another issue is that legislation should exclude the possibility of manipulation from the outside in relation to this critical decision made by a person[299]; In the second half of the twentieth century, especially in the last 10-20

years, there was a phenomenon not seen in the history of mankind before, the aging of societies. The midlife crisis is shifted to around 60 years in the western countries. 60-70-year-olds go to re-training courses, travel around the world. This is a powerful challenge for all the developed states. Euthanasia might also be a derivative from this tendency[300].

The today's world faces a terrible differentiation. There are, on one hand, bioethics, on the other side the traditional schools of thought: post-structuralism, existentialism, phenomenology, analytic philosophy, philosophy of language, pragmatism. In the States, they are actively involved in the process of thinking about death; there were books and even textbooks. But continental philosophy is distanced from that. Thirdly, there are theology, medicine and culture which the modern discourse about bioethics should also consider for[301].

Euthanasia is performed by medical doctors. Collision of two professional dogmas, saving lives and freedom from suffering can push conscientious physicians to the state of cognitive dissonance when the right decision is impossible to choose. Such selection is hard to do, even in respect to a close person, even though such examples are known[302].

The dilemma on euthanasia should also consider the type of society. For example, in the archaic, conservative countries or countries of jail dictatorships and authoritarian regimes the authorities believe that a person is not free to shape their own life and death. People belong to the state, and the law is strictly on the side of protection of state property[303]; The answers to these fundamental questions are very difficult. But bioethics creates a special type of knowledge, when a doctor (investigator) and patient (subject) seek a dialogue of equality and mutually accounting arguments[304]. Value-based position of a particular person does not allow for an approach in terms of "right / wrong" or "true / false" on the part of other subjects. Therefore, any decision taken by a patient consciously and on the basis of sufficient information is a manifestation of his

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personal autonomy, and thus requires respect for themselves from others, organizations, society and the state[305].

Euthanasia is complicated social issue, which implies numerous factors and considerations. Nowadays, the term euthanasia includes a number of mandatory elements. A death is considered euthanasia, if it was caused by an act or omission (in the case of non-treatment) of another person by a physician. The world is generally moving towards improved legislation regarding euthanasia and permission under certain, numerous circumstances. Several developed countries have already adopted the corresponding laws, while the debates continue in many other states. The idea of permitting euthanasia is fueled by the idea of human rights, with the related idea of death in dignity.

Generally speaking, euthanasia-related recommendations and applications to bioethics should consider been built and designed based on strong evidence and consistent research. At the same time, they should consider individual cases, each time when the euthanasia dilemma applies. In terms of poor ethics, euthanasia is different from suicide with that it still transfers the responsibility from one person to another, and thus so many issues arise. None of legislations and recommendations is capable of envisioning every possible concern and every possible consideration on euthanasia.

3.c) Conclusion:

In conclusion, this chapter discusses the pivotal life issues of abortion and assisted death to indicate and resolve clinical Conflicts of Interest that can arise. It explores the nexuses between human dignity and pluralism and consent and financial incentives in abortion. And it explores types of assisted death with accompanying issues related to rights, law, and religion. These clinical issues can engender professional Conflicts of Interest, and these conflicts must be

resolved via a balance between professional obligations, legal requirements, and patient interests,

as discussed in the next chapter.

[1] Nussbaum, Martha, and Rosalind Dixon. "Abortion, dignity, and a capabilities approach." *Feminist Constitutionalism: Global Perspectives* (December 1, 2013): 4.

[2] Halliday, S. "Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life." *Contemporary Issues in Law* 13.4 (2016): 287-322. ISSN 1357-0374

[3] Gelman, Sheldon. "Life and Liberty: Their Original Meaning, Historical Antecedents, and Current Significance in the Debate over Abortion Rights." *Minn. L.* (1993): 586.

[4] Halliday, S. "Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life." *Contemporary Issues in Law*, 13 (2016): 287-322. ISSN 1357-0374

[5] Kaposy, Chris. "Two stalemates in the philosophical debate about abortion and why they cannot be resolved using analogical arguments." *Bioethics* 26.2 (2012): 84-92.

[6] Gelman, Sheldon. "Life and Liberty: Their Original Meaning, Historical Antecedents, and Current Significance in the Debate over Abortion Rights." *Minn. L. Rev.* 78 (1993): 588.

[7] Kaposy, Chris. "Two stalemates in the philosophical debate about abortion and why they cannot be resolved using analogical arguments." *Bioethics* 26.2 (2012): 84-92.

[8] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[9] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[10] Yardi, Sarita, and Danah Boyd. "Dynamic debates: An analysis of group polarization over time on Twitter." *Bulletin of Science, Technology & Society* 30.5 (2010): 316-327.

[11] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

[12] Lopez, Raquel. "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between." *European Journal of Social Sciences* 27.4 (2012): 511-517.

H.A.M.J. Ten Have & M.S. Jean (eds.): *The UNESCO Universal Declaration on Bioethics and Human Rights. Background, principles and application*. (Paris: UNESCO Publishing, 2009), 91.

[14] Pazol K, Zane SB, Parker WY et al. "Abortion surveillance, United States 2007.*" MMWR Surrveill Summaries.* 60 (SS 1): 1-39; http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf, (2011): 16.

[15] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[16] Finer LB, Henshaw SK. *Disparities in rates of unintended pregnancy in the United States*, 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006; 38(2)* 90.

[17] World Health Organization. Unsafe Abortion: *Global and Regional Estimates of the Incidence of Unsafe Abortion and an associated Mortality in 2003. 5th edition.* (Geneva: WHO, 2007), 1.

[18] Kost, K., Henshaw, S., & Carlin, L . (2010). U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity. Retrieved January 26, 2010, from http://www.guttmacher.org/pubs/USTP-trends.pdf.

[19] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[20] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[21] Pazol K, Zane SB, Parker WY et al. Abortion surveillance, United States 2007. *MMWR Surrveill Summaries.* 60 (SS 1): 1-39; http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf, (2011): 16.

[22] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[23] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States" 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1983.

[24] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006; 38(2):*96.

[25] Pazol K, Zane SB, Parker WY et al. "Abortion surveillance" *United States 2007. MMWR Surrveill Summaries.* 60 (SS 1): 1-39; http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf, (2011): 20.

[26] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[27] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006; 38(2):* 90 -96.

[28] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[29] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[30] Pazol K, Zane SB, Parker WY et al. "Abortion surveillance" *United States 2007. MMWR Surrveill Summaries.* 60 (SS 1): 1-39; http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf, (2011): 32.

[31] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 82.

[32] Sara E. Davies: *Global politics of health*. (Malden, MA: Polity Press, 2010), 224.

[33] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[34] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[35] World Health Organization. Unsafe Abortion: Global and Regional Estimates of theIncidence of Unsafe Abortion and An associated Mortality in 2008. 6th edition. Geneva: WHO, 2008.

[36] Guttmacher Institutes. "Induced Abortion Worldwide." *In Brief* , World Health Organization , 2012, www.who.int/reproductivehealth/publications/unsafe_abortion/induced_abortion_2012.pdf.

[37] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[38] Finer LB, Henshaw SK. "Disparities in rates of unintended pregnancy in the United States", 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006; 38(2)* 98.
Pazol K, Zane SB, Parker WY et al. "Abortion surveillance" *United States 2007. MMWR Surrveill Summaries.* 60 (SS 1): 1-39; http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf, (2011): 36.

[40] Shadigian, Elizabeth. *"Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion"*, testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

[41] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[42] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later,*" Scientific* (2012): 4

[43] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later,*" Scientific* (2012): 4

[44] H.A.M.J. Ten Have & M.S. Jean (eds.): *The UNESCO Universal Declaration on Bioethics and Human Rights. Background, principles and application*. (Paris: UNESCO Publishing, 2009), 91.

[43] World Health Organization. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and An associated Mortality in 20 03. 5th edition.(Geneva: WHO, 2007), http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241596121/en/

[46] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States." 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1996.

[47] Paul Farmer. "Pathologies of power. Health, human rights, and the new war on the poor." (Berkeley/Los Angeles/London: University of California Press 2005), 438.

[48] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006; 38(2):* 92.

[49] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[50] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[49] World Health Organization. Unsafe Abortion: *Global and Regional Estimates of the Incidence of Unsafe Abortion and an associated Mortality in 2003. 5th edition.* (Geneva: WHO, 2007), 1.

[52] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[53] Byron C. Calhoun, "Preterm Birth Update." The Linacre Quarterly. (2012): 231.

[54] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[53] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[56] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later,*" Scientific* (2012): 5.

[57] World Health Organization. Unsafe Abortion: Global and Regional Estimates of theIncidence of Unsafe Abortion and An associated Mortality in 2008. 6th edition. Geneva: WHO, 2008.

[58] L.G. Johnson, et al., "The Relationship of Placenta Previa and History of Induced Abortion" *81 Int'l J. Gynecology & Obstetrics* (2002): 191.

[57] World Health Organization. Unsafe Abortion: *Global and Regional Estimates of the Incidence of Unsafe Abortion and an associated Mortality in 2003. 5th edition.* Geneva: WHO, 2007, 1.

[60] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later," *Scientific* (2012): 5.

[61] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[62] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[61] World Health Organization. Unsafe Abortion: *Global and Regional Estimates of the Incidence of Unsafe Abortion and an associated Mortality in 2003. 5th edition.* (Geneva: WHO, 2007), 1.

[64] Byron C. Calhoun, "Preterm Birth Update." *The Linacre Quarterly*. (2012): 231.

[65] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health 2006, 38(2):* 90.

[66] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 82.

[65] World Health Organization. Unsafe Abortion: *Global and Regional Estimates of the Incidence of Unsafe Abortion and an associated Mortality in 2003. 5th edition.* (Geneva: WHO, 2007), 1.

[68] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[69] Sawicki, Nadia N. "The Abortion Informed Consent Debate: Lighter, Less Heat." *Cornell JL & Pub. Poly* 21 (2011): 19.

[70] Jones, Rachel K., Ushma D. Upadhyay, and Tracy A. Weitz. "At what cost? Payment for abortion care by US women." *Women's Health Issues* Volume 23, Issue 3, (2013): e173-e178.

[71] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States" 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1983.

[72] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later," *Scientific* (2012): 5.

[71] Sedgh G, Singh S, Henshaw S et al. "Induced abortion: the global reality and avoidable risks." Lance t (2007): 1887-1892.

[74] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later," *Scientific* (2012): 5.

[75] L.G. Johnson, et al. "The Relationship of Placenta Previa and History of Induced Abortion." *81 Int'l J. Gynecology & Obstetrics (2002):* 191.

[76] Byron C. Calhoun, "Preterm Birth Update." *The Linacre Quarterly*. (2012): 231.

[75] Sedgh G, Singh S, Henshaw S et al. "Induced abortion: the global reality and avoidable risks." *Lance t 2007*, 368:1887.

[78] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 38:72-81.

[79] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[80] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 78.

[81] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States." 1982-2002. [Advance Data, no. 350]. (Hyattsville MD:

National Center for Health Statistics, 2004), 1982.

[82] American Association of Prolife Obstetricians and Gynecologists(AAPLOG), *Induced Abortion and Subsequent Breast Cancer Risk: An Overview (2008),* available at http://www.aaplog.org/complications-of-inducedabortion/induced-abortion-and-breast-cancer/induced-abortion-and-subsequent-breast-cancer-risk-an-overview/

[81] Sedgh G, Singh S, Henshaw S et al. "Induced abortion: the global reality and avoidable risks." Lance t (2007): 1890.

[84] Byron C. Calhoun, "Preterm Birth Update." The Linacre Quarterly. (2012): 231.

[85] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[86] Robinson, D. "Confronting biopiracy. Challenges, cases and international debates" *Earthscan: London/New York, (2010/2012).*

[87] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[86] Sedgh G, Singh S, Henshaw S et al. "Induced abortion: the global reality and avoidable risks." Lance t (2007): 1890.

[89] John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40 Years Later," *Scientific* (2012): 5.

[90] American Association of Prolife Obstetricians and Gynecologists(AAPLOG), *Induced Abortion and Subsequent Breast Cancer Risk: An Overview(2008),* available at http://www.aaplog.org/complications-of-inducedabortion/induced-abortion-and-breast-cancer/induced-abortion-and-subsequent-breast-cancer-risk-an-overview/ (last visited Apr. 20, 2010).

[89] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States" 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1983.

[92] L.G. Johnson, et al., "*The Relationship of Placenta Previa and History of Induced Abortion*" 81 *Int'l J. Gynecology & Obstetrics (2002):* 191.

[93] Shadigian, Elizabeth. *"Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion"*, testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

[94] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 76.

[95] Donna Dickenson. *Me medicine vs We medicine. Reclaiming biotechnology for the common good.* (New York: Columbia University Press, 2013), 22.

[96] H.A.M.J. Ten Have & M.S. Jean (eds.). "The UNESCO Universal Declaration on Bioethics and Human Rights. Background, principles and application." (Paris, *UNESCO Publishing, 2009)*, 91.

[97] Shadigian, Elizabeth. *"Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion"*, testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

[98] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 72.

[99] Robinson, D. "Confronting biopiracy. Challenges, cases and international debates. Earthscan"

London/New York, 2010/2012.

[98] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States" 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1984.

[101] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[102] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[103] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[104] Mosher WD, Martinez GM, Chandra A et al. "Use of Contraception and Use of Family Planning Services in the United States" 1982-2002. [Advance Data, no. 350]. (Hyattsville MD: *National Center for Health Statistics*, 2004), 1984.

[105] Shadigian, Elizabeth. "Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion", testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

[106] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual & Reproductive Health (2006), 38(2):* 93.

[107] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 82.

[108] World Health Organization. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and An associated Mortality in 2008. 6th edition. Geneva: WHO, 2008.

[109] L.G. Johnson, et al. "The Relationship of Placenta Previa and History of Induced Abortion," 81 *Int'l J. Gynecology & Obstetrics (2002*): 191.

[110] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[111] Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive Medicine* (2007): 929-937, 931.

[112] Major B, Appelbaum M, Beckman L, et al. "Report of the Task Force on Mental Health and Abortion" *American Psychological Association, Task Force on Mental Health and Abortion* (Washington, DC, 2008): 1.

[113] Santelli J, Ott MA, Lyone M et al. "Abstinence and abstinence-only education." *A Review of U.S. Policies and Programs Journal of Adolescent Health (2006):* 73.

[114] Shadigian, Elizabeth. *"Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion"*, testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

[115] Robinson, D. "Confronting biopiracy. Challenges, cases and international debates. Earthscan" London/New York, (2010/2012).

[116] Green-Pedersen, Christoffer. "The conflict of conflicts in comparative perspective: Euthanasia as a political issue in Denmark, Belgium, and the Netherlands." *Comparative politics* (2007): 273-291.

[117] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama*

221, no. 2 (1972): 174-179.

[118] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[119] Van der Lee, Marije L., Johanna G. van der Bom, Nikkie B. Swarte, A. Peter M. Heintz, Alexander de Graeff, and Jan van den Bout. "Euthanasia and depression: a prospective cohort study among terminally ill cancer patients." *Journal of Clinical Oncology* 23.27 (2005): 6607-6612.

[120] Kübler-Ross Elisabeth, Wessler, Stanford, and Avioli, Louis V. "On death and dying." *Jama* 221, no. 2 (1972): 174-179.

[121] Van der Lee, Marije L., Johanna G. van der Bom, Nikkie B. Swarte, A. Peter M. Heintz, Alexander de Graeff, and Jan van den Bout. "Euthanasia and depression: a prospective cohort study among terminally ill cancer patients," *JCO* 23, no. 27 (2005): 6607-6612.

[122] Chao, D. V. K., N. Y. Chan, and W. Y. Chan. "Euthanasia revisited." *Family Practice*, Volume 19, Issue 2, (2002): 128–134.

[123] Chapple, Alison, S. Ziebland, A. McPherson, and A. Herxheimer. "What people close to death say about euthanasia and assisted suicide: a qualitative study." *Journal of Medical Ethics* 32.12 (2006): 706-710.

[124] Chao, D. V. K., N. Y. Chan, and W. Y. Chan. "Euthanasia revisited." *Family practice* 19.2 (2002): 128-134.

[125] Chapple, Alison, S. Ziebland, A. McPherson, and A. Herxheimer. "What people close to death say about euthanasia and assisted suicide: a qualitative study." *Journal of Medical Ethics* 32.12 (2006): 706-710.

[126] De Boer, Marike E., Cees MPM Hertogh, Rose-Marie Dröes, Cees Jonker, and Jan A. Eefsting. "Advance directives in dementia: issues of validity and effectiveness." *International Psychogeriatrics* 22.2 (2010): 201-208.

[127] Schneider, Carl E. "Rights discourse and neonatal euthanasia." *California Law Review* 76.1 (1988): 151-176.

[128] Pellegrino, Edmund D. "Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship." *J. Contemp. Health L. & Poly* 10 (1994): 47.

[129] Pellegrino, Edmund D. "Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship." *J. Contemp. Health L. & Poly* 10 (1994): 50.

[130] Schneider, Carl E. "Rights discourse and neonatal euthanasia." *California Law Review* 76.1 (1988): 151-176.

[131] Strinic, Visnja. "Arguments in Support and Against Euthanasia." *British Journal Of Medicine And Medical Research* 9.7 (2015): 1-12.

[132] Strinic, Visnja. "Arguments in Support and Against Euthanasia." *British Journal Of Medicine And Medical Research* 9.7 (2015): 1-12.

[133] Pierre, Joseph M. "Culturally Sanctioned Suicide: Euthanasia, Seppuku, and Terrorist Martydom." *World Journal of Psyhiatry.* Vol. 5, no. 1, (2015): 5.

[134] Zenz, Julia, Michael Tryba, and Michael Zenz. "Palliative Care Professionals' Willingness to Perform Euthanasia or Physician Assisted Suicide". *BMC Palliative Care*, Vol. 14, No. 1, (2015): 1.

[135] Khan, Farooq, and George Tadros. "Physician-Assisted Suicide and Euthanasia in Indian Context: Sooner or Later the Need to Ponder!". *Indian Journal of Psychological Medicine,* Vol. 35, No. 1, (2013): 102.

[136] MacLeod, Rod Duncan, Donna M Wilson, and Phillipa Malpas. "Assisted or Hastened Death:

The Healthcare Practitioner's Dilemma". *Global Journal of Health Science,* Vol. 4, No. 6, (2012): 87.

[137] Keown, Damien. "End of life: the Buddhist view." *The Lancet*, Vol. 366, No 9489. (2005): 952.

[138] Hicks, Madelyn Hsiao-Rei. "Physician-Assisted Suicide: A Review of the Literature Concerning Practical and Clinical Implications for UK Doctors". *BMC Family Practice,* Vol. 7, No. 1, (2006): 2.

[139] Pereira, J.. "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls". *Current Oncology*, Vol. 18, No. 2. (2011): e38.

[140] Buiting, Hilde, Johannes van Delden, Bregje Onwuteaka-Philpsen, Judith Rietjens, Mette Rurup, Donald van Tol, Joseph Gevers, Paul van der Maas, and Agnes van der Heide. "Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study". *BMC Medical Ethics,* Vol. 10, No. 1, (2009): 1.

[141] Wilson, Keith G, Tracy L Dalgleish, Harvey Max Chochinov, Srini Chary, Pierre R Gagnon, Karen Macmillan, Marina De Luca, Fiona O'Shea, David Kuhl, and Robin L Fainsinger. "Mental Disorders and the Desire for Death in Patients Receiving Palliative Care for Cancer". *BMJ Supportive & Palliative Care,* Vol. 6, No. 2, (2014): 170.

[142] Matiti, Milika R., and Gillian M. Trorey. "Patients' expectations of the maintenance of their dignity." *Journal of Clinical Nursing,* Vol. 17, No. 20, (2008): 2709-2717.

[143] Nordenfelt, Lennart."The varieties of dignity." *Health care analysis*, Vol. 12, No. 2, (2004): 69-81.

[144] Grumbach, Kevin, and Thomas Bodenheimer "Can health care teams improve primary carepractice?." *Jama*, Vol. 291, No. 10, (2004): 1246-1251.

[145] Nordenfelt, Lennart. "The varieties of dignity." *Health care analysis*, Vol. 12, no. 2, (2004): 69-81.

[146] Propp et al. "Meeting the complex needs of the health care team: Identification of nurse-team communication practices perceived to enhance patient outcomes." *Qualitative Health Research*, Vol. 20, No. 1, (2010): 15-28.

[147] Swick, Herbert M., Charles S. Bryan, and Lawrence D. Longo. "Beyond the physician charter: Reflections on medical professionalism." *Perspectives in Biology and Medicine*, Vol. 49, No. 2, (2006): 263-275.

[148] Burns, Elizabeth, and Stephen Law. *Philosophy For AS and A2*. New York: Psychology Press, (2004): 59.

[149] Lewins, Frank W. *Bioethics for Health Professionals*. (South Melbourne: Macmillan Education Australia, 1996), 114.

[150] Meyers, Diana T. *Poverty, Agency, and Human Rights*. (Oxford: Oxford University Press, 2014), 287.

[151] Smith, Stephen W. *End-Of-Life Decisions in Medical Care: Principles and Policies for Regulating the Dying Process.* (Cambridge: Cambridge University Press, 2012), 161.

[152] Sterckx, Sigrid, Kasper Raus, and Freddy Mortier. *Continuous Sedation at the End of Life: Ethical, Clinical and Legal Perspectives.* (New York: *Cambridge University Press*, 2013), 234.

[153] Salkind, Neil J. *Encyclopedia Of Human Development.Thousand* (Oaks, Calif. Sage Publications, 2007)*,* 481.

[154] Kuhse, Helga, Udo Schüklenk, and Peter Singer. "Bioethics: An Anthology." (Hoboken: John Wiley & Sons, 2015), 267.

[155] Garrard, E. "Passive Euthanasia". *Journal of Medical Ethics*, Vol. 31, No. 2, (2015): 64.

[156] Singer, Peter. *Practical Ethics.* (New York: Cambridge University Press. 2015), 171.

[157] Wells, Celia, Nicola Lacey, and Oliver Quick. Lacey, Wells and Quick Reconstructing Criminal Law. (Cambridge: Cambridge University Press, 2012), 634.

[158] Loucks N., S. Smith Holt. *Why We Kill: Understanding Violence Across Culture And Disciplines.* (New York: Taylor & Francis. 2009), 105.

[159] Devettere, Raymond J. *Practical Decision Making in Health Care Ethics: Cases, Concepts, and the Virtue of Prudence.* 4th ed. (Georgetown: Georgetown University Press, 2016), 426.

[160] Sanbar, Shafeek S. *Legal Medicine.* (New York: *Elsevier Health Sciences*. 2017), 246.

[161] USA, Congress. "*Congressional Record.*" (Washington: *INIAP Archivo Historico*. 2009), 33001.

[162] Henk ten Have, M. D., Jos VM Welie, and J. D. MMedS. "Palliative Sedation Versus Euthanasia: An Ethical Assessment." *Journal of Pain and Symptom Management,* Vol. 47, No. 1, (2014): 123.

[163] Henk ten Have, M. D., Jos VM Welie, and J. D. MMedS. "Palliative Sedation Versus Euthanasia: An Ethical Assessment." *Journal of Pain and Symptom Management* 47, no. 1 (2014): 124.

[164] Maltoni, M., C. Pittureri, E. Scarpi, L. Piccinini, F. Martini, P. Turci, L. Montanari, O. Nanni, and D. Amadori. "Palliative sedation therapy does not hasten death: results from a prospective multicenter study." *Annals of Oncology* 20, no. 7 (2009): 1164.

[165] Sinclair, Christian T., and Richard C. Stephenson. "Palliative sedation: assessment, management, and ethics." *Hospital Physician,* Vol. 42, No. 3, (2006): 36.

[166] Khader, M. M., and M. T. Mrayyan. "The Use of Palliative Sedation for Terminally Ill Patients: Review of the Literature and an Argumentative Essay." *Journal Palliative Care Medicine,* Vol. 5, No. 226, (2015): 3.

[167] Khader, M. M., and M. T. Mrayyan. "The Use of Palliative Sedation for Terminally Ill Patients: Review of the Literature and an Argumentative Essay." *Journal Palliative Care Medicine,* Vol. 5, No. 226, (2015): 3.

[168] Khader, M. M., and M. T. Mrayyan. "The Use of Palliative Sedation for Terminally Ill Patients: Review of the Literature and an Argumentative Essay." *Journal Palliative Care Medicine,* Vol. 5, No. 226, (2015): 4.

[169] Sinclair, Christian T., and Richard C. Stephenson. "Palliative sedation: assessment, management, and ethics." *Hospital Physician.* Vol. 42, No. 3, (2006): 36.

[170] Sinclair, Christian T., and Richard C. Stephenson. "Palliative sedation: assessment, management, and ethics." *Hospital Physician,* Vol. 42, No. 3, (2006): 37.

[171] Gray, Carol, and Jenny Moffett. *Handbook of Veterinary Communication Skills*. (New York, NY, John Wiley & Sons, 2013), 77.

[172] Berman, Jeffrey. *Death Education in the Writing Classroom: Writing about Love and Loss*. (New York: SUNY Press, 2009), 181.

[173] Hardwig, John. *Is there a Duty to Die?: And other Essays in Bioethics*. (New York: Routledge, 2014), 94.

[174] Clarke, Patrick J. *Examining Philosophy and Ethics*. (New York: Nelson Thornes, 2002), 146.

[175] Cherny, Nathan I, and Nathan I Christakis. *Oxford Textbook of Palliative Medicine*. (New York: Oxford University Press, 2011), 43.

[176] Devettere, Raymond J. *Practical Decision Making in Health Care Ethics: Cases, Concepts, and the Virtue of Prudence*. 4th ed. (Georgetown: Georgetown University Press, 2016, 431.

[177] Somerville, Margaret A. *Death Talk*. (New York: McGill-Queen's Press, 2001), 266.

[178] Werth, James L. *Contemporary Perspectives on Rational Suicide*. (Hoboken: Routledge, 2013), 54.

[179] Jaishankar, K, and Natti Ronel. *Third International Conference of the South Asian Society of Criminology and Victimology (SASCV), 28-29, January 2016, Goa, India: SASCV Proceedings*. Mumbai: Jaishankar, (2016): 49.

[180] Keown, John. *Euthanasia, Ethics, and Public Policy: An Argument against Legalisation*. (Cambridge: Cambridge University Press, 2002), 285.

[181] Gorsuch, Neil M. *The Future of Assisted Suicide and Euthanasia*. (Princeton, N.J.: Princeton University Press, 2009), 159.

[182] Biggs, Hazel. *Euthanasia, Death with Dignity and the Law*. (London: Hart Publishing, 2001), 154.

[183] Dinstein, Yoram, and Fania Domb. *Israel Yearbook on Human Rights*. (Leiden: Martinus Nijhoff Publishers, 2000), 140.

[184] Bosek, Marcia Sue DeWolf, and Teresa A Savage. *The Ethical Component of Nursing Education: Integrating Ethics into Clinical Experience*. (New York: Lippincott Williams & Wilkins, 2007), 266.

[185] Howarth, Glennys, and Oliver Leaman. *Encyclopedia of Death and Dying*. (New York: Routledge, 2003), 177.

[186] Givens, Jane L., and Susan L. Mitchell. "Concerns about End-Of-Life Care and Support for Euthanasia". *Journal of Pain and Symptom Management*. Vol. 38, No. 2, (2009): 170.

[187] Bryant, Clifton D. *Handbook of Death and Dying*. (New York: SAGE, 2003), 427.

[188] Biggs, Hazel. *Euthanasia, Death with Dignity and the Law*. (New York: Hart Publishing, 2001), 146.

[189] Cameron, Peter, George Jelinek, Anne-Maree Kelly, Lindsay Murray, and Anthony F T Brown. *Textbook of Adult Emergency Medicine E-Book*. (New York: Elsevier Health Sciences, 2011), 656.

[190] Nathan, Rae. "Is Euthanasia Morally Permissible? Why or Why Not?" *Sound Decisions: An Undergraduate Bioethics Journal,* Vol. 1, No. 1, (2015): 4.

[191] Nathan, Rae. "Is Euthanasia Morally Permissible? Why or Why Not?" *Sound Decisions: An Undergraduate Bioethics Journal,* Vol. 1, No. 1, (2015): 4.

[192] Winter, Roberta E. *Unraveling U.S. Health Care*. (Lanham, Md.: Rowman & Littlefield, 2013), 157.

[193] Magnusson, Roger S. The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States. *Pacific Rim Law & Policy Journal*. Vol. 6, No. 1, (1997): 9.

[194] Baranzke, Heike.. "Sanctity-of-Life" – A Bioethical Principle for a Right to Life?" *Ethical Theory and Moral Practice*. Vol. 15, (2012): 300.

[195] Ekeke, Emeka C. and Ephraim A. Ikegbu. "The Sanctity of Human Life in the Twenty First Century: The Challenge of Euthanasia and Assisted Suicide." *Educational Research*. Vol. 1, No. 9, (2010): 312.

[196] Perrett, Roy W. "Buddhism, Euthanasia and the Sanctity of Life." *Journal of Medical Ethics*. Vol. 22, (1996): 310.

[197] Keown, John. "The Legal Revolution: From 'Sanctity of Life' to 'Quality of Life' and 'Autonomy'". *Journal of Contemporary Health Law & Policy*. Vol. 14, No. 2, (1998): 253.

[198] Rabiu, Aldul-Rasheed and Kapil Sugand. "Has the Sanctity of Life Law 'Gone Too Far'?: Analysis of the Sanctity of Life Doctrine and English Case Law Shows That the Sanctity of Life

Law Has Not 'Gone Too Far'." *Philosophy, Ethics, and Humanities in Medicine*. Vol. 9, No. 5, (2014): 1-3.

[199] Jewell, Paul. *Rationality, Euthanasia, and the Sanctity of Life*. Australian Association for Professional and Applied Ethics, 12th Annual Conference in Adelaide Held on 28-30 September 2005): 1-7.

[200] Harigovind, P.C. "Sanctity of Human Life: Glimpses of Ethical and Jurisprudential Aspects." *International Journal of Humanities and Social Science Invention*. Vol. 2, No. 4, (2013): 1.

[201] Weingarten, Michael A. "On the Sanctity of Life" *British Journal of General Practice*. Vol. 57, No. 537 (2007): 333.

[202] Galliher, James M. and John F. Galliher. "Criminology: A "Commonsense" Theory of Deterrence and the "Ideology" of Science: The New York State Death Penalty Debate." *Journal of Criminal Law & Criminology*. Vol. 92, No. 307, (2002): 1.

[203] Weingarten, Michael A. "On the Sanctity of Life" *British Journal of General Practice*. Vol. 57, No. 537 (2007): 333.

[204] Harris, John. "Consent and End of Life Decisions." *Journal of Medical Ethics*. Vol. 29, No. 1, (2003): 10.

[205] Singh, Subbash Chandra. "Euthanasia and Assisted Suicide: Revisiting the Sanctity of Life Principle." *Journal of the Indian Law Institute*. Vol. 54, No. 2, (2012): 196–197.

[206] Jones, David Albert. "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" *Southern Medical Journal*. Vol. 108, No. 10, (2015): 602.

[207] Nunes, Rui and Guilhermina Rego. "Euthanasia: A Challenge to Medical Ethics." *Journal of Clinical Research & Bioethics*. Vol. 7, No. 4, (2016): 3.

[208] Ardelt, Monika. *Physician-Assisted Death*. In *Handbook of Death and Dying* by C.D. Bryant. (Thousand Oaks, CA: SAGE, 2003), 425.

[209] Steinberg, Donald R. "Limits to Death with Dignity." *Harvard Journal of Law and Technology*. Vol. 1, (1988): 129.

[210] Secretariat of Pro-Life Activities. *Assisted Suicide and Euthanasia: Beyond Terminal Illness*. U.S. Conference of Catholic Bishops, (2014): 2.

[211] Cohen-Almagor, Raphael. "An Urgument for Physician-Assisted Suicide and against Euthanasia." *Ethics, Medicine and Public Health*. Vol. 1, (2015): 438.

[212] Goel, Vaibhav. "Euthanasia – A Dignified End of Life!" *International NGO Journal*. Vol. 3, No. 12, (2008): 224-225.

[213] Kimsma, Geritt K., and Evert van Leeuwen. "The role of the family in euthanasia decision making." *HEC Forum*. Vol. 19. No. 4. Springer Netherlands, (2007): 365-376.

[214] Kimsma, Geritt K., and Evert van Leeuwen. "The role of the family in euthanasia decision making." *HEC Forum*. Vol. 19. No. 4. Springer Netherlands, (2007): 365-376.

[215] Fraser, Sharon I., and James W. Walters. "Death-whose decision? Euthanasia and the terminally ill." *Journal of Medical Ethics* 26.2 (2000): 121-125.

[216] Fraser, Sharon I., and James W. Walters. "Death-whose decision? Euthanasia and the terminally ill." *Journal of Medical Ethics* 26.2 (2000): 121-125.

[217] Goel, Vaibhav. "Euthanasia A dignified end of life!." *International NGO Journal* 3.12 (2008): 224-231.

[218] Goel, Vaibhav. "Euthanasia A dignified end of life!." *International NGO Journal* 3.12 (2008): 224-231.

[219] Van der Maas, Paul J., Johannes JM Van Delden, Loes Pijnenborg, and Caspar WN Looman. "Euthanasia and other medical decisions concerning the end of life." *The Lancet* 338.8768

(1991): 669-674.

[220] "Should the Government be involved in Patients' End-of-Life Decision." ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[221] Churchill, Larry R., and N. M. King. "Physician-assisted suicide, euthanasia, or withdrawal of treatment." *BMJ: British Medical Journal* 315.7101 (1997): 137.

[222] "Should the Government be involved in Patients' End-of-Life Decision," ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[223] Churchill, Larry R., and N. M. King. "Physician-assisted suicide, euthanasia, or withdrawal of treatment." *BMJ: British Medical Journal* 315.7101 (1997): 140.

[224] "Should the Government be involved in Patients' End-of-Life Decision," ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

[225] Nitschke, Philip. "The Role of Religion in Assisted Suicide and Voluntary Euthanasia Laws," *The New York Times,* accessed April 10, 2012. https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/the-role-of-religion-in-assisted-suicide-and-voluntary-euthanasia-laws.

[226] Nitschke, Philip. "The Role of Religion in Assisted Suicide and Voluntary Euthanasia Laws," *The New York Times,* accessed April 10, 2012. https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/the-role-of-religion-in-assisted-suicide-and-voluntary-euthanasia-laws.

[227] Olukunle, O.A. "Religion and Euthanasia." *Orita: Ibadan Journal of Religious Studies* 16, no. 1 (2008): 54.

[228] Olukunle, O.A. "Religion and Euthanasia." *Orita: Ibadan Journal of Religious Studies* 16, no. 1 (2008): 61.

[229] Bowling, Ann. "The Hospitalization of Death: Should More People Die at Home?" *Journal of Medical Ethics*. Vol. 9, (1983): 158.

[230] Gentzler, Jyl. "What Is a Death with Dignity?" *Journal of Medicine and Philosophy*. Vol. 28, No. 4, (2003): 478.

[231] Joseph, Jay. "The 1942 'Euthanasia' Debate in the American Journal of Psychiatry." *History of Psychiatry*. Vol. 16, No. 2, (2005): 173.

[232] Cohen-Almagor, Raphael. *Physician-Assisted Suicide – A Qualified Endorsement*. In *Health Care, Bioethics and the Law*. (Amsterdam Law Forum – VU University Amsterdam, 2011), 116-126.

[233] Allmark, Peter. "Death with Dignity." *Journal of Medical Ethics*. Vol. 28, (2002): 255, 256.

[234] Goel, Vaibhav. "Euthanasia – A Dignified End of Life!" *International NGO Journal*. Vol. 3, No. 12, (2008): 224.

[235] Chao, D.V.K., N.Y. Chan and W.Y. Chan. "Euthanasia Revisited." *Family Practice – An International Journal*. Vol. 9, No. 2, (2002): 133.

[236] Da Silva, Rudval Souza, Alvaro Pereira and Fernanda Carneiro Mussi. "Comfort for a Good Death: Perspective Nursing Staffs of Intensive Care." *Escola Anna Nery Revista de Enfermagen*. Vol. 19, No. 1, (2015): 44-45.

[237] Parker, Malcolm. "Moral Intuition, Good Deaths and Ordinary Medical Practitioners." *Journal of Medical Ethics*. Vol. 16, (1990): 30.

[238] Center for Bioethics, University of Minnesota. *End of Life Care: An Ethical Overview*. (University of Minnesota, 2005), 12.

[239] Patrick, Donald L., Ruth A. Engelberg and J. Randall Curtis. "Evaluating the Quality of Dying and Death." *Journal of Pain and Symptom Management*. Vol. 22, No. 3, (2001): 718.

[240] Boudreau, J. Donald and Margaret A. Somerville. "Euthanasia and Assisted Suicide: A Physician's and Ethicist's Perspectives." *Medicolegal and Bioethics*. Vol. 4, (2014): 3.

[241] Emanuel, Ezekiel J. "What Is the Great Benefit of Legalizing Euthanasia of Physician-Assisted Suicide?" *Ethics*. Vol. 109, No. 3, (1999): 629.

[242] De Castro, Mariana, Guilherme Cafure Antunes, Livia Maria Pacelli Marcon, Lucas Andrade, Sarah Ruckl and Vera Angelo Andrade. "Euthanasia and Assisted Suicide in Western Countries: A Systematic Review." *Rev. Bioet. (Impr)*. Vol. 24, No. 2, (2016): 355.

[243] Grewal, Bhajneek, Jennifer Harrison and David Jeffrey. "Licensed to Kill – The Impact of Legalizing Euthanasia and Physician Assisted Suicide on the Training of UK Medical Students." *Scottish Universities Medical Journal*. Vol. 1, No. 1, (2012): 8.

[244] Severs, Sjef. "Euthanasia: Law and Practice in the Netherlands." *British Medical Bulletin*. Vol. 52, No. 2, (1996): 327.

[245] Anneser, Johanna, Ralf J. Fox, Tamara Thurn and Gian Domenico Borasio. "Physician-Assisted Suicide, Euthanasia and Palliative Sedation: Attitudes and Knowledge of Medical Students. *GMS Journal for Medical Education*. Vol. 33, No. 1, (2016): 1.

[246] Australian Human Rights Commission. *Euthanasia, Human Rights and the Law – Issues Paper*. AHRC. 2016.

[247] Cohen-Almagor, Raphael. "Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement." *Issues in Law & Medicine*. Vol. 24, No. 3, (2009): 190.

[248] Kai, Katsunori. "Euthanasia and Death with Dignity in Japanese Law." *Waseda Bulletin of Comparative Law*. Vol. 27, (2008): 1.

[249] Patil, Yuvraj Dilip and Ajeenkya D.Y. Patil. "Euthanasia and Death with Dignity." *Journal of Krishna Institute of Medical Sciences University*. Vol. 5, No. 3, (2016): 143.

[250] Lemmens, Trudo and Bernard Dickens. "Canadian Law on Euthanasia: Contrasts and Comparisons." *European Journal of Health Law*. Vol. 8, (2001): 137.

[251] Purvis, Taylor E. "Debating Death: Religion, Politics, and the Oregon Death with Dignity Act." *Yale Journal of Biology and Medicine*. Vol. 85, (2012): 271.

[252] Chin, Arthur Eugene, Katrina Hedberg, Grant K. Higginson and David W. Fleming. *Oregon's Death with Dignity Act: The First Year's Experience*. (Oregon Health Division, 1999), 2.

[253] Emanuel, Ezekiel J., Bregje D. Onwuteaka-Philipsen, John W. Urwin and Joachim Cohen. "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe." *JAMA*. Vol. 316, No. 1, (2016): 79.

[254] Fraser, Sharon I. and James W. Walters. "Death – Whose Decision? Euthanasia and the Terminally Ill." *Journal of Medical Ethics*. Vol 26, (2000): 121.

[255] Leechaianan, Yingyos and Dennis R. Longmire. "The Use of the Death Penalty for Drug Trafficking in the United States, Singapore, Malaysia, Indonesia and Thailand: A Comparative Legal Analysis." *Laws*. Vol. 2, (2013): 115.

[256] Fraser, Sharon I. and James W. Walters. "Death – Whose Decision? Euthanasia and the Terminally Ill." *Journal of Medical Ethics*. Vol 26, (2000): 121.

[257] Meier, Diane E., Carol-Ann Emmons, Sylvan Wallenstein, Timothy Quill, R. Sean Morrison and Christine K. Cassel. "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States." *The New England Journal of Medicine*. Vol. 338, No. 17, (2009): 1200.

[258] Albright, Dianne E., and Richard J. Hazler. "A right to die?: Ethical dilemmas of euthanasia." *Counseling and Values* 39, no. 3 (1995): 177-179.

[259] Albright, Dianne E., and Richard J. Hazler. "A right to die?: Ethical dilemmas of euthanasia." *Counseling and Values* 39, no. 3 (1995): 179-181.

[260] Albright, Dianne E., and Richard J. Hazler. "A right to die?: Ethical dilemmas of euthanasia." *Counseling and Values* 39, no. 3 (1995): 182-183.

[261] Albright, Dianne E., and Richard J. Hazler. "A right to die?: Ethical dilemmas of euthanasia." *Counseling and Values* 39, no. 3 (1995): 184-187

[262] Daar, Abdallah S., and A. Khitamy. "Bioethics for clinicians: 21. Islamic bioethics." *Canadian Medical Association Journal* 164, no. 1 (2001): 60-63.

[263] *QURAN: The Final Testament*. Universal Unity, 2000*,* Chapter 5, verse 32.

[264] *QURAN: The Final Testament*. Universal Unity, 2000*,* Chapter 4, verse 29.

[265] *QURAN: The Final Testament*. Universal Unity, 2000*,* Chapter 6, verse 151.

[266] Dworkin, Ronald M. *Life's dominion: An argument about abortion, euthanasia, and individual freedom*. (Vintage, 1993), 30-42.

[267] Dworkin, Ronald M. *Life's dominion: An argument about abortion, euthanasia, and individual freedom*. (Vintage, 1993), 24-29.

[268] Griffiths, John, Heleen Weyers, Maurice Adams, and Maurice Adams. *Euthanasia and law in Europe*. (Oxford and Portland: Hart, 2008), 12-30.

[269] Griffiths, John, Heleen Weyers, Maurice Adams, and Maurice Adams. *Euthanasia and law in Europe*. (Oxford and Portland: Hart, 2008), 15-20.

[270] Griffiths, John, Heleen Weyers, Maurice Adams, and Maurice Adams. *Euthanasia and law in Europe*. (Oxford and Portland: Hart, 2008), 40-65.

[271] Cohen, J., Marcoux, I., Bilsen, J., Deboosere, P., van der Wal, G. and Deliens, L. European public acceptance of euthanasia: socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 European countries. *Social science & medicine*, *63*(3). (2006): 743-756.

[272] Sercu, Marij, Peter Pype, Thierry Christiaens, Maria Grypdonck, Anselme Derese, and Myriam Deveugele. "Are general practitioners prepared to end life on request in a country where euthanasia is legalised?." *Journal of medical ethics* (2012): 2-10.

[273] Griffiths, John, Heleen Weyers, Maurice Adams, and Maurice Adams. *Euthanasia and law in Europe*. (Oxford and Portland: Hart, 2008), 40-65.

[274] Emanuel, Ezekiel J., Elisabeth R. Daniels, Diane L. Fairclough, and Brian R. Clarridge. "The practice of euthanasia and physician-assisted suicide in the United States: adherence to proposed safeguards and effects on physicians." *Jama* 280, no. 6 (1998): 507-513.

[275] Lo, Bernard. "Euthanasia in the Netherlands." *Bioethics: An Anthology* (2015): 377.

[276] Lo, Bernard. "Euthanasia in the Netherlands." *Bioethics: An Anthology* (2015): 378.

[277] Dierickx, Sigrid, Luc Deliens, Joachim Cohen, and Kenneth Chambaere. "Euthanasia in Belgium: trends in reported cases between 2003 and 2013." *Canadian Medical Association Journal* 188, no. 16 (2016): 3-10.

[278] Bosshard, Georg, Ueli Zellweger, Matthias Bopp, Margareta Schmid, Samia A. Hurst, Milo A. Puhan, and Karin Faisst. "Medical end-of-life practices in Switzerland: A comparison of 2001 and 2013." *JAMA internal medicine* 176, no. 4 (2016): 555-556

[279] Bosshard, Georg, Ueli Zellweger, Matthias Bopp, Margareta Schmid, Samia A. Hurst, Milo A. Puhan, and Karin Faisst. "Medical end-of-life practices in Switzerland: A comparison of 2001 and 2013." *JAMA internal medicine* 176, no. 4 (2016): 580.

[280] Bosshard, Georg, Ueli Zellweger, Matthias Bopp, Margareta Schmid, Samia A. Hurst, Milo A. Puhan, and Karin Faisst. "Medical end-of-life practices in Switzerland: A comparison of 2001 and 2013." *JAMA internal medicine* 176, no. 4 (2016): 571.

[281] Soh, Tze Ling Gwendoline Beatrice, Lalit Kumar Radha Krishna, Shin Wei Sim, and Alethea

Chung Peng Yee. "Distancing sedation in end-of-life care from physician-assisted suicide and euthanasia." *Singapore medical journal*57, no. 5 (2016): 220.

[282] Soh, Tze Ling Gwendoline Beatrice, Lalit Kumar Radha Krishna, Shin Wei Sim, and Alethea Chung Peng Yee. "Distancing sedation in end-of-life care from physician-assisted suicide and euthanasia." *Singapore medical journal*57, no. 5 (2016): 221.

[283] Soh, Tze Ling Gwendoline Beatrice, Lalit Kumar Radha Krishna, Shin Wei Sim, and Alethea Chung Peng Yee. "Distancing sedation in end-of-life care from physician-assisted suicide and euthanasia." *Singapore medical journal*57, no. 5 (2016): 220.

[284] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 10.

[285] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 15.

[286] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 24.

[287] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 27-32.

[288] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 33-40.

[289] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 41-54.

[290] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 4.

[291] Malik, Mohammad Manzoor. *Indispensability of enhancing palliative care and rebuttal of utilitarian autonomy argument for euthanasia.* In: 14th Asian Bioethics Conference: Ethics in Emerging Technologies to Make Lives Better together, Chennai, India, (19-23 Nov. 2013): 10-15.

[292] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 50-78.

[293] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 53.

[294] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 81.

[295] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 58.

[296] Baker, Robert, Tom L. Beauchamp, Michael Boylan, Bernard Gert, Lawrence O. Gostin, Akiko Ito, Peter Tan, and Rosemarie Tong. "Global Bioethics and Human Rights: Contemporary Issues." (2014): 57.

[297] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 60-70.

[298] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 83.

[299] Baker, Robert, Tom L. Beauchamp, Michael Boylan, Bernard Gert, Lawrence O. Gostin, Akiko Ito, Peter Tan, and Rosemarie Tong. "Global Bioethics and Human Rights: Contemporary Issues." (2014): 54.

[300] Keown, Damien V. "Buddhism, brain death and organ transplantation." *Journal of Buddhist Ethics* 17 (2010): 73.

[301] Baker, Robert, Tom L. Beauchamp, Michael Boylan, Bernard Gert, Lawrence O. Gostin, Akiko Ito, Peter Tan, and Rosemarie Tong. "Global Bioethics and Human Rights: Contemporary Issues." (2014): 62.

[302] Baker, Robert, Tom L. Beauchamp, Michael Boylan, Bernard Gert, Lawrence O. Gostin, Akiko Ito, Peter Tan, and Rosemarie Tong. "Global Bioethics and Human Rights: Contemporary Issues." (2014): 40.

[303] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 84.

[304] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 86.

[305] Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. (WW Norton & Company, 2015), 88.

Chapter 4: Professional Conflicts of Interest:

The previous chapters discuss Conflicts of Interest that can arise with regard to patient consent and in clinical contexts such as with abortion and assisted death. This chapter explores Conflicts of Interest that arise more broadly for professionals in healthcare. The chapter centers on professional ethics and codes of ethics and the distinction between Conflicts of Interest and Conflicts of Commitment.

4.a) Professional Ethics & Codes of Ethics:

Conflicts of Interest may arise from the tension between codes of ethics and professional leadership and the tension between moral culture and decision making. In the contemporary environment of health reform, which is replete with opportunities as well as challenges for health care executives, there are high stakes for patients, communities, and organizations.[1] For that reason, there is a need for an ethical foundation for making of decisions and leadership in the HCOs. The American College of Healthcare Executives (ACHE) was instituted to provide an ethical foundation for health care executives, and thus empower them to make morally sound decisions as well as demonstrate exemplary ethical leadership.[2]

It is imperative to note that the American College of Healthcare Executives is a global professional body which comprises 40,000 HC managers who guide healthcare organizations like systems of healthcare, hospitals, and other forms of healthcare organizations. The primary end of this professional society involves the advancement of the members in addition to promotion of the excellence of health care management.[3] Clearly, the American College of Healthcare Executives provides its high-status FACHE® credential to signify board accreditation of HC management. Moreover, American College Healthcare Executives has a devised a system of seventy-nine units which offer entrance to networking, career development, and education at

the grassroots level.[4] The society also prints a magazine, Healthcare Executive, as well as public policy and career development programs. Owing to its wide-ranging efforts, ACHE actualizes its aspirations of becoming the dominant professional organization for healthcare executives, which is committed to enhancing health.[5]

What is more, ACHE formulated the Foundation of the American College of Healthcare Executives with the aim of further advancing excellence in the purview of healthcare management through education as well as research.[6] In fact, this particular foundation is mostly reputed for its meticulous instructive or scholastic programs, which include the yearly Congress on Healthcare Leadership (CHL) that comprises to the tune of four thousand participants, and groundbreaking research. Moreover, it has a publishing division, which publishes journals and books on health services management, including course books that are utilized in higher learning institutions such as universities and colleges.[7]

4.a.i) Codes & Professional Leadership:

There is an intricate connection between the codes of ethics and professional leadership.[8] Codes of ethics provide ethical benchmarks that regulate professional leadership in healthcare organizations.[9] That is, codes of ethics delineate values, principles, and standards that guide professional leadership in healthcare.[10] Cathy Flite and Laurinda Harman highlight the reciprocity between professional values medical codes of ethics.[11]

Codes of ethics inform the professional practice of healthcare leaders because it strengths decision-making processes and assists in resolving ethical problems that arise in their interactions with patients. Professional Conflicts of Interest are a prominent example of these problems.[12]

Health care providers are often confronted with convoluted concerns in their daily

practice, which they can only address by the application of the code of ethics.[13] In particular, the code of ethics provides fundamental guidelines for medical professionals as they endeavor to prioritize patients' interests by delivering high-quality care.[14]

Because of the intricate connection between codes of ethics and professional leadership in healthcare, the failure to observe the tenets encapsulated in the codes may engender professional Conflicts of Interest. Specifically, codes of ethics regulate the physician-patient relationship to ensure the professional leadership leads to the prioritization of patients' interest. For that reason, disregarding codes of ethics may interfere with physician-patient relationship and therefore engender serious professional Conflicts of Interest.

Moreover, codes of ethics inform professional ethics which encompass the organizational and personal standards of behavior that clinicians exhibit.[15] In the field of healthcare, professional ethics comprise the principles that tend to govern professional leadership.[16] The code of ethics is the primary source of professional ethics which outlines the ethical principles that regulate healthcare professionals.[17] Typically, the code of ethics for healthcare comprise the following ethical principles: trustworthiness, honesty, accountability, avoidance of Conflicts of Interest, adherence to the law, and respect for others.[18] Professional codes of conduct depend on the above professional ethical principles as the basis for prescribing required behavior standards for healthcare professionals.[19] They anticipate that adherence to professional ethics to avert Conflicts of Interest between clinicians and patients in the provision of high-quality care.[20]

The intention of codes of ethics and professional ethics is to afford guidelines for the standards for suitable behavior in healthcare settings.[21] They benefit the public (patients), health care professionals, the healthcare profession, and healthcare organizations.[22] They facilitate professional leadership to avert professional Conflicts of Interest that may cripple the traditional

purpose of medicine of providing a supporting model for decision-making. And they "provide a common understanding and acceptable practice which builds collegiality and allows for fairer disciplinary procedures."[23]

Assuming the core notion of the Medical Code of Ethics, it can be stated that in term of the leadership and ethical behavior, clinicians are also responsible for maintaining primary duties, defined by the HIPAA regulations. From this perspective, it is worth to mention that medical staff is supposed to notify patients which data is recorded or might be recorded during the treatment process, and how this data will be used within the medical institution. Moreover, clinicians should get authorization from patients and legal agreement to collect their data to ensure that any further realization of private information will be done with patients' allowance. Returning to the ethical behavior and the Code of Ethics, it is worth to mention that medical staff takes responsibility to protect patients' data from unauthorized access, as it is stated in the HIPAA regulations. Beyond, as medical leadership is related to policy and law development within the facility, the HIPAA policies allow clinicians to create specific prohibitions to secure confidential data.

There an intricate nexus between codes of ethics, professional ethics, and professional leadership in healthcare contexts. This connection can help to highlight potential Conflicts of Interest when medical personnel exhibit unprofessional leadership for failing to observe professional practice delineated in the code of ethics. This reciprocity (that is, codes of ethics inform professional ethics, and professional ethics inform professional leadership) helps to identify and resolve professional Conflicts of Interest in healthcare. The inception of the Foundation of ACHE was based on the need "to advance a philanthropic initiative of strengthening the purview of HC leadership using scholarships and educational programs."[24] To

accomplish this objective, it established the Fund for Healthcare Leadership which solicits donations from members and well-wishers to promote its sustenance.[25] What is more, to advance excellence in HC management, ACHE designed a Code of Ethics to regulate the conduct and decision-making among HC executives and thus foster ethical leadership in HCOs. The Foundation of the American College of Healthcare Executives is operated as a not-for-profit organization, which provides face to face education programs, distance education programs, tutorials, and online seminars related to health care management. Evidently, the Foundation of ACHE tends to serve the interests of communities from around the globe.[26]

The society inaugurated its first Code of Ethics in 1941.[27] Nonetheless, it has undergone numerous reviews and revisions. In 2010, ACHE conducted a survey of its members to examine the ethical issues relating to the Code and established that it guides members in their professional relationships as well as decision-making processes.[28] The society's Board of Ethics adopted the current Code in 2011. In essence, ACHE believes that the Code of Ethics comprises an integral part of the practice of HC management; therefore, all members must coincide with and uphold it.[29] It is essential to appreciate that the Foundation of the American College of Healthcare Executives rests on individuals who are dedicated and overly committed to the enhancement of health care delivery. In summary, it focuses on the provision of the FACHE® credential, seventy-nine chapters that boast with the provision of development programs associated with education and career and networking at the grassroots' level, the Healthcare Executive magazine, development and career services, journals and books with essential information regarding health care management, especially textbooks often used for university and college courses.[30]

After the establishment of the American College of Healthcare Executives, the professional organizations initiated the Foundation of ACHE in a bid to advance excellence in

the purview of healthcare management through research and education; this endeavor is realized

through the yearly Congress on Health Leadership.[31] In addition, the Foundation of the American

College of Healthcare Executives has fashioned the Career EDGE™ program, which constitutes

a comprehensive and interactive tool for the planning and management of careers at all levels. In

reality, this program is offered as a complimentary benefits to members of the American College

of Health Executives. To fully appreciate the history of ACHE, it is imperative to understand the

various departments that constitutes it: marketing and communication, career services, human

resources, Health Administration Press, management information system (MIS), professional

development and performance excellence, as well as member services.[32] Historically speaking,

the professional society formed these department during different times as need arose and in

response to dynamics in the health care sector.[33] For instance, the American College of Health

Executives established the Career EDGE™ program in 2015. In essence, Career EDGE™

program denotes a career portal that an individual can personalize to benefit his or her career

stage. To be specific, the program offers resources which assist in leveling the niches and thus

augmenting marketability of an individual's career. Through the subject tool, a person has

unlimited access to tools for creating career plans, taking assessments like the Myers-Briggs

Type Indicator or Emotional Intelligence (EI), creating tailored job feeds, and finding a coach or

mentor.[34]

In addition, the American College of Healthcare Executives formulated the Career

EDGE™ program to provide planning frameworks that its members can utilize in thinking about

health care career success.[35] It also affords a procedure through which members can clarify goals

as well as identify the competencies required for success. In 2016, the professional society

established the Interview EDGE: this is a virtual interview tool that individuals can exploit in

providing verifiable answers to sample interview questions, which the management role or even leadership position organizes.[36] The users can utilize the tool on daily basis in recording answers so that he or she can review them and make the necessary changes prior to stepping into a real-world interview.[37]

The American College of Healthcare Executives has also launched The Thomas C. Dolan Executive Diversity Program, which seeks to achieve greater diversity in HC leadership. The program is fashioned to further the American College of Healthcare's commitment to achieving greater diversity among HC leaders. In 1991, the program conducted the first study on racial comparisons regarding career attainment. The program has resulted the evolution of the American College of Healthcare Executives' platform for initiatives related to diversity which include internships, policy statements, and active and scholarship affiliations with the Institute of Diversity in Health Management (IDHM). The Foundation of the American College of Healthcare Executives assisted the subject organization to establish the Asian Health Care Leaders Association (it was renamed to Asian Healthcare Leaders Forum (AHLF)), National Forum for Latino Healthcare Executives (NFLHE), and the National Association for Health Services Executives (NAHSE). The diversity program has assisted the American College of Healthcare Executives to become a HC model in its own right; hence, it has benefited numerous individuals explicitly and implicitly, whereby they have been able to pursue their careers as HC executives. To demonstrate its commitment to ethics, ACHE formulated the Code of Ethics and numerous ethical policy statements, includes Considerations for Healthcare Executive-Supplier Relationships, Decisions Near the End of Life, Health Information Confidentiality, and Promise-Making, Keeping and Rescinding. To maximize the ethics self-audit that the American College of Healthcare Executives provides and deal with any potential red flags that HC executives may

come across while fulfilling their mandate under the ACHE Code of Ethics, the professional

society created an Ethics Self-Assessment. What is more, it has established an Ethics Toolkit

which affords guidance to HC executives as they seek to fully appreciate and apply the

"American College of Healthcare Executives Code of Ethics, Ethical Policy Statements, and

Ethics Self-Assessment",[38] demarcate a specific process through which the subject leaders can

respond to HC organizational ethical challenges, and propose additional guideline and reading

related to ethical leadership in the context of HC.

1) Relating HC Leadership with Organizational Moral Agency:

To begin with, scholars opine that individuals can treat an entity as a person capable of

making ethical decisions as well as actualizing them.[39] As a consequence, one can judge it based

on its obligations to the society, employees, and environment. In other words, an establishment

becomes accountable for the predictive repercussions of its actions.[40] In addition, it means that

an organization bears a responsibility to the public to act ethically. It is noteworthy that the law

portends that organizations are morally responsible because they can reach moral decisions and

distinctions. The moral agency and moral culture of an establishment derive from the

appreciation of its ethical values, norms, and expectations by its main stakeholders and

personnel.[41] Notably, the law construes a firm as an individual whose actions are subject to

moral or ethical scrutiny. For that reason, Organizational Moral Agency (OMA) relates to "the

moral code and actions of an organization taken on a moral scale to determine whether or not it

is a moral agency for good."[42] Therefore, an organization portends specific obligations to the

public and its personnel. Markedly, the responsibility to the public is commonly referred to as

corporate social responsibility (CSR).[43]

There are five primary sources of OMA: the power to act, effects, viability,

responsibility, and legality.[44] First, a firm's moral agency derives from its collective power to act. Therefore, since an organization possesses power, it is obliged to make ethical decisions. Second, organizational decisions, whether moral or immoral, affect employees, customers, and the larger society; thus, HC executives should monitor decision-making to ensure that they strictly adhere to established ethical tenets. It is necessary for HC executives to align their decision-making processes with existing codes of ethics in a bid to promote the organizational moral culture of healthcare organizations and avoid Conflict of Interest issues. Third, organizational moral agency derives its basis from the concept of viability because an entity's actions underline its feasibility in the industry. For example, healthcare organizations that do not serve the best interests of others served and patients may not succeed in a highly competitive HC market. For that reason, even in difficult circumstances, managers should always strive to make ethical decisions to remain afloat.[45] Fourth, an organization (including stakeholders, staff, and executives) is responsible for the aftermath of its initiative, whether ethical or unethical. In fact, its executives should endeavor to reach morally aligned decisions. To be specific, since HC executives have unlimited access to information regarding healthcare organizations and comprise the decision-making body, they carry greater responsibility for the actions of the organizations than the personnel, who have limited access to information. The last source of the organizational moral agency is the government instituted legal frameworks that regulate the conduct of firms to protect the public from unethical business practices.[46] Notably, observing such regulations limits an establishment's legal liability. Nonetheless, morality surpasses self-protection; hence, to express organizational moral agency, a firm must go beyond legal requirements by adhering to ethical practices.[47] It is critical to note that individuals can only assign organizational moral agency to entities that are capable of making moral decisions. In most instances, large HCOs

tend to make decisions through a procedure whereby the stakeholders taking part disavow moral responsibility for their decisions. To address this phenomenon, ethical rules and regulations assign moral agency to HCOs on the ground that the subsistence of a corporate personality and corporate culture empowers them to make moral choices. In other words, organizational moral agency derives from the capability of HCOs to make moral decisions. Consequently, to strengthen its organizational moral agency, a healthcare organization should exceed government-instituted legal frameworks by fostering ethical leadership in healthcare. In this way, it will help in reduction of Conflict of Interest issues and frame a reputation for integrity in the HC market.

One critical element of organizational moral agency is the moral culture of the subject entity.[48] The concept of organizational moral culture derives from the need for healthcare leadership to be based on moral values that afford suitable direction for the utilization of institutional authority and power. Because leadership in healthcare requires managerial skills, knowledge, and competence, HC executives can elect to utilize these noble qualities in valuable or contemptable purpose. To guarantee proper use of the resources (power and authority vested in HC executives), professional organizations in HC establish moral foundations which provide moral fiduciaries which impel HC leaders to ensure the best welfare of the patients as well as other persons that HCOs serve while performing their duties. The moral fiduciaries comprise the moral foundations that inform HC management decisions. On the other hand, the moral foundations form an integral part of organizational moral culture, which promotes four primary professional virtues among HC executives and personnel: self-sacrifice, integrity, self-effacement, and compassion. It is important to note that through the application of these virtues in HC, the subject leaders can formulate an organizational moral culture of professionalism in HCOs. That notwithstanding, HC executives should be wary of the vices that undermine

organizational moral culture of professionalism in HCOs, including hard-heartedness, unwarranted bias, corruption, and primacy of self-interest. Notably, a good moral culture empowers a health care organization to fully accomplish its obligation or responsibility toward the society. Notably, a health care organization can inculcate a good moral culture (which then informs its moral agency through the utilization of an excellently crafted ethical program.[49] In essence, in a bid to strength its moral culture and thus its moral agency, a health care organization must develop an ethics program which is targeted at governing activities like policy review and development, consultation and training, as well as communication between the subordinate staff and management.[50] To ensure that the organizational moral agency of a health care institution bears appreciable fruit, it is incumbent upon the establishment to bolster its moral culture among its workers through the process of evaluating the activities that tend to affect it in addition to the determination whether or not the personnel fulfils its purposes to the health care organization. In addition, the moral agency and moral culture of a health care organization is utterly dependent on the understanding of its ethical expectations, values, and norms by its different stakeholders and personnel. The entity's employees' attitudes towards the manner in which the organization satiates the set standards also significantly affects its moral agency and moral culture.[51]

The ethical program that considerably influences the moral agency and moral culture of a health care organization is substantiated through the code of ethics. Clearly, there are multiple factors that may affect a health care institutions code of ethics, and consequently its organizational moral agency: the society, departmental policies, and duties to different parties in the society. In essence, balancing these factors strengths the health care organization's moral culture; hence, it ensures that its operations (which are often realized through its staff members)

lead to the full realization of its organizational moral agency which also helps in reduction of the chances of Conflict of Interest issues.[52]

Clearly, organizational moral culture is directly related to ethical leadership. Therefore, an ethics-based HC leadership significantly influences the OMA of HCOs. Markedly, patients, others served, and stakeholders tend to reward and appreciate HCOs with high ethical principles as well as moral culture. Moreover, since HCOs play an indispensable role in the delivery of quality HC services, the concepts of organizational moral agency and organizational moral culture are important for fostering ethical leadership, which then assists them to maintain their professionalism. Besides, HC leaders should strive to utilize the American College of Healthcare Executives Code of Ethics to shape organizational moral agency and organizational moral cultures that buttress the fiduciary professionalism of HC personnel. In reality, to maintain the relationship between ethical leadership in HC, organizational moral agency, and organizational moral culture, HCOs should strictly apply code of ethics (in this case ACHE Code of Ethics), perform audit and regular performance reviews, and institute other mechanisms. The thing is that these measures promote ethical leadership in HC by restraining moral autonomy among HC executives. In other words, moral culture and moral agency can only foster ethical leadership in healthcare if the American College of Healthcare Executives Code of Ethics minimize the inconsistencies that exist when HC executives attempt to correlate private standards of behavior and ethical standards of conduct.

2) Leadership Responsibility to the Organization:

The American College of Healthcare Executives Code of Ethics underlines HC executives' leadership responsibility to the health care organization. Within the scope of their authority, the Code of Ethics requires HC executives to offer HC services that are in harmony

with the available resources.[53] However, where resources are limited, the health care executives are required to devise processes of resource allocation that tend to consider ethical ramifications. Moreover, the American College of Healthcare Executives Code of Ethics commands HC executives to perform cooperative as well as competitive events in order to encourage community HC services. Accordingly, the Code of Ethics requires the healthcare executives in a particular healthcare institution to champion it in the utilization in addition to improvement of management standards and rigorous business practices. By way of inference, the subject Code of Ethics seeks to better the healthcare management profession by encouraging healthcare leaders to continually use the leadership best practices which are grounded on the values and principles of ethical leadership in decision-making with HCOs. What is more, the American College of Healthcare Executives' Code of Ethics mandates the HC executives to highly esteem patients' cultural inclinations with the objective of fostering evenness with the philosophy of their respective healthcare organizations.[54] The Code of Ethics also obligates HCOs to work toward demonstrating truthfulness in all forms of organizational as well as professional communication in ways that allow them to eschew the publication of untrue, illusive, as well as disingenuous information.[55] What is more, the American College of Healthcare Executives Code of Ethics requires respective HC executives to accurately register any adverse financial information as well as other information and then take the necessary action to remedy the accompanying consequences. In this way, the healthcare executives will be able to prevent Conflict of Interest issues and administer ethical behavior among staff members in their respective health care organizations. In accomplishing his or her leadership responsibility to the HCO, a HC executive should work toward the prevention of fraud, abuse, as well as aggressive accounting practices that may engender questionable financial reports. Perhaps, ethical leadership seeks to stem or

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substantially reduce any form of malpractice and financial misapplication that can rob HCOs resources that are employed in serving the best interests of the patients, stakeholders, and other persons that these organizations serve. For that reason, preventing fraud, abuse, and aggressive accounting practices improves HC management as concerned parties properly exploit the financial resources that a particular HCO is endowed with. In addition, they should implement an organization code of ethics and monitor strict compliance with the same. In the end, HC executives should provide ethical resources and mechanisms through which the personnel in HCO can deal with ethical, organizational, and clinical Conflict of Interest issues.[56]

By performing their responsibilities to the HCOs, HC executives will expedite the actualization of organizational moral culture. For instance, implementing organizational codes of ethics will foster ethical decision-making and thus ensure that HCOs observe ethical business practices, become visible in the health sector, and adhere to existing legal frameworks which regulate their conduct.[57] To summarize, the American College of Healthcare Executives Code of Ethics spells multiple responsibilities for HC executives to HCOs; therefore, it explicitly seeks to foster ethical leadership in HC contexts. In addition, the subject Code acts as an ethical program that inculcates a moral culture among the stakeholders as well as workers of a healthcare organization. As a consequence, it buttresses the ethical standards and thus promotes moral agency through an effective evaluation of a healthcare organization's ethical culture climate. Through the ethical program enunciated by the American College of Healthcare Executives Code of Ethics, the staff members and stakeholders will be able to fully appreciate the subject healthcare organization's ethical expectations, values, and norms; hence, it will positively influence the establishment's moral agency and moral culture. In the end, it will affirmatively affect the employees' attitudes toward the ways in which the ethical standards set out are

actualized. As a matter of fact, when the healthcare executives perform their responsibilities toward the health care organizations (these obligations are set out in the ACHE Code of Ethics), they will strength their moral culture and therefore affirm their organizational moral agency.

4.a.ii) Moral Culture & Decision-making:

Codes of ethics significantly influence the moral culture of healthcare organizations. Consequently, moral culture influences decision-making by clinicians as they relate to patients and others served. In other words, the moral culture of a healthcare organization determines how well clinicians engage in ethical decision-making. Bruning and Baghurst emphasize that "Healthcare change occurs rapidly and increases tension and mistrust between payers, providers, and patients, which may consequently create constant Conflicts of Interests."[58] The lack of ethical decision-making creates serious Conflicts of Interest in healthcare contexts. Therefore, the "application of ethical standards to decision-making improves trust and minimizes the occurrence of Conflicts of Interests between physicians and patients."[59] The moral culture of a healthcare organization impels medical professionals to make ethical decisions regarding patients and thus minimizes the incidence of professional Conflicts of Interest.

According to Donnellan, suitable moral culture results in ethical decision making and ethical behavior, which "results in better patient care, a more committed and satisfied staff, more efficient care delivery, and increased market share."[60] In addition, the moral culture of a healthcare organization provides a comprehensive view of the function of ethical programs, which allow medical professionals to cultivate an efficient, well-sustained ethical culture. Consequently, it transforms the healthcare organization into an ethical organization with "integrated and shared ethical values and practices, an effective ethics infrastructure, ongoing ethics education for staff at every level, ethical and morally courageous leaders, and a culture

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that is consistent with the organization's values."[61] Such an organization provides effective avenues for ethical decision-making, and thus they help to identify and resolve professional Conflicts of Interest between doctors and clients. However, when there is a lack of moral culture, physicians do not have a robust ethical decision-making context to address Conflicts of Interest. This translates to poor decision-making, and consequently, non-resolved Conflicts of Interest between physicians and patients.

The wide-ranging interpretations and possible connotations of moral culture are difficult to grasp. Moral culture, which influences ethical behavior, is stipulated in either unwritten or written codes of values and principles formulated by a particular society. In the purview of healthcare, the American College of Healthcare Executives Code of Ethics is the instrument that fosters ethical leadership. It is important to note that the values and principles the Code of Ethics contains influences behavior within professions, personal level, and at the organizational level.[62] In essence, the present section uses the Code of Ethics to relate moral culture to the work environment pertinent to healthcare organizations.

1) Relating Moral Culture to the Work Environment:

The American College of Healthcare Ethics Code of Ethics obliges HC executives to show leadership in fostering organizational moral culture. In fact, it mandates them with the responsibility of creating an organizational environment whereby both management and clinical mistakes are appreciably minimized.[63] The Code of Ethics also requires the effective disclosure as well as expeditious addressing of management and clinical mistakes that take place with the precincts of healthcare organizations.[64] It is noteworthy that reducing clinical mistakes and disclosing and addressing them when they occur demonstrates respect for patients and adherence to the moral culture of an entity.[65] In the long-term, the American College of Healthcare

Executives Code of Ethics influences the organizational moral culture of healthcare organizations, hence enabling the personnel and management to exhibit ethical or moral behavior to the benefits of others served as well as patients.

In keeping with organizational moral culture, HC executives have significant professional and ethical obligations toward the workers that they tend to manage. To begin with, they should create an environment of work that often emphasizes Conflict of Interest challenges and encourages ethical conduct. Given this, they will motivate the members of the working fraternity to act morally and thus propagate organizational moral culture.[66] In addition to the obligation enumerated above, the leaders of healthcare organizations are required to create a conducive workplace environment in a bid to permit the personnel to freely express any pertinent moral concerns and therefore concoct a leeway for deliberations aimed at coming up with permanent solutions to address them. The American College of Healthcare Executives Code of Ethics encourages the creation of a HCO that highlights the need for freedom from sexual in addition to other categories of coercion and harassment targeted at impelling individual to orchestrate illegal as well as unethical acts.[67] In addition, American College of Healthcare Executives Code of Ethics obligates the HC executives to foster an inclusivity culture; one that endeavors to preclude prejudice that is founded upon factors such as ethnicity, sex orientation, race, age, religion, gender, or disability.[68] In an effort to establish a conducive environment with their respective healthcare organizations and thus foster organizational moral culture, the subject HC leader should offer the personnel with a workspace that encourages the proper exploitation of their respective skills, knowledge, as well as expertise. In the end, they should endeavor to provide a safe as well as healthy work environment in which HC workers can freely actualize organizational moral culture in everyday clinical and management practice within a particular

healthcare organization.[69]

From the foregoing, the American College of Healthcare Executives Code of Ethics asserts mandatory responsibilities upon leaders of healthcare organizations with the aim of fostering moral culture and ethical leadership within the context of healthcare. Clearly, a strong organizational moral culture begets adherence to ethical behavior that often translate into valued and honest relationships with others served and patients. Using the American College of Healthcare Executives Code of Ethics, HC executives can ensure reduction in Conflict of Interest challenges and encourage ethical leadership and hence maintain ethical standards in the workplace through the formulation of expectations, provision of guidance to the personnel, as well as consistently acting ethically.[70] To sum it up, the American College of Healthcare Executives Code of Ethics implicitly stipulates a relationship between organizational moral culture and the work environment pertinent to healthcare contexts.[71] By appreciating such a relationship and executing their mandate under the Code, healthcare executives can foster ethical leadership in healthcare setting (healthcare organizations) for the benefit of both others served and patients (clients to the healthcare organizations). Further, HC executives can exploit the dictates of the ACHE Code of Ethics in bolstering the moral culture of healthcare organizations. For a HCO to build a strong moral culture, its leaders must demonstrate trust and act for the benefit of parties involved, whether within or without its precincts. In addition, it must have leadership that exhibits high moral values and create a work environment where its personnel have a sense of belonging and promotes its interests. Any HCO can use the ethical stipulations of the ACHE Code of Ethics outlined in this subsection to formulate a procedure of moral leadership or moral culture. Given this, the HCO will create a conducive work environment where workers can engage in emulative moral character development. When HC executives

create the work environment that the ACHE Code of Ethics intimate, they will adopt the Codes moral message and thus adhere to the dictates of the moral culture of their HCO.

2) Virtuous Leadership as contributing to Moral Culture:

Virtuousness is a rare terminology in contemporary business circles.[72] The extant practice in organizational studies (OS) insinuates that discourses regarding virtuousness are often related to religious dogmatism, social conservatism, and scientific irrelevance.[73] An assortment of studies provides that virtuousness tends to be culturally restraining as well as narrow-minded, and therefore its relevance to the domain of work or even organizations portends pint-side weight, particularly when it faces stakeholders' demands and economic pressures.[74] Nonetheless, some contemporary researchers have coined the concept of virtuous leadership as an antecedent of responsible and ethical leadership.[75] A critical study of virtuousness divulges that it is related to concepts such as moral virtues, virtue ethics, civic virtues, and virtues. Virtuous leadership also encourages organizational moral culture, and three central concepts typify it: "eudemonic assumption (EA), an amplification assumption (AA), and inherent value assumption (IVA)."[76] To begin with, the facet of eudemonic assumption provides that individuals retain a predisposition of moral goodness; thus, virtuous leadership assists in unlocking their predisposition toward acting in ways that are beneficial to others. Some scholars utilize functional terms to denote virtual leadership to be evolutionarily develop since it enables individuals in healthcare organizations to coexist, pursue communal ends, as well as safeguard against persons whose actions are likely to endanger the social ethical order pertinent within a particular healthcare organization.[77] By way of inference, the eudemonic assumption suggests that that HC executives (human beings) act as the primary drivers of organizational moral culture since whenever exercise responsible leadership.[78]

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The second presumption of virtuous leadership is the inherent value assumption which posits that the subject type of leadership often represents "good of first intent."[79] It is notable that the inherent value assumption of virtuous leadership goes beyond ethical leadership because it often transforms the character of the affiliations among members of a specific HCO by causing the evolution of their behavior into "another technique of positive manipulation and discipline."[80] In simpler terms, the inherent value assumption of virtuous leadership connotes inherent value with a specific healthcare organization. The concepts that are indicative of virtuous leadership as per the inherent value assumption include reciprocity, exchange, and self-serving motives. In the context of healthcare, virtuous leadership is closely related to notions such as ethics, social responsibility, and citizens; nonetheless, the meaning of the subject concept surpasses that of the above terminologies. For that reason, by following this core element of virtuous leadership to establish responsible leadership, HC executives can foster the development of organizational moral culture and avoidance of Conflict of Interest challenges.

The third component of virtuous leadership that implicitly impacts ethical leadership and organizational moral culture is the amplification assumption.[81] Notably, virtuous leadership creates and promotes sustainable positive energy. In other words, its observance engenders a self-reinforcing inclination toward responsible and ethical leadership. Virtuous leadership tends to be self-perpetuating and elevating by dint of the fact it entails no extraneous motivator during its pursuit. As a consequence, fostering virtuous leadership often results in upward spirals related to positive dynamics. For example, "compassion begets gratitude, gratitude motivates improved relationships, witnessing good deeds leads to elevation, elevation stimulates prosocial behavior, and observing virtuousness leads to responsible leadership."[82] Stated otherwise, observing virtuous leadership expands organizations' and employees' social and moral capacities.[83]

According to the amplification assumption of virtuous leadership, when the personnel in a specific healthcare organization strictly observes virtuous or exemplary behavior, it formulates the broaden and build theory, triggers positive emotions, and thus fosters virtuous leadership within the subject establishment. In the long term, when healthcare executives promote virtuousness with healthcare organizations, their personnel experience the heliotropic effect; this fosters positive energy among the workers and dejects negative energy, therefore allowing ethical leadership to flourish within the subject entities. By way of inference, virtuous leadership is a vital enabler of the moral culture of an organization as it behooves HC executives to exercise responsible and ethical leadership. When leaders of healthcare organizations promote virtuous leadership, their staff members experience a strongly compelling proclivity to continue the achievements of their predecessors, resulting in the perpetuation of virtuous spirals that foster ethical leadership in the subject establishments.[84] The thing is that observing virtuous leadership eventually engenders a self-reinforcing cycle of responsible leadership.

It is vital to appreciate that endorsing virtuous leadership within the precincts of healthcare organizations is a central element of responsible leadership. In reality, virtuous leadership offers to critical functional benefits: creating a fixed point that fosters decision-making processes and augmenting performance of healthcare organizations. Notably, healthcare organizations are replete with turbulence as change is agreeably constant and ubiquitous. As a result, virtuous leadership, which in turn promote responsible leadership, creates an unchanging and stable reference point which allows healthcare leaders to clearly determine progress and direction of healthcare organizations. In other words, virtuous leadership stabilizes the organizational moral culture of healthcare organizations in line with the notion of organizational moral agency. In this way, virtuous leadership provides clear guidance to leaders in healthcare

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organizations where there exists high-velocity change, turbulence, and ambiguity.[85] Besides, virtuous leadership results in affirmative organizational outcomes. To be specific, it instigates organizational moral culture, engenders ethical leadership, and thus produces the desirable outcomes. The existing body of literature reveals that virtuous leadership promotes organizational moral culture by encouraging responsible leadership; one that realizes tonic and phasic virtuous leadership. As a result, healthcare leaders can establish systems that enable staff members to bounce back from difficult circumstances, absorb system shocks, collaborate, as well as heal relationships.[86] When healthcare establishments possess virtuous leaders, both physically and tonically, they can easily promote organizational moral culture. Through virtuous leadership (and thus establishment of a strong organizational moral culture), healthcare executives can establish leadership models to assist their staff members to lead effectively by continually growing in virtue.[87]

It is noteworthy that contemporary scholars opine that virtuous leadership comprises the foremost holistic and systematic attempt to associate classical values and virtues of professional leadership today. It is often based on the Harvard's Leadership Model which fosters authentic leadership based on the science that focuses on the study of virtue (aretology).[88] According to the Harvard Leadership Model, virtuous leadership promotes organizational moral culture by underscoring humility and magnanimity (these two values comprise the lifeblood of ethical leadership) and fostering the virtues of practical wisdom (prudence), the bedrock virtues of ethical leadership. In this way, healthcare executives can make decisions which are becoming of the ethical values and principles the American College of Healthcare Executives Code of Ethics stipulates to guide their professional leaderships.[89] In addition, the Harvard Leadership Model that accentuates virtuous leadership promotes the underlines virtue ethics rather than rule-based

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ethics. Markedly, the proponents of virtuous leadership posit that virtue ethics tend to redound to creative and original leadership, which is predominantly based on the promotional of organizational moral culture within organizations (in the present case healthcare organizations).[90] In other words, they establish a strong relationship between virtuous leadership, responsible leadership, moral culture, and ethical leadership with healthcare organizations.

Moreover, virtuous leadership is strongly connected to moral culture because it creates the ethical and moral boundaries within which HC organizations operate. HC executives possess inferable professional obligations (under the American College of Healthcare Executives) to act virtuously by avoiding corruption and Conflict of Interests as well as the abuse of personnel within the precincts of HCOs.[91] Notably, virtuous leadership promotes organizational moral culture by going beyond the two most obvious techniques of governing human behavior: community censure and the use of legal regulations. The reason is that community censure is rife with blindspots and the legal regulations are often blunt instruments for ensuring morality within HCOs.[92] Virtuous leadership underlines the concept of the "impartial spectator" that keys in on the overall long-standing value an act portends upon the entire system. By exercising virtuous leadership, prudent leadership in addition to the concept of perspective promotes the moral culture of healthcare organizations by enabling HC leaders to act as embodiments of ethical leadership in the society. In essence, virtuous leadership promotes ethical and moral restraints. In this way, virtuous leadership fosters adherence to responsible leadership, which has the capability of allowing healthcare executives to perform their mandate within the precincts of the ethical values, principles, and standards the American College of Healthcare Executives Code of Ethics postulates.[93] Ultimately, virtuous leadership strengthens the organizational moral culture of HCOs; therefore, it fosters ethical leadership within the crocus of healthcare management.

When HC leaders exercise ethical leadership within HCOs, they will allow the subject entities to flourish. Markedly, flourishing culminates in all stakeholders and staff members in HCOs experiencing positive emotions, flow or engagement, meaningfulness in all their activities, satiating relationships, and achievement (these comprise the entirety of virtuous objectives).[94]

Moreover, virtuous leadership engenders sustainable leadership in HCOs. The world is replete with enormous diversities, thus different healthcare establishments utilize varied philosophies of leadership that lack sustainability in the long-term. However, the institution of virtuous leadership in HCOs results in the creation of strong organizational moral cultures that determine the behavior of the concerned healthcare leaders and personnel. As stated in the previous sections, organizational moral culture necessitates the creation of ethical programs that significantly influence behavior of individuals within HCOs. This means that different generations of HC executives exhibit similar behavior as they are influenced by the same ethical programs. Therefore, virtuous leadership creates a continuum of ethical programs that engender sustainable moral leadership that leads to avoid Conflict of Interest issues in the healthcare sector. Notably, the American College of Healthcare Executives Code of Ethics comprises one of the ethical plugin that ensures virtuous leadership within the healthcare management profession, and by extension HCOs. By dint of its operative continuity, the Code will ensure sustainable responsible and ethical leadership. Stated otherwise, healthcare leaders can utilize the subject Code of Ethics to promote virtuous leadership and thus ensure sustainable ethical leadership in the crocus of healthcare.

In the long-term, virtuous leadership is associated with positive organizational outcomes, which include a strong moral culture.[95] The reason is that tonic and phasic virtuousness encourage leaders to create a resilient organization where all stakeholders are committed to

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upholding its existing moral rubric. Ultimately, virtuous leadership begets responsible

leadership, which then engenders morals and ethics constraints.[96] As a consequence, moral and

ethical constraints shape HC executives' decision-making; a major tool for shaping the

organizational moral culture of any HCO.

3) Leadership Responsibility for Ethical Decision-making to the Profession:

The American College of Healthcare Executives Code of Ethics provides that the subject

executives hold significant duties toward the profession of HC management.[97] It postulates that

an HC executive should uphold the Code of Ethics as well as the mission of ACHE. Moreover, it

entails the need for HC executives to carry out all professional activities honorably, justly, with

veracity, deference, and in good faith in order to foster the good image of the HC management

profession.[98] The American College of Healthcare Executives Code of Ethics mandates the HC

executives with the obligation of complying with regulations as well as laws pertaining to HC

management in their respective jurisdictions. In addition, the subject Code impels HC leaders to

strive to maintain competence and proficiency in HC management through the application of a

personal program aimed at continually progressing with professional education and assessment.[99]

Furthermore, the American College of Healthcare Executives urges HC managers to

abstain from certain actions that engender the indecorous manipulation of specialist relationships

for individual benefits. The thing is that such behavior would help to increase Conflict of

Interest issues and hamper them from proceeding in the best interests of others served and

patients. In essence, the indecorous manipulation of professional relationships by healthcare

executives for personal gain compromises the ethical and moral values associated with ethical

leadership, which the ACHE Code of Ethics seeks to foster. Stated otherwise, they should

circumvent "financial and disclose" to completely obliterate likely conflicts of interest from

arising. The HC executives' ultimate goal should be the utilization of the ACHE Code of Ethics

in furthering the interests of the profession of healthcare management in a bid to demonstrate

unquestionable respect for professional confidence.[100] What is more, the American College of

Healthcare Executives Code of Ethics posits that the leaders of healthcare ought to strive to show

significant respect for all forms of confidences associated to the healthcare management

profession. In other words, the Code of Ethics anticipates the existence of certain professional

confidences, and thus it obliges the healthcare executives to safeguard and respect them.

Moreover, they should utilize programs related to affirmative public information in enriching the

impression and respectability of the subject profession. In the end, HC professionals should

abstain from taking part in activities that demean the dignity and credibility of the HC

management profession.[101]

The American College of Healthcare Executives Code of Ethics places numerous

responsibilities to HC executives aimed at safeguarding the image of the profession of healthcare

management. For instance, in impelling the healthcare leaders to uphold the Code of Ethics as

well as ACHE's mission, it requires them to utilize the ethical values and principles it contains to

underscore the welfare of the profession. In other words, when these ethical principles and values

(postulated by the ACHE Code of Ethics) guide the performance of their mandate, others served

and patients will receive high-quality health services from healthcare organizations, resulting in

greater respect for the subject profession. Furthermore, by providing the responsibilities of the

healthcare executives toward the vocation of HC management, the American College of

Healthcare Executives Code of Ethics subsists as a yardstick for ethical conduct for the ACHE

members. In reality, it enumerates specific standards of ethical behavior that HC executives

should abide by as they execute their duties within the profession of HC management.[102] In

performing their responsibilities to the profession of healthcare management, HC executives

create multiple professional relationships, including others served, patients, colleagues,

community, members of the healthcare executives' organization, other organizations, and the

larger society. The professional relationships provide avenues through which healthcare

executives, acting ethically, can foster respect for the profession of HC management.[103]A

inferential appreciation of Section I of the American College of Healthcare Executives Code of

Ethics reveals that it communicates specific paradigms of ethical behavior in a bid to regulate the

individual behavior of HC executives as their perform their duties or exhibit their identity. This

is in tandem with the foremost and fundamental goals of the profession of healthcare

management: enhancing or maintaining the dignity, overall quality of life, as well as well-being

of all persons in need of healthcare services and creating an equitable, efficient, effective, and

accessible healthcare system.[104] Arguably, the strict performance of their obligations toward the

profession of healthcare management means that the HC executives will demonstrate ethical

leadership in HCOs as they will strive to uphold the dignity and credibility of the HC

management profession among the community and society at large.[105]

4) Leadership Responsibility for Ethical Decision-making to Patients and Community:

The American College of Healthcare Executives Code of Ethics presupposes that HC

executives can foster ethical leadership in HC settings by performing specific responsibilities to

patients and others served.[106] Within the scope of their power, HC executives should work

toward guaranteeing the existence of processes for evaluating the quality of health services that

HCOs provide to others served as well as patients. In executing their duties, HC executives

should desist from discriminatory practices through the adoption of strategies which are aimed at

curtailing bigoted practices within their respective HCOs.[107] Moreover, they are obligated to

frame courses which are targeted at counseling others served as well as patients on the responsibilities, rights, risks, and opportunities related to the available HC services.[108] What is more, the subject leaders must strive to originate structures targeted at settling disputes in situations where patients' or their families' values go into the values of physicians or other employees within the precincts of healthcare organizations.[109] It is noteworthy that such structures will ensure harmony within HCOs because of expeditious resolutions of Conflict of Interest that arise between physicians and staff members and patients or their families. What is more, the subject HC leaders should show zero tolerance for the misapplication of power to prevent compromises of patients' interests and those of individuals served by their respective HCOs.[110] As a result, HC executives will ensure that the employees and healthcare organizations prioritize the interests of patients by curtailing any form of power abuse within healthcare organizations. To ensure the self-determination and autonomy of patients in addition to the community, the American College of Healthcare Executives Code of Ethics requires HC leaders to afford procedures and equip them to safeguard their privacy and confidentiality.[111] In this fashion, patients and other individuals that healthcare organizations serve will be free to express themselves and their values.[112] Moreover, the ACHE Code of Ethics obliges HC executives to guarantee the subsistence of procedures that are aimed at safeguarding the privacy and confidentiality of patients and other persons that healthcare organizations serve. Therefore, HC executives should create procedures and processes for safeguarding the privacy and confidentiality of patients and the community and then establish mechanisms to guarantee their continued existence. To successfully perform their assigned duties, HCO managers should formulate permanent processes and procedures for examining, concocting, and constantly applying clinical practices that are evidence-based in their corresponding healthcare

organizations."[113] Evidently, the Code seeks to promote ethical leadership in HC contexts for the benefits of patients and others served by requiring executives to perform their responsibilities toward them.[114]

Additionally, the American College of Healthcare Executives Code of Ethics enumerates certain responsibilities that HC executives ought to perform to the society and community.[115] It states that HC executives should work toward identifying and satiating the community's healthcare needs.[116] In other words, they should guide HCOs to correctly identify and fully attend to the needs of the community as well as those of the larger society. In a bid to meet this obligation, the Code of Ethics requires the subject HC leaders to establish systems for supporting an unlimited access to HC services by all members of the community and the larger society.[117] To be specific, they should frame mechanisms that allow for equitable distribution of healthcare goods and services in the community for the benefit of all individuals. To achieve this objective, HC executives should eliminate all forms of discrimination and partiality that may instigate inequalities of access to HC services in the community or society.[118] The American College of Healthcare Executives Code of Ethics posits that HC leaders should aim at fostering and taking part in public dialogue on issues related to HC policy. They should also advocate and support solutions that are capable of improving the health status of the members of the community and society.[119] In so doing, ACHE Code of Ethics mandates HC executives with the duty of promoting quality HC in the community and society. Inferentially, the Code of Ethics anticipates that HC executives will create support systems and advocacy campaigns to assist them in meeting this responsibility. Besides, it predicts that they will formulate public forums to allow for discourses on HC policy issues.[120] Through such forums, they will devise policies and that will allow healthcare organizations to advance solutions for enhancing communities' and

societies' health statuses. What is more, they will coin effective techniques for fostering quality HC services for the benefits of the members of the community and the larger society.[121] The American College of Healthcare Executives Code of Ethics also implement immediate and long-standing evaluations to the decisions of the management which tend to affect the community and society. In this way, the will be able to streamline such decision to ensure that they adhere to the ethical values, standards, and principles that are contained in the subject Code of Ethics. Additionally, they will promote ethical leadership in HC for the benefits of both the community and society. The American College of Healthcare Executives Code of Ethics provides that HC executives ought to provide potential patients and other individuals that HCOs are capable of serving with sufficient and correct information in a bid to empower them to reach enlightened decisions regarding healthcare services.[122] Notably, this is critical to promoting the autonomy of community members as they can voluntarily seek the services that are in line with their health needs.

A close reading of the Section V of the American College of Healthcare Executives Code of Ethics demonstrates that it requires HC executives to perform specific duties to the community and the society. Because these responsibilities are concomitant to healthcare ethics, an individual may argue that the ACHE Code of Ethics fosters ethical leadership in healthcare by impelling HC executives to perform specific duties to the community and society.[123] In the short- and long-term, the execution of the HC executives to the community and society results in improved health statuses and promotion of quality HC.

4.b) Conflicts of Interest & Conflicts of Commitment:

Having discussed the crucial connection between professional ethics and codes of ethics for understanding how to identify and resolve Conflicts of Interest as a function of professional

leadership and organizational culture, the following discussion explains the distinction between Conflicts of Interest and Conflicts of Commitment.

4.b.i) Conflicts of Interest:

In healthcare, Conflicts of Interest denote competition between personal interests and the professional interests and judgments of physicians.[124] Specifically, these conflicts take place when the central objective of upholding the interests of the patients collides with the healthcare provider's secondary goals, particularly the need for personal gain.[125] Conflicts of Interest may stem from the need to augment revenues of healthcare institutions from vending healthcare services as well as products.[126] Notably, healthcare organizations expect physicians to maintain appropriate affiliations with patients by avoiding Conflicts of Interest.[127] This is because Conflicts of Interest inhibit the traditional role of medicine, augment problematic claims against health care organizations, and above all undermine the moral status of the profession. Conflicts of interest are an expanding worry across, possibly, every sector ranging from business, politics, government, education, healthcare, and finance[128]. Daily newspapers, for example, are filled with stories of the aftermath stemming from organizations and individuals engaged with circumstances of conflicts of interest. Healthcare industry surely is not resistant to these concerns. Thus, healthcare executives are required to be competent and accomplish their duties in a manner that shows the standards and code of ethics of their profession[129]. Besides, the executives and another staff in the healthcare organization are obliged to direct their decisions and actions towards fulfillment of the values and the mission of their organizations. Therefore healthcare professionals should deliver these duties bearing in mind that they are respected for their recognized competence as well as for carrying a public expectation that they will act on behalf and in the best interest of both their patients and the mission of their organizations[130]. For

that reason, conflicts of interest betray trust and challenge the primary fiduciary duty of a medical professional and a healthcare organization to offer quality patient care[131].

Relationships between doctors and the healthcare industry, including device suppliers and manufacturers and pharmaceutical companies, have the ability to advance medical science and advantage patients[132]. The interaction between healthcare professionals and manufacturers can be valuable in developing new technologies and products. Physicians play a crucial role in development, extensive training and testing for production of safe and effective medical devices such as pacemakers, medical lasers, and heart valves. Besides, they perform clinical trials, conduct research, provide feedback and ideas, and contribute their knowledge by involvement in medical education programs[133]. The companies may respond by legitimately compensating the doctors for their intellectual assistance and actual time on product innovations and training in the suitable use of devices. However, in situations where clinicians regularly accept substantial compensation from pharmaceutical and medical devise industries through royalty agreements, stock options, research grants, fellowships, and consulting agreements, research implies that a high risk exists that such payments will influence medical decision making negatively[134]. Furthermore, physician-industry relationships are pervasive and the urge to reciprocate for even little rewards and gifts has a significant effect on behavior. Although doctors might oppose the argument that secondary interest such as subsidized trips, gifts, or free lunches, might unconsciously influence their medical inferences, research proves otherwise by showing that such prerequisites may affect how people act[135].

Physicians often find themselves playing the role of examiners. This occurs when they participate in pre-employment examination, doing a domestic medical examination for foreign workers, issuing fitness for work certificate, fitness to drive or fly, and certification of mental

capacity[136]. In these circumstances, medics might find themselves faced with a statutory component linked with the law and the public interest, and in other situations, they find themselves in a contractual relationship with third parties such as employers or insurers. Often, there is a dual obligation position to the third parties and the examinees. Physicians ought to balance the interest of both parties with the overriding obligation or primary interest of preserving accuracy, objectivity and integrity of professional inferences[137]. However, failure to balance the interest of both parties by favoring one side amounts to a conflict of interest and unprofessionalism in healthcare delivery. Besides, doctors may sit in judgment of their colleagues where the primary interest is upholding the rules of natural justice and the rule of law. Medics in these settings are expected to serve without fear or favor in their deliberations[138]. Besides, secondary interests would compromise judgment due to the formed opinions, thus, undermining public confidence and trust in the judgment system.

In the healthcare fraternity, every practitioner has at least two main categories of goals: the primary and secondary goals[139]. Primary goals are concerned with patient protection including promotion of the health of the patient. A caregiver is expected to treat the patient in the best way possible. At times, taking care of patients may involve personal sacrifice like working for a prolonged period at the expense of one's leisure time[140]. Similarly, the healthcare workers may have to forgo their families just to ensure that patients receive the best care possible. The primary goal, which ensures that the patients are accorded optimal care, may be too demanding[141]. The conflict of interest policies in medicine primarily aim at safeguarding the integrity of professional judgment and preserve trust of the public rather trying to remediate mistrust or bias after it takes place. Researchers and physicians should act in their professional roles to show acceptance of the primacy of these interests. They do this by exercising discretion

and judgment in their work. Patients, research participants, the public, residents, medical students and fellows need to have confidence on the physicians and researchers' ability to act and make judgments in a manner consistent with the primary interests. Regardless of the primary interests, the aim of regulating conflicts of interest is to try to ensure that secondary interests do not subvert researchers' and physicians' actions and decisions concerning those primary interests, and do not destabilize trust in their scientific or clinical decision-making[142].

On the other hand, a healthcare professional is also a human being with specific needs and wants. Secondary interests do not exist only on financial perspective, but also include interests such as the desire to do favors for family, friends, colleagues or students, and the hunt for professional advancement and recognition. Besides, the workers need to rest, to build their families, to make financial advancement and to do any other activities that any other person does[143]. Striking a balance between the need to spend one's life while attending to other people's health and developing one's own life can be difficult. Therefore, the concept of conflict arises in some situations in the modern medicine industry since the primary goals and obligations lie at risk of being affected and compromised by the undue quest for secondary interests such as the financial gains[144]. The other need that healthcare workers have that is common to everyone in life comprises the secondary goals or the professional gains. However, for secondary goals, conflict of interest policies mostly focus on financial gains since they are relatively quantifiable, fungible, and more objective. Therefore, financial gain lies at more effective and fair regulation position compared to the other secondary interests[145].

The two aspects determining the severity of a conflict of interest include: first, the probability that professional inferences made under the relevant circumstances would be unduly inclined by a secondary interest, and that the seriousness of the wrong or harm that could arise as

a result of such an influence. The value of the secondary interest, the extent of discretion that the healthcare practitioner has in making crucial decisions as well as the duration and depth of this secondary interest, affect the possibility of undue influence[146]. The conflict of interest policies normally highlight management and prevention rather than punishment. They eliminate the assumption that any specific healthcare professional will allow financial gain to bias his or her judgment. Besides, these policies reject the assumption that an individual with a conflict of interest is unethical. Such judgments are based on a single assumption that some circumstances are generally known to pose an intolerable risk that decisions or inferences may be unduly predisposed by considerations that should be irrelevant[147].

Primary goals and secondary goals spark an internal conflict within an individual. Each of the competing sides wants to be satisfied[148]. Since individuals desire to treat the patient and witness positive treatment outcome, the individuals also require to develop professionally and to have a balanced life. Failure to strike a balance between these two competing needs can lead to disorganization of individuals[149]. However, most secondary objectives, including the financial interests, lie within limits, legitimate and even desirable goals[150]. They are neither unethical nor illegal, and are unavoidable and in several instances, the only solution involves appropriate management or reduction to acceptable levels. Besides, the assertions of good will and honesty, capacity for personal discretion and personal integrity in professional judgments are insufficient measure to guarantee that a person is not affected by a weighty conflict[151]. Indeed, if a conflict is not properly resolved, there is always some destruction. In the event of these two categories of conflicts, failure to reach a personal resolution can compromise human health; the professional's and or the clients'; as discussed in the next section.

1) How the Conflict Affects the Health Industry:

Interpersonal conflicts between primary and secondary goals have far-reaching consequences if not controlled[152]. Primary goals aim at ensuring high quality health care. Most of the people who fail to strike an appropriate balance between the two conflicts are likely to develop psychotic disorders of care that may affect the quality of care that they accord to patients[153]. The amount of money that is paid in healthcare profession may not be commensurate with the physical and mental effort exerted in the same job. People therefore, may try to find other means of making money by working in multiple hospitals[154]. A person who is involved in a job in more than one hospital is less likely to provide the highest level of attention to the patients in the hospitals. For instance, if an obstetric surgeon is working in two hospitals, say hospital A and B, and the person is called to attend to an emergency surgery in hospital A while the surgeon was still performing a procedure in hospital B, he will have to perform the first surgery in a hurried manner[155]. In the event of hurrying to catch up with the emergency surgery, the surgeon may end up making surgical errors like failing to close surgical incisions as recommended in the elective operation.

Clinicians who observe the primary goals aim at evaluating quality so that they can improve and monitor the services they offer to individual patients. Nonetheless, conflicts between the primary and secondary goals limit physicians from ensuring quality improvement. Besides, these conflicts divert their attention from activities that aim at ensuring that the healthcare organization they serve meets the minimal standards or is taking credible initiatives towards enhancing care quality. Consumers and other healthcare purchasers seek information that they can use to select healthcare organizations or clinicians[156]. Health institutions where medical practitioners succumb to conflicts between primary and secondary goals tend to receive

less demand for their services since the consumers have information regarding decision-making behaviors of these physicians. Institutions with low patients count experience financial challenges such as losses that may lead to closure.

Apart from affecting the modality of care, the conflicts can also affect the relationship between healthcare providers and the clients[157]. Since the healthcare worker is in a hurry to meet other financial needs, the person does not take time to develop a good rapport with the patient. This may lead to the disclosure of some information by the patient. The information obtained from the patient may not be reflective of the history of the presenting illness. Clinical analysis of insufficient patient data leads to misdiagnosis[158]. Since making the correct diagnosis is the first step of patient management, when it is missed, the entire process of patient management becomes affected negatively leading to poor prognosis of the disease. Quality healthcare reveals itself in the degree to which the health services for individuals and the communities increase the probability of achieving the desired health outcomes and are consistent with the present professional knowledge[159].

Biotechnological, medical device and pharmaceutical companies might influence medical researchers, especially those with financial objectives, towards generating research that favors their products[160]. These companies may send human participants with significant financial attention on a potential or existing product or company that might be affected by the research outcomes. Researchers with severe secondary goals involving financial wants might forego the primary goals and end up compromising the integrity of their research at the expense of patients' safety. When physicians and clinicians utilize biased research in their care practice, they tend to offer incorrect diagnosis and might even threaten patient lives. Such relationships with these companies exert inappropriate influence on making decisions and professional judgment. This

undermines the integrity of such decisions and damages the trust of the public. At times, the relationships might not result to actual compromise of patient care or medical judgment but they threaten the credibility of both the healthcare institution and the professional.

Primary and secondary conflicts of interests determine how physicians treat some health conditions with regard to evidence-based care. Patient openness depends on the approach made by the physician. Doctors with financial objectives tend to offer care depending on the mode of compensation the patient uses. The financial incentives for physicians combine with the patients' expectations and this leads to unintended concerns of particular quality metrics[161]. This results to aggressive diagnostic tests and procedures. Therefore, misaligned incentives arising from the physician conflicts of interest and the patient expectations may subvert the support by healthcare systems for evidence-based decisions made by physicians[162]. This may limit adequate access to healthcare resources for patients.

The sophistication of the pharmaceutical companies' marketing strategies may focus on utilizing physicians with financial interests as their marketing agents. Some biotechnological, medical device and pharmaceutical companies often provide physicians with gifts drug samples and meals, or other items of material value as method of creating friendships with the clinicians. These clinicians give diagnosis inclined towards the products of the companies that offer them goodies at the expense of quality[163]. Besides, these physicians may ensure sale of products through biased prescribing habits, where the healthcare practitioners only prescribe drugs manufactured by the company that rewards them financially. Additionally, physicians play a critical role in determining the medical devises to use in treatment of their patients. Complex medical devices are implanted or used in clinical process or in patient stay for which the health institution is reimbursed[164]. Treating physicians normally decide or powerfully influence the

decision concerning the medical devise to use in the hospital environment. As a result, device

manufacturers have a strong financial incentive to convince the treating doctor to recommend or

use their device[165]. This implies that patients might receive false diagnose, and in turn, a wrong

prescription. This leads to deteriorated health standards for the community served by such

physicians. Patients use huge sums of money to seek safe and evidence-based healthcare services

with the hope of enhancing their health, but in turn, the services they receive fail to meet the

expected levels[166].

Modern day healthcare institutions aim at providing patient-centered care. These

institutions encourage their physicians to care for patients and their families in a meaningful

manner that is valuable to the individual patient by listening to, involving and informing patients

on their care, and making clinical decisions based on patient values[167]. However, clinicians

affected by the conflict between primary and secondary goals, fail to observe the guidelines for

patient centered care. Some, especially those overwhelmed by financial interests, tend to offer

care with respect to the financial wellbeing of their patient. Additionally, secondary objectives

may influence a healthcare practitioner towards violating the equity provision of patient centered

care. This provision requires one to give care that does not vary in quality due to personal

features such as gender, relationship, geographical location and ethnicity[168]. Physicians may

perform exemplarily well with regard to patient-centered care by observing timeliness and

efficiency when treating friends and family compared to other random patients. This leads to

inconsistency in the patient outcome results observed.

The conflict between primary goals and secondary goals also affects the cost of service

delivery. Private practitioners tend to increase the cost of healthcare services, at times beyond the

acceptable maximums[169]. The high charges may be aimed at meeting the expensive cost of

maintaining hospitals or may be out of pure greed. In South Africa, financial medicine has been

reported as a common practice amongst the paramedics. The paramedics ask for money from the

patients before offering them any service[170]. The exorbitant prices may affect the health seeking

behavior of the population thereby degrading public health.

2) Ethics in the Conflicts of Interest:

There is a professional obligation for physicians to manage responsibly conflicts of

interest as a profession and as individual practitioners[171]. The ethical foundation of this

obligation in healthcare lies in the primacy of patient welfare principle. The primary interests of

a doctor in a therapeutic relationship are the patient's best interest. Otherwise, other interests

become secondary[172]. The patient-doctor relationship is founded on trust where patient place

their medical well-being and health on the hands of a physician. Besides, the relationship is

described as that of imbalance of knowledge, power, and experience, and, thus, the need to

identify vulnerability and abstain from exploitation[173]. This makes trust a crucial ingredient in

meeting the goals of medicine. Therefore, ethical principles are essential in governing this

relationship since trust is fragile and requires continuous nurturing[174]. Thus, even a perception by

a member of the society that a medic puts other interest above that of the patient may undermine

confidence and trust in the doctor and the entire healthcare profession.

Medical device and pharmaceutical manufacturers have the ethical duty as part of the

health care industry to promote the welfare of patents by their commitment to product

development and research. They have benefited uncountable number of patients by investing in

developing, discovering, and distributing new medical devices and pharmaceutical agents.

Besides, several industries of this kind aid Continuing Medical Education (CME)[175].

Nonetheless, most of these investing companies have a fiducially obligation to their shareholders

who expect huge profits on their investments. Therefore, several manufacturers ignore their ethical responsibility to promote the primary goals of healthcare by facilitating the conflict between profit incentives and patient vulnerability. Investigations have revealed how often company practices compromise the welfare of their patients by embracing their profit-seeking character[176].

There are several ethical issues involved in the conflict of interest. A professional can accept benefits before rendering services. This is tantamount to bribery. The person involved is specifically employed to render services to the patients and has a salary at the end of the month. Extortion of patients by accepting benefits from them is unethical[177]. The main motive of bribery is to increase the total pay accrued from a job, and this is the conflict of interest. According to healthcare ethics, in a clinical setting, harm is referred to as that which worsens a patient's condition. Physicians cause harm when they offer biased diagnosis due to influence caused on them by the biotechnological, medical device, and pharmaceutical companies. Additionally, they cause harm when they fail to monitor the conditions of their patients effectively. When patients are harmed, the trust in the healthcare profession becomes weakened. Healthcare workers have developed several protocols aimed at protecting families, patients, the community and themselves[178]. However, some fail to obey these protocols due to secondary interests. Failure to engage in those protocol amounts to the act of omission since the person fails to exercise due diligence expected of their role as a medical practitioner[179].

Furthermore, Academic Medical Centers (AMCs), including the medical teaching institutions and their affiliated hospitals, should offer leadership medicine. Both the medical profession and the manufacturers of pharmaceuticals seek influential advice and support from the AMCs[180]. Besides, these canters have a responsibility to train their house staff and their medical

students. Research states that the acquired or learned habits during training continue in practice. The central tenets of physicians both in practice and in training should be scientific integrity and objectivity[181]. AMCS are entitled to the ethical obligation of ensuring integrity and objectivity among their medical trainees. These centers should take immediate action to eliminate the influence of conflicts of interest in the medical centers. They should be well organized to gain the trainee's commitment to a set of new set principles within a short duration[182]. Besides, they should ensure research independency to boost the impact of devices and medications on the health of the society. AMCs have the ability to ensure medical integrity by eliminating unwarranted influence by the device and drug manufacturing industries, through leadership reforms and implementation of firm standards[183].

Self-dealing is another ethical issue in conflict of interest. In this case, the healthcare worker operates a separate hospital other than where the person is employed[184]. When patients approach the individual for treatment in the public hospital, the healthcare worker refers them to the private hospital where he works. This is a form of corruption where one diverts funds from public coffers to their own pockets[185]. Activities of self-dealings by doctors make healthcare expensive. Several doctors have their clinics where they have installed scarce machines such as the CAT and MRI scans. Additionally, others own medical device manufacturing industries and other related business[186]. The doctor's return on investment from the business venture may inspire their choice of device in care delivery. Therefore, they refer patients for imaging to these private facilities, and this escalates the cost of healthcare. Such doctors focus on financial gains rather than the primary healthcare goals of quality and evidence-based. When device manufacturers pay doctors to influence the use or recommendations for products from these industries, the extra costs are forwarded to the patients, private insurers, and federal healthcare

programs, hence resulting to unfair relative therapeutic value for these products[187].

Healing ethics require the healthcare professional to sublime their personal interests to those of the patients. This implies that physicians and other medical staff should primarily focus on the primary healthcare objective and should avoid secondary goals from influencing their work ethics. A healthcare professional who fails to understand the need to sublime their own interest to those of his or her role or those of the patient has no yet become a health professional[188]. Healing ethics require healthcare professional to first avoid harm and ensure that whatever actions they take aim at providing benefit. Surrendering to secondary interests shows that physicians fail to act in accordance with the essentials of honorable behavior for physicians as stipulated in the principles of medical ethics[189]. The traits relative to virtue ethics combine to create not only a good physician, but also a person of good character who prioritizes on the primary health goals[190]. Besides being technically competent, good physicians are persons of good character and respectable morals. Their actions merge to reveal integrity and ethical character. These individuals have internalized the ethical expectations to an extent that doing the right things builds their identity[191]. Physicians who allow secondary goals to interfere with their primary goals in healthcare delivery fail to act according to the ethical principles that should form the core of identification of own self with their roles.

Conflict of interest can lead to breach of patient confidentiality. A doctor may attend to two patients at the same time due to the need to save time to attend to other income-generating activities[192]. Confidentiality is the key pillar for preserving trust between doctors and patients[193]. While the two patients are in the same consultation room, they are bound to hear the particulars of each other including sensitive information like the disease that one is suffering from, the family background of an individual and the obstetrics and gynecological history involved. It is

mandatory that the contract between a doctor and a patient preserve a high level of confidentiality without leaking any of the patient's details. This conflict of interest can cause the unethical breach of the confidentiality that is required in the doctor-patient relationship[194]. There exists a huge communitarian public interest in securing of confidences, and this makes preservations of confidentiality necessary to secure public health. Breach of medical confidentiality is allowed under certain circumstances without compromising the ethical character of the medical practitioner[195]. These include disclosures required by law, disclosures with consent, and disclosures in the public interest. However, when clinicians disclose a patient record for other reasons rather than those that are accepted by the professional code of conduct, their ethics are questionable.

Moonlighting is an unethical issue conceived of self-interest. In this case, a hospital employee sets up a competing business near the hospital. Secondary interests are the main influences to moonlighting. The person then collaborates with other workers in the hospital and asks them to send patients to the facility for services that are as well provided by the hospital in which the individual is employed[196]. Besides, some healthcare practitioners have additional jobs in addition to their primary full time job[197]. Organization theories of moonlighting argue that even though moonlighting provides healthcare workers with extra income, training and other secondary benefits, it could also affect their decisions, behaviors, and perceptions at their primary jobs. Therefore, this affects their performance negatively at their primary healthcare jobs, increases absenteeism, and lowers turnover. Governance theory sees moonlighting as a poor governance indicator in health care delivery. Besides, the theory perceives it as a form of corruption that influences health system performance and provide-patient interactions[198]. Moonlighting exacerbates cases of low staff morale, inadequate production, and sub-optimal

performance among the medical staff.

In summary, the main issue in the conflict of interest is the desire to gain more money from the sickness that a patient is undergoing. However, it is also important to note that healthcare workers also need to have employment benefits like any other professionals[199]. Even though performing underhand activities to raise money from patients is not justifiable, it is justified to live a decent life and make financial strides in life.

4.b.ii) Conflict of Commitment:

Conflicts of Commitment occur whenever professional, personal, financial or commercial activities or interests outside healthcare organizations have the capacity of interfering with the ability of physicians to fully satiate their mandate.[200] They include compromises of the professional judgment of the concerned experts, and they result in doctors inappropriately gaining at the expense of the patient and the healthcare organization.[201] To avoid Conflicts of Commitment, medical professionals must avoid engagements that can either influence or appear to interfere with objective and independent judgment in patient-related decisions or interactions.[202] Moreover, they should circumvent these conflicts by avoiding the use of a health care organization's resources for non-organizational or personal purposes.[203] In other words, they should not participate in extraneous business interests, professional organizations, or public service that may culminate in conflicts related to allocation of energies or time, or concern their professional loyalty to specific healthcare organizations.[204] Conflict of commitment is generated when an individual working in a particular institution has other activities out of the institution that competes for his interests. In this case, the activities are not necessarily income generating, but they can be[205]. Family, social, and economic activities all contribute to the conflict of commitment. In this case, an individual is not able to balance the time that schedules for daily

activities. Conflict of commitment differs from conflict of interest in that physician's interest might have not been sacrificed for the sake of advantaging himself or herself, although some people may be affected negatively by the conflicting commitments of the healthcare professional[206]. Issues other than the job, compete for the time of the healthcare worker leading to poor service delivery at the center of employment. In healthcare, conflict of commitment occurs when members of the medical staff commitment to external activities harmfully affects or seems to influence his or her capacity to meet their healthcare responsibilities. This conflict form is recognizable via a perceptible reduction of a person's focus, time, and/or energy devoted to their medical activities. Balancing medical responsibilities with other external activities such as public service and family time might pose a huge challenge for medical staff. Some physicians work for long hours and rest for the remaining few hours. This means limited time for friends and families. Their children and spouse might feel neglected, and this might cause conflicts within the family. Normally, conflicts of commitment involve matters concerned with allocation of time and energy[207].

Conflicts of commitment result from different factors. Job satisfaction and coping with tension are key factors that contribute to a physician's organization commitment. Research reveals that organizational commitment links directly to job characteristics, work role, and demographic characteristics such as age, gender, and job tenure[208]. Organizational commitment lies at central position on the web comprised of behaviors and attitudes that have positive or negative influence on the organizational outcomes. Three components explain organizational commitment conflicts, which include affective, normative, and continuance. Affective commitment is associated with the employee's emotional connection to, and identification with an organization[209]. Normative commitment is linked to the obligation the workers feel about

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continuing working for an organization. Continuance commitment relates to the alleged cost of leaving an organization. The nature of the three components may differ, but they have equal impact on a physician's decision to discontinue or continue their employment with the healthcare institution that is responsible for their employment.

Divided loyalty between several entities in a physician's life might lead to conflict of commitment. The conflicts often arise when the demands of responsibility outdo the resources and time available for them. They might arise when healthcare professionals find it difficult to attend all their clinical, teaching, and research duties in the same way and the same time. As a result, their students, patients, and family members may lack the quality or quantity of attention they need or even deserve. Organizational commitment requires employee's loyalty and bond to the activities of their employing institution. Conflict of commitment may arise when physicians show little strength in their identification with and involvement in the healthcare institutions they serve[210]. This shows a negative appraisal for the work environment, and this result in weak believes in the organizational values and goals, and a low desire to preserve membership in the organization. Besides, low payments may be a key contributor to conflict of commitment. Doctors and other healthcare workers who receive low incomes start other income generating projects to sustain their financial needs. These projects might be time-demanding and similar to the healthcare roles. This places physicians at crossroads on where to commit more of their time and energy.

Particularly, the family can be a great source of conflict of commitment[211]. Health workers and other employees worldwide, experience more conflict between family roles due to the increase in hours worked and women's participation in the workforce. A doctor on call may receive a patient five minutes to the end of office hour. The procedure to be done on the patient,

say, osteotomy, may require more than one hour. At the same time, the doctor is needed to pick his child from school[212]. The person is placed in such a situation where he has to compromise one of the activities. If the person forgoes attending to the patient, the life of the patient is placed at risk. If he forgoes going to school to pick the child, the life of the child is also placed at risk, and the relationship of the employee with the family is compromised[213]. Besides, a physician might be a passionate member of a local sports team that practices daily on the evenings. However, in certain weeks their healthcare schedule might coincide with the team's training sessions. This might affect the working attitude of the healthcare practitioner since at the back of their minds they feel their commitment should be at some other place rather than their work place. Therefore, time management is at the center of conflict of commitment as explained in the next section.

1) What Makes an Employee to Engage in Activities Generating Conflict of Commitment:

Poor time management or engaging in too many activities are responsible for generating the conflict of commitment[214]. The activities compete for the limited time that one has. The reason that makes employees engage in such activities are based on living a balanced life where one is not only involved in professional activities but other aspects of life too[215]. For instance, if an employee wants to get married, the person will have to spare time for courtship. This time will have to compromise with the usual working hours if it is not well planned. Since marriage is a paramount institution in life, one has compromised the profession to get married[216]. Similarly, standing by friends during their good and bad times also causes a conflict of commitment. For example, when a friend has lost a relative, or when a colleague is getting married, it is wise to offer psychological support at such events.

Job satisfaction is a major influence to employee engagement to activities that generate

conflict of commitment. Organizational commitment comprehends an employee's attitude towards the entire organization. On the other hand, job satisfaction might refer to one's affective attachment to their duty, either in its wholeness or with respect to specific facets such as their supervisor, their satisfaction with career advancement, and their colleagues[217]. Physicians who experience job satisfaction tend to have minimal or no conflicts of commitment to their healthcare roles. Physicians who are satisfied with their supervisors, careers and co-workers are less likely to seek other employment and are more likely to identify with the healthcare institutions where they work[218].

Leadership positions in the society may also lead to the conflict of interest. In the communities, a person can be selected to lead a given group of people[219]. The meeting times of these groups may conflict with the work schedule at the hospital. If the person fails to lead the societal meeting, it may collapse. People may, therefore, create time during their work schedule to chair meetings in the community at the expense of work[220]. The main reason behind conflict of commitment due to such leadership positions is the desire to be relevant in the society and to acquire some social status.

Physicians may engage in activities that result in conflict of commitment due to lack of empowerment. Employee empowerment contributes to the increase in the workers' sense of ownership, improves the ability of healthcare teams to govern their own actions, and increase self-management opportunities. Besides, it enhances job satisfaction and, hence, indirectly affects organizational levels of commitment[221]. Physicians value their involvement in decision-making and policy development, and they appreciate the opportunities provided by the healthcare management. They respond to this by being more committed towards their primary roles and organization in general. Empowerment presents the physicians and other medical staffs

with the opportunity to show their ability to take charge of a situation, deliver on time, and take risks[222]. A combination of these factors plays a crucial role on physician's career advancement, hence this limits the chances for development of conflicts of commitment.

Role ambiguity and role conflict may influence the occurrence conflicts of commitments among employees. Role ambiguity refers to situations where a worker is not clear about what the organization requires from him or her. Role conflict occurs when people have an urge to manage competing expectations from both work and non-work settings[223]. Intense levels of role conflict and role ambiguity may significantly lower the level of job satisfaction. When the two antecedents influence levels of job satisfaction, they create an avenue for growth of commitment conflicts. Role conflict and ambiguity affects levels of satisfaction of both institutional leadership and career advancement. Physicians having issues with the organization's leadership have divided commitment between their personal differences with the superiors and their level of service delivery. Such conflicts may result in lack of practice of patient-based healthcare. Research confirms that commitment to the organization is higher in environments with less conflicting and ambiguous relationships within or outside work settings[224]. Role clarity, however, engenders the commitment and effectiveness of the employees towards achieving the health care objectives.

Furthermore, the potential for job motivation might cause conflict of commitment. Physicians who work in institutions that rarely motivate their workers have low levels satisfaction and, thus, might shift their commitment to other interesting activities. Health institutions that have interesting jobs and those that require higher levels of skill tend to have a high motivating potential. Physicians working in such institutions have more opportunities to excel and expand, thereby engendering their commitment since they have a chance to advance

their healthcare careers[225]. Moreover, the leadership style exercised in a healthcare institution might lead to development of commitment conflicts among the medical staff. Leadership influences the employee's attitudes towards their jobs and the organization[226]. Consideration leadership behaviors represent a leadership style that shows concern for the personal welfare of all employees, friendship, mutual trust, and interpersonal relationships. Physicians working in institutions with such leadership have a low likelihood of experiencing commitment conflicts. Likewise, acceptance by co-workers might have a hand on a physician's engagement in activities that might induce a conflict of commitment. The concept of acceptance by colleagues implies a mutually protective and supportive work atmosphere established among coworkers[227]. Gaining acceptance from others and forming social attachments relates to the primary motivational requirements for belongingness. Physicians who feel accepted in their workplaces are less vulnerable to the conflict of commitment since social inclusion influences a person's emotions positively.

2) The Ethics Associated with Conflicts of Commitment:

Selection bias arises when a person is not able to attend to all the patients in the queue and is forced to select only a few patients to attend to. This is a common issue in the conflict of commitment since the employee does not have sufficient time in the workplace[228]. The bias may have racial, gender or some social predilection depending on the employee executing it. The bias can generate a sense of mistrust amongst the catchment population of a given hospital which may, in turn, inform the health seeking behavior of the population. To solve this bias, an individual needs to be committed to a single activity at a time[229].

Commitment crisis may influence lack of beneficence and low moral burden. The ethical principle of engaging in beneficent or altruistic acts means that medical workers have a moral

obligation to take direct and positive initiatives to help others[230]. In relation to ethical theories, the greatest good for the greatest number is the fundamental principle of consequentialism, which in itself is a phrase of beneficence. Lack of commitment for healthcare workers amounts to ethical egoism, where workers believe that selfishness is a virtue and that their main obligation is to themselves. Ethical egoism is disconnected to healthcare since beneficence is the underlying principle of healthcare ethics[231]. This ethical statue believes that people engage in healthcare profession with the aim of helping others and commitment crises should not affect this motive. Courtesy and kindness are mandatory acts expected from healthcare workers. As a healthcare worker, allowing commitment issues to cloud logical judgment amounts to unprofessionalism.

The poor clinical judgment that is not based on evidence is another ethical issue affected by lack of commitment to one's job. Since the clinician is in a hurry, he does not run the necessary clinical tests as required[232]. For instance, a patient presenting with a cough for more than two weeks, drenching night sweats and weight loss may be started on anti-tuberculosis medication if proper investigations are not conducted. However, the actual disease affecting the patient may develop just a lymphoma that has metastasized to the lung and is presenting with the B-symptoms of lymphomas and myeloproliferative disorders[233]. This might amount to violation of distributive justice concerned with resource allocation. Physicians should allocate enough time for all the patients as a sign of commitment to their roles to avoid giving rush diagnosis that might endanger a patient's health.

3) Outcome of the Conflicts in the Healthcare System:

Policy makers and researchers have dedicated significant attention to the daily incentives for inappropriate medical practice linked to physician payment arrangements. Each of the main modes of paying physicians and other healthcare workers has the possibility to antagonize the

primary interest of the physicians in promoting patient's best interest with their secondary

interests, which include financial interests[234]. Studies found out that paying doctors for every

service they provide encourages the physicians to increase the service volume, while increasing

their income and the amount spent by the society on healthcare[235]. Higher reimbursement levels

for procedural services such as diagnostic imaging compared to reimbursement levels for non-

procedural services such as medical evaluations have contributed to an increase in the use of

procedures. This escalates the change in the performance of specific profitable procedural

services from the public hospitals to the physician's offices. These business actions contribute to

higher medical cost, hence, the need for policymakers to intervene and regulate physicians'

conflict of interest, and consider methods for curbing these financial incentives[236].

The catchment population of the healthcare system develops a sense of mistrust on the

institution due to the negative impact on the organization's integrity and obligation to its value

and mission statements. The people are always in doubt of the level of quality of services that

they are likely to receive from the institution, and they lessen their image of the individuals

involved in conflict of interest and commitment[237]. The number of patients attended to in the

facility, thus, is likely to reduce. In case the hospital is a privately-owned profit-making

organization, there will be losses incurred. This is because the hospital will have to pay the

overhead maintenance costs while receiving the suboptimal number of clients. Eventually, the

losses accrued may lead to liquidity of the institution and, eventually, its closure.

The primary ethical principle of respect for patients motivates the commitment of

healthcare institutions to the well-being of their patients and confers organizational

responsibilities to enhance clinical excellence, prudent stewardship of resources, and

collaborative case management[238]. Health institutions with workers who allow conflicts of

interest and commitment to influence their clinical role fail to fulfill their organizational responsibilities. These institutional responsibilities necessitate that patients be cared for in the most suitable clinical setting[239]. This implies that organizations should offer services with the most targeted resources and skills. Delivery of quality patient care requires the healthcare professionals to act ethically while focusing on their primary clinical objectives. Otherwise, these institutions would fail to offer quality patient care as required of them[240]. To avoid this, institutional support and direction is crucial through assuming ownership of easing appropriate inter-service transfers[241].

An organization with employees with interpersonal conflicts may experience a surge in the number of legal suits against it[242]. Currently, several activist organizations advocate for patients' welfare. Also, the patients themselves are empowered and know their rights[243]. The patients can sue a conflict that might infringe on the patients right and or cause poor prognosis of a disease leading to stern action being taken against the hospital and the particular employee[244]. The overall effect of the lawsuit is tainting of the image of the involved hospital in the public arena. An organization with a tainted image is unlikely to make profit leading to closure.

A lot of productive time in organizations with employees that have the conflict of interest and conflict of commitment is taken in solving the outcomes of the conflict[245]. For instance, an employee who misses duty due to a competing interest is likely to get into problems not only with the management of the hospital but also with fellow employees who he or she was supposed to be changing shifts with since they will have to take cover up for the malingering employee[246]. The time taken in solving these disputes could have been invested in developing reissuing quality improvement strategies or any other program that is likely to improve the services rendered by the facility[247].

4) Impact of the Conflicts on the Health of the Society:

Conflict of interest and commitment result in poor prognosis of disease and disease management[248]. The practitioner competing for interest is not able to offer the best level of service to the patients[249]. As a result, the condition of the client is likely to worsen. If a disease, which is not self-limiting, is not treated properly within a given timeframe, the pathologic features involved tend to worsen, and the management increases in complexity. The life of the patient is in danger and may lead to unnecessary death[250]. Thereby, the mortality rates within the catchment population increase by a significant value, especially if the people involved are not able to find an alternative to the poor services rendered to them[251]. Besides, since the conflict develops mistrust in the organization, the health seeking behavior of the people involved diminishes leading to worsening of disease at home[252]. The general impact of this conflict in the society is poor public health.

Conflicts of interest and commitment not only raise ethical concerns but also might cause potential harms resulting from inappropriate conduct of professionals in a healthcare setting[253]. Individuals in the society may suffer physical harm when clinicians base medical decisions on what is advantageous to themselves or third parties, rather than on what is best for the patients who place their hope and trust on them[254]. Violation of the integrity of a clinical judgment may occur regardless of whether a particular patient or the society suffers the harm. The society suffers when physicians violate the standards for good practice to foster their own interest and that of third parties, since future patients may experience adverse medical outcomes[255]. Trust between the society and the healthcare institutions with such professionals might be undercut due to patient's perceptions and fear that if the physicians would be willing to compromise their health in certain situations, then there would be no reason for these clinicians to act on their

behalf in other circumstances[256].

4.c) Conclusion:

In conclusion, this chapter discusses professional Conflicts of Interest in healthcare. The analysis suggests that the relationship between codes of ethics and professional leadership, moral culture and decision making can help to identify and resolve Conflicts of Interest and Conflicts of Commitment. Healthcare organizations can effectively address Conflicts of Interest through codes of ethics and professional leadership. Also, creating a moral culture that facilitates ethical decision-making is necessary for ensuring that physicians prioritize patients' interests before personal gain. Professional Conflicts of Interest arise in many different setting, and a sound organizational culture can help to identify and resolve them. This awareness of organizational culture leads to a more extensive discussion of Organizational Conflicts of Interest in the next chapter.

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[1] Buell, John M. "Ethics and Leadership: Setting the Right Tone and Structure Can Help Other in Their Decision Making." *Health Care Management* (2009): 53-57. https://www.ache.org/abt_ache/MA09_Ethics.pdf

[2] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[3] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[4] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[5] Ho, Anita and Stephen Pinney, "Redefining Ethical Leadership in a 21st-century Healthcare System." In *Healthcare Management Forum* 29, no. 1. (Los Angeles: SAGE Publications, 2016): 39.

[6] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[7] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[8] Lere, John C., and Bruce R. Gaumnitz. "The impact of codes of ethics on decision making: Some insights from information economics." *Journal of Business Ethics* 48.4 (2003): 365-379 at 367.

[9] Lere, John C., and Bruce R. Gaumnitz. "The impact of codes of ethics on decision making: Some insights from information economics." *Journal of Business Ethics* 48.4 (2003): 367.

[10] Noddings, Nel. *Caring: A relational approach to ethics and moral education*. (University of California Press, 2013), 78.

[11] Flite, Cathy A., and Laurinda B. Harman. "Code of ethics: principles for ethical leadership." *Perspectives in Health Information Management/AHIMA, American Health Information Management Association* 10. (Winter 2013): 1-11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3544144/.

[12] Noddings, Nel. *Caring: A relational approach to ethics and moral education*. (University of California Press, 2013), 81.

[13] Zahedi, F., Sanjari, M., Aala, M., Peymani, M., Aramesh, K., Parsapour, A., Maddah, S.B., Cheraghi, M.A., Mirzabeigi, G.H., Larijani, B. and Dastgerdi, M.V. "The code of ethics for nurses." *Iranian journal of public health* 42. Supple1 (2013): 1.

[14] Zahedi, F., Sanjari, M., Aala, M., Peymani, M., Aramesh, K., Parsapour, A., Maddah, S.B., Cheraghi, M.A., Mirzabeigi, G.H., Larijani, B. and Dastgerdi, M.V. "The code of ethics for nurses." *Iranian journal of public health* 42. Supple1 (2013): 3.

[15] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority, accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[16] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority, accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[17] Slomka, Jacquelyn, Beth Quill, Mary Desvignes-Kendrick, and Linda E. Lloyd. "Professionalism and ethics in the public health curriculum." *Public health reports* 123.2_suppl (2008): 29.

[18] Kangasniemi, Mari, Piiku Pakkanen, and Anne Korhonen. "Professional ethics in nursing: an integrative review." *Journal of advanced nursing* 71.8 (2015): 1746.

[19] Kangasniemi, Mari, Piiku Pakkanen, and Anne Korhonen. "Professional ethics in nursing: an integrative review." *Journal of advanced nursing* 71.8 (2015): 1749.

[20] Dehghani, Ali, Leila Mosalanejad, and Nahid Dehghan-Nayeri. "Factors affecting professional ethics in nursing practice in Iran: a qualitative study." *BMC medical ethics* 16.1 (2015): 61.

[21] Dehghani, Ali, Leila Mosalanejad, and Nahid Dehghan-Nayeri. "Factors affecting professional ethics in nursing practice in Iran: a qualitative study." *BMC medical ethics* 16.1 (2015): 65.

[22] "Professional ethics and codes of conduct/ethics," Immigration Advisers Authority, accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

[23] Memarian, Robabeh, Mahvash Salsali, Zohreh Vanaki, Fazlolah Ahmadi, and Ebrahim Hajizadeh. "Professional ethics as an important factor in clinical competency in nursing." *Nursing Ethics* 14.2 (2007): 208.

[24] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm

[25] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[26] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[27] Baker, Robert, "A Draft Model Aggregated Code of Ethics for Bioethicists", *TAJB* 5, no. 5 (2005): 33-41.

[28] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[29] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[30] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[31] ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

[32] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[33] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[34] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[35] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[36] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[37] Budziak, Sherry. "Celebrating Associations: American College of Healthcare Executives." *.orgCommunity*. 31 Mar. 2016. https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations-american-college-of-healthcare-executives/.

[38] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[39] Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds., *Managerial Ethics in Healthcare: A New Perspective* (Chicago IL: Health Administration Press, 2014), 94.

[40] Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds., *Managerial Ethics in Healthcare: A New Perspective* (Chicago IL: Health Administration Press, 2014), 94.

[41] Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds., *Managerial Ethics in Healthcare: A New Perspective* (Chicago IL: Health Administration Press, 2014), 95.

[42] Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds., *Managerial Ethics in Healthcare: A New Perspective* (Chicago IL: Health Administration Press, 2014), 95

[43] Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds., *Managerial Ethics in Healthcare: A New Perspective* (Chicago IL: Health Administration Press, 2014), 96.

[44] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China Public Administration* 9, no. 3 (2012): 290-302.

[45] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China Public Administration* 9, no. 3 (2012): 295

[46] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China*

Public Administration 9, no. 3 (2012): 298

[47] Shale, Suzanne, *Moral leadership in medicine: Building Ethical Healthcare Organizations* (Cambridge UK: Cambridge University Press, 2011), 53.

[48] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China Public Administration* 9, no. 3 (2012): 299.

[49] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China Public Administration* 9, no. 3 (2012): 299.

[50] Berce, Jaro, "New Leadership Approach for Better Public Management", *Journal of US-China Public Administration* 9, no. 3 (2012): 300.

[51] Shale, Suzanne, *Moral leadership in medicine: Building Ethical Healthcare Organizations* (Cambridge UK: Cambridge University Press, 2011), 56.

[52] Shale, Suzanne, *Moral leadership in medicine: Building Ethical Healthcare Organizations* (Cambridge UK: Cambridge University Press, 2011), 54.

[53] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[54] van Dijk Hans, Marloes van Engen, and Jaap Paauwe, "Reframing the Business Case for Diversity: A Values and Virtues Perspective", *JBE* 111, no. 1 (2012): 73-84.

[55] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[56] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[57] Al-Sawai, Abdulaziz, "Leadership of Healthcare Professionals: Where do we stand?" *OMJ* 28, no. 4 (2013): 285-287. Doi: https://dx.doi.org/10.5001%2Fomj.2013.79.

[58] Bruning, P., and T. Baghurst. "Improving Ethical Decision Making in Health Care Leadership." *Bus Eco J* 4 (2013): e101.

[59] Bruning, P., and T. Baghurst. "Improving Ethical Decision Making in Health Care Leadership." *Bus Eco J* 4 (2013): e101.

[60] Donnellan Jr, John J. "A moral compass for management decision making: a healthcare CEO's reflections." *Frontiers of health services management* 30.1 (2013): 14-26.

[61] Donnellan Jr, John J. "A moral compass for management decision making: a healthcare CEO's reflections." *Frontiers of health services management* 30.1 (2013): 14-26.

[62] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[63] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[64] Cantor, Michael D., Paul Barach, Arthur Derse, Claire W. Maklan, Ginger Schafer Wlody, and Ellen Fox. "Disclosing Adverse Events to Patients", *The Joint Commission Journal on Quality and Patient Safety* 31, no. 1 (2005): 5-12.

[65] Bai, Xuezhu and Nicholas Morris. "Leadership and Virtue Ethics: A Daoist Approach", *PI* 16, no. 2 (2014): 173-186.

[66] Gabriele, Edward F, "Ethics Leadership in Research, Healthcare and Organizational Systems: Commentary and Critical Reflections", *JRA 42*, no. 1 (2011): 88-102. http://files.eric.ed.gov/fulltext/EJ955014.pdf

[67] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[68] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[69] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[70] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American

College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[71] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[72] Mullner, Ross M., ed. *Encyclopedia of Health Services Research* (Thousand Oaks CA: Sage, 2009), 337.

[73] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 25-35.

[74] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 25.

[75] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 26

[76] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 27.

[77] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 27.

[78] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.

[79] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 28.

[80] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30

[81] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[82] Riggio, Ronald E., Weichun Zhu, Christopher Reina, and James A. Maroosis, "Virtue-based Measurement of Ethical Leadership: The Leadership Virtues Questionnaire", *Consulting Psychology Journal: Practice and Research* 62, no. 4 (2010): 235.

[83] Lachman, Vicki D, *Ethical Challenges in Health Care: Developing Your Moral Compass* (Berlin Germany: Springer Publishing Company, 2009), 86.

[84] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 29

[85] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 29.

[86] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[87] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[88] Johnson, Craig E, *Organizational Ethics: A Practical Approach* (Thousand Oaks CA: Sage, 2015), 127.

[89] Johnson, Craig E, *Organizational Ethics: A Practical Approach* (Thousand Oaks CA: Sage, 2015), 128.

[90] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 33.

[91] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[92] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[93] Lawler, Patricia A., "The ACHE code of ethics: Its role for the profession", *TJCHE* 48, no. 3 (2000): 31-34.

[94] Cameron, Kim, "Responsible Leadership as Virtuous Leadership", *JBE* 98, no. 1 (2011): 30.

[95] Johnson, Craig E, *Organizational Ethics: A Practical Approach* (Thousand Oaks CA: Sage, 2015), 124.

[96] Philip JB & David EG et al., *Organizational Ethics in Health Care* (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 42.

[97] Lawler, Patricia A., "The ACHE code of ethics: Its role for the profession", *TJCHE* 48, no. 3 (2000): 31-34.

[98] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[99] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

[100] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[101] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[102] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[103] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[104] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[105] Squellati, Robin, "Ethical Challenges in Health Care: Developing Your Moral Compass", *CN* 17, no. 2 (2011): 106.
[106] Lawler, Patricia A., "The ACHE code of ethics: Its role for the profession", *TJCHE* 48, no. 3 (2000): 31-34.
[107] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[108] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[109] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[110] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[111] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[112] Lawler, Patricia A., "The ACHE code of ethics: Its role for the profession", *TJCHE* 48, no. 3 (2000): 31-34.
[113] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[114] Lawler, Patricia A., "The ACHE code of ethics: Its role for the profession", *TJCHE* 48, no. 3 (2000): 31-34.
[115] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[116] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[117] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[118] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[119] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[120] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[121] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[122] ACHE. "ACHE Code of Ethics." *ACHE*, 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.
[123] Higgins, Wayne, "Ethical Guidance in the Era of Managed Care: An Analysis of the American College of Healthcare Executives' Code of Ethics", *Journal of Healthcare Management* 45, no. 1 (2000): 32-42.
[124] de Brantes, Francois and Conway, Patrick H. "Patient-Provider Conflict: The Perfect Environment," *NEJM Catalyst*, accessed March 17, 2018. https://catalyst.nejm.org/videos/patient-provider-conflict-perfect-environment/.
[125] de Brantes, Francois and Conway, Patrick H. "Patient-Provider Conflict: The Perfect

Environment," *NEJM Catalyst*, accessed March 17, 2018.
https://catalyst.nejm.org/videos/patient-provider-conflict-perfect-environment/.

[126] Benaiche, Lionel, and Maxime Lassalle. "Conflicts of Interest and Healthcare." *Les Tribunes de la santé* 2 (2013): 29.

[127] Eccles, Martin P., Jeremy M. Grimshaw, Paul Shekelle, Holger J. Schünemann, and Steven Woolf. "Developing clinical practice guidelines: target audiences, identifying topics for guidelines, guideline group composition and functioning and conflicts of interest." *Implementation Science* 7.1 (2012): 60.

[128] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[129] Romain, Paul L. "Conflicts of interest in research: looking out for number one means keeping the primary interest front and center." Current reviews in musculoskeletal medicine 8, no. 2 (2015): 122-127.

[130] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[131] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[132] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 170.

[133] Emanuel, Linda L. "Ethics and the Structures of Healthcare." *Cambridge Quarterly Of Healthcare Ethics* 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[134] Muth, Christopher C. "Conflict of Interest in Medicine." Jama 317, no. 17 (2017): 1812-1812. doi:10.1001/jama.2017.4044

[135] Demske, Gregory E. "Examining the Relationship Between the Medical Device Industry and Physicians." *Hearing Before the Senate Special Committee on Aging*. Washington DC (2008): 10.

[136] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[137] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[138] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[139] Emanuel, Linda L. "Ethics and the Structures of Healthcare." *Cambridge Quarterly Of Healthcare Ethics* 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[140] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No.4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[141] Hackland, Stuart, and Christopher Stein. "Factors Influencing The Departure Of South African Advanced Life Support Paramedics From Pre-Hospital Operational Practice." *African Journal Of Emergency Medicine* 1 (2011): 62-68. doi:10.1016/j.afjem.2011.07.005.

[142] Romain, Paul L. "Conflicts of interest in research: looking out for number one means keeping the primary interest front and center." Current reviews in musculoskeletal medicine 8, no. 2 (2015): 122-127.

[143] Min, Soon. and Hye Sook Kim. "Effects Of Nurse's Organizational Conflict On Organizational Commitment And Labor Union Commitment In University Hospitals." *Journal Of Korean Academy Of Nursing Administration* 18 No. 4 (2012): 374.

234

doi:10.11111/jkana.2012.18.4.374.

[144] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 170.

[145] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 171.

[146] Romain, Paul L "Conflicts of interest in research: looking out for number one means keeping the primary interest front and center." Current reviews in musculoskeletal medicine 8, no. 2 (2015): 122-127. doi: 10.1007/s12178-015-9270-2

[147] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 171.

[148] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[149] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No. 3 (2013): 263-270. doi:10.1017/s0963180113000078.

[150] Romain, Paul L. "Conflicts of interest in research: looking out for number one means keeping the primary interest front and center." Current reviews in musculoskeletal medicine 8, no. 2 (2015): 122-127. doi: 10.1007/s12178-015-9270-2

[151] Post, Linda Farber. *Handbook for health care ethics committees*. (Washington DC: Johns Hopkins University Press, 2015), 283.

[152] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[153] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1235.

[154] Kant, Immanuel. *The Metaphysical Elements Of Ethics*. 1st ed. (Lanham: Dancing Unicorn Books, 2016), 39.

[155] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[156] Thompson, Dennis Frank. *Restoring responsibility: ethics in government, business, and healthcare.* (Cambridge: Cambridge University Press, 2005), 60.

[157] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017) : 1-2. doi:10.24321/2455.9199.201704.

[158] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017) : 2

[159] Schofferman, Jerome A., Marjorie L. Eskay-Auerbach, Laura S. Sawyer, Stanley A. Herring, Paul M. Arnold, and Eric J. Muehlbauer. "Conflict of interest and professional medical associations: the North American Spine Society experience." The Spine Journal 13, no. 8 (2013): 974-979

[160] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 171.

[161] O'Malley, Ann S., Anna Collins, Kara Contreary, and Eugene C. Rich. "Barriers to and facilitators of evidence-based decision making at the point of care: implications for delivery systems, payers, and policy makers." MDM Policy & Practice 1, no. 1 (2016): 1-12 2381468316660375.

[162] O'Malley, Ann S., Anna Collins, Kara Contreary, and Eugene C. Rich. "Barriers to and facilitators of evidence-based decision making at the point of care: implications for delivery systems, payers, and policy makers." MDM Policy & Practice 1, no. 1 (2016): 1-12 2381468316660375

[163] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[164] Demske, Gregory E. "Examining the Relationship Between the Medical Device Industry and Physicians." *Hearing Before the Senate Special Committee on Aging*. Washington DC (2008): 10.

[165] Demske, Gregory E. "Examining the Relationship Between the Medical Device Industry and Physicians." *Hearing Before the Senate Special Committee on Aging*. Washington DC (2008): 10.

[166] Lo, Bernard, and Marilyn J. Field. Conflict of interest in medical research, education, and practice. (Washington, D.C.: National Academies Press, 2009), 172.

[167] Epstein, Ronald M., and Richard L. Street. "The values and value of patient-centered care." (2011): 100-103.

[168] Epstein, Ronald M., and Richard L. Street. 2011. "The values and value of patient-centered care.": 100-103.

[169] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No. 3 (2013): 263-270. doi:10.1017/s0963180113000078.

[170] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[171] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[172] Muth, Christopher C. "Conflict of Interest in Medicine." Jama 317, no. 17 (2017): 1812-1812. doi:10.1001/jama.2017.4044

[173] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[174] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[175] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433.

[176] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433.

[177] Hackland, Stuart, and Christopher Stein. "Factors Influencing The Departure Of South African Advanced Life Support Paramedics From Pre-Hospital Operational Practice." *African Journal Of Emergency Medicine* 1 No. 2 (2011): 62-68. doi:10.1016/j.afjem.2011.07.005.

[178] Post, Linda Farber. *Handbook for health care ethics committees.* (Washington DC: Johns Hopkins University Press, 2015), 283.

[179] Summers, Jim, and E. Morrison. 2009. "Principles of healthcare ethics." *Health Care Ethics.* 2nd ed. Sudbury: Jones and Bartlett Publishers. (2009): 41-58.

[180] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of

interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433

[181] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433

[182] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433

[183] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman et al. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295, no. 4 (2006): 429-433

[184] Kant, Immanuel. *The Metaphysical Elements Of Ethics*. 1st ed. (Lanham: Dancing Unicorn Books, 2016), 39.

[185] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No. 3 (2013): 263-270. doi:10.1017/s0963180113000078.

[186] Demske, Gregory E. "Examining the Relationship Between the Medical Device Industry and Physicians." *Hearing Before the Senate Special Committee on Aging*. Washington DC (2008): 10.

[187] Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." Healthcare executive 24, no. 2 (2008): 42-44.

[188] Morrison, Eileen E., and John F. Monagle. *Health care ethics: critical issues for the 21st century*. (Sudbury, Mass: Jones and Bartlett Publishers, 2009), 251.

[189] Morrison, Eileen E., and John F. Monagle. *Health care ethics: critical issues for the 21st century*. (Sudbury, Mass: Jones and Bartlett Publishers, 2009), 251.

[190] Summers, Jim, and E. Morrison. "Principles of healthcare ethics." Health Care Ethics. 2nd ed. Sudbury: Jones and Bartlett Publishers (2009): 41-58.

[191] Morrison, Eileen E., and John F. Monagle. *Health care ethics: critical issues for the 21st century*. (Sudbury, Mass: Jones and Bartlett Publishers, 2009), 251.

[192] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[193] Blightman, K., S. E. Griffiths, and C. Danbury. "Patient confidentiality: when can a breach be justified?." Continuing Education in Anaesthesia, Critical Care & Pain 14, no. 2 (2013): 52-56.

[194] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 2

[195] Post, Linda Farber. *Handbook for health care ethics committees*. (Washington DC: Johns Hopkins University Press, 2015), 284.

[196] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[197] Rispel, Laetitia C., Duane Blaauw, Tobias Chirwa, and Katinka de Wet. "Factors influencing agency nursing and moonlighting among nurses in South Africa." Global health action 7, no. 1 (2014): 23585. doi: 10.3402/gha.v7.23585

[198] Rispel, Laetitia C., Duane Blaauw, Tobias Chirwa, and Katinka de Wet. "Factors influencing agency nursing and moonlighting among nurses in South Africa." Global health action 7, no. 1 (2014): 23585. doi: 10.3402/gha.v7.23585

[199] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of*

Healthcare Education & Medical Informatics 4 (2017): 1-2. doi:10.24321/2455.9199.201704.

[200] Kälvemark, Sofia, Anna T. Höglund, Mats G. Hansson, Peter Westerholm, and Bengt Arnetz. "Living with conflicts-ethical dilemmas and moral distress in the health care system." *Social science & medicine* 58. 6 (2004): 1075-1084.

[201] Benaiche, Lionel, and Maxime Lassalle. "Conflicts of Interest and Healthcare." *Les Tribunes de la santé* 2 (2013): 34.

[202] Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas, Jordan J. Cohen, Janlori Goldman. "Health industry practices that create conflicts of interest: a policy proposal for academic medical centers." *Jama* 295. 4 (2006): 429-433.

[203] Marc A. Rodwin. *Conflicts of Interest and the Future of Medicine: The US, France, and Japan*. Vol. 392 (Oxford: Oxford University Press, 2011), 78.

[204] Patricia Backlar. "Managed Mental Health Care: Conflicts of Interest in the Provider/Client Relationship. « *Community Mental Health Journal* 32, no. 2 (1996): 102.

[205] Edger, Chris. *Professional Area Management*. (Faringdon, Oxfordshire: Libri Publishing, 2014), 297.

[206] Post, Linda Farber. *Handbook for health care ethics committees*. (Washington DC: Johns Hopkins University Press, 2015), 284.

[207] Mosadeghrad, Ali Mohammad, and Masoud Ferdosi. "Leadership, job satisfaction and organizational commitment in healthcare sector: Proposing and testing a model." Materia socio-medica 25, no. 2 (2013): 121.

[208] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." Journal of Health Organization and Management 25, no. 1 (2011): 7-33.

[209] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." Journal of Health Organization and Management 25, no. 1 (2011): 7-33.

[210] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." Journal of Health Organization and Management 25, no. 1 (2011): 7-33.

[211] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[212] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary."b*Cambridge Quarterly Of Healthcare Ethics* 22 No. 03 (2013): 263-270. doi:10.1017/s0963180113000078.

[213] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[214] Kant, Immanuel. *The Metaphysical Elements Of Ethics*. 1st ed. (Lanham: Dancing Unicorn Books, 2016), 39.

[215] Emanuel, Linda L. "Ethics and the Structures of Healthcare." Cambridge Quarterly Of Healthcare Ethics 9 No. 02 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[216] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[217] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." Journal of Health Organization and Management 25, no. 1 (2011): 7-33.

[218] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." Journal of Health Organizatíon and Management 25, no. 1 (2011): 7-33.

[219] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 48

[220] Min, Soon. and Hye Sook Kim. "Effects Of Nurse's Organizational Conflict On Organizational Commitment And Labor Union Commitment In University Hospitals." *Journal Of Korean Academy Of Nursing Administration* 18 No. 4 (2012) : 374. doi:10.11111/jkana.2012.18.4.374.

[221] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." *Journal of Health Organization and Management* 25, no. 1 (2011): 7-33.

[222] Demir, Cesim, Bayram Sahin, Kadir Teke, Muharrem Ucar, and Olcay Kursun. "Organizational commitment of military physicians." *Military medicine* 174, no. 9 (2009): 929-935.

[223] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." *Journal of Health Organization and Management* 25, no. 1 (2011): 7-33.

[224] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." *Journal of Health Organization and Management* 25, no. 1 (2011): 7-33.

[225] Bhatti, Waqas Khaliq, Rizwana Bashir, and Mubashar Nadeem. "Impact of Conflict on Organizational Commitment of the Employees." *Global Management Journal for Academic & Corporate Studies* 5, no. 1 (2015): 114.

[226] Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key organizational commitment antecedents for nurses, paramedical professionals and non-clinical staff." *Journal of Health Organization and Management* 25, no. 1 (2011): 7-33.

[227] Bhatti, Waqas Khaliq, Rizwana Bashir, and Mubashar Nadeem. "Impact of Conflict on Organizational Commitment of the Employees." *Global Management Journal for Academic & Corporate Studies* 5, no. 1 (2015): 114

[228] Pal, Ms. Ranabir Pal. 2017. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2009): 1-2. doi:10.24321/2455.9199.201704.

[229] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 (2013): 263-270. doi:10.1017/s0963180113000078.

[230] Morrison, Eileen E., and John F. Monagle. *Health care ethics: critical issues for the 21st century*. (Sudbury, Mass: Jones and Bartlett Publishers, 2009), 397.

[231] Summers, Jim, and E. Morrison. "Principles of healthcare ethics." *Health Care Ethics*. 2nd ed. Sudbury: Jones and Bartlett Publishers (2009): 41-58.

[232] Kakuk, Peter, and Andrea Domján. "Healthcare Financing And Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No. 3 (2013): 268.

[233] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[234] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of*

Healthcare Education & Medical Informatics 4 No. 1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[235] Romain, Paul L. "Conflicts of interest in research: looking out for number one means keeping the primary interest front and center." *Current reviews in musculoskeletal medicine* 8, no. 2 (2015): 122-127.

[236] Lo, Bernard, and Marilyn J. Field. *Conflict of interest in medical research, education, and practice.* (Washington, D.C.: National Academies Press, 2009), 172.

[237] Kant, Immanuel. *The Metaphysical Elements of Ethics*. 1st ed. (Lanham: Dancing Unicorn Books, 2016), 39.

[238] Post, Linda Farber. *Handbook for health care ethics committees.* (Washington DC: Johns Hopkins University Press, 2015), 285.

[239] Post, Linda Farber. *Handbook for health care ethics committees.* (Washington DC: Johns Hopkins University Press, 2015), 285.

[240] Kakuk, Peter, and Andrea Domján. "Healthcare Financing and Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No..3 (2013): 263-270. doi:10.1017/s0963180113000078.

[241] Post, Linda Farber. Handbook for health care ethics committees. (Washington DC: Johns Hopkins University Press, 2015), 285.

[242] [242] Kakuk, Peter, and Andrea Domján. "Healthcare Financing and Conflict Of Interests In Hungary." *Cambridge Quarterly Of Healthcare Ethics* 22 No..3 (2013): 263-270. doi:10.1017/s0963180113000078.

[243] Min, Soon. and Hye Sook Kim. "Effects Of Nurse's Organizational Conflict On Organizational Commitment And Labor Union Commitment In University Hospitals." *Journal Of Korean Academy Of Nursing Administration* 18 No. 4 (2012): 374. doi:10.11111/jkana.2012.18.4.374.

[244] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[245] Hackland, Stuart, and Christopher Stein. "Factors Influencing The Departure Of South African Advanced Life Support Paramedics From Pre-Hospital Operational Practice." *African Journal Of Emergency Medicine* 1 No. 2 (2011): 62-68. doi:10.1016/j.afjem.2011.07.005.

[246] Hackland, Stuart, and Christopher Stein. "Factors Influencing The Departure Of South African Advanced Life Support Paramedics From Pre-Hospital Operational Practice." *African Journal Of Emergency Medicine* 1 No. 2 (2011): 65. doi:10.1016/j.afjem.2011.07.005.

[247] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No.1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[248] Emanuel, Linda L. "Ethics and the Structures of Healthcare." *Cambridge Quarterly Of Healthcare Ethics* 9 (2015): 1234-1238. doi:10.1017/s0963180100902032.

[249] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[250] Hackland, Stuart, and Christopher Stein. "Factors Influencing The Departure Of South African Advanced Life Support Paramedics From Pre-Hospital Operational Practice." *African Journal Of Emergency Medicine* 1 No. 2 (2011): 62-68. doi:10.1016/j.afjem.2011.07.005.

[251] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No.1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[252] Min, Soon. and Hye Sook Kim. "Effects Of Nurse's Organizational Conflict On Organizational Commitment And Labor Union Commitment In University Hospitals." *Journal Of Korean Academy Of Nursing Administration* 18 No. 4 (2012): 374. doi:10.11111/jkana.2012.18.4.374.

[253] Pal, Ms. Ranabir Pal. "Disclosure Of Conflict Of Interest." *International Journal Of Healthcare Education & Medical Informatics* 4 No.1 (2017): 1-2. doi:10.24321/2455.9199.201704.

[254] Post, Linda Farber. *Handbook for health care ethics committees*. (Washington DC: Johns Hopkins University Press, 2015), 285.

[255] Karsten, Margo. "Patient Safety: Commitment Versus Compliance". *Nurse Leader* 9 No. 4 (2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

[256] Post, Linda Farber. *Handbook for health care ethics committees*. (Washington DC: Johns Hopkins University Press, 2015), 285.

Chapter 5: Organizational Conflicts of Interest:

This chapter discusses organizational Conflicts of Interest. It centers on the nexus between moral agency and ethics programs and as well as conflicts in data sharing to explain how to identify and resolve organizational Conflicts of Interest.

5.a) Moral Agency & Ethics Programs:

Conflicts of Interest may arise from the tension between organizational moral agency and complicity and the failure to observe the standards encapsulated by organizational ethical programs in healthcare. Each is discussed in turn. Healthcare organizations act as moral agents since they strive towards goals that improve the health and welfare of the society. Accordingly, these institutions can be divided into subgroups that meet specific needs of the patient. For example, hospitals provide acute care, rehabilitation centers offer psychiatric assistance, and children's hospitals serve patients of a certain age limit. The organizations have policies that enable them to reach certain goals, which may not be moral in nature. However, the success of attaining these aims is a direct measure of the moral excellence of that organization. Conversely, the immoral policies of an organization are what constitute to its complicity. The moral culture of a healthcare organization encompasses the objectives, views, and beliefs of the staff of the firm. Notably, the interpretation of what is moral in an organization depends on the norms and the cultural composition of it. Moreover, it determines what is considered right and wrong. This paper will analyze the relationship between the organizational moral agency, moral culture in healthcare facilities, and complicity in morality. Moreover, it will show how the organization contributes to developing a moral culture among its staff. The paper is divided into sections that discuss the development of ethics in healthcare organizations, the role of various stakeholders in improving the ethical performance of the organization, and how an institution can deal with

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ethical issues in various departments.

5.a.i) Moral Agency and Complicity:

In legal terms, organizations are individual entities with moral duties to enhance the welfare and well-being of individuals in the society.[1] Notably, moral agency derives from healthcare organizations' norms, ethics, and expectations, elements that delineate its social responsibilities.[2] In reality, healthcare organizations are moral agents that are guided by strong moral cultures so that they can fulfill their responsibilities to the society.[3]

The concept of moral complicity in medical ethics captures the notion that "a person can do wrong by being associated, in some way, with the wrongdoing of other individuals or of a collective he or she is part of."[4] However, this understanding of complicity may be too broad to provide practical moral guidance.[5] Because healthcare organizations are moral agents, they are privy to the causal and non-causal conceptions of moral complicity.[6] The tension between organizational moral agency and complicity creates provider-initiated Conflicts of Interest,[7] involving collective action, collective wrongdoing, moral taint, and moral responsibility.[8]

The moral agency of an organization is inseparable from the behavior of individuals in the organization.[9] Through individual behavior, healthcare organizations may participate in immoral conduct that can affect society.[10] To assess organizational complicity, people should analyze to determine different levels of involvement.[11] It is necessary for workers in healthcare organizations to create a sustainable culture that promotes moral agency in their collective efforts.[12]

In this way, they will be able to reduce the incidence of Conflicts of Interest between physicians and their clients. To avoid these Conflicts of Interest, ethics programs seek to train personnel about moral complicity.

An organization can be treated as an individual person, which means that its actions can be judged based on its responsibilities to its society, surroundings, and employees. The moral culture and moral agency in a firm depend on the understanding of ethical values, expectations, and norms of the organization by its stakeholders and staff members.[13] An organization can be seen as an individual entity, implying that any actions that it takes can be judged morally or ethically as either being right or wrong. Accordingly, an organization's moral agency refers to its moral code of conduct and actions taken on a moral scale thereby gauging whether it is a moral agent for good or otherwise. It also means that the company has specific responsibilities to its employees and to the public, which is known as corporate social responsibility.[14] This section of the paper describes how the organization is an agent of developing a moral culture in the healthcare sector. It also covers the evaluation process of a company or rather the way that it gauges its moral culture's efficacy.

1) Moral culture of a healthcare organization:

Further, for an organization to accomplish its responsibility to the society, it should have a good moral culture, which can only be inculcated into its core through an ethics program. In effect, the organization develops an ethics program that governs activities such as policy development and review, training, consultation, and communication between the management and the subordinate staff.[15] One of the responsibilities of the firm is to strengthen the moral culture among its personnel by evaluating the activities that affect the facility and determining if they fulfill the purpose of the institution. Indeed, the structure and activities of an ethics program are simple, and they do not require complicated evaluation strategies and designs. However, a wrong approach used in the program will result in misleading information, which may be useless in promoting a moral culture in the healthcare organization.[16]

An ethics committee supports and promotes the moral cultures established in an organization. Given that, the success of the commission is determined by comparing the actual outcome with that one that is desired.[17] For example, if a healthcare facility aims at improving gender equality among its staff yet its evaluation shows that the number of female employees constitutes 10% of the total number of personnel, the committee has failed. For this reason, when an organization creates an ethics working group, it should design a strategy to evaluate all possible outcomes. Accordingly, the moral culture and moral agency in a healthcare institution depend on the understanding of ethical values, expectations, and norms of the organization by its stakeholders and staff members.[18] In addition, the attitude of the employees towards how the organization lives up to the standards it has set will affect the moral culture and agency. In turn, the results of the evaluation of the ethics committee's performance are used by an institution to develop ethical codes and guidelines for its workers.

One of the evaluation tools is an organizational survey that collects feedback from all stakeholders of the healthcare facility.[19] The purpose of the survey is to determine the level of awareness in the organization of the mission and code of ethics, the values supported by the facility, the effectiveness of the code of ethics, and its importance to the staff members.[20] Another means of evaluation is using a structural approach that assesses the ethics program. Structural standards developed in or outside the organization are used in the structural approach.[21] For example, an institution can evaluate the gender composition or the activities it supports against standards developed by an internationally recognized body. Consequently, the organization promotes moral culture through evaluating the ethical culture climate.

Notably, various factors influence the code of ethics in a healthcare institution. One of the factors is the society.[22] The interaction of the staff members with those outside the organization

affects its course in pursuing its goals based on the values it upholds. A healthcare institution, which is dedicated to its ethical standards can use its ethical program to avoid Conflict of interest and analyze the relationships with groups that interact with the patients.[23] An organization should also ensure that the conditions of its relationship with the society and other facilities are consistent with its mission statement and code of ethics. Moreover, the ethical program can include guidelines to review departmental policies to ascertain that there are no conflicts of interest and that all divisions work on their individual task, pursuing the overall goal of the healthcare organization.

Often, the review of policies leads to the development of new approaches, which replace existing ones that may be insufficient to meet the objectives of the organization.[24] Another factor that can lead to the development of new courses of action is the occurrence of a new situation. For example, if an institution opens a new branch in an area where racial discrimination is high, a new policy should be developed to ensure that the staff provides high-quality service to all patients.

The organization also has a duty to its clients, staff, and society. Indeed, these responsibilities constitute its moral agency meaning that the healthcare institution should be a moral agent in the health sector. In addition, the moral culture of the organization facilitates its moral agency, implying that the success of policies will determine the moral agency of the firm. The suggested ethics program is the best way to instill good moral cultures and policies into the organization's DNA, making it morally sound and ethical. The consequences for creating moral codes lie in identifying their possible value in relation to the moral setting and attitudes that are shared by health care workers.[25]

When it comes to cooperation, it involves the subordinate staff, and management level

staff working together to meet the company's goals of moral culture. The leaders have a role and the subordinate workers. In today's age, individual institutions can wield much power such that their actions may affect whole communities and even nations. Prominent healthcare organizations can have a major impact on their surroundings, implying that their complicity will affect the health sector immensely. [26] Accordingly, complicity refers to an institution's culpability or involvement in unethical behavior. To gauge an organization's complicity, it is important to analyze each of its important departments and their level of complicity.

Accordingly, the divisions in question include the marketing department, the finance/accounting department, and the Human Resource department among others. Building a moral culture in an organization involves trust and considering the benefits of all the participating sides.[27] The strategy for improving the moral culture of an organization includes recruiting leaders with the highest moral values and creating an environment whereby employees feel a sense of belonging.[28] The leaders set an example and a framework for the subordinates to follow. Accordingly, this section considers the principle of cooperation as regards leaders and their subordinates' collaboration, various departments, and their commitment to the institution's moral culture.

2) Role of leadership, subordinate staff and cooperation:

Effective leadership involves inspiring members of a healthcare institution to work efficiently, improve their performance, and make a profit. Conversely, poor leadership results in inefficient services offered by staff members, a decrease of income, and number of clients.[29] The managers of an organization leave a legacy for their members and the society. Nonetheless, as it is evident from the news, all leaders are vulnerable if they are involved in ethical scandals that may cause their career come to an end. For example, a report showed that a popular painkiller

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called Vioxx puts citizens at a high risk of heart attack because its manufacturers withheld information about its side effects.[30]

Indeed, a leader in an organization should have managers whose integrity cannot be questioned by anyone. Accordingly, an ethical behavior depends on leaders that have to carry the moral burden of being managers despite all the benefits this position brings.[31] Such leaders are needed by the institution as they inspire the rest of the personnel to behave ethically. The advantages of having a leader with high moral values are that the employees' turnover, stress levels, and absenteeism cases reduce. Moreover, the personnel are satisfied with what they do and show the willingness to work extra hard to achieve the goals of the organization.[32] Consequently, when a facility ensures its leaders follow the code of ethics, the subordinates will have someone to look up to and get inspired by the example.

Indeed, most people have experienced the positive impact of leaders in the society. Specifically, chief physicians at the hospitals and managing directors play the role of ensuring all staff members attain their potential in the institution. However, one cannot ignore the probability that a leader can cast a shadow on the rest of the organization. Human nature forces people to concentrate on the positive characteristics of leaders and to ignore their flaws.[33] Research shows that leaders that engage in immoral activities and display dysfunctional characteristics can harm their subordinates and, eventually, the organization. For example, such managers may not directly participate in activities that are against the code of ethics but they will tolerate these behaviors.[34] The head of the department that stores medication may be oblivious to behaviors, such as theft of medicine or inaccurate entries of inventory. For this reason, an organization should not overlook bad leadership but instead, ensure that the leaders portray the moral characteristics desired.

The strength of a team depends on the character and contribution of its members. However, they should not forget about fulfilling their individual responsibilities of promoting a moral culture in the organization.[35] Accordingly, the subordinates should follow a set of procedures to improve the ethical performance of an institution, including cooperation, performing the work allocated to them, being open and supportive, and offering feedback. Cooperation is important for an employee since the success of an individual depends on the achievement of his or her teammates in one way or another. As it is evident from observing people participating in group work, the members of the team reduce their effort when working together.[36] However, employees who value the moral culture of the organization apply the same amount of effort when working individually and when working in a team. Notably, one of the reasons for the decrease in effort when working in a group is expectancy, whereby people are willing to apply the effort that they judge will make the team achieve its goal. Another reason is the degree to which an individual views the outcome of the task to be desirable.[37] A person can improve the output of a group by performing their fair share of work.

Further, an individual's cooperation with the leaders means that the whole institution will display a great culture of morality through teamwork as each person will be contributing towards the culture of the organization. The emphasis on teamwork and cooperation led by the management of the organization is to produce a group that is a moral agent.[38] In turn, it will have a positive impact on the society and healthcare. Apart from individuals, various departments also should collaborate in their inner workings based on the moral structures set by the leadership.

The role of a marketing department in a healthcare organization is different from other companies since it offers services, unlike many organizations that sell products.[39] Accordingly, the main role of the marketing unit in a healthcare facility is to improve brand recognition which,

in turn, will ensure that the number of clients increases and the existing patients continue to use the services of the organization.[40] Evidently, the department carries out research to identify the factors that make clients choose certain services. Moreover, it organizes and participates in activities that increase the awareness of the society on services that the organization provides. However, some moral issues can arise in the marketing department, including the ethical responsibility and behavior of the research team in the recording of results, privacy related issues, integration of ethical questions in marketing education, and estimating the cost of marketing. In addition, problems can arise based on the laws that govern ethics within the above-mentioned field as well as from the Internet such as identity theft, web privacy, and online auctions.[41] These issues should be evaluated and stopped if needed especially if they comply with the concept of Conflict of Interest and are not in line with the institution's moral culture and principles.

One of the ways a healthcare organization can handle the ethical issues in the marketing department is to determine the amount of value to place on the clients. However, this strategy, though, has two sides. On one hand, some marketers value the interests of the service provider. They operate under the principle of maximizing profits, whereby they may use loopholes to gain a competitive advantage. Moreover, marketers believe that if an activity is moral, then it is legal. Various cases show that some marketers oversell products and services to attract more clients. For example, a merchandiser in a healthcare facility can give false information about the cost of consultation or carrying diagnostics. Conversely, some consumers or clients have the freedom to select a healthcare institution that will meet their needs and one that they can afford.[42] Considering the above-mentioned facts about marketing, the organization should ensure the clients are provided with accurate information. If a facility fails to attract the expected number of

clients, it should either improve the quality of its services or offer those services that are required by the society.

Another strategy it can use is to employ a marketing team that applies ethical theories and values in solving challenges and making decisions. Other qualities that the marketing team should have are aspirations to do the best ethically, respect, transparency, and valuing citizenship, which will enable them to engage in activities that improve the society.[43] For this reason, a healthcare facility should reform its marketing department to mitigate ethical issues arising from its activities.

The finance and accounting departments provide support for various operations of a healthcare organization, such as the purchase of medical equipment, drugs, and remuneration of employees. Accordingly, some ethical challenges of Conflict of Interest may arise in these departments, revolving around financial markets. For example, ethical conduct is required while purchasing of products that the healthcare institution needs. Financial managers are in charge of the allocation of money to various departments within a given company. They also responsible for maintaining the code of ethics of the organization as they use corporate funds. Another area in the accounting and finance department that ethical issues might arise in is tax accounting.[44] Tax returns should be filed truthfully not to break the existing law. Overall, the problem that may arise is fraud, which should be dealt with. Accordingly, one of the ways to deal with ethical issues in these divisions is employing an auditing firm to estimate the likelihood of financial fraud and to analyze if the activities of the departments coincide with the mission statement and code of ethics of the organization. Moreover, the facility should motivate its employees by giving them bonuses, discounts, and rewarding the most hardworking for their efforts.[45] Financial analysis shows that one of the reasons for committing fraud is debt resulting from

issues such as gambling and other addictions, for example, drugs and alcohol.

The HR department handles the recruitment, training, and development of employees. Some ethical challenges of Conflict of Interest may arise in this department, including job design, restructuring, and retrenchment of workers. Given that, the members of the HR department should ensure that they carry out their activities in accordance with the code of ethics. For example, before the department gives an order to lay off employees, it should consider job redefinition, enlargement, and enrichment. One of the ways the department can deal with ethical issues is employing human resource planning, which ensures that the institution is neither overstaffed nor understaffed.[46] Primarily, this strategy ensures that the organization has well-trained employees.

Usually, most moral predicaments contain a struggle between the wishes of the part and those of the whole, in other words, the personal versus the organizational or the organization's against the entire social order. For instance, if a certain drug is illegal in the US but due to a different country's laxity in legislation, the drug is not disallowed, would it be ethical to sell it there even though it has been banned elsewhere? Undoubtedly, an organization's leadership should make such tough decisions and wager between profit and complicity as it is in their hands. Besides, even law enforcement may not be qualified enough to decipher the morality of these delicate circumstances.[47] The individuals' contributions, leadership, and the organization should be a moral agent for good even in instances whereby there are loopholes, which could be exploited.

For a company to avoid being complicit, it should have a proper framework of moral culture coupled with employee cooperation. The moral agency of the organization will depend on the moral culture, employee cooperation, and departmental compliance to moral ethics as

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prescribed by the moral culture. Given that, it is directly related to its moral culture and complicity. Moreover, institutions develop ethical programs that ensure a climate of moral culture in the organization.[48] This paper has proven that the moral culture of an organization depends on various groups, including managers and their subordinates. With a good moral culture, an organization will avoid being complicit unless its embraces immoral practices.

5.a.ii) Organizational Ethics Programs:

The role of organizational ethics programs in healthcare is to enlighten the behavior of employees and ensure that they act in patients' or clients' best interests.[49] Moreover, they inform good moral conduct and avoid moral complicity within healthcare organizations.[50] The Health Ethics Committee guides the formulation and implementation of these programs.[51] The ethics programs pertinent to healthcare organizations comprise the principles, norms, and standards that govern the behavior of physicians as well as their decision-making.[52] The structure and shape the moral environment of healthcare organizations, and they guide ethical behavior. In this way, they impel physicians to act responsibly within their confines.[53] In particular, they anticipate Conflicts of Interest that may arise from the physician-patient relationship and curb them.[54] Organizational ethical programs anticipate potential Conflicts of Interest and complicity and devise norms and standards to govern the provider-patient relationship. The proper integration of organizational ethics programs into healthcare fosters sound moral agency.[55] These programs build a strong moral culture that helps to identify and resolve provider-patient Conflicts of Interest as moral complicities that hamper the ethos of medicine.[56] One of the most common examples of Conflicts of Interest that arise in the context of organizational moral agency deals with Conflicts of Interest regarding data sharing.

1) Establishing an ethics program in Healthcare Institutions

An ethics program is part of a Healthcare institutions policy to ensure that its employees adhere to its moral standards and code of conduct.[57] It is necessary for the organizations to come up with ethics programs and a solid foundation of moral culture because the organization is viewed as a moral agent in society.[58] A well planned and executed ethics program leads to a good moral culture and avoidance of complicity on the organization's part. In the planning of an Ethics program, a company needs to form a Healthcare Ethics Committee (HEC). The Healthcare Ethics Committee is charged with the task of drafting the institution's ethics program and implementing it along with multiple other roles that the committee is expected to fill. The committee also delegates duties and evaluates the execution of the ethics plan and there are various ways in which the healthcare program can be monitored and evaluated.[59] Therefore, in understanding the ethics program, there is need to consider all facets of the program, from the contents of the program, role of the HEC, the execution process and the method of evaluation of the Ethics committee.

Therefore, it is important to develop a compliance program, which is popularly known as an ethics program, for an institution that is part of a regulated industry. The health industry is a highly-regulated industry due to the delicacies involved with medicine and the need for integrity in the field as medical errors could be life or death situations.[60] Principally, a compliance program keeps an organization safe from through prevention and detection of improper conduct in addition to placing emphasis on the institution's moral culture and ethics policies.[61] As a regulation, the United States Sentencing Commission drafted specific guiding principles that determine a good ethics program. The guidelines cover a multitude of organizations including hospitals, pharmacological companies, foreign companies, government contractors and investors

in the health sector. The guide is applied by the Healthcare Ethics Committee in developing and executing a plan for the ethics program. The policy guidelines dictate a number of components that must be included in a good compliance program.[62] The components include moral culture and organizational leadership, policies and ethics, Training and education, disciplinary actions and incentivization, applicable corrective action, assessment and monitoring of the program, risk evaluation, and managerial level accountability checks. The first step, however, is the formation of a HEC.

2) Formation of a Healthcare Ethics Committee:

Healthcare Ethics committees ensure proper decision making in hospitals and assist patients without tampering with the doctor-patient relationship. Modern medicine and the incorporation of technology in the health sector has led to ethical challenges of Conflict of Interest that can only be addressed by such a committee.[63] Emerging ethical issues such as euthanasia or use of drugs that are still being tested are too complex and require a governing body within the institution to iron out the issues.[64] From a religious perspective, ethics and morals are important especially in healthcare organizations which are expected to treat their patients and employees fairly under all circumstances.

Prior to forming a HEC, the organization needs to undertake a needs assessment to provide a basis for the work of the committee. A needs assessment is important as it gives an opportunity to employees to air out their grievances or areas of concern while allowing the organization to analyses all the avenues by which ethical challenges of Conflict of Interest may arise in their institution.[65] By lending an avenue for staff members to contribute to policy decisions, the institution gains the trust of the employees and leads the employees understanding their role in the moral culture of the organization. A needs assessment can be conducted using

two methods; by use of survey methods and by use of focus groups. [66]

The use of focus groups in needs evaluation is rather time-consuming.[67] What the method lacks in time-saving, it makes up for in its often rich and deep analysis of ethical issues covering all possible angles. A focus group must have an ethicist who acts as the leader and moderator of proceedings and discussions instead of the traditional chairperson. The ethicists act as leaders for the needs assessment subcommittee which comprise of employees that are under all the various departments in the health institution. Forming a focus group would be the best method for needs analysis in healthcare as it covers all probabilities and through this, prepares the ethics committee for any potential eventuality.

Surveys are done using well structured, open-ended questions catering to ethical topics and sources of Conflict of Interest within the institution.[68] The survey results are analyzed in order to inform the ethics committee formation process. The survey must cover all organizational departments and managerial levels in order to get a broader perspective.[69] The main departments that must be assessed include the human resource, marketing, and financial/accounting departments. A survey can be done electronically over the internet in order to ensure that the normal organizational functions are not interrupted.

The next step after needs assessment is the selection of members of the ethics committee. Most institutions draft their own by-laws and policies for HECs in a constitution or rule book and policies for HECs.[70] The rules dictate what kind of employees are expected to participate in the ethics committee. The participants, however, must possess certain abilities such as knowledge, expertise, and experience in their respective job description and departments. It is worth noting that membership and participation in such a committee is expected to be unpaid as it is a voluntary service aimed at improving the organization.

The types of individuals that the ethics committee needs have certain character traits, expertise, and qualities. One of the qualities expected is the orientation towards, and in support of normative principles and informed moralities of Ethos and in the case of religious institutions, the individual must be a supporter of the religious practices and guideline.[71] For example, a catholic organization has specific commands that it must adhere to and specific legal guidelines which committee members must be at the forefront of applying.[72] Second, the individual must have knowledge in the appropriate field, experience and integrity as these are important traits to look for in potential committee members.

Third, the potential candidate should have the ability to make proper ethical arguments and discussions. Fourth, the individual should display competence and honesty in their dealings which are a hallmark for any ethicist or pioneer in ethics. Fifth, the committee members should be ready to do any preparations necessary for making informed arguments on ethics through training programs, courses, clinics, crash programs and studying.[73] Finally, the committee members need to have experience working at the organization such that they know the ins and outs of the organization allowing them to possess the proper background information required for making decisions that will place the institution at a better ethical and moral position.[74]

The most important role in an ethics committee is that of the chairperson. Instead of delving directly at who should be given the role, it is better to consider who should not and why. First and foremost, the chairperson must possess all the aforementioned traits and qualities. It is best to avoid placing the professional ethicist at the helm as the ethicist is viewed as an equal. Placing a lawyer or advocate whether a resident lawyer or an outsourced one is also ill-advised due to a Conflict of Interest between law and ethics, such a chairperson would be guided by law instead of ethics.[49]The CEO or vice president of the company are bad choices for this post due to

the fact that such individuals have great authority and a huge sway. It would be difficult for other group members to be able to voice their opinions which affect the efficacy of the commission. In conclusion, the position of chairman should be delegated to an individual who possesses the necessary expertise and qualities, should not be in a position of power and must not be a lawyer, any committee member is viable and voting can be used to delegate this role.

The purpose or role of an ethics committee can be summarized under four titles; case consultation, education, prevention, and policy development.[75] In order to cover all these areas and roles, the committee members should take part in self-education, show an interest in the healthcare organization's policies, study controversial patient cases, and address not only medical issues about the patient cases but also moral issues.

When it comes to education, the HEC is charged with a responsibility to inform the personnel and patients in the hospital about ethical issues through the distribution of resources and information regarding ethics. Moreover, the HEC uses a number of methods to administer its educational role including; resource centers, seminars, tours of the hospitals, conferences, consultation and provision of educational materials.[76] The educational purpose must be undertaken methodically, starting with the core group of employees and leaders, then extending to the rest of the workers. The education of staff members and patients is done in order to help employees in their decision-making ability and equip them for worst-case scenarios.[77]

Second, the ethics committee undertakes consultation for specific cases whereby patient care compromises ethics and morals. The consultation process involves a discussion of a patient's case by the committee consultant and the physician assigned to the case. Such consultations are done after a request has been forwarded to a staff member or a patient. There are two methods in which consultation is done, the first one involves what is referred to as a

retroactive review which entails an analysis of the outcome of a tough ethical decision that was already made to gauge its positive and negative aspects.[78] The second approach is known as probable or prospective review which involves active discussions between the decision makers and the consultation team as the decision is being made or before the decision is made.[79] Patient care is a crucial element of health care and is, therefore, a requirement for every healthcare organization.

Finally, the HEC may take part in policy development despite the fact that it is not the primary role of the ethics committee to come up with policies. The ethics committee acts as the most well-positioned body for addressing ethical challenges of Conflict of Interest, which affords them the trust of the company in ethics policy making.[80] In most cases, the top management drafts policies for the various departments while the HEC plays a consultation role to approve or reject policies based on their ethical perspective and merit.[81] The ethics committee comes up with policies on a wide variety of emerging issues in healthcare as discussed below.

First off, the commission drafts policies to deal with issues arising from surrogacy and the decision making in this regard. For instance, the one surrogate naturally forms an attachment with the child which means that she finds it difficult to give up the child and policies must be put in place to address such a case as the surrogate is technically the biological mother. Certain states in the US consider surrogacy to be wrong and is, therefore, illegal according to the states' legislations. Legally, a lot of issues arise when it comes to surrogacy, therefore, requiring the drafting of contracts which always introduce legal complications such as breach of contract.[82] Health problems may also be encountered during surrogacy such as complications during birth, for instance, the ethical stance on a woman who dies giving birth to a child who does not even belong to her must be considered.[83] Finally, religious issues abound when it comes to such

delicate matters as surrogacy and the ethics committee must make its stance known through the development of relevant guidelines to address such challenges.

Second, policies on Do Not Incubate and Do Not Resuscitate orders are developed by the ethics commission. The moral dilemma involved in DNR and DNI orders is quite broad with far reaching implications.[84] When an order is given that affects the chance of the life of a patient while the patient is unconscious and unable to state his/her decision on the matter. Adult patients have an ability to make decisions while children have to depend on their parents. The ethics committee makes policies that help physicians make morally consistent decisions in case the need arises for Do Not Incubate or Do Not Resuscitate orders.

Finally, other ethical issues that require policy development in health care include; determination of competency, non-natural modern nutrition and hydration, guardianship, informed consent, clinically ineffective treatment, and other innovative or complex directives.[85] The ethical issues in medicine are broad and cover many areas of healthcare. The ethics committee works towards consulting and policy making as regards to such complex medical matters. The role of policy making is not a primary role for an ethics committee, but it is quite crucial in terms of the bigger picture.

3) The fundamental components that make up a good ethics program:

A proper compliance program is judged by its handling and execution of key mechanism in organizational ethics, which are the responsibility of the ethics committee. These essential components include; moral culture and organizational leadership, policies and ethics, Training and education, disciplinary actions and incentivization, applicable corrective action, assessment and monitoring of the program, risk evaluation, and managerial level accountability checks.[86]

Moral culture and organizational leadership require that the top management of a

healthcare company should be at the forefront of ethics and morality by spearheading the Ethics committee processes and providing all the resources required by the commission.[87] Therefore, the board of directors or top management is required to supervise and monitor the undertakings of the ethics committee's program to ensure efficacy. It is helpful to assign a few top-level officials to the committee so as to allow them the necessary access to the commission and provide oversight in all the committee's processes.[88] The access ensures that the governing body has all the information pertaining to the ethics program for accountability purposes. The leadership also has to draft policies that ensure prevent Conflict of Interest, foster a good moral culture, incentives for a job well done and an atmosphere that gains the trust of the subordinates or other personnel.[89]

When it comes to policy making, a proper ethics program needs a framework of good policies that allows for its functions to run smoothly.[90] The institution's leadership should lay down certain laws and codes of conduct in order to curb any illegal or improper behavior. The laws should cover the program's complete description, practical solutions, and guidelines for all types of ethical and moral situations.[91] The guidelines must delegate tasks and duties to the personnel of the institution, point out the chain of command which covers the order in which reporting of cases should be done.[92] Additionally, the policies must identify rewards for proper conduct and consequences for indiscipline or code violation. Consequently, ethical dilemmas that may affect the organization such as politics conflicts of interest and record keeping must be addressed by the guiding framework.[93] The ethics committee can consult the top-level management on policy development.

Apart from policy creation, an organization must ensure that it trains its employees and patients accordingly on matters concerned with ethical conduct. The ethics committee plays a

pivotal role in administering the information and training methods.[94] All staff members and managers in an organization are required to have adequate knowledge and expertise on the code of conduct and morality that the organization lives by as well as the rules set aside by government regulations in the health sector. In case employees lack the knowledge, the ethics committee can take measures to distribute materials and learning aids that will help the employees to gain the needed training and in special cases, specialized training may be necessary especially for specific departments which have their own range of moral challenges and concerns.[95] The committee must vet employees and document progress of the training process in order to ensure the ethics program is moving according to schedule.[96]

To ensure the smooth running of the ethics program and progression, an ethics committee and board of directors must come up with ways to reward good conduct and punish poor conduct.[97] As a guideline, it is important to reward or punish proportionately to the deeds or in other words a reward or punishment must be equal to the case specific behavior of the employee. Some of the punishments that can be enforced include termination of work, suspension from duty without pay or firing of the employee who acted inappropriately.[98] In contrast, incentives could include the employee of the month awards, promotion or even a bump in remuneration.[99]

Corrective action should be undertaken by the ethics commission if need be. In a situation, whereby criminal conduct has been detected, the institution must take specific steps to prevent such an issue from arising in the future and to deal with the matter after it has been detected.[100] An ineptitude to deal with arising matters proves that the ethics program is inefficient. There are legal ramifications for the recurrence of such criminal conduct as the organization is liable for its employees' mistakes.[101] Thereby it is crucial for an ethics program to plan remedies for specific situations and likely misconduct.

Corporations are required to perform risk evaluation protocols for analysis of their ethics programs over certain durations of time.[102] Assessment precedes any amendment or modifications to the ethics program. Apart from making changes, the risk evaluation provides a basis for gauging certain factors that contribute to Conflict of Interest and risk.[103] The factors affecting risk are as follow; accounting and audit summary, trends in the health sector, employee reports, clients or patient complaints, court settlements, and policy assessment.[104] The risk assessment is documented and plotted in a tabular manner to distinguish the degree of risk per factor, the harm it may cause the company and the probability that such an issue may arise in the near future.[105] Most organizations undertake risk assessment annually which sets a tone for the ethics program for the following year.

The directors, managers and top-level employees must be free from immoral conduct and unethical behavior which is why organizations must ensure their top-level staff goes about their day to day activities with moral uprightness.[106] The institution can use a vetting process to investigate an individual's criminal background and history by conducting background checks and inquiries from former employers and referees.[107] These procedures are carried out prior to hiring a prospective manager or in case the company wants to promote a lower-level staff member. When it comes to government contracts or government partnerships, it is essential for a company to screen the government database for any employee that may be ineligible to partake of federal grants may be due to citizenship issues or criminal history and bans.[108] Consequently, the vetting process will ensure that any partnership or collaboration is not hindered while maintaining integrity and high standards within the organization.

4) Evaluation of an ethics program:

The most extensive and key component of an ethics program is the evaluation,

measurement, auditing and assessment of the ethics program which allows an institution to gauge the efficacy and compliance of their program.[109] The ethics program should be equipped with well-designed controls that aid in the detection of improper conduct or criminal behavior within the organization.[110] The adequacy of the monitoring system is scrutinized while an audit is done periodically to assess the progress and positive or negative impacts of the ethics program considering what the program has been able to achieve and its drawbacks.[111] An audit is best done by an external party to avoid Conflict of Interest and if need be an internal employee who is part of a different department from the one being audited.

The assessment is not only based on the auditor's perspective, the employees are also queried as to their opinion on the efficiency of the ethics program, areas of concern, and whether there are areas where they feel that the ethics program does not cover comprehensively.[112] To achieve this, the organization requires a proper line of communication between employees and the top-level company decision makers. The subordinate staff and other employees must be made to feel comfortable when speaking to compliance committee members or officers and an effective report system can prove useful in executing this.[113] Besides the company should enforce a non-retaliatory rule such that the company officials cannot punish an employee for reporting an incident.

There are immense benefits that a company can derive from an audit and assessment report on the ethics program. First, there are short-term advantages such as an increased responsiveness of the ethics program, assisting in periodic statistics, and an improved capability to identify trends and react accordingly which helps the competition gain a competitive edge.[114] Long-term advantages of measuring the ethical program are as follows; it aids in benchmarking, it helps the company line up its goals with perceived risks, and can be used as a reference point

in risk planning.[115] Subsequently, the measurement and assessment of progress enable the healthcare ethics committee to see the big picture and determine progress in a more holistic way. The tools used in the evaluation process range from statistics or metrics, report matrices, employee surveys, and self-assessments. Metrics refer to a mathematical or logical analysis that breaks down the effort put in vis-à-vis the results or output produced.[116] The work of the ethics program is analyzed showing progress and areas whereby the effort is not paying off. Employee surveys are a way of the company collecting opinions and concerns raised by employees by employing research techniques such as on-line questionnaires.[117] Self-assessments, on the other hand, is a more detailed analysis of the program providing additional documentation. Eventually, the assessments yield a document that can be used by top management to set the tone for the rest of the year.[118]

Healthcare organizations integrate the ethics into the daily operations of the institution by implementing the ethics program that is prepared by the HEC. In the implementation process, the ethics commission renews or reinforces the organization's moral values. Second, the committee secures the commitment of top-level management and the board of directors which is expected to provide funds for the implementation and maintenance of the program.[119] Furthermore, the commission sets out guidelines and a code of ethics that the whole organization must adhere to and follow to ensure avoidance of Conflict of Interest issues. It is essential for the organization to include the ethics and morality of their organization in the company vision and goals.[120]

Most importantly, the company, with the aid of the ethics committee is supposed to assimilate the ethics program into all the departments and sectors of the institution. The company infrastructure can be used effectively in the integration process allowing for maximum utilization of resources.[121] The integration process also involves departmental inclusion thus ensuring that

all the departments of the organization are compliant. The most crucial departments that must be catered to first include the financial department, marketing department, and the HR department.[122]

5) Ethical issues in different departments and how to deal with them:

The marketing department plays a huge role especially in creating a good company image and a great reputation. In marketing, the moral decisions must fit the desires and preference of customers and other business associates. Unethical conduct is detrimental to the company's image and public perception.[123] For instance, practices, such as deception in advertising, selective ads, and other marketing misdemeanors serve to tarnish the company standing in society. The ethics program must address such issues and ensure that the marketing department is compliant.

The accounting department handles the organization's money by producing financial reports and audit reports that help the company in managing funds. Morality in finance is key as any falsification of accounts could have extreme ramifications for the company.[124] Unethical practices such as fraud and embezzlement in a finance department must be stopped by the ethics committee through detection measures and punishments for any culprits. Loss of money through criminal financial practices must be met with harsh punishments to curb such behaviors.[125]

The Human resource department has ethical issues that they must deal with. An ethics program contains guidelines for the company in the sector of employee recruitment and treatment.[126] For instance, one of the guidelines in human resource ethics is a policy for equal opportunity employment whereby all eligible candidates for employment should all have a chance of gaining the employment justly without favoritism or corrupt practices.[127]

In addition, the organization must provide favorable working conditions for the

employees as well as proper remuneration. Many ethical issues arise in the human resource department, but a proper assessment and amendment of the ethics program ensures that the employees get the best treatment from the organization.

The ethics committee is the main body charged with drafting and implementing a sound ethics program. Once an ethics program is implemented, a company gains a moral culture through the application of the ethical and moral practices prescribed by an ethics committee. For a company to avoid being complicit, it should have a proper framework of moral culture coupled with employee cooperation. The moral agency of the organization will depend on the moral culture, employee cooperation, and departmental compliance to moral ethics as prescribed by the moral culture. Given that, it is directly related to its moral culture and complicity.

Moreover, institutions develop ethical programs that ensure a climate of moral culture in the organization. The moral culture of an organization depends on various groups, including managers and their subordinates. With a good moral culture, an organization will avoid being complicit unless its embraces immoral practices. High-level managers have a huge part to play in enforcing ethics and providing support to the HEC. Finally, an organization can only be a positive moral agent in society if it has an effective ethics program in place.

5.b) Conflicts in Data Sharing:

Organizational Conflicts of Interest may arise from the distribution, privacy, confidentiality, and misuse of data by physicians or health care officers in healthcare settings.
5.b.i) Background & Benefits:

A contemporary trend in medicine involves teams of care providers from different healthcare organizations providing healthcare services to patients. This necessitates cross-organizational data sharing, creating an ethical concern about inter-related healthcare

organizations. Some scholars emphasize that "quality of care can be put at risk when patients are transferred from one organization to another; hence, the need for cross-organizational data sharing."[128] Hence, data sharing is critical to ensuring quality care even when physicians from different healthcare organizations treat the same patient. In addition, data sharing is critical because it enables healthcare organizations to minimize readmissions, circumvent medication errors, and diminish replicate testing. These benefits underline the need for healthcare information exchange to ensure the delivery of high-quality care services. Despite these benefits, other scholars note that "the need for protecting patient privacy is sometimes an inhibitor to providing Information and Communication Technologies' solutions to facilitate data sharing."[129] This means that data sharing presents a critical context for identifying and resolving related Conflicts of Interest in health care, especially regarding privacy and confidentiality.

1) Historical and Philosophical Background:

From a historical perspective, data sharing has accompanied all innovations and other advancements in healthcare. In the early days, data regarding disease and illness interventions was shared mainly through scholarly journals. This was particularly essential as it aided in research and provided knowledge that would be taught to students. However, with increased governmental involvement in healthcare, it became apparent that data relating to the population health and financial issues has to be shared with the government. Essentially, the government, which is a major health care financier, requires the information to support its planning initiatives. More importantly, the provision of health insurance introduced a new group of stakeholders that needed health-related data to enable it pay for health insurance.

Perhaps the most significant historical event that revolutionized data sharing is the information technology explosion. Towards the end of the 20th Century, advancements in

computer technology and the invention of the Internet enabled the easy and efficient sharing of information in real-time[130]. Over the years, the cost of internet connectivity has reduced. More importantly, the level of penetration has increased to cover almost every part of the globe. The investments in data connectivity have enabled researchers, academic institutions, health providers, and governmental agencies to share health-related data. Apart from the Internet technology, advancements in information systems, including storage capabilities and databases, have allowed the storage of enormous amounts of data coupled with easy access. Furthermore, the proliferation of hand-held devices and wireless technology has enabled the sharing of data in remote locations.

Legally, the historical journey of data sharing has entailed the enactment of laws and regulations as a way of enhancing the protection of individuals' data. One of the earliest laws is the Federal Trade Commission Act, which was first enacted in 1914, prohibits deceptive and unfair practices[131]. The regulation, in the recent past, has been used to online and online privacy policies to prevent the unauthorized disclosure of individual data. Another important piece of legislation is the Financial Services Modernization Act of 1999. Although this law targets financial institutions, it is applicable to the health care sector and health organizations collect people's financial information. The HIPAA, on its part, was enacted specifically to regulate the use and sharing of medical information and, as a result, it applies to providers, pharmacies, data processors, payers, and other related entities[132]. In addition to the federal legislations, there are state statutes that prohibit the unauthorized use private information.

Frameworks for sharing data in the global health care industry have remained fragmented until the recent past. However, in September 2015, leading stakeholders drawn from diverse parts of the world met a World Health Organization (WHO) convention where they discussed the

need to enhance the transparency and timeliness of sharing data, especially during times of emergencies[133]. The convention included participants dawn from top biomedical journals. Apart from early disclosures, the participants maintained that researchers continue to bear the responsibility to ensuring the accuracy of preliminary findings in research activities before they are disseminated to the public[134]. Recent developments in data sharing continue to underscore the value of sharing and the need for stewards and data generators to support this cause[135]. Furthermore, the trends in the industry point to a situation where many organizations are willing to support data-related activities[136].

From a philosophical point of view, data sharing poses a dilemma, which means that a compromise must be attained. On one hand, there are those who feel that data sharing supports the goals of the society as a whole. In particular, the use of data in research leads to the creation of better medicines and other interventions, which then improve the overall health of the population. More importantly, proponents argue that the risk of privacy and confidentiality infringement could be avoided through anonymization and other tools that secure information. The utilitarianism ethical theory seems to support this preposition as it argues that a good action is the one that maximizes utility[137]. In essence, utilitarianism is an example of the consequentialism theories that perceive right and wrong based on the outcomes. In this case, the outcomes, which benefit the majority of the people, are because of data sharing in scholarly research.

In contrast, opponents argue that data sharing subjects' individuals to harm. In essence, data could be misused resulting in harm to the individual. The deontological perspective, which is based on rights and duties, could be used in support of the opposition to data sharing. This perspective argues for the need to do right things, not based on the consequences[138]. The rights

depended on could be legal, human, contract, and position rights. Considering that there are laws that protect the right to privacy, individuals cannot be forced to provide their information for research purposes. In addition, when visiting a health provider, the patient has a contract with the provider, which prohibits information sharing without an informed consent.

2) The Harms and Benefits of Data Sharing:

The cycle of research starts with idea identification, design of the scientific questions, conducting and evaluating results as well as publishing findings. In the healthcare industry, patients demand for the best information possible concerning the safety and effectiveness of their treatments. Evidently, sharing of clinical data has significant benefits, especially when it occurs amidst the authorized health providers, patients, researchers, and sanctioned public. For instance, sharing of clinical data is vital in treatment procedures since it fosters sound regulatory decisions. It avails information to various health experts and creates opportunities to new therapies and diagnosis for better treatment.

Moreover, data sharing from patients has led to the concept of big data. As discussed earlier, big data involves the collection of enormous amounts of information that can be analyzed to provide insights about trends and the current situations in the healthcare industry. Through this analysis, an organization can improve patient care by providing effective interventions. Besides, the analysis can help reduce the costs of care, enhance the early detection of diseases, improve prescribed treatments, and increase remote patient monitoring. Further, a healthcare organization can analyze the data collected from patients and other entities in the healthcare system to identify gaps in the market that can be utilized to improve profitability.

Consequently, sharing of clinical data promotes research for the benefit of the community and individual patients. The reason is that it supports the scholarly community in their quest of

creating knowledge. Besides, data sharing enables pooling of information since it improves the understanding of the individual clinical trial results. This, therefore, fosters scientific research, which is the foundation of effective and safe clinical care. Further, data sharing generates new research hypotheses that foster the continued adoption of evidence-based practice that aims at producing better disease interventions. Data sharing also enhances the utilization of public funds. For patients and other individuals, information sharing helps to optimize data usage in treatments and removes the burdensome replication of data.

However, data sharing presents ethical challenges of Conflict of Interest to the core principles of patient-doctor relationship, which are confidentiality and privacy. Lack of data protection, in terms of privacy and confidentiality, can have adverse effects on the patients as well as the organization in question. When the process is not conducted in the right way and information is shared among individuals for wrong reasons, it may result in great damages as well as breach of the patients' rights. Various common ethical issues arise from clinical data sharing, such as the issue of patients' privacy and confidentiality of clinical data and information, the misuse of clinical data, and data stewardship.

Additionally, data sharing can sometimes undermine effective treatment of patients. In the past years, various cases of misuse and misinterpretation of data have occurred because sharing of clinical data sometimes leaves out crucial matters of how the data was collected and interpreted and the condition of the population of the patients.[139] Such misinterpretation may results into misleading information being shared with the wrong individuals; hence, escalating the problem rather than establishing the solution.

As previously documented, data sharing fosters better medicine and improved patterns of healthcare through promoting scientific research. It supports the scholarly community in their

quest of creating knowledge. The scientific and practical arguments for data sharing process include strengthening collaborations in the scientific research, which accelerates biomedical studies. Besides, the process improves accuracy of research by ensuring that results are properly analyzed. Through this analysis, organization can improve patient care by providing effective interventions. Further, the analysis helps in reducing the costs of care by promoting strategies that enhance early detection of diseases, prescribed treatments, and increased remote patient monitoring. As a result, data sharing assists in improving the patterns of healthcare by ensuring that new medicines and approaches are discovered for dealing with new diseases as well as enhancing the existing treatment options.

The ethical and moral reasoning for data sharing focuses on minimizing safety risks, meeting the obligations to the participants as well as honoring the nature of research. It is apparent that most medical researches aim at achieving the public good. During data sharing process, principles such as privacy and confidentiality must be maintained since they are essential aspects of human existence. Besides, the parties involved must adhere to the implemented policies that are aimed at protecting the privacy and confidentiality of information. Such legislations include the Health Insurance Portability and Accountability Act (HIPAA), which was enacted in 2003[140]. They explain the covered entities in the disclosure and use of individually identifiable patient information (PHI) for payment, treatment, and other healthcare operations without the need for authorization or consent.

3) Professional Models of Behavior Connected with Data Sharing:

The professional models of behavior for those individuals concerned with the issue of data sharing are classified into two broad categories. The first class is concerned with the individual moral and ethical acts. This category focuses on the necessity of these people to fulfill

obligations to the participants of the research as well as honoring the nature of the study. Hence, those people that are concerned with data sharing must adhere to the implemented moral policies aimed at protecting privacy and confidentiality of the information. For instance, individuals should observe the informed consent since it is a valid concept in clinical data sharing. A valid consent is one that is voluntary, informed, and within capacity[141]. Voluntary means that an individual should not be coerced into giving information that he or she does not wish to disclose. The second category is concerned with scientific and practical acts. These actions include deterring from inaccurate or selective sharing of information, preventing replication of results or study questions in new studies, as well as informing risks involved. All these behaviors aim at ensuring prevention of Conflict of Interest issues and efficiency of the research.

5.b.ii) Privacy & Misuse:

Organizational Conflicts of Interest may arise from a breach of privacy, confidentiality, and misuse of shared data. Some explain that "interoperable organizations are utterly reluctant to collaborate on patient information due to fear of breach of personal health information."[142] In such cases, all medical institutions are to implement and correspond to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 so that data privacy and patient's confidential information are under not only legal protection, bit also secured due to the national standards in software and hardware. The implementation of the HIPAA into healthcare organizations' body will reduce or, even, prevent any inconvenient situations with data flow streams and private security. Interoperable healthcare organizations fear that patient health information may be used or the privacy or confidentiality of patients breached, thereby resulting in serious Conflicts of Interest. Also, the confidential information of patients may fall into the wrong hands during distribution and thus instigate grave Conflicts of Interest between physicians

and patients or healthcare organizations and patients. Conflicts of Interest may also arise from the misuse of patients' personal data by other health care officers or physicians. In summary, data sharing raises serious confidentiality, privacy, misuse, and distribution issues that establish a crucial context for identifying and resolvingg Conflicts of Interest that may significantly harm the reputation of the relevant healthcare organizations.

1) Critical Enduring Matters for Data Distribution:

During data distribution, the fundamental aspects of the human nature, which are privacy and confidentiality, are critical. As previously discussed, privacy refers to having the right to keep information or things to one's self while confidentiality entails the right to keep information about yourself from being disclosed to other parties. These two concepts are critical during data distribution since they have an intersection with legal and ethical requirements. In the healthcare industry, laws and regulations are developed from moral and ethical reasoning, which entails asking whether an action is right or wrong. From a moral viewpoint, privacy and confidentiality have often been construed to be an essential aspect of human existence in that a normal person possesses aspects that make him unique. In other words, keeping an individual's information private and confidential is what constitutes being a person. It also means upholding the individual's right to freedom. Therefore, individuals involved in clinical data distribution must ensure that privacy and confidentiality are maintained.

During the evaluation of research endeavors and practices, it is vital to consider people's characters in the scientific fields. The reason is that individual discipline is the building block of science since it determines the procedures, theories, solutions, and problems that are addressed, prescribed, and permitted. Scientific character refers to the occurrences that happen when patients, advocates, medical practitioners as well as scientists are called to defend themselves in

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the public regarding technical matters. In most cases, these technical matters usually have direct implications for human life. The primary concerns of scientific character are the legal and ethical aspects. When patients, doctors, nurses, and advocates are called to defend their actions, the main interest is on whether their actions have focused on ensuring public safety. For instance, scientists and other individuals involved in a study should aim at minimizing safety risks, meeting the obligations to the participants as well as honoring the nature of research. The reason is that most medical researches aim at achieving the public good. Besides, these evaluations aim at ensuring that advocates, patients, and medical practitioners have not committed any violation in regard to Conflict of Interest and followed legal policies established in the healthcare field.

There are two main factors that must be considered before an open entrance to clinical data. The first factor is the accuracy of the data provided. Before sharing clinical data, there is a need to identify its accuracy to ensure that it does not cause harm or undermine effective treatment of patients. In the past years, various cases of misuse and misinterpretation of data have occurred because sharing of clinical data sometimes leaves out crucial matters of how the data was collected and interpreted and the condition of the population of the patients. Besides, sharing inaccurate data can escalate problems in the healthcare rather than establishing a solution. The second factor is reliability of the source of the information. Obtaining information from unreliable sources can result in misinterpretation and breaching of individuals' privacy and confidentiality. There are set procedures and policies that are followed before sharing of data. Therefore, before making an open entrance to clinical data, one should consider the reliability of the source providing the information to ensure he or she does not undermine ethical and legal aspects.

2) Privacy and Confidentiality of Clinical Data:

Privacy is the act of limiting the access of one's personal information that may include medical information, personal thoughts, identity, and other physical data.[143] In the clinical data-sharing sector, privacy of patients' information is very critical. During the treatment process and in ethical medical research, it is paramount to protect the rights of the patients[144]. The primary goal for upholding the right to privacy is to protect the interest of the patient by ensuring security and confidentiality to his or her clinical information.[145] Maintenance of privacy promotes personal autonomy, enhances the softness and dignity of human beings, and upholds respect and individuality. In this regard, the use of computers and advanced data sharing mechanism in the contemporary world has had a great impact on the element of privacy of clinical data.[146] The system has made the access and sharing of data easier; hence, it is promoting increased illegal access to clinical data that at times may be used for malicious purposes.

Sharing of clinical data is vital for research to assist both individual patients and the community as a whole. It avails information to various health experts and creates opportunities to new therapies and diagnosis for better treatment.[147] Given the significance of the process and the ethical challenges of Conflict of Interest that arise from it, it is essential to come up with effective strategies of dealing with the situation. The current privacy regulations pose a great barrier to the acquisition and reuse of clinical data for both research and learning purposes. Despite the great desire for development and innovation in medical research, there has been great concern on the privacy of clinical data, especially due to various unethical practices that have been witnessed in the sector.[148] There are two main ethical concerns why people are reluctant to allow their clinical data to be shared without their consent, such as the fear that the data may be used for dubious purposes and the fear that data might have an impact on their reputation,

employment status, and medical insurance.[149] Therefore, various ethical factors revolve around the data sharing controversy and its impact on the concerned patients.

Privacy and confidentiality are often used interchangeably but refer to different but related concepts. On one hand, privacy means having the right to keep information or things to one's self[150]. In contrast, confidentiality entails the right to keep information about yourself from being disclosed to other parties. Ethical issues often have an intersection with legal requirements. Essentially, laws and regulations are developed from moral and ethical reasoning, which entails asking whether an action is right or wrong. From a moral viewpoint, privacy and confidentiality have often been construed to be an essential aspect of human existence in that a normal person possesses aspects that make him unique. In other words, keeping an individual's information private and confidential is what constitutes being a person. It also means upholding the individual's right to freedom.

As information technologies are being adopted in the workplaces and industries, policymakers have implemented policies aimed at protecting the privacy and confidentiality of information. One of these legislations is the Health Insurance Portability and Accountability Act (HIPAA), which was enacted in 2003[151]. This legislation includes the Privacy Rule that explains the covered entities in the disclosure and use of individually identifiable patient information (PHI) for payment, treatment, and other healthcare operations without the need for authorization or consent[152]. For example, during treatment, a provider is allowed to share information with another provider without securing the approval of the patient[153]. However, organizations sharing the information must ensure that it is shared in a manner it least identifies the patient. Nonetheless, the law prohibits the sharing of PHI without the consent of the patient unless in situations where the law permits it[154]. The HIPAA, together with other federal and state laws,

provide harsh penalties for individuals and entities that engage in the unlawful sharing of patient-related data.

Informed consent is an important concept in clinical data sharing to ensure avoidance of Conflict of Interest issues. Essentially, a valid consent is one that is voluntary, informed, and within capacity[155]. Voluntary means that an individual should not be coerced into giving information that he or she does not wish to disclose. Informed means that the patient should know the potential ramifications of the action of disclosing personal information. Logically, an individual can only make a rational decision if he possesses the right information. Lastly, the patient in question should have the capacity of making that disclosure.

There are vulnerable populations who, because of their nature or situation, are unable to make an informed decision regarding data disclosure. Vulnerability means the lack of capacity or being at risk of abuse. Apart from assessing the individual characteristics, a healthcare professional should be able to assess the situation, the degree of risk, the nature of the decision, and the context when assessing vulnerability. A critical vulnerable population is children as they do not possess the capacity to make informed decisions and are easily swayed[156]. As a result, it is important to devise strategies of dealing with such a demographic.

3) Strategies of Dealing with, and Solutions to the Issues of Privacy and Confidentiality:

Currently, there are many initiatives put in place to address the dilemma of privacy and confidentiality in the issue of Conflict of Interest in sharing clinical data. Some of these initiatives include federal regulations and general guidelines put in place to protect the rights of patients.[157] To begin with, the common rule is one of the federal regulations that calls for the protection of subjects' privacy and ensures that the confidentiality of clinical data is maintained. The HIPAA privacy rule is a regulation that ensures confidentiality of data and privacy of

participants in clinical researches[158]. Another significant technique used in addressing the issue of privacy and confidentiality in clinical data sharing is the sharing of "de-identified" data. This type of data cannot be linked to an individual in whatever way. Personal details are first extracted before the data is shared either for clinical research or for education. Thus, upholding confidentiality to patients' information contributes to effective use and sharing of clinical data.

To find a solution to the privacy and confidentiality issue on sharing of clinical data, various reforms are necessary to ensure that both ethics standards are observed as well as to improve sharing of clinical data for the benefit of the whole community and individual patients. The existing regulations have been effective in upholding patients' privacy and the confidentiality of data. However, they have also been obstacles to effective sharing of clinical data for research and education. The most effective solution, therefore, is the one that permits sharing of de-identified as it promotes innovation in clinical research while safeguarding the privacy of the patients as well.

Data de-identification is performed through the process of anonymizing. The goal of this process is to permit the sharing of data without exposing the owners of the data to potential adverse consequences[159]. There are a number of ways of anonymizing quantitative data. Firstly, one can remove the direct identifiers, which include the patient's photo, address, residential address, and names[160]. The removal of direct identifiers is particularly essential as it makes it difficult for a third party to be sure of the individual in question.

Another tactic for anonymizing data encompasses reducing the detail or precision of patient-related variables using aggregation. For example, instead of giving the exact date of birth, one could simply provide the year. Similarly, instead of giving the specific career of the person, it might be necessary to provide the occupational category. A healthcare professional could also

generalize the meaning of available in a detailed text such as occupational expertise[161]. A fourth tactic encompasses restricting the lower and upper ranges as a way of hiding outliners. Generally, such ranges are utilized with variables such as age and income. A fifth tactic might involve combining variables, such as coming up with a non-disclosive urban/rural variable from the place variables.

Similar to quantitative data, qualitative data can also be anonymized. To start with, the professional could remove direct identifiers or replace them. In research, pseudonyms could be used as the name of the participant has little or no significance. Secondly, it is essential to avoid blanking out. As the anonymization occurs, it is important to store the logs of the changes separately from the information files[162]. It is also vital to edit data during the transcription. However, the researcher should avoid over-anonymizing as it might affect the integrity of the data. Anonymizing audio-visual data through digital means, such as image blurring and voice alteration can also be done. However, such processes are expensive, require a lot of labor, and may damage the potential of the data for use in research. Therefore, a better option would be to collect such information while avoiding capturing sensitive data.

A second solution for addressing data privacy and confidentiality in the issue of Conflict of Interest in sharing clinical data, in addition to de-identification, is the adoption of information management systems use policies. Generally, data breaches are often due to both intentional and unintentional human actions. In order to prevent such risks, it is important to institutionalize an acceptable use policy that defines the kind of information a user in an organization has access to and the permitted uses[163]. For example, sharing patient information with authorized parties is prohibited. In addition, failure to observe the policy requirements would result in harsh penalties that include legal action, suspension, and termination. The policy should also stress the need for

employees to go through data security training and awareness programs[164]. With these training

programs, unintentional sharing of patient data through, for instance, social engineering could be

avoided. The policy could also mandate background checks for new hires to avoid recruiting

individuals with evil motives.

A third strategy entails implementing user access controls. When developing information

systems, it is important to deny access to third parties by using diverse tools such as passwords.

Ideally, only authorized individuals should access patient-related data[165]. Even in an

organizational setting, user access rights should differ based on the roles and responsibilities of a

user[166]. For example, some users can have the capability to view and not to transmit or alter the

data[167]. A final strategy entails data encryption in which, as data is being shared, it is translated

into a code or form that only the recipient is able to comprehend it using a decryption key[168]. The

advantage of encryption is that it protects the data from being utilized by people who gain access

into the system maliciously[169]. The use of technological tools such as user rights management,

access control, and encryption are critical in enhancing the privacy and confidentiality of patient-

related information.

4) Misuse of Clinical Data:

Sharing of clinical data has always been encouraged because of its main purpose in

promoting research for the benefit of the community and individual patients. However, there

have been concerns regarding the use of this data.[170] Various cases of misuse and

misinterpretation of data have occurred because sharing of clinical data sometimes leaves out

crucial matters of how the data was collected and interpreted and the condition of the population

of the patients.[171] Such misinterpretation may results into misleading information being shared

with the wrong individuals; hence, escalating the problem rather than establishing the solution.[172]

It is, therefore, very important that sharing of data and secondary analysis be carried out in a responsible and ethical manner.

It is also important to agree that clinical data is very sensitive and its misuse may results into fatal consequences including death of patients or escalation of an adverse health condition within a community[173]. For instance, when sensitive information about a patient's health conditions lands in the wrong hands, it may be used to the disadvantage of the person be it in business, politics, or defamation cases. This condition places the patient at a high risk. Such incidences have raised great concerns over the ethical standards of sharing clinical data, which must be observed critically to ensure that patients' interests are protected.

A common motivation for misusing patient information is monetary gain. Increasingly, people and individuals are seeing information as the most essential asset in an organization[174]. Using the information, organizations are able to devise and implement their corporate strategies[175]. In a society where competition exists among providers and insurers, the loss of information could mean the loss of operational effectiveness and organizational performance[176]. Misuse of data for monetary gains also affects individuals as personal data could be sold[177]. Because the patient may fear his or her information being disclosed, he or she might become a victim of extortion.

The essence of data protection is to help secure information that could harm the owner when it lands in the wrong hands[178]. An example of this information is the kind of disease an individual is suffering from. For example, individuals suffering from HIV/AIDS continue to be stigmatized in society. However, during diagnosis and intervention, it is important that the patient disclose such information to the healthcare personnel[179]. In case this information gets to other parties, the individual could be prejudiced or discriminated upon[180]. In the community, the

individual might become the target of ridicule or physical attacks. In extreme conditions, the victim may resort to suicide.

Apart from diseases and ailments, the socio-economic data of a person could also be misused[181]. For example, in societies where sexuality remains a challenge, it is important for healthcare professionals to secure such information. Still, in order for the professional to be able to deliver effective interventions and treatments, the patient should disclose the information[182]. Essentially, certain demographics are vulnerable to different diseases and ailments. For example, homosexuals are particularly vulnerable to sexually transmitted diseases. Therefore, while it is important for the patient to disclose this information, the provider has a responsibility of securing it to protect the patient from adverse consequences[183].

The proliferation of electronic payment systems also predispose patients to a myriad of vulnerabilities. Increasingly, people are using credit cards, electronic banking, mobile banking, and other electronic means to pay for services in healthcare facilities, especially when those payments relate to out-of-pocket fees. Failure to secure logins could result in massive losses for the patient[184]. For example, if poor authentication and encryption techniques are utilized, third parties might be able to intercept the information and steal from the patient. In addition, malicious people might be able to access the individual's financial statements and threaten to disclose them to the public[185]. The disclosure can have far-reaching implications on the individual, including affecting his or her social life[186].

Data mining, which is a growing trend in healthcare, promises many advantages but also provides an avenue for clinical data misuse. In data mining, organizations collect both structured and unstructured data from demographic, pharmacy, laboratory, surveys, medical records, health risk evaluation, and medical inpatient and outpatient sources. This data is then subjected to

medical informatics that encompass database, data mining, clinical expertise, database technologies, predictive analytics, and published papers[187]. The results of the analytics could help in diverse situations, including preventing fraud, improving health outcomes, containing costs, optimizing quality, ensuring seamless exchange of information, and supporting collaborative care. However, during this process, there is a threat of privacy violations[188]. The violation could be intentional or unintentional.

A final data misuse is utilizing it to revenge against others[189]. In organizational setups, employees have the privilege of accessing private and confidential information[190]. Instead of using the information for the intended purposes, the employees might use to get back at other people. For example, an individual working in a healthcare organization could use a patient's data to revenge against him or her due to the mistakes committed earlier. More often than not, employees use an organization's data to revenge against it because of perceived injustices. For instance, an employee who believes that he was bypassed unfairly in promotions might steal private data and disclose or sell it.

5) Strategies of Dealing with, and Solutions to the Issues of Misuse of Clinical Data:

Misuse of clinical data has been one of the main barriers to effective sharing of the data. Nevertheless, given the great significance of sharing this data, it is paramount to come up with tactics and solutions of dealing with the issue.[191] The full access and no access model of data sharing can be used in controlling the issue of misuse. Data can be shared with the aim of reproducing already published data or commenting on the original results without modification. In addition, it may be used to come up with new findings. In this case, any changes made to the original data and analysis need to be clearly indicated.

Another strategy of mitigating against the issue of Conflict of Interest in clinical data

misuse is by establishing strict regulations that will identify the eligibility of a user to access and modify clinical data.[192] This initiative can be implemented by scrutinizing every individual who wants to reuse clinical data either for research or for education purpose.[193] Before gaining access to the data, they should confirm that they are bona fide researchers through the submission of detailed documentation of their study objectives and the procedure to be used.[194] There should also be strict regulation and personal confirmation that ethics will be held when using private medical data[195]. In this context, protection of a patient's private information remains critical despite the situation. No disclosure of patient information should occur as this can punishable by law.[196] Through this procedure, it is possible to identify the required datasets for the study; hence, avoid sharing other crucial data not relevant to the study. In addition, the detailed documentation of the procedures to be used in the research ensures that data shared will be used entirely for that research and not any other purpose that is against the ethics of clinical data sharing.[197] Hence, maintenance of ethics in clinical data sharing is important among the data users.

In addressing the the issue of Conflict of Interest of misuse of clinical data, it is important for the parties involved to engage fully in the creation of the stringent procedures needed when sharing any medical information of a patient. This team should include the representatives of the participants, the independent researchers, as well as initial handlers of the data.[198] Through this initiative, the interests of the entire stakeholders will be represented to ensure that the data is used in an appropriate way for a mutual benefit. Strict measures should be put in place to ensure that those who do not comply with the conditions of sharing clinical data are denied the access[199]. Equally, strict legal actions should be taken upon those who already have the access to the data but do not abide by the required ethical standards of using the information.[200]

Fourthly, another strategy for protecting data against misuse entails continually auditing and monitoring the environment[201]. More often than not, risks to clinical data come from within the organization or the association. Therefore, it is of importance to track users in a real-time manner. Today, a number of technologies exist that an organization could utilize to monitor all the users with a view of detecting unusual activity. For example, if the organization notices some unusual connections to the system, it may be necessary to disconnect them to establish their authenticity. Nowadays, it is impractical to continue the practice of reactively assessing logs to determine what went wrong. Using a proactive system of monitoring the environment, enables the management to detect undesired behavior before it escalates to a misuse of clinical data. More importantly, when users see that their actions are being watched, the likelihood of misusing clinical data is reduced.

Lastly, preventing the misuse of clinical data also means demonstrating leadership in enforcing the policies and regulations. Effective leadership entails being assertive, especially when undertaking disciplinary action against individuals that contravene the regulations. Usually, organizations develop good regulations but fail to punish those who disclose patient information. However, in order to act as a warning to those who intend to break the laws, it is important to ensure that culprits are punished. The punishments may range from suspension to facing legal action in a court of law.

6) Data Stewardship:

Data stewardship refers to the responsible and careful data management in an organization[202]. It encompasses doing the prudent and necessary things to ensure the data is accurate, consistent, usable, and reliable[203]. In addition, the data should also be available, protected, and well-defined. Every organization holding data has a responsibility of maintaining

data stewardship[204]. This means that health care organizations are also included. Whereas IT providers have a responsibility of developing, managing, and maintaining application and systems utilized in the creation, collection, storage, and retrieval, deletion, and processing of data, businesses, including health care organizations have the responsibility of protecting and utilizing the content of the data[205].

Total transparency and openness regarding the acquisition and use of clinical data is mandatory. It is obligatory for all individuals and organization dealing with clinical data to uphold the integrity and security of the data they handle at all times.[206] Therefore, it is crucial to be transparent on the purpose of using the data and the outcome should be communicated too. In the contemporary world, cases of secret experiment and illegal use of clinical data have been so rampant[207]. Organization and individuals in charge of clinical databases have failed to ensure security and confidentiality of the data they hold. It is an obligation for both the federal government, the concerned organizations, and involved individuals to ensure stewardship of clinical data.[208] This involves effective security control to promote the security of data as well as the use of legal and ethical means to obtain clinical data[209]. Secret experimental procedures have been major contributors of violation of the rights of participants.[210] Therefore, to protect both individual and public welfare, it is significant to implement effective strategies that will prevent the ethical challenges of Conflict of Interest and promote stewardship of clinical data[211].

In practice, data stewardship is the most essential aspect of data governance programs. On its part, data governance refers to the process of executing and enforcing authority in the management of data and other related assets[212]. In this view, therefore, stewardship entails the formalization of accountability in the management of the assets. The term formalization means that there is already a level of accountability, which stewards must observe. In an organizational

setup, a steward is an individual charged with the responsibility of defining, producing, and using data and is required to maintain a level of responsibility in ensuring quality[213]. Data stewards are usually held accountable for the manner in which data is used in the organization[214].

In the operational realm, data stewards have a role of defining the data to be utilized in the organization as well as the manner in which that data ought to be utilized[215]. Stewardship also has to include the production, creation, deletion, updating, archiving, and retiring of data. Data stewardship also entails using data in this process[216]. In other words, effective data stewardship must be driven by data-driven decisions[217]. Furthermore, operational data stewards have to ensure that the usage of data is transparent. The decisions that a data steward makes tend to affect all users in the organization and, as a result, it is important to possess effective communication skills. When communicating, it is imperative to have clarity and seek feedback from other users. Evidently, data stewardship must be user-centered, as it must address the needs of the users as they offer services to the consumer base.

Data stewardship can be either proactive or reactive. Proactive stewardship largely entails incorporating data governance into the day-to-day duties of the stewards[218]. This means that all activities that stewards, which refers to all users utilizing organizational information, must consider the values of stewardship as they manage and utilize data[219]. For example, when transmitting patient-related data, it is important to encrypt it to prevent access from third parties. In addition, proactive stewardship requires one to consider appropriate data governance strategies in the system development life cycle. In a typical organization, projects are undertaken regularly as a way of addressing challenges or taking advantage of opportunities in the marketplace. When developing new information systems, it is important to consider the security capabilities, which is proactive thinking.

Reactive data stewardship, which follows a data quality methodology, occurs after events have taken place. The first step in reactive stewardship is identifying the issue and the affected domains. Secondly, it is essential to recognize the users or data stewards in that domain. Thirdly, a data resource discovery should be conducted. Thereafter the root causes of the issue ought to be analyzed. In this step, the use of team problem-solving techniques are essential. It is also imperative to conduct a cost-benefit evaluation to estimate the impact of the issue[220]. Further, the team should analyze and recommend the best solution. Finally, after securing funding and implementing the solution, the team should evaluate the solution with a view of improving it even further.

7) Strategies of Dealing with, and Solutions to the Issue of Stewardship of Clinical Data:

Different measures and statutory regulations are rolling to address the issue of Conflict of Interest of data stewardship in clinical data sharing.[221] For example, the Records, Computers, and the Rights of Citizens (RCRC) has been implemented in the United States to promote transparency and openness in the collection and use of clinical data[222]. This regulation and many others promote ethical undertakings in the realm of clinical data sharing. The use of clinical data for commercial goals by healthcare providers is unethical unless the intension is communicated in advance.[223] Initiatives that provide restrictions on the collection and use of clinical data are effective mechanism to ensure stewardship in sharing of clinical data.

An important solution to the issue of data stewardship is making the data policies transparent[224]. For employees, the policies governing both internal and external data ought to be easily understandable. The organization should develop and adhere to disclosures and contracts concerning data use and stewardship. Clarity also means avoiding the temptation to collect information about the users using, for example, cookies. Another solution to data stewardship

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encompasses verifying data quality on a regular basis. Generally, data undergoes diverse phases as it used by the organization in vital processes and procedures. In these phases, the quality of the data may be compromised. Therefore, data stewards must establish the standards of data and perform adequate routine verifications. However, this can only be possible if the stewards are trained and have the capacity to undertake this role.

To add on that, it is critical to hire data stewards with the ability to ensure consistent data quality and security. Essentially, stewards have challenging duties which encompass performing data quality and control, coordination, and process definition and the conducting of data reconciliation and validation process. Apart from the technical skills, stewards must be accountable by focusing on quality, effective processes, and acting as a single point of data access in an organization. They should also be authoritative in terms of enforcing decisions and assigning and overseeing data-related work. Lastly, they must be organized, which is necessary for minimizing changes to processes and frequent system transformations.

The next strategy ensuring data protection as there is always a risk of destruction through deliberate, unintentional, and natural causes. Therefore, it is important to ensure that data is backed up to prevent the loss of patient data. There should also be replication through redundant systems utilized in interactive adverting processes. In essence, data protection entails the production and maintenance of backed up copies to prevent the loss of information. Further, it is important for data stewardship to specify the timeframe in which data should be retained. Of course, certain types of data should be held for longer times as compared to others. In addition, decisions relating to the duration of holding of data should take into account the needs of the organization and the privacy laws and regulations. Researchers might be tempted to store information for extended periods to enable future research studies. However, they must

understand that storing data over a long period enhances the susceptibility to theft and disclosure.

The next solution to data stewardship is ensuring contracts with other firms are clear and detailed. In the healthcare industry, organizations have to develop partnerships with other firms involved in the supply chain. It is critical to ensure that the parties an organization collaborates with are reputable. More importantly, the partnership should be contractually documented. Essentially, partnering with organizations that are questionable predisposes the firm to data breaches and other violations. To ensure validity of the contracts, the firm should also ensure that they follow all the laws and regulations as well as the industry standards. The provisions in the contracts ought to specify the details of the exchanged data and the resources if available. Although it is important for firms to negotiate remedies with partners, they must also be strong to terminate contracts that violate standards and laws.

Overall, privacy and confidentiality is essential when dealing with clinical data. Generally, this data is sensitive as it includes health information as well as data related to the socio-economic situation of the patient. To secure data confidentiality and privacy, it is important to adopt a variety of technological tools that make it impossible for authorized individuals to access the data. It is also necessary to implement policies that guide the use and transmission of data within the organizational setting.

Due to the sensitive nature of clinical data, it is susceptible to misuse. One common misuse entails acquiring a patient's data and using it to extort money from him or her. The data could also be sold to other organizations to enrich an individual. In fact, companies today are perceiving information as the most essential asset an organization can possess. To prevent Conflict of Interest in data misuse, organizations should also adopt technologies that monitor user's actions in real-time. More importantly, severe action must be taken against individuals

that are involved in the misuse. Lastly, data stewardship is critical, especially in the health care industry, as it helps to protect data from being altered or accessed by people who are not authorized. In order to benefit from the data, companies should use it in a manner that does not endanger the lives of the owners. It is also essential to adhere to data protection laws including the HIPAA. Nevertheless, data sharing is an important practice, especially in research, as it could help in the development of more effective interventions for diseases.

5.c) Conclusion:

In conclusion, this chapter discusses organizational Conflicts of Interest. Understanding organizational moral agency and recognizing the value of ethics programs create an enlightened context to identify and resolve organizational Conflicts of Interest. Healthcare organizations should foster moral cultures such as via organizational ethics programs to develop awareness about organizational Conflicts of Interest. The emerging expansion of data sharing presents a particularly complex problem for Conflicts of Interest in healthcare. Healthcare organizations must address data sharing by using technologies that strictly adhere to state privacy and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations regarding patient information. By doing so, Organizational Conflicts of Interest can be effectively identified and resolved as a hallmark of an excellent organizational moral culture.

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[1] Gini, A. R., and David Ozar. "Appendix 1: Patricia H. Werhane's Publications." *The Moral Imagination of Patricia Werhane: A Festschrift* 47 (2018): 94.

[2] Gini, A. R., and David Ozar. "Appendix 1: Patricia H. Werhane's Publications." *The Moral Imagination of Patricia Werhane: A Festschrift* 47 (2018): 95.

[3] Pellegrino, Edmund D. "Societal duty and moral complicity: the physician's dilemma of divided loyalty." *International journal of law and psychiatry* (1993): 373.

[4] Johnson, Craig E. *Organizational ethics: A practical approach*. (Thousand Oaks, CA: SAGE Publications, 2018), 211.

[5] Orr, Robert D. "The role of moral complicity in issues of conscience." *The American Journal of Bioethics* 7.12 (2007): 23.

[6] Orr, Robert D. "The role of moral complicity in issues of conscience." *The American Journal of Bioethics* 7.12 (2007): 23.

[7] Pellegrino, Edmund D. "Societal duty and moral complicity: the physician's dilemma of divided loyalty." *International journal of law and psychiatry* (1993): 373.

[8] Devolder, Katrien, and John Harris. "Compromise and moral complicity in the embryonic stem cell debate." *Philosophical Reflections on Medical Ethics*. (Palgrave Macmillan, London, 2005), 94.

[9] Boyle, Philip J., et al. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (John Wiley & Sons, 2001), 33

[10] Boyle, Philip J., et al. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (John Wiley & Sons, 2001), 33

[11] Boyle, Philip J., et al. *Organizational ethics in health care: Principles, cases, and practical solutions*. Vol. 10. (John Wiley & Sons, 2001), 123

[12] Musto, Lynn C., Patricia A. Rodney, and Rebecca Vanderheide. "Toward interventions to address moral distress: Navigating structure and agency." *Nursing Ethics* 22.1 (2015): 91.

[13] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 94.

[14] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 95.

[15] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 95.

[16] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 165.

[17] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 97.

[18] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 97.

[19] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 110.

[20] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 34.

[21] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 39.

[22] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 110.

[23] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 111.

[24] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 115.

[25] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 211

[26] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 211.

[27] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 211.

[28]Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 212.

[29] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 239.

[30] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 240.

[31] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 247.

[32] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 247.

[33]Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 248.

[34] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 255.

[35] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 213.

[36] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 215.

[37] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 228.

[38] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 338.

[39] Filerman, Gary L., Anne E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. (Chicago IL: Health Administration Press, 2014), 160.

[40] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 337.

[41] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 338.

[42] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 338.

[43] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 337.

[44] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 340.

[45] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 345.

[46] Johnson, Craig E. Organizational ethics: A practical approach. (Thousand Oaks, CA: SAGE Publications, 2018), 356.

[47] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 114.

[48] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 115.

[49] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1458.

[50] Masters, Kathleen. *Role Development in Professional Nursing Practice* (Burlington: Jones & Bartlett Publishers, 2015), 165.

[51] Dyer, Kirsti A. "Ethical challenges of medicine and health on the Internet: a review." *Journal of Medical Internet Research*3.2 (2001). https://dx.doi.org/10.2196%2Fjmir.3.2.e23.

[52] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1461.

[53] Dyer, Kirsti A. "Ethical challenges of medicine and health on the Internet: a review." *Journal of Medical Internet Research*3.2 (2011). https://dx.doi.org/10.2196%2Fjmir.3.2.e23.

[54] Limentani, Alexander E. "An ethical code for everybody in health care: The role and limitations of such a code need to be recognized." *BMJ: British Medical Journal* 316.7142 (1998): 1461.

[55] Candy, Val. "Integrated Ethics Programs in the Healthcare Industry." *American Journal of Health Sciences* 5.1 (2014): 5.

[56] Candy, Val. "Integrated Ethics Programs in the Healthcare Industry." *American Journal of Health Sciences* 5.1 (2014): 5.

[57] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 113.

[58] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 113.

[59] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 113.

[60] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 113.

[61] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 113.

[62] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 114.

[63] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 114.

[64] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 114.

[65] Mary JM. Can a health care market be moral? A Catholic vision. (Washington, D.C.: Georgetown University Press, 2007), 115.

[66] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 29.

[67] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 30.

[68]Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 32.

[69] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 33.

[70] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 33.

[71] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 33.

[72] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 40.

[73] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 41.

[74] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 43.

[75] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 43.

[76] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 43.

[77] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 44.

[78] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[79] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[80] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[81] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[82] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[83] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 50.

[84] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 51.

[85] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 52.

[86] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 52.

[87] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 52.

[88] Philip JB & David EG et al. Organizational ethics in health care. (Hoboken MA: Jossey-Bass: Wiley & Sons, 2001), 52.

[89] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[90] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[91] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[92] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[93] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[94] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[95] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[96] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[97] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[98] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[99] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[100] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[101] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[102] Gregory M. Complicity and moral accountability. (Notre Dame, Indiana: University of Notre Dame, 2016), 112.

[103] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 17.

[104] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 29.

[105] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 29.

[106] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 40.

[107] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 41.

[108] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 47.

[109] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 56.

[110] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 57.

[111] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 70.

[112] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 17.

[113] Christopher K. Complicity: Ethics and Law for a Collective Age. (Cambridge: Cambridge University Press, 2007), 72.

[114] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[115] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[116] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[117] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[118] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[119] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[120] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[121] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[122] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 13.

[123] Elizabeth J., Forrestal, and Leigh, WC. Ethics and Professionalism for Healthcare Managers. (Chicago, IL: Health Administration Press, 2016), 2.

[124] Helen W. ed. Cooperation, complicity, & conscience. Problems in healthcare, science, law, and public policy. (London: The Linacre Centre, 2005), 45.

[125] Helen W. ed. Cooperation, complicity, & conscience. Problems in healthcare, science, law, and public policy. (London: The Linacre Centre, 2005), 48.

[126] Helen W. ed. Cooperation, complicity, & conscience. Problems in healthcare, science, law, and public policy. (London: The Linacre Centre, 2005), 49.

[127] Helen W. ed. Cooperation, complicity, & conscience. Problems in healthcare, science, law, and public policy. (London: The Linacre Centre, 2005), 52.

[128] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425.

[129] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425.

[130] Lang, T: "Advancing global health research through digital technology and sharing data." *Science* 331 (2011): 714-717.

[131] Hodge Jr, JG, Lawrence OG, and Jacobson PD: "Legal issues concerning electronic health information: privacy, quality, and liability." *Jama* 282 (15) (1999): 1467.

[132] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 44(2) (2016): 353.

[133] Modjarrad, K, Vasee SM, Piers M, Pierre-Stéphane G, Roth C and Kieny M: "Developing global norms for sharing data and results during public health emergencies." *PLoS Medicine,* 13(1) (2016): e1001935.

[134] Modjarrad, K, Vasee SM, Piers M, Pierre-Stéphane G, Roth C and Kieny M: "Developing global norms for sharing data and results during public health emergencies." *PLoS Medicine,* 13 (1) (2016): e1001935.

[135] Modjarrad, K, Vasee SM, Piers M, Pierre-Stéphane G, Roth C and Kieny M: "Developing global norms for sharing data and results during public health emergencies." *PLoS Medicine,* 13 (1) (2016): e1001935.

[136] Modjarrad, K, Vasee SM, Piers M, Pierre-Stéphane G, Roth C and Kieny M: "Developing global norms for sharing data and results during public health emergencies." *PLoS Medicine,* 13 (1) (2016): e1001935.

[137] Aita, M, and Richer M: "Essentials of research ethics for healthcare professionals." *Nursing & Health Sciences* 7(2) (2005): 119-125.

[138] Aita, M, and Richer M: "Essentials of research ethics for healthcare professionals." *Nursing & Health Sciences* 7(2) (2005): 119-125.

[139] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. *Managing and sharing research data: A guide to good practice*. (London: SAGE Publication, 2014), 61.

[140] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 44(2) (2016): 353.

[141] Kuther, TL, "Medical decision-making and minors: Issues of consent and assent," *Adolescence* 38(150) (2003): 344.

[142] Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton. "A review of cross-organizational healthcare data sharing." *Procedia Computer Science* 63 (2015): 425.

[143] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 162(4) (2015): 306-7.

[144] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 162(4) (2015): 306.

[145] Institute of Medicine. *Sharingclinical trial data: Maximizing benefits, minimizing risk.* The National Academies Press, Washington DC, January 2015 (http://www.nap.edu/openbook.php?record_id=18998).

[146] Borgerson Kims: Redundant, secretive, and isolated: when are clinical trials scientifically valid? *Kennedy Institute of Ethics Journal* 24(4) (2014): 385-411.

[147] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 162(4) (2015): 306-7.

[148] Borgerson Kims: Redundant, secretive, and isolated: when are clinical trials scientifically valid? *Kennedy Institute of Ethics Journal* 24(4) (2014): 385-411.

[149] Knoppers BM, Harris JR, Budin-Ljøsne I and Dove ES: A human rights approach to an international code of conduct for genomic and clinical data sharing. *Human Genetics* 133(7) (2014): 895-903.

[150] Knoppers BM, Harris JR, Budin-Ljøsne I and Dove ES: A human rights approach to an international code of conduct for genomic and clinical data sharing. *Human Genetics* 133(7) (2014): 896.

[151] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 44(2) (2016): 353.

[152] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 2016, 44(2): 354.

[153] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 44(2) (2016): 355.

[154] Rothstein, MA, "The end of the HIPAA privacy rule?," *Journal of Law, Medicine & Ethics* 44(2) (2016): 354.

[155] Kuther, TL, "Medical decision-making and minors: Issues of consent and assent," *Adolescence* 38(150) (2003): 344.

[156] Kuther, TL, "Medical decision-making and minors: Issues of consent and assent," *Adolescence* 38(150) (2003): 346.

[157] Drazen JM: Sharing individual patient data from clinical trials. *New England Journal of Medicine* 372 (3) (2015): 201-2.

[158] Drazen JM: Sharing individual patient data from clinical trials. *New England Journal of Medicine* 372 (3) (2015): 202.

[159] Saunders, B, Kitzinger, J, and Kitzinger, C: "Anonymising interview data: challenges and compromise in practice." *Qualitative Research* 15(5) (2015): 619.

[160] Saunders, B, Kitzinger, J, and Kitzinger, C: "Anonymising interview data: challenges and compromise in practice." *Qualitative Research* 15(5) (2015): 620.

[161] Saunders, B, Kitzinger, J, and Kitzinger, C: "Anonymising interview data: challenges and compromise in practice." *Qualitative Research* 15(5) (2015): 619

[162] Saunders, B, Kitzinger, J, and Kitzinger, C: "Anonymising interview data: challenges and compromise in practice." *Qualitative Research* 15(5) (2015): 621

[163] Lane, J, and Schur I: "Balancing access to health data and privacy: A review of the issues and approaches for the future," *Health Services Research* 45(5p2) (2010): 1457.

[164] Lane, J, and Schur I: "Balancing access to health data and privacy: A review of the issues and approaches for the future," *Health Services Research* 45(5p2) (2010): 1458.

[165] Rivero-García, A, Iván S, Candelaria H, Pino C, and Moti Y: "Patients' data management system protected by identity-based authentication and key exchange," *Sensors (14248220)* 17(4) (2017): 2.

[166] Rivero-García, A, Iván S, Candelaria H, Pino C, and Moti Y: "Patients' data management system protected by identity-based authentication and key exchange," *Sensors (14248220)* 17(4) (2017): 3.

[167] Rivero-García, A, Iván S, Candelaria H, Pino C, and Moti Y: "Patients' data management system protected by identity-based authentication and key exchange," *Sensors (14248220)* 17(4) (2017): 4.

[168] Qin, B, Deng, H, Wu, Q, Domingo-Ferrer, J, Naccache, D, & Zhou, Y: 'Flexible attribute-based encryption applicable to secure e-healthcare records'.*International Journal of Information Security*, 14(6) (2015): 501.

[169] Qin, B, Deng, H, Wu, Q, Domingo-Ferrer, J, Naccache, D, & Zhou, Y: 'Flexible attribute-based encryption applicable to secure e-healthcare records'.*International Journal of Information Security*, 14(6) (2015): 503.

[170] Borgerson Kims: Redundant, secretive, and isolated: when are clinical trials scientifically valid? *Kennedy Institute of Ethics Journal* 24(4) (2014): 385-411.

[171] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014), 70.

[172] Drazen JM: Sharing individual patient data from clinical trials. *New England Journal of Medicine* 372(3) (2015): 201-2.

[173] Drazen JM: Sharing individual patient data from clinical trials. *New England Journal of Medicine* 372(3) (2015): 201.

[174] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 280.

[175] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 281.

[176] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 290.

[177] Khan, SI and Abu SL. "Digital health data: A comprehensive review of privacy and security risks and some recommendations." *Computer Science Journal of Moldova* 24(2) (2016): 273-292.

[178] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 280.

[179] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 277.

[180] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 3.

[181] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 4.

[182] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 289.

[183] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 277.

[184] Appari, A, and Johnson ME. "Information security and privacy in healthcare: current state of research." International journal of Internet and Enterprise Management 6(4) (2010): 276

[185] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 4.

[186] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 4.

[187] Raghupathi, W, and Viju R: "Big data analytics in healthcare: promise and potential." *Health information science and systems,* 2(1) (2014): 3.

[188] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 4.

[189] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 7.

[190] Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views about the security and privacy of Electronic Health Records (EHRs) in the UK: results from a mixed methods study." *BMC Medical Informatics & Decision Making* 15 (2015): 7.

[191] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014), 71.

[192] Knoppers BM, Harris JR, Budin-Ljøsne I and Dove ES: A human rights approach to an international code of conduct for genomic and clinical data sharing. *Human Genetics* 133(7) (2014): 895-903.

[193] Institute of Medicine. *Sharingclinical trial data: Maximizing benefits, minimizing risk.* The National Academies Press, Washington DC, January 2015 (http://www.nap.edu/openbook.php?record_id=18998).

[194] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014), 71.

[195] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014)71.

[196] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 2015; 162(4): 306-7.

[197] Drazen JM: Sharing individual patient data from clinical trials. *New England Journal of Medicine* 372(3) (2015): 201-2.

[198] Borgerson Kims: Redundant, secretive, and isolated: when are clinical trials scientifically valid? *Kennedy Institute of Ethics Journal* 24(4) (2014): 385-411.

[199] Borgerson Kims: Redundant, secretive, and isolated: when are clinical trials scientifically valid? *Kennedy Institute of Ethics Journal* 24(4) (2014): 387.

[200] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 162(4) (2015): 306-7.

[201] Rosenblatt M, Jain SH and Cahill M. Sharing of clinical trial data: Benefits, risks, and uniform principles. *Annals of Internal Medicine* 162(4) (2015): 308.

[202] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1442.

[203] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 2010; 45(5p2) (2010): 1443.

[204] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1447.

[205] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1444.

[206] Committee on Strategies for Responsible Sharing of Clinical Trial Data: *Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities.* (Washington DC: National Academies Press, February 2015), 1-72.

[207] Committee on Strategies for Responsible Sharing of Clinical Trial Data: Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities. (Washington DC: National Academies Press, February 2015), 1-72.

[208] Committee on Strategies for Responsible Sharing of Clinical Trial Data: Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities. (Washington DC: National Academies Press, February 2015), 1-72.

[209] Committee on Strategies for Responsible Sharing of Clinical Trial Data: Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities. (Washington DC: National Academies Press, February 2015), 1-72.

[210] Committee on Strategies for Responsible Sharing of Clinical Trial Data: Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities. (Washington DC: National Academies Press, February 2015), 1-72.

[211] Committee on Strategies for Responsible Sharing of Clinical Trial Data: Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities. National Academies Press, (Washington DC, February 2015)

[212] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1448.

[213] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1450.

[214] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1451.

[215] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1444.

[216] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1445.

[217] Rosenbaum, S: "Data governance and stewardship: Designing data stewardship entities and advancing data access." *Health Services Research* 45(5p2) (2010): 1442.

[218] Laric, MV and Dennis AP: "Preserving patient privacy in the quest for health care economies." *The Journal of Consumer Marketing* 26(7) (2009): 479.

[219] Laric, MV and Dennis AP: "Preserving patient privacy in the quest for health care economies." *The Journal of Consumer Marketing* 26(7) (2009): 480.

[220] Laric, MV and Dennis AP: "Preserving patient privacy in the quest for health care economies." *The Journal of Consumer Marketing* 26(7) (2009): 481.

[221] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014), 80.

[222] Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. Managing and sharing research data: A guide to good practice. (London: SAGE Publication, 2014), 80.

[223] Institute of Medicine. *Sharingclinical trial data: Maximizing benefits, minimizing risk.* The National Academies Press, Washington DC, January 2015 (http://www.nap.edu/openbook.php?record_id=18998).

[224] Institute of Medicine. *Sharingclinical trial data: Maximizing benefits, minimizing risk.* The National Academies Press, Washington DC, January 2015 (http://www.nap.edu/openbook.php?record_id=18998).

Chapter 6 : Conclusion:

In retrospect, conflicts of interest are prevalent across all walks of society, and unfortunately, the healthcare industry is not immune to these impediments. Conflicts of interest arise when the objective of upholding a patients' interest collide with the physicians' secondary goals and is mostly but not always related to monetary gain. For instance, when practitioners in healthcare fail to obtain patient consent or respect the patients' autonomy in decision making, ethical challenges pertaining to conflict of interest arise. While autonomy relates to the freedom in making crucial decisions related to their health, consent refers to the fact that the patient is well informed of the medical procedures or medication they are supposed to undertake. These two concepts are highly relatable with informed consent being the most critical constraint associated with respect for autonomy. Giving patients such power such as declining surgeries that they do not deem to protect them from unwanted interventions thus preventing them from encountering any associated conflict of interest. In addition to resolving such conflicts, appreciation for autonomy facilitates the adherence to medical ethics and respect of patients. However, the respect for patient autonomy could also risk the patients' wellbeing, especially in circumstances where they are provided with insufficient information prior to their decision making or when they are afraid of the consequences.

To avoid conflict of interest, it is advisable for medical practitioners to weigh the pros and cons that their actions would inflict. Medical practices whose benefits outweigh the associated risks are ethically upright hence avoid conflict of interest. However, respect for patient autonomy negatively affects the patient-physician relationship, which is key to preventing conflict of interest. As a result, the ability of the doctor to act in a fiduciary manner is limited. Focusing on informed consent and autonomy favors the patient-centered approach over

physician-centered models in making decisions. Autonomy is granted after considerations about what the law stipulates and the patients' ability to understand the ensuing dynamics is guaranteed. Nonetheless, the law has gaps that leave room for errors that can facilitate the making of irrational decisions by patients. On the other hand, the information provided to patients to gain their consent should be adequate and should not favor a certain outcome. To prevent such conflict of interest, the physician should also disclose any information that could lead to the changing of the patient's decision, but only if it is reasonable. The gained consent should also be recorded.

When it comes to autonomy, questions pertaining to issues such as privacy, fidelity, confidentiality and honesty arise. For instance, physicians may withhold crucial information from the patient in order to favor an outcome they prefer and while it may be harmless in most situations, sometimes it could have grave consequences. Some doctors feel that since patients lack the knowledge in medical practice, giving them information they would most likely fail to understand or interpret correctly could impede them from efficiently conducting their practice. Nonetheless, these physicians are usually correct to some extent since despite the benefits of patient autonomy, it also risks the patient's life. When physicians feel that a patient is competitive enough, they are left to make their own decisions, which leaves them vulnerable, unprotected and abandoned, and this in turn raises ethical issues. When abandoned, despite it's not being the doctor's intentions, the patient is denied a conducive environment that facilitates the making of rational decisions and this is recommended to be punishable by law since it is against healthcare ethics. However, since it is mostly an honest mistake, it is recommended that the capacity for autonomous choice to be based on ones' ability to understand and the law.

The disclosure of information could be through the subjective and rational physician and

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patient standards. Of these methods, the rational patient standards approach is the most convenient as it represents the patient's interest unlike the rational physician and subjective standards which present a massive conflict of interest and are challenging respectively. Nonetheless, the most efficacious approach is the subjective standard. The making of decisions is based on healthcare ethics principles of autonomy, justice, beneficence, and non-maleficence, which enhance patient autonomy and comprehension and guide the decisions of physicians. Beneficence focuses on bringing about benefits while none-maleficence entails the avoidance of causing harm. These obligations are often in conflict with the autonomy of a patient with dementia. Due to the dependency associated with patients with dementia, the issue of conflict of interest arises due to the patient's vulnerable state. Physicians should address such vulnerabilities to respect the patients' autonomy and to avoid incidences where a conflict of interest arises, the clinicians should be responsive, responsible, competent, and attentive given that it demands continuous involvement and decision making.

The ethical approaches for handling patients with dementia are normative, complementary, and sometimes descriptive, but the principle of beneficence is incorporated in such decisions. However, since dementia patients have memory problems, their mental capacity should be taken into consideration when it comes to approving their autonomy and validating their consent. As a result, substitutes are often involved. Often, as the disease progresses, conflicts of interest arise among family members, friends, patients, and physicians who get conflicted on whether to support the patients' autonomy, make decisions together, act as substitutes or when it interferes with the physician's medical practices. There might be conflicting views on preferred methods of treatment between family members, the family and the physician, the patient and physician, and how medical ethics relate to societal norms.

Contemporarily, the society is widely involved in such decisions but the conflict of interest that arises is how it uses its power to prioritize collective over individual interests. Still, the best way to avoid conflict of interest between care givers and patients is through proper adherence to care standards by the medical practitioners.

With doctors tasked to ensure the wellbeing of patients, in some instances the best way to achieve this is to alleviate their pain suffering hence the dilemma to end a patient's life or provide care despite the high probability of death. Such voluntary death – euthanasia – and abortion represent perfect clinical scenarios where numerous conflicts of interest arise, mostly due to the tension between rights, law and religion for the former, and financial incentives and consent, and dignity and pluralism for the latter. Both proponents and opponents of abortion give numerous reasons that suit their argument for and against, but the tension between dignity and pluralism leads to a conflict of interest. One group argues for prioritization of choice over the unborn while the other views life as sacred. In clinics, conflict of interest might arise when a physician's stance on the issue makes them hinder or inappropriately assist women that seek an abortion in order to accommodate their own beliefs. Still, despite the debate, international organizations such as the UDHBR advocate for the rights and dignity of all life including the unborn, while others still are in support of the vice and advocate for the right of choice.

It has been argued that abortion is medically safe when conducted by experts, or even justifiable in extreme cases such as rape, but destroying life at the offenders' expense results in a conflict of interest. Nonetheless, the cons outweigh the pros and most abortion cases, despite the employed technique precede immediate and future health complications due to the intrinsic risk the procedure carries. Some of these health complications could even result to death and the health risks include barrenness, excessive hemorrhage, injury to the cervix, cardiac arrest, renal

failure, metabolic disorders, miscarriages or preterm birth in subsequent pregnancies, placenta Previa, and in addition to these physical complications, psychological ones such as depression could arise. Moreover, abortion could negatively impact the health of future children and even result to their early mortality. The conflict of interest arises since both groups – pro-life and pro-choice individuals – have remained adamant and always promote their agenda regardless of the situation. Their predisposed stance and perception on the matter indirectly influences their decisions either knowingly or without their knowledge.

The financial interests associated with abortion procedures also pose a conflict of interests as organizations and hospitals could only be practising it for financial gain and not due to having the patients' interests at heart. This conflict could also be reflected in laws. Disparate jurisdictions implement different laws pertaining to abortion with most terming it as illegal. Nevertheless, this does not aid in controlling the issue. Therefore, people take drastic and unsafe measures to procure abortions. It is recommended that a government should gain the consent of its people before legalizing or prohibiting such acts. However, the public division on the matter, which is almost by a fifty per cent ratio poses problems for the passing of such laws. Conflicts have emerged across most societies due to differing opinions and in addition to public conflict, cases of political conflict also arise. Politicians for instance could lean on either side of the pro-choice or pro-life groups depending on how the majority of his or her electorate perceive the matter, and conflict of interests arise since by advocating for a certain outcome, they stand to gain some political mileage against their political opponents. Furthermore, failure to gain consent from the people is unethical and a potential source of conflict.

The debate on whether death should occur naturally or in an assisted manner results to conflict of interest in healthcare given that euthanasia could be induced to save hospital costs or

as a way of avoiding the burden associated with offering lengthy care to the patient. On the other hand, opponents of the practice also encounter a conflict of interest in situations such as when personal beliefs dictate their actions despite the patients' wishes. Cultural inclinations dictate how people perceive things such as death, and though the influence could be indirect, a predisposition on any issue generates a conflict of interest since one might be only supporting or opposing it in order to promote or support his or her cultural stance. The issue of autonomy also raises contradictions when it comes to euthanasia since a patient is given the right to decide how he or she would love to proceed after diagnosis. However, to avoid any arising confusion or ethical issues on who is eligible for mercy killing and who is not, it is vital that proper patient categorizations and ones with no vague definitions are made such as easily healable, healable, unhealable but manageable, and unhealable and unmanageable.

Healthcare personnel have the duty of being compassionate towards their patients, but challenges associated with differentiating it from empathy and sympathy could result to a conflict of interests in the making of decisions such as ending a life to stop suffering. When a patient or family member asks for this procedure, the real reason should be investigated and the reasons should be sufficient. To avoid a conflict of interest, doctors should not mistake the need to alleviate suffering from death since the aim of medicine is usually to aid an ill individual and help them to live longer hence not to end their life. If a family member is the one who requests for the procedure, investigations should be undertaken on whether they stand to benefit through the patient's quick death. With such examples, it is clear that euthanasia is associated with certain moral demerits that could result to ethical issues. Nonetheless, the act is justifiable and considered ethical when all the other available options are exhausted.

The arguments for the administration of euthanasia are based on patient's rights such as

to a dignified death, and practical issues including proof that the patient is going to die despite any efforts by doctors. However, only the patient holds the moral ground to sanction their death. Arguments against euthanasia are mostly derived from ethics and religion, which sanctifies life and acts as the society's moral compass. Similar to abortion, the government too has a role to play through enacting policies, laws, and regulations that address such conflicts. The role of the family in decision making generates a conflict of interest when the doctors, patients, and each member has a differing opinion, either supporting or opposing the deed. Still, the doctor has a duty of notifying the patient's kin about the option of euthanasia when they are under unmanageable conditions. This could be instances of failing or heavy medication after a certain duration. Due diligence must be exercised to ensure the process is not undertaken too soon. More countries are gradually embracing euthanasia in their laws but the humanistic principle of all religions make them oppose the practice. Still, the legal definition of euthanasia is the most controversial and debated topic and is among the most difficult decision made by the family.

Healthcare professionals often encounter incidences where conflicts of interest emerge due to the tension between professional leadership and code of ethics, and cultural values and decisions. As a result, ethical foundations such as the ACHE were formulated to generate a standard code of ethics that guide the physician-patient relationship and ensure the leadership prioritizes the patients' interests. Failure to observe the ethical standards results in a conflict of interest due to the connection between professional leadership and code of ethics. The code entails principles of honesty, conflict avoidance, accountability, and respect to the law and others. They avert conflict of interest between patients and clinicians by anticipating the adherence to professional ethics. Moreover, the reciprocity where the code of ethics informs professional ethics, which inform professional leadership, aids in the identification and resolving

of professional conflicts of interest. The code of ethics by ACHE regulates the conduct of healthcare executives, which in turn fosters ethical leadership in HCOs.

HC executives must align their decisions with an established code of ethics to promote moral culture and prevent conflict of interest issues in HCO. As a result, in addition to running HC programs such as EDGE, the institution developed a code of ethics, which HC executives must use to shape organizational moral culture and agency. Organizational moral culture is clearly related to ethical leadership, creating a need to adhere to this code of ethics. As per the code, some leadership responsibilities to the organization entail obligating HCOs to work towards demonstrating faithfulness, offer services in harmony with the available resources, foster equality, register financial information, and implement an organizational code of ethics and monitor its strict compliance. This way, HC executives would administer ethical behaviour among staff members, preventing any conflict of interest. In the healthcare setting, lack of ethical decision making among professionals creates a serious conflict of interest issues. In this light, instilling such moral cultures curbs similar problems. The effective avenues that promote ethical decision making facilitate the simplicity of identifying and resolving the conflict of interest between clinicians and patients.

Other ethical obligations for HC executives as per ACHE's code of ethics entail creating a work environment that puts emphasis on the challenges of conflict of interest and one that workers can freely actualize organizational moral culture, and permits free expression of any pertinent moral concerns by employees. The HC executives should also lead by example and foster ethical leadership practices throughout the HCO. As a form of virtuous leadership, this has been noted to contribute to organizational moral culture by establishing moral and ethical boundaries throughout the HCO. HC managers are also required to abstain from actions that

could engender a conflict of interest issues, such as manipulating specialist relationships and discriminatory practices. Their priority should be satiating a community's needs and creating structures that caution the HCO from incidences of conflict of interests. In healthcare, conflicts of interest can arise in disparate scenarios such as when practitioners receive monetary aid or rewards inform of different items. This often has an indirect effect on the outcome of the specific objective at hand, such as treatment, research, or test groups.

The primary goal of medical practitioners is promoting the patients' health while secondary ones' entail financial gain, family time, recognition, or professional advancements. These spark an internal conflict within an individual given that each has to be satisfied and if not controlled, the consequences could be fatal as it jeopardizes the patients' wellbeing and limits the clinician's capability to ensure quality improvement. Moreover, pharmaceutical companies are usually reliant on physicians since they play a crucial role in the production of new drugs and medical devices. However, these clinicians in turn get access to substantial amounts of compensation in the form of grant, stock options and consulting and royalty agreements hence the resulting conflict of interest. Such Payments could influence the practitioners' verdict, on whether the company's drugs are safe and efficient in treating a specific illness. One particular secondary goal, which entails monetary gain is the primary cause for conflict of interest in healthcare. Doctors could be focused on seeing numerous patients in a short duration and the hurry could lead to the provision of insufficient patient data by the patient and quality of care would be based on patients' financial capabilities, which is unethical.

Other ethical issues that amount to a conflict of interest classification entail, accepting benefits before rendering services, self-dealing, and moonlighting. Accepting benefits before rendering services amounts to bribery, which aims to increase one's wages hence the conflict of

interest. Self-dealing occurs when a medical practitioner especially one operating in public hospitals owns or operates a separate clinic and when approached by a patient, he or she refers them to that clinic. The case in moonlighting is almost similar since an employee in a particular hospital sets up another similar business near it and asks his or her colleagues to refer their patients to it. While advantageous arguments for this exist, with money involved, it has the capability to affect the decisions in their primary workplace. Another common scenario where conflicts of interest arise occurs when medical practitioners play the role of examiners such as fitness tests. Here, the physician has to appease the statutory law, public interest and the contracts they signed with insurers or employers. Nonetheless, physicians have a professional and moral obligation to responsibly manage their conflicts of interest both individually and professionally.

On the other hand, conflicts of commitment occur when activities outside one's profession, which in this case is healthcare, interfere with the practitioner's ability to perform their duties. As a result, similarly to the case of conflict of interest, the medical practitioner's judgement gets compromised since the physicians gain inappropriately at the expense of the HCO they are working in and the patients. Organizational commitment conflicts could be described as affective, normative and continuance where the first is associated with how the employee identifies with the organization and his or her emotional connection. The others constitute the obligation to continue working for an organization and costs for switching employers respectively hence conflict of commitment may arise when medical practitioners exhibit no will in identifying with and their involvement in the HCOs they work in. Additionally, such matters are concerned with the allocation of time and energy, and could be caused by factors pertaining to job dissatisfaction and tension in workplace, divided loyalties between

several entities, family time, poor time management, and scheduling of activities, lack of empowerment, role ambiguity and conflict, and lack of motivation.

Such conflicts of commitment could result in ethical issues such as selection bias to treat only patients within a certain time frame and it could also influence the lack of beneficence and the establishment of a low moral burden in a HCO. Furthermore, it could result to ethical egoism where healthcare workers would start believing that their main obligation is to themselves and not their customers, and also it could lead to poor clinical judgement due to the hurry to commit to another job, leading to misdiagnosis of patients. Organizational commitment constitutes one of the major factors that have a positive or negative influence on the outcomes of an organization. As a result, in time, the conflict of commitment would generate mistrust towards the institution among patients hence reduce the number of patients visiting the HCO, which is associated with company losses. Legal suits may also increase, which degrades the hospital's reputation and resolving disputes associated with conflicts of interest and commitment consume a considerable amount of time. Poor disease management as a result of lack of commitment could in turn result to a surge in mortality rate across society and patients could also be subjected to harm.

Organizations act as moral agents but their policies that aim to achieve certain objectives could not be morally upright, and this is what constitutes complicity. A HCO's moral agency is inseparable from employees' behavior and the tension between this and complicity results to a provider-initiated a conflict of interest. A good moral culture is key for a HCO to accomplish its responsibility in society and ethics programs can be used to instil a moral culture among employees. One way to achieve this is through the evaluation of activities that have an impact on the organization and determine if they are in line with the mission. This could be achieved through surveys and structural approaches. Other factors that influence the code of ethics in an

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institution include the society, occurrence of a new situation, and stakeholders and staff whose understanding of the organization's ethical values and expectations is key. Ethics programs pose the best way to instil ethical practices in organizations, but leaders should also lead by example and appoint personnel with unquestionable integrity. Unethical leaders and subordinates have the ability to contaminate the whole organization with their immoral activities, creating a need for a proper framework of moral culture coupled with employee cooperation to avoid being complicit.

The disparate departments in HCOs are encountered with unique moral issues and the main departments include marketing, finance and accounting, and human resource departments. Some of the moral issues that could arise in the various departments entail ethical behavior and responsibility of the marketing team in the marketing department, and falsifying tax records in the finance and accounting departments. As a result, each requires a distinctive and tailored way of handling any ethical issues, such as employing a marketing time that applies ethical theories in solving challenges for the marketing department, conducting independent audits in the financial departments and employing human resource planning for the human resource department. Such organizational ethics programs anticipate potential conflicts of interest and complicity and provide standards that guide the provider-patient relationship. In addition to these ethics programs, a proper moral cultural framework, departmental compliance to the programs and employee cooperation are key for an organization to avoid being complicit.

The HEC is fundamental to the success of these ethical programs as it drafts, implements, and oversees them. Before formulation of the committee, a needs assessment is conducted by the organization where all personnel make contributions through focus groups or surveys after which the selection of members possessing certain traits, qualities, and expertise, and with no conflict of interest occurs. The candidate must also be able to make proper ethical arguments and

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discussions, exhibit honesty and competence and some experience in the organization. Basically, the HEC is tasked with education, consultation, prevention, and policy development. The committee reinforces moral values, secures managerial commitment and sets out a code of ethics and guidelines to avoid conflict of interest. All these objectives are at par with essential components of a good ethics program, which include education and training, corrective and disciplinary action moral culture, organizational leadership, policies and ethics, and accountability. Furthermore, the program should be equipped with efficient controls able to detect any misconduct mostly through periodic auditing and employee assessment. With the aid of the ethics programs, HECs anticipate any potential conflicts of interest in the patient-physician relationship and counters them.

Given that most HCOs share their data with other parties, such as government agencies, hospitals, and pharmaceuticals, data sharing raises issues of confidentiality and privacy due to malicious use of data hence the organizational conflict of interest. In some instances, the data is sold for monetary gain, leading to a conflict of interest since the aim is not to help the patients access better care through the research but for the physicians to enrich themselves. Still, data sharing poses a dilemma given that, while it could subject individuals to harm, it also supports the society's goals as a whole as it results to research and analysis, which leads to the discovery of trends and or new treatment methods. For instance, sharing clinical data concerning treatment procedures results to fostering of sound regulatory decisions and it promotes research and new treatment procedures. Nevertheless, the breach of doctor-patient confidentiality for the gain of others poses a conflict of interest, and sometimes, misuse and misinterpretation undermines effective patient treatment. Other instances where the issue of conflict of interest may arise entail the misuse of patient data by physicians, using data to plot a revenge and confidential

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information making its way into the wrong hands.

The violation of patient privacy and misuse of their data by physicians raises serious conflict of interest issues, which violate the legal and ethical requirements of healthcare standards. Before sharing clinical data, its accuracy and source's reliability must be verified to ensure all the right policies and procedures are followed. Maintaining a patient's privacy facilitates the perpetuation of personal autonomy, which as noted early in this dissertation is key in solving the issue of conflict of interest. The initiatives that currently address privacy and confidentiality issues in sharing patient data entail federal regulations such as the HIPAA, anonymizing data through data de identification, implementing policies on suing information management systems and adopting user access controls. To curb the issue conflict of interest that arises as a result of misuse, strategies such as adopting the full access and no access models, implementing strict regulations in systems, establishing accompanying stringent procedures associated with data sharing, performing continuous audits and demonstrating leadership in the implementation of such measure. Finally, data stewardship also provides an overall solution to conflict of interest issues of misuse, privacy and confidentiality, and this could be enforced through practices such as hiring competent data stewards, making data policies transparent, data protection and ensuring clarity in contracts.

Each section addresses the issue of conflicts of interest in the healthcare setting and proposes solutions for the conflicts in disparate healthcare contexts, and thus the dissertation's immense contribution to the field. For instance, the study proved normative methods to be key to ethical decision making in healthcare as they establish rules, procedures, and regulations necessary to achieve informed consent. Moreover, they ensure the patient's full autonomy as it puts them in a comprehensive position that they can voluntarily make their own decisions. This

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could comprise the most needed solutions in healthcare to ensure patient autonomy and informed consent hence solve the issue of conflict of interest in this context. The dissertation further illustrates how the importance of patient-physician relationship and involvement of family members in meaningful decision making can result in no conflicts of interest. The use of abortion and euthanasia as case studies availed meaningful statistics that are of significant impact in healthcare. These eye-openers raised important debates on the government involvement in such issues and how the current policies are only making the situation worse. In order to make certain legislation effective, the dissertation proved the need for gaining people's consent in passing laws that affect them, and thus its contribution to society.

The dissertation also elucidates the role of the government in shaping the moral fabric of the society hence its need to be involved in addressing conflict of interest issues in society. On the professional context, the dissertation emphasizes the need to prioritize the code of ethics as a guideline to prevent conflict of interest and proves how they benefit all stakeholders involved. The dissertation notes some proven finding to solutions to conflict of interest and commitment, such as higher reimbursements and payment for every service and highlights the need for policymakers to intervene. Finally, the analysis of organizational conflicts of interest sheds light on the importance of establishing a HEC as a strategy for countering conflicts of interest at the organizational level. Furthermore, the dissertation's propositions on of the effective solutions to curb conflict of interest, especially regarding data privacy and confidentiality are widely applicable in both healthcare and other fields. Some of these entail data de-identification, reduction of patient-related variables, instilling strict regulations, continuous auditing, transparency, and adoption of user access controls and management system.

Bibliography

"Professional Ethics and Codes of Conduct/Ethics," Immigration Advisers Authority, accessed March 17, 2018. http://www.iaa.govt.nz/ethics-toolkit/professional.asp.

"Should the Government be Involved in Patients' End-of-Life Decision." ProCon.org, accessed March 16, 2018. https://euthanasia.procon.org/view.answers.php?questionID=000174.

ACHE. "ACHE Code of Ethics." *ACHE*. 20 Nov. 2017, https://ache.org/abt_ache/code.cfm.

ACHE. "Achieving Greater Diversity in Healthcare Leadership." *ACHE*. 20 Nov. 2017, https://www.ache.org/executivediversity/tcd_commitment.cfm.

Aita, M, and Richer M: "Essentials of Research Ethics for Healthcare Professionals." *Nursing & Health Sciences* 7, no. 2 (2005): 119-125.

Al-Sawai, Abdulaziz. "Leadership of Healthcare Professionals: Where do we stand?" *Oman Med Journal* 28, no. 4 (2013): 285-287. doi: https://dx.doi.org/10.5001%2Fomj.2013.79.

Albright, Dianne E., and Richard J. Hazler. "A right to die?: Ethical dilemmas of euthanasia." *Counseling and Values* 39, no. 3 (1995): 177-187.

Allmark, Peter. "Death with Dignity." *Journal of Medical Ethics* 28 (2002): 255-256.

American Geriatrics Society Ethics Committee, Clinical Practice and Models of Care Committee. "American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement." *Journal of the American Geriatrics Society* 62, no. 8 (2014): 1590 1593.

Anneser, Johanna, Ralf J. Fox, Tamara Thurn and Gian Domenico Borasio. "Physician-Assisted Suicide, Euthanasia and Palliative Sedation: Attitudes and Knowledge of Medical Students." *GMS Journal for Medical Education* 33, no. 1, (2016): 1.

Appari, A, and Johnson ME. "Information Security and Privacy in Healthcare: Current State of Research." *International Journal of Internet and Enterprise Management* 6 no. 4: (2010): 279-314.

Appelbaum, Paul S. "Assessment Of Patients' Competence To Consent To Treatment". *New England Journal Of Medicine* 357, no. 18 (2007): 1834-1840. doi:10.1056/nejmcp074045.

Ardelt, Monika. *Physician-Assisted Death*. In *Handbook of Death and Dying* by C.D. Bryant. (Thousand Oaks, CA: SAGE, 2003), 425.

Ashby, Michael, and Brian Stoffell. "Artificial Hydration and Alimentation at the End of Life: a Reply to Craig." *Journal of Medical Ethics* 21, no. 3 (1995): 135-140.

Australian Human Rights Commission. *Euthanasia, Human Rights and the Law – Issues Paper*. AHRC. 2016.

Azarm-Daigle, Mana, Craig Kuziemsky, and Liam Peyton, "A Review of Cross-Organizational Healthcare Data Sharing", *Procedia Computer Science* 63 (2015): 425-432.

Bai, Xuezhu, and Nicholas Morris. "Leadership and Virtue Ethics: A Daoist Approach." *Public Integrity* 16, no. 2 (2014): 173-186.

Baker, Robert, Tom L. Beauchamp, Michael Boylan, Bernard Gert, Lawrence O. Gostin, Akiko Ito, Peter Tan, and Rosemarie Tong. "Global Bioethics and Human Rights: Contemporary Issues." (2014): 40-57.

Baker, Robert. "A Draft Model Aggregated Code of Ethics for Bioethicists." *The American Journal of Bioethics* 5, no. 5 (2005): 33-41.

Baranzke, Heike. "Sanctity-of-Life" – A Bioethical Principle for a Right to Life?" *Ethical Theory and Moral Practice*. 15, (2012): 300.

Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. Oxford

    University Press, USA, 2001.

Benaiche, Lionel, and Maxime Lassalle. "Conflicts of Interest and Healthcare." *Les Tribunes de*

    la santé 2 (2013): 29-48.

Berce, Jaro. "New Leadership Approach for Better Public Management." *Journal of US-China*

    Public Administration 9, no. 3 (2012): 290-302.

Berman, Jeffrey. *Death Education in the Writing Classroom: Writing about Love and Loss.*

    New York: SUNY Press, 2009.

Bhatti, Waqas Khaliq, Rizwana Bashir, and Mubashar Nadeem. "Impact of Conflict on

    Organizational Commitment of the Employees." *Global Management Journal for*

    Academic & Corporate Studies 5, no. 1 (2015): 114.

Biggs, Hazel. *Euthanasia, Death with Dignity and the Law*. London: Hart Publishing, 2001.

Blightman, K., S. E. Griffiths, and C. Danbury. "Patient Confidentiality: When can a Breach be

    Justified?." *Continuing Education in Anaesthesia, Critical Care* & Pain 14, no. 2 (2013):

    52-56.

Borgerson Kims "Redundant, Secretive, and Isolated: When are Clinical Trials Scientifically

    Valid?" *Kennedy Institute of Ethics Journal* 24, 4 (2014): 385-411.

Bosek, Marcia Sue DeWolf, and Teresa A Savage. *The Ethical Component of Nursing*

    Education: Integrating Ethics into Clinical Experience. New York: Lippincott

    Williams & Wilkins. 2007.

Bosshard, Georg, Ueli Zellweger, Matthias Bopp, Margareta Schmid, Samia A. Hurst, Milo

    A. Puhan, and Karin Faisst. "Medical end-of-life practices in Switzerland: A

    comparison of 2001 and 2013." *JAMA internal medicine* 176, no. 4 (2016): 555-580.

Boudreau, J. Donald and Margaret A. Somerville. "Euthanasia and Assisted Suicide: A

      Physician's and Ethicist's Perspectives." *Medicolegal and Bioethics*, 4 (2014): 3.

Bowling, Ann. "The Hospitalization of Death: Should More People Die at Home?"

      Journal of Medical Ethics, 9, (1983): 158.

Boyle, Philip J., et al. *Organizational Ethics in Health Care: Principles, Cases, and Practical*

      Solutions. 10. San Francisco: John Wiley & Sons, 2001.

Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan C. Chimonas,

      Jordan J. Cohen, Janlori Goldman et al. "Health Industry Practices that Create Conflicts

      of Interest: A Policy Proposal for Academic Medical Centers." *Jama internal Medicine*

      95, no. 4 (2006): 429-433.

Bruning, Paul, and Timothy Baghurst, "Improving Ethical Decision Making in Health Care

      Leadership," *Bus Eco Journal* 4 (2013): e101.

Bryant, Clifton D. *Handbook of Death and Dying*. New York: SAGE, 2003.

Budziak, Sherry "Celebrating Associations: American College of Healthcare Executives."

      .orgCommunity. 31 Mar. 2016.

      https://celebratingassociations.wordpress.com/2016/03/31/celebrating-associations

      american-college-of-healthcare-executives/.

Buell, John M. "Ethics and Leadership: Setting the Right Tone and Structure Can Help Other in

      Their Decision Making." *Health Care Management* (2009): 53-57.

      https://www.ache.org/abt_ache/MA09_Ethics.pdf.

Buiting, Hilde, Johannes van Delden, Bregje Onwuteaka-Philpsen, Judith Rietjens, Mette Rurup,

      Donald van Tol, Joseph Gevers, Paul van der Maas, and Agnes van der Heide.

      "Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands:

Descriptive Study". *BMC Medical Ethics,* 10, No. 1 (2009): 1.

Burns, Elizabeth, and Stephen Law. "Philosophy For AS and A2." New York: Psychology

Press, 2004.

Byrne, Judi. *Palliative Care in Neurological Disease: A Team Approach*. Oxford: Radcliffe

Pub, 2009.

Byron C. Calhoun, et.al., "Cost Consequences of Induced Abortion as an Attributable Risk for

Preterm Birth and Impact on Informed Consent" *The Journal of Reproductive*

Medicine. 52 (2007): 929-937.

Byron C. Calhoun, "Preterm Birth Update." *The Linacre Quarterly*. (2012): 231.

Cameron, Kim. "Responsible Leadership as Virtuous Leadership." *Journal of Business Ethics*

98, no. 1 (2011): 25-35.

Cameron, Peter, George Jelinek, Anne-Maree Kelly, Lindsay Murray, and Anthony F T Brown.

Textbook of Adult Emergency Medicine E-Book. New York: Elsevier Health

Sciences, 2011.

Candy, Val, "Integrated Ethics Programs in the Healthcare Industry," *American Journal of*

Health Services 5, no. 1 (2014): 5.

Cantor, Michael D., Paul Barach, Arthur Derse, Claire W. Maklan, Ginger Schafer Wlody, and

Ellen Fox. "Disclosing Adverse Events to Patients." *The Joint Commission Journal on*

Quality and Patient Safety 31, no. 1 (2005): 5-12.

Caykoylu, Sinan, Carolyn P. Egri, Stephen Havlovic, and Christine Bradley. "Key

Organizational Commitment Antecedents for Nurses, Paramedical Professionals and

Non-Clinical Staff." *Journal of Health Organization and Management* 25, no. 1 (2011):

7-33.

Center for Bioethics, University of Minnesota. *End of Life Care: An Ethical Overview*.

     University of Minnesota, 2005.

Chao, DVK, NY Chan, and WY Chan, "Euthanasia Revisited," *Family Practice* 19, no. 2 (2002):

     128-134.

Chapple, Alison, S. Ziebland, A. McPherson, and A. Herxheimer. "What People Close to Death

     Say About Euthanasia and Assisted Suicide: A Qualitative Study." *Journal of Medical*

     Ethics 32.12 (2006): 706-710.

Cherny, Nathan I, and Nathan I Christakis. *Oxford Textbook of Palliative Medicine*. New York:

     Oxford University Press, 2011.

Chin, Arthur Eugene, Katrina Hedberg, Grant K. Higginson and David W. Fleming. *Oregon's*

     Death with Dignity Act: The First Year's Experience. Oregon Health Division, 1999.

Christopher K. *Complicity: Ethics and law for a collective age.* Cambridge: Cambridge

     University Press, 2007.

Churchill, Larry R., and N. M. King. "Physician-Assisted Suicide, Euthanasia, or Withdrawal of

     Treatment." *BMJ: British Medical Journal* 315, no. 7101 (1997): 137- 140.

Clarke, Patrick J. *Examining Philosophy and Ethics*. New York: Nelson Thornes, 2002.

Cohen-Almagor, Raphael. *Physician-Assisted Suicide – A Qualified Endorsement*. In *Health*

     Care, Bioethics and the Law. (Amsterdam Law Forum – VU University Amsterdam,

     2011), 116-126.

Cohen-Almagor, Raphael. "Euthanasia Policy and Practice in Belgium: Critical Observations

     and Suggestions for Improvement." *Issues in Law & Medicine* 24, No. 3, (2009): 190.

Cohen-Almagor, Raphael. "An Urgument for Physician-Assisted Suicide and against

     Euthanasia." *Ethics, Medicine and Public Health* 1, (2015): 438.

Cohen, J., Marcoux, I., Bilsen, J., Deboosere, P., van der Wal, G. and Deliens, L. "European Public Acceptance of Euthanasia: Socio-Demographic and Cultural Factors Associated with the Acceptance of Euthanasia in 33 European countries." *Social science & medicine*, *63*(3), (2006): 743-756.

Committee on Strategies for Responsible Sharing of Clinical Trial Data: *Discussion Framework for Clinical Trial Data Sharing. Guiding principles, elements, and activities.* Washington DC: National Academies Press, February 2015.

Crisp, Roger. "Medical Negligence, Assault, Informed Consent, and Autonomy." *Journal of Law and Society* 17, no. 1 (1990): 77-89.

Da Silva, Rudval Souza, Alvaro Pereira and Fernanda Carneiro Mussi. "Comfort for a Good Death: Perspective Nursing Staffs of Intensive Care." *Escola Anna Nery Revista de Enfermagen* 19, No. 1, (2015): 44-45

Daar, Abdallah S., and A. Khitamy. "Bioethics for clinicians: 21. Islamic bioethics." *Canadian Medical Association Journal* 164, no. 1 (2001): 60-63.

de Boer, Marike E., Cees MPM Hertogh, Rose-Marie Dröes, Cees Jonker, and Jan A. Eefsting. "Advance Directives in Dementia: Issues of Validity and Effectiveness." *International Psychogeriatrics* 22, no. 2 (2010): 201-208.

de Brantes, Francois and Conway, Patrick H. "Patient-Provider Conflict: The Perfect Environment," *NEJM Catalyst*, accessed March 17, 2018. https://catalyst.nejm.org/videos/patient-provider-conflict-perfect-environment/.

De Castro, Mariana, Guilherme Cafure Antunes, Livia Maria Pacelli Marcon, Lucas Andrade, Sarah Ruckl and Vera Angelo Andrade. "Euthanasia and Assisted Suicide in Western Countries: A Systematic Review." *Revista Bioetica.* 24, No. 2, (2016) 355.

Dehghani, Ali, Leila Mosalanejad, and Nahid Dehghan-Nayeri. "Factors Affecting Professional

    Ethics in Nursing Practice in Iran: A Qualitative Study." *BMC Medical Ethics* 16, no. 1

    (2015): 61-65.

Demir, Cesim, Bayram Sahin, Kadir Teke, Muharrem Ucar, and Olcay Kursun. "Organizational

    Commitment of Military Physicians." *Military Medicine* 174, no. 9 (2009): 929-935.

Demske, Gregory E. "Examining the Relationship between the Medical Device Industry and

    Physicians." *Hearing Before the Senate Special Committee on Aging*. Washington DC.

    (2008): 10.

Devettere, Raymond J.. *Practical Decision Making in Health Care Ethics: Cases, Concepts,*

    and the Virtue of Prudence. 4th ed. Georgetown: Georgetown University Press, 2016.

Devolder, Katrien, and John Harris. "Compromise and Moral Complicity in the Embryonic Stem

    Cell Debate." In *Philosophical Reflections on Medical Ethics*, (London: Palgrave

    Macmillan, 2005), 88-108.

Dierickx, Sigrid, Luc Deliens, Joachim Cohen, and Kenneth Chambaere. "Euthanasia in

    Belgium: Trends in Reported Cases Between 2003 and 2013." *Canadian Medical*

    Association Journal 188, no. 16 (2016): 3-10.

Dinstein, Yoram, and Fania Domb. *Israel Yearbook on Human Rights*. Leiden: Martinus Nijhoff

    Publishers, 2000.

Donna Dickenson: Me *medicine vs We medicine. Reclaiming biotechnology for the common*

    good. New York: Columbia University Press, 2013.

Donnellan Jr., John J., "A Moral Compass for Management Decision Making: A Healthcare

    CEO's Reflections," *Frontiers of health services management* 30, no. 1 (2013): 14-26.

Drazen JM. "Sharing Individual Patient Data from Clinical Trials. *New England Journal of*

Medicine; 372(3): (2015): 201-2.

Dworkin, Gerald. "Autonomy and Informed Consent." In *Ethical Health Care*, eds. Patrician

Illingworth and Wendy Parmet, (Upper Saddle River, NJ: Pearson Prentice-Hall,

Volume Three: Appendices (Studies on the Foundations of Informed Consent).

Washington, D.C.: The Commission; (1982): 63-81.

Dworkin, Ronald M. *Life's dominion: An argument about abortion, euthanasia, and

individual freedom*. Vintage, 1993

Dyer, Kirsti A. "Ethical Challenges of Medicine and Health on the Internet: A Review." *Journal

of Medical Internet Research* 3, no. 2 (2011). https://dx.doi.org/10.2196%2Fjmir.3.2.e23.

Eccles, Martin P., Jeremy M. Grimshaw, Paul Shekelle, Holger J. Schünemann, and Steven

Woolf. "Developing Clinical Practice Guidelines: Target Audiences, Identifying Topics

for Guidelines, Guideline Group Composition and Functioning and Conflicts of Interest."

Implementation Science 7, no. 1 (2012): 60.

Edger, Chris. *Professional Area Management*. Faringdon, Oxfordshire: Libri Publishing, 2014.

Edwards, Steven D. "Is There a Distinctive Care Ethics?" *Nursing Ethics* 18, no. 2 (2011):

91-184.

Ekeke, Emeka C. and Ephraim A. Ikegbu. "The Sanctity of Human Life in the Twenty First

Century: The Challenge of Euthanasia and Assisted Suicide." *Educational Research*.

1, No. 9, (2010): 312.

Elizabeth J., Forrestal, and Leigh. *Ethics and Professionalism for Healthcare Managers*.

Chicago, IL: Health Administration, 2016.

Emanuel, Ezekiel J. "What Is the Great Benefit of Legalizing Euthanasia of Physician-

Assisted Suicide?" *Ethics*. 109, No. 3, (1991): 629.

Emanuel, Ezekiel J., Bregje D. Onwuteaka-Philipsen, John W. Urwin and Joachim Cohen. "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe." *JAMA Internal Medicine* 316, No. 1, (2016): 79.

Emanuel, Ezekiel J., Elisabeth R. Daniels, Diane L. Fairclough, and Brian R. Clarridge. "The Practice of Euthanasia and Physician-Assisted Suicide in The United States: Adherence to Proposed Safeguards and Effects on Physicians." *Jama Internal Medicine* 280, no. 6 (1998): 507-513.

Emanuel, Linda L. "Ethics and the Structures of Healthcare." *Cambridge Quarterly Of Healthcare Ethics* 9, no. 02 (2015): 1234-1238.

Entwistle, Vikki A., Stacy M. Carter, Alan Cribb, and Kirsten McCaffery. "Supporting Patient Autonomy: The Importance of Clinician-Patient Relationships." *Journal of General Internal Medicine*, 25, 7, (2010): 741-745.

Epstein, Ronald M., and Richard L. Street. "The Values and Value of Patient-Centered Care." (2011): 100-103.

Filerman, Gary L., Ann E. Mills, Paul M. Schyve, eds. *Managerial Ethics in Healthcare: A New Perspective*. Chicago IL: Health Administration Press, 2014.

Finer LB, Henshaw SK. "Disparities In Rates of Unintended Pregnancy in The United States, 1994 and 2001." *Perspectives on Sexual & Reproductive Health* 2006; 38(2):90 -98.

Flite, Cathy A., and Laurinda B. Harman. "Code of Ethics: Principles for Ethical Leadership." *Perspectives in Health Information Management/AHIMA, American Health Information Management Association* 10.Winter (2013): 1-11.

Forbes, Dorothy, Emily J. Thiessen, Catherine M. Blake, Scott C. Forbes, and Sean Forbes. "Exercise Programs for People with Dementia." *Cochrane Database System Review* 12.0

(2013). http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD006489.pub4/full

Fraser, Sharon I., and James W. Walters. "Death-Whose Decision? Euthanasia and the
Terminally Ill." *Journal of Medical Ethics* 26, no. 2 (2000): 121-125.

Gabriele, Edward F. "Ethics Leadership in Research, Healthcare and Organizational Systems:
Commentary and Critical Reflections." *Journal of Research Administration* 42, no. 1
(2011): 88-102. http://files.eric.ed.gov/fulltext/EJ955014.pdf.

Galliher, James M. and John F. Galliher. "Criminology: A "Commonsense" Theory of
Deterrence and the "Ideology" of Science: The New York State Death Penalty Debate."
Journal of Criminal Law & Criminology 92, No. 307, (2002): 1.

Garrard, E. "Passive Euthanasia". *Journal of Medical Ethics* 31, No. 2, (2005): 64.

Gelman, Sheldon. "Life and Liberty: Their Original Meaning, Historical Antecedents, and
Current Significance in the Debate over Abortion Rights." *Minnesota Law Review,*
78, (1993): 585-588.

Gentzler, Jyl. "What Is a Death with Dignity?" *Journal of Medicine and Philosophy* 28, No. 4,
(2003): 478.

Gert, Bernard, Charles M. Culver, and K. Danner Clouser. *Bioethics: A systematic approach*.
Oxford University Press, USA, 2006.

Gill, Robin. *Health care and Christian ethics*. Cambridge University Press, 2006.

Gini, A. R., and David Ozar. "Appendix 1: Patricia H. Werhane's Publications." *The Moral
Imagination of Patricia Werhane: A Festschrift* 47 (2018): 94-95.

Givens, Jane L., and Susan L. Mitchell. "Concerns about End-Of-Life Care and Support for
Euthanasia". *Journal of Pain and Symptom Management*. 38, No. 2, (2009): 170.

Goel, Vaibhav. "Euthanasia – A Dignified End of Life!" *International NGO Journal* 3, No. 12,

(2008): 224-231.

Gorsuch, Neil M.. *The Future of Assisted Suicide and Euthanasia*. Princeton, N.J.:

    Princeton University Press, 2009.

Gray, Carol, and Jenny Moffett.. *Handbook of Veterinary Communication Skills*. New York,

    NY: John Wiley & Sons, 2013.

Green-Pedersen, Christoffer. "The Conflict of Conflicts in Comparative Perspective: Euthanasia

    as a Political Issue in Denmark, Belgium, and the Netherlands." *Comparative Politics*

    (2007): 273-291.

Gregory M. *Complicity and moral accountability*. Notre Dame, Indiana: University of Notre

    Dame, 2006.

Grewal, Bhajneek, Jennifer Harrison and David Jeffrey. "Licensed to Kill – The Impact of

    Legalizing Euthanasia and Physician Assisted Suicide on the Training of UK Medical

    Students." *Scottish Universities Medical Journal* 1, No. 1, (2012): 8.

Griffiths, John, Heleen Weyers, Maurice Adams, and Maurice Adams. *Euthanasia and law in

    Europe*. Oxford and Portland: Hart, 2008.

Groenhout, Ruth, E. *Connected Lives: Human Nature and an Ethics of Care*. New York: Rowan

    and Littlefield, 2004.

Grumbach, Kevin, and Thomas Bodenheimer. "Can Health Care Teams Improve Primary

    Carepractice?." *Jama Internal Medicine*, 291, No. 10, (2004): 1246-1251.

Guttmacher Institutes. "Induced Abortion Worldwide." *In Brief* , World Health Organization ,

    2012,

www.who.int/reproductivehealth/publications/unsafe_abortion/induced_abortion_2012.pdf.

H.A.M.J. Ten Have & M.S. Jean (eds.): *The UNESCO Universal Declaration on Bioethics*

and Human Rights. Background, principles and application. Paris: UNESCO Publishing, 2009.

Hackland, Stuart, and Christopher Stein. "Factors Influencing the Departure of South African Advanced Life Support Paramedics from Pre-Hospital Operational Practice." *African Journal of Emergency Medicine* 1, no.2 (2011): 62-68.

Hall, Daniel E, Allan V. Prochazka, and Aaron S. Fink, "Informed Consent for Clinical Treatment," *Canadian Medical Association Journal* 184, no. 5 (2012): 533-540.

Hallliday, S, "Protecting Human Dignity: Reframing the Abortion Debate to Respect the Dignity of Choice and Life," *Contemporary Issues in Law* 13, no. 4 (2016): 287-322.

Hardwig, John. *Is there a Duty to Die?: And other Essays in Bioethics*. New York: Routledge, 2014.

Harigovind, P.C. "Sanctity of Human Life: Glimpses of Ethical and Jurisprudential Aspects." *International Journal of Humanities and Social Science Invention*. 2, No. 4, (2013): 1.

Harris, John. "Consent and End of Life Decisions." *Journal of Medical Ethics*. 29, No. 1, (2003): 10.

Held, Virginia. *The Ethics of Care. Personal, Political, and Global*. Oxford: Oxford University Press, 2006.

Helen W. ed. *Cooperation,Ccomplicity, & Conscience. Problems in healthcare, science, law, and public policy*. London: The Linacre, 2005.

Henk ten Have, M. D., Jos VM Welie, and J. D. MMedS. "Palliative Sedation Versus Euthanasia: An Ethical Assessment." *Journal of Pain and Symptom Management,* 47, No. 1, (2014): 123-124.

Hicks, Madelyn Hsiao-Rei. "Physician-Assisted Suicide: A Review of the Literature

    Concerning Practical and Clinical Implications for UK Doctors". *BMC Family*

    Practice 7, No. 1, (2006): 2.

Higgins, Wayne. "Ethical Guidance in the Era of Managed Care: An Analysis of the American

    College of Healthcare Executives' Code of Ethics." *Journal of Healthcare*

    Management 45, no. 1 (2000): 32-42.

Ho, Anita, and Stephen Pinney. "Redefining Ethical Leadership in a 21st-century Healthcare

    System." In *Healthcare Management Forum* 29, no. 1. (Sage CA: Los Angeles, CA:

    SAGE Publications, 2016): 39.

Hodge Jr, JG, Lawrence OG, and Jacobson PD: "Legal Issues Concerning Electronic Health

    Information: Privacy, Quality, and Liability." *Jama* Internal Medcine 282(15) (1999):

    1466-1471.

Howarth, Glennys, and Oliver Leaman. *Encyclopedia of Death and Dying*. New York:

    Routledge, 2003.

Hughes, Julia and Jill Common. "Ethical Issues in Caring for Patients with Dementia." *Nursing*

    Standard 29, no. 49 (2015): 45.

Institute of Medicine. *Sharingclinical trial data: Maximizing benefits, minimizing risk.* The

    National Academies Press, Washington DC, January 2015

    (http://www.nap.edu/openbook.php?record_id=18998).

Jagsi, Reshma, "Conflicts of Interest and the Physician-Patient Relationship in the Era of Direct

    to-Patient Advertising," *Journal of Clinical Oncology* 25, no. 7 (2007): 902-905

Jaishankar, K, and Natti Ronel. *Third International Conference of the South Asian Society*

    of Criminology and Victimology (SASCV), 28-29, January 2016, Goa, India: SASCV

Proceedings. Mumbai: Jaishankar. (2016): 49.

Janssens, Louis. "Artificial Insemination: Ethical Considerations." *Louvain Studies,* 8, no. 1
(1980): 3-29.

Jewell, Paul. *Rationality, Euthanasia, and the Sanctity of Life*. Australian Association for
Professional and Applied Ethics, 12th Annual Conference in Adelaide Held on (28-30
September 2005): 1-7.

John M. Thorp, Jr., "Public Health Impact of Legal Termination of Pregnancy in the US. 40
Years Later," *Scientific* (2012): 5

Johnson, Craig E. *Organizational Ethics: A Practical Approach*. Thousand Oaks, CA: SAGE
Publications Inc., 2015.

Jones, David Albert. "How Does Legalization of Physician-Assisted Suicide Affect Rates of
Suicide?" *Southern Medical Journal* 108, No. 10, (2015): 602.

Jones, Rachel K, Ushma D. Upadhyay, and Tracy A. Weitz, "At What Cost? Payment for
Abortion Care by US Women," *Women's Health Issues* 23, no. 3 (2013): e173-e178.

Jonsen, Albert R. *A short history of medical ethics*. Oxford University Press, 2000.

Jonsen, Albert R. *The birth of bioethics*. Oxford University Press, 2003.

Joseph, Jay. "The 1942 'Euthanasia' Debate in the American Journal of Psychiatry." *History
of Psychiatry*. 16, No. 2, (2005): 173.

Kai, Katsunori. "Euthanasia and Death with Dignity in Japanese Law." *Waseda Bulletin of
Comparative Law* 27, (2008): 1.

Kakuk, Peter, and Andrea Domján. "Healthcare Financing and Conflict of Interests In Hungary."
Cambridge Quarterly of Healthcare Ethics 22, no. 03 (2013): 263-270.

Kälvemark, Sofia, Anna T. Höglund, Mats G. Hansson, Peter Westerholm, and Bengt Arnetz.

"Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System."
Social Science & Medicine 58, no. 6 (2004): 1075-1084.

Kangasniemi, Mari, Piiku Pakkanen, and Anne Korhonen. "Professional Ethics in Nursing: An
Integrative Review." *Journal of Advanced Nursing* 71, no. 8 (2015): 1744-1757.

Kant, Immanuel. *The Metaphysical Elements of Ethics*. 1st ed. Lanham: Dancing Unicorn Books,
2016.

Kaposy, Chris. "Two Stalemates in the Philosophical Debate about Abortion and Why They
Cannot be Resolved using Analogical Arguments." *Bioethics* 26, no. 2 (2012): 84-92.

Karsten, Margo. "Patient Safety: Commitment versus Compliance". *Nurse Leader* 9, no. 4
(2011): 47-49. doi:10.1016/j.mnl.2010.12.003.

Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic health care ethics*.
Washignton DC: Georgetown University Press, 2013.

Keown, Damien V. "Buddhism, Brain Death and Organ Transplantation." *Journal of Buddhist
Ethics* 17 (2010): 10-73.

Keown, Damien. "End of Life: the Buddhist View." *The Lancet* 366, No. 9489, (2005): 952.

Keown, John. *Euthanasia, Ethics, and Public Policy: An Argument against Legalisation*.
Cambridge: Cambridge University Press, 2002.

Keown, John. "The Legal Revolution: From 'Sanctity of Life' to 'Quality of Life' and
'Autonomy'". *Journal of Contemporary Health Law & Policy* 14, No. 2, (1998): 253.

Khader, M. M., and M. T. Mrayyan. "The Use of Palliative Sedation for Terminally Ill
Patients: Review of the Literature and an Argumentative Essay." *Journal Palliative
Care Medicine* 5, No. 226, (2015): 3-4.

Khan, Farooq, and George Tadros. "Physician-Assisted Suicide and Euthanasia in Indian

Context: Sooner or Later the Need to Ponder!". *Indian Journal of Psychological Medicine* 35, No. 1, (2013): 102

Khan, SI and Abu SL. "Digital health data: A comprehensive Review of Privacy and Security Risks and Some Recommendations." *Computer Science Journal of Moldova* 2016; 24(2): (2016): 273-292.

Killeen, Jan. "Dementia Autonomy and Decision-Making: Putting Principles into Practice." *Edinburgh: Alzheimer Scotland* (2012): 1-28.

Kimsma, Geritt K., and Evert van Leeuwen. "The Role of the Family in Euthanasia Decision Making." *HEC Forum*. 19. No. 4. Springer Netherlands, (2007): 365-373.

Knoppers BM, Harris JR, Budin-Ljøsne I, and Dove ES. "A Human Rights Approach to an International Code of Conduct for Genomic and Clinical Data Sharing." *Human Genetics* 133(7): (2014): 895-903.

Kost, K., Henshaw, S., & Carlin, L . *U. S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends and Trends by Race and Ethnicity*. Retrieved January 26, 2010, from http://www.guttmacher.org/pubs/USTP-trends.pdf

Kübler-Ross, Elisabeth, Stanford Wessler, and Louis V. Avioli. "On Death and Dying." *Jama Internal Medicine* 221, no. 2 (1972): 174-179

Kuhse, Helga, Udo Schüklenk, and Peter Singer. *Bioethics: An Anthology*. Hoboken: John Wiley & Sons, 2015.

Kuther, TL: "Medical Decision-Making and Minors: Issues of Consent and Assent." *Adolescence* 38(150): (2003): 343-358.

Lachman, Vicki D. *Ethical Challenges in Health Care: Developing Your Moral Compass*. Berlin Germany: Springer Publishing Company, 2009.

Lane, J, and Schur I: "Balancing access to Health Data and Privacy: A Review of the Issues and Approaches for the Future." *Health Services Research*; 45(5p2): (2010): 1456-1467.

Lang, T: "Advancing Global Health Research Through Digital Technology and Sharing Data." *Science*; 331 (2011): 714-717.

Laric, MV and Dennis AP: "Preserving Patient Privacy in the Quest for Health Care Economies." *The Journal of Consumer Marketing*; 26(7): (2009): 477-486.

Lawler, Patricia A. "The ACHE Code of Ethics: Its Role for the Profession." *The Journal of American College of Healthcare Executives* 48, no. 3 (2000): 31-34.

Leechaianan, Yingyos and Dennis R. Longmire. "The Use of the Death Penalty for Drug Trafficking in the United States, Singapore, Malaysia, Indonesia and Thailand: A Comparative Legal Analysis." *Laws* 2, (2013): 115.

Lemmens, Trudo and Bernard Dickens. "Canadian Law on Euthanasia: Contrasts and Comparisons." *European Journal of Health Law*. 8, (2001): 137.

Lere, John C., and Bruce R. Gaumitz, "The Impacts of Code of Ethics on Decision-Making: Some Insights from Information Economics," *Journal of Business Ethics* 48, no. 4 (2003): 367-379.

Lewins, Frank W. *Bioethics for Health Professionals*. South Melbourne: Macmillan Education Australia, 1996.

Limentani, Alexander E, "An Ethical Code for Everybody in Health Care: The Role and Limitations of Such a Code Need to be Recognized," *British Medical Journal* 316, no. 7142 (1998): 1458.

Lo, Bernard, and Marilyn J. Field. *Conflict of Interest in Medical Research, Education, and Practice.* Washington, D.C.: National Academies Press. 2009.

Lo, Bernard. "Euthanasia in the Netherlands." *Bioethics: An Anthology* (2015): 377-378.

Lopez, Raquel, "Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in Between,
European Journal of Social Sciences 27, no. 4 (2012): 511-517.

Louise Corti, Veerle Van den Eynden, Libby Bishop and Matthew Woollard. *Managing and
sharing research data: A guide to good practice*. London: SAGE Publication, 2014.

L.G. Johnson, et al. "The Relationship of Placenta Previa and History of Induced Abortion," 81
Int'l J. Gynecology & Obstetrics (2002): 191.

Mackler, Aaron L. *Introduction to Jewish and Catholic bioethics: A Comparative Analysis.*
Gorgetown University Press, 2003.

MacLeod, Rod Duncan, Donna M Wilson, and Phillipa Malpas. "Assisted or Hastened Death:
The Healthcare Practitioner's Dilemma". *Global Journal of Health Science* 4, No. 6,
(2012): 87

Magnusson, Roger S. The Sanctity of Life and the Right to Die: "Social and Jurisprudential
Aspects of the Euthanasia Debate in Australia and the United States." *Pacific Rim Law
& Policy Journal* 6, No. 1, (1997): 9.

Major B, Appelbaum M, Beckman L, et al. Report of the APA Task Force on Mental Health
and Abortion, *American Psychological Association, Task Force on Mental Health and
Abortion.* (Washington, DC, 2008): 1

Malik, Mohammad Manzoor. *Indispensability of enhancing palliative care and rebuttal of
utilitarian autonomy argument for euthanasia.* In: 14th Asian Bioethics Conference:
Ethics in Emerging Technologies to Make Lives Better together, Chennai, India, (19-23
Nov. 2013): 10-15.

Maltoni, M., C. Pittureri, E. Scarpi, L. Piccinini, F. Martini, P. Turci, L. Montanari, O. Nanni,

and D. Amadori. "Palliative Sedation Therapy Does not Hasten Death: Results from a

    Prospective Multicenter Study." *Annals of Oncology* 20, no. 7 (2009): 1164.

Marc A. Rodwin. *Conflicts of Interest and the Future of Medicine: The US, France, and Japan*.

    Vol. 392. Oxford: Oxford University Press, 2011.

Mary JM. *Can a health care market be moral? A Catholic vision*. Washington, D.C.:

    Georgetown University Press, 2007.

Masters, Kathleen. *Role development in professional nursing practice*. Burlington: Jones &

    Bartlett Publishers, 2015.

Matiti, Milika R., and Gillian M. Trorey. "Patients' Expectations of the Maintenance of Their

    Dignity." *Journal of Clinical Nursing,* 17, No. 20. (2008): 2709-2717.

McGregor, Joan. "Consent and Autonomy." In *Is it Rape?* (London: Routledge, 2017), 113-148.

    https://www.taylorfrancis.com/books/e/9781351926157/chapters/10.4324%2F97813152

        1806-10.

Meier, Diane E., Carol-Ann Emmons, Sylvan Wallenstein, Timothy Quill, R. Sean Morrison

    and Christine K. Cassel. "A National Survey of Physician-Assisted Suicide and

    Euthanasia in the United States." *The New England Journal of Medicine* 338, No. 17,

    (2009): 1200.

Memarian, Robabeh, Mahvash Salsali, Zohreh Vanaki, Fazlolah Ahmadi, and Ebrahim

    Hajizadeh. "Professional Ethics as an Important Factor in Clinical Competency in

    Nursing." *Nursing Ethics* 14, no. 2 (2007): 203-214.

Meyers, Diana T. *Poverty, Agency, and Human Rights*. Oxford: Oxford University Press, 2014.

Min, Soon. and Hye Sook Kim. "Effects of Nurse's Organizational Conflict on Organizational

    Commitment and Labor Union Commitment In University Hospitals." *Journal of Korean*

Academy of Nursing Administration 18, no. 4 (2012): 374.

Mitchell, Susan L. "Palliative Care of Patients with Advanced Dementia." *UpToDate* (2014). http://www.uptodate.com/contents/palliative-care-of-patients-with-advanced-dementia.

Mitchell, Susan L., Black Betty S., Ersek, Mary RN, Hanson, Laura C., Miller Susan C., Sachs, Greg A Teno, Joan M and Morrison, Sean R. "Advanced Dementia: State of the Art and Priorities for the Next Decade." *Annals of Internal Medicine* 156, no. 1 (2012): 45 51.

Modjarrad, K, Vasee SM, Piers M, Pierre-Stéphane G, Roth C and Kieny M: "Developing

Global Norms for Sharing Data and Results During Public Health Emergencies." *PLoS Medicine,* 13 (1) (2016): e1001935.

Mohanti, Bidhu K. "Ethics in palliative care." *Indian journal of palliative care* 15, no. 2 (2009): 89-92.

Morrison, Eileen E., and John F. Monagle. *Health Care Ethics: Critical Issues for the 21st Century*. Sudbury, Mass: Jones and Bartlett Publishers, 2009.

Mosadeghrad, Ali Mohammad, and Masoud Ferdosi. "Leadership, Job Satisfaction and Organizational Commitment in Healthcare Sector: Proposing and Testing a Model." *Materia Socio-Medica* 25, no. 2 (2013): 121.

Mosher WD, Martinez GM, Chandra A et al. *Use of Contraception and Use of Family Planning Services in the United States: 1982-2002*. [Advance Data, no. 350]. Hyattsville MD: National Center for Health Statistics, 2004.

Mullner, Ross M., ed. *Encyclopedia of Health Services Research*. Thousand Oaks CA: Sage, 2009.

Musto, Lynn C., Patricia A. Rodney, and Rebecca Vanderheide. "Toward Interventions to

Address Moral Distress: Navigating Structure and Agency." *Nursing Ethics* 22.1 (2015): 91-102.

Muth, Christopher C. "Conflict of Interest in Medicine." Jama Internal Medicine3 17, no. 17 (2017):1812-1812. doi:10.1001/jama.2017.4044.

Loucks N., S. Smith Holt. *Why We Kill: Understanding Violence Across Culture And Disciplines*. New York: Taylor & Francis, 2009.

Nathan, Rae. "Is Euthanasia Morally Permissible? Why or Why Not?" *Sound Decisions: An Undergraduate Bioethics Journal,* 1, No. 1, (2015): 4.

Nelson, William A. "Conflicts of interest. Clarity, transparency, action are keys to maintaining trust, avoiding conflicts." *Healthcare executive* 24, no. 2 (2008): 42-44.

Nitschke, Philip. "The Role of Religion in Assisted Suicide and Voluntary Euthanasia Laws," *The New York Times,* April 10, 2012. https://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/the-role-of-religion-in-assisted-suicide-and-voluntary-euthanasia-laws.

Noddings, Nel. *Caring: A relational approach to ethics and moral education*. Oakland: University of California Press, 2013.

Nordenfelt, Lennart. "The Varieties of Dignity." *Health care analysis* 12, No. 2, (2004): 69-81.

Nunes, Rui and Guilhermina Rego. "Euthanasia: A Challenge to Medical Ethics." *Journal of Clinical Research & Bioethics* 7, No. 4, (2016): 3.

Nussbaum, Martha, and Rosalind Dixon. "Abortion, dignity, and A Capabilities Approach." *Feminist Constitutionalism: Global Perspectives* (December 1, 2013): 4.

O'Neill, Onora. "Some Limits of Informed Consent." *Journal of medical ethics* 29, no. 1 (2003): 4-7.

O'Malley, Ann S., Anna Collins, Kara Contreary, and Eugene C. Rich. "Barriers to and

    Facilitators of Evidence-Based Decision Making at the Point of Care: Implications for

    Delivery Systems, Payers, and Policy Makers." MDM Policy & Practice 1, no. 1 (2016):

    1-12 2381468316660375.

Olukunle, O.A. "Religion and Euthanasia." *Orita: Ibadan Journal of Religious Studies* 16, no. 1

    (2008): 54-66.

Orr, Robert D. "The Role of Moral Complicity in Issues of Conscience." *The American Journal*

    of Bioethics 7, no. 12 (2007): 23-24.

Pal, Ms. Ranabir Pal. "Disclosure of Conflict of Interest." *International Journal Of*

    Healthcare Education & Medical Informatics 4, no. 1 (2017): 1-2.

    doi:10.24321/2455.9199.201704.

Papoutsi, C, Julie ER, Cicely M, Lewis M, Majeed A, and Bell D: "Patient and public views

    about the security and privacy of Electronic Health Records (EHRs) in the UK: results

    from a mixed methods study." *BMC Medical Informatics & Decision Making* (2015):

    1-15.

Parker, Malcolm. "Moral Intuition, Good Deaths and Ordinary Medical Practitioners."

    Journal of Medical Ethics. Vol. 16, (1990): 30.

Patil, Yuvraj Dilip and Ajeenkya D.Y. Patil. "Euthanasia and Death with Dignity." *Journal of*

    Krishna Institute of Medical Sciences University 5, No. 3, (2016): 143.

Patricia Backlar. "Managed Mental Health Care: Conflicts of Interest in the Provider/Client

    Relationship." *Community Mental Health Journal* 32, no. 2 (1996): 102.

Patrick, Donald L., Ruth A. Engelberg and J. Randall Curtis. "Evaluating the Quality of Dying

    and Death." *Journal of Pain and Symptom Management* 22, No. 3, (2001): 718.

Paul Farmer: *Pathologies of power. Health, human rights, and the new war on the poor*.

> Berkeley/Los Angeles/London: University of California Press, 2005.

Pazol K, Zane SB, Parker WY et al. "Abortion surveillance, United States 2007." *MMWR*

> *Surveillance Summaries* (2011): 60 (SS 1): 1-39;

> http://www.cdc.gov/mmwr/pdf/ss/ss6001.pdf .

Pellegrino, Edmund D. "Patient and Physician Autonomy: Conflicting Rights and Obligations in

> the Physician-Patient Relationship." *Journal of Contemporary Health Law. & Policy* 10

> (1994): 47.

Pellegrino, Edmund D. "Societal Duty, and Moral Complicity: The Physician's Dilemma of

> Divided Loyalty." *International Journal of Law and Psychiatry* 16, no. 3-4 (1993): 371

> 391.

Pereira, J. "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and

> Controls". *Current Oncology* 18, No. 2, (2011): e38.

Perrett, Roy W. "Buddhism, Euthanasia and the Sanctity of Life." *Journal of Medical Ethics*.

> 22, (1996): 310.

Philip JB & David EG et al. *Organizational Ethics in Health Care*. Hoboken MA: Jossey-Bass:

> Wiley & Sons, 2001.

Pierre, Joseph M. "Culturally Sanctioned Suicide: Euthanasia, Seppuku, and Terrorist

> Martydom." *World Journal of Psyhiatry* 5, no. 1, (2015): 5.

Post, Linda Farber. *Handbook for Health Care Ethics Committees*. Washington DC: Johns

> Hopkins University Press, 2015.

Press, Daniel, and Michael Alexander. "Management of Neuropsychiatric Symptoms of

> Dementia." *UpToDate* (2014). http://www.uptodate.com/contents/management-of-

neuropsychiatric-symptoms-of-dementia.

Press, Daniel, and Michael Alexander. "Safety and Societal Issues Related to Dementia."
UpToDate (2014). http://www.uptodate.com/contents/safety-and-societal-issues-
related-to-dementia.

Press, Daniel, and Michael Alexander. "Treatment of Dementia." *UpToDate* (2014).
http://www.uptodate.com/contents/treatment-of-dementia.

Propp et al. "Meeting the Complex Needs of the Health Care Team: Identification of Nurse-team
Communication Practices Perceived to Enhance Patient Outcomes." *Qualitative Health
Research* 20, No. 1, (2010): 15-28.

Purtilo, Ruth B. and Henk ten Have, eds. *Ethical Foundations of Palliative Care for
Alzheimer Disease*. Baltimore: Johns Hopkins University Press, 2004.

Purvis, Taylor E. "Debating Death: Religion, Politics, and the Oregon Death with Dignity
Act." *Yale Journal of Biology and Medicine* 85, (2012): 271.

Qin, B, Deng, H, Wu, Q, Domingo-Ferrer, J, Naccache, D, & Zhou, Y: 'Flexible attribute-based
encryption applicable to secure e-healthcare records'. *International Journal of
Information Security*; 14(6): (2015): 499-511.

QURAN: The Final Testament. Universal Unity, 2000.

Rabiu, Aldul-Rasheed and Kapil Sugand. "Has the Sanctity of Life Law 'Gone Too Far'?:
Analysis of the Sanctity of Life Doctrine and English Case Law Shows That the
Sanctity of Life Law Has Not 'Gone Too Far'." *Philosophy, Ethics, and Humanities
in Medicine* 9, No. 5, (2014): 1-3.

Raghupathi, W, and Viju R: "Big Data Analytics in healthcare: Promise and Potential." *Health
information science and systems*; 2(1): (2014): 3-13.

Riggio, Ronald E., Weichun Zhu, Christopher Reina, and James A. Maroosis. "Virtue-based Measurement of Ethical Leadership: The Leadership Virtues Questionnaire." *Consulting Psychology Journal: Practice and Research* 62, no. 4 (2010): 235.

Rispel, Laetitia C., Duane Blaauw, Tobias Chirwa, and Katinka de Wet. "Factors Influencing Agency Nursing and Moonlighting among Nurses in South Africa." *Global Health Action* 7, no. 1 (2014): 23585. doi: 10.3402/gha.v7.23585

Rivero-García, A, Iván S, Candelaria H, Pino C, and Moti Y: "Patients' Data Management System Protected by Identity-based Authentication and Key Exchange." *Sensors (14248220)* 17(4): (2017): 1-16.

Robinson, D. "Confronting biopiracy. Challenges, cases and international debates. Earthscan" London/New York, (2010/2012).

Romain, Paul L. "Conflicts of Interest in Research: Looking out for Number One means Keeping the Primary Interest front and Center." *Current Reviews in Musculoskeletal Medicine* 8, no. 2 (2015): 122-127.

Rosenbaum, S: "Data governance and stewardship: Designing Data Stewardship Entities and Advancing Data Access." *Health Services Research*; 45(5p2) (2014): 1442-1455.

Rosenblatt M, Jain SH and Cahill M. "Sharing of Clinical Trial Data: Benefits, Risks, and Uniform Principles." *Annals of Internal Medicine*; 162(4): (2015): 306-7.

Rothstein, MA: "The End of The HIPAA Privacy Rule?." *Journal of Law, Medicine & Ethics*; 44, 2 (2016): 352-358.

Salkind, Neil J. *Encyclopedia Of Human Development*. Thousand Oaks, Calif.: Sage Publications, 2007.

Sanbar, Shafeek S. *Legal Medicine*. New York: Elsevier Health Sciences, 2017. 246.

Santelli J, Ott MA, Lyone M et al. "Abstinence and Abstinence-only Education: A Review of

U.S. Policies and Programs." *Journal of Adolescent Health* (2006): 72-81.

Sara E. Davies: *Global politics of health*. Malden, MA: Polity Press, 2010.

Saunders, B, Kitzinger, J, and Kitzinger, C: "Anonymising Interview Data: Challenges and

Compromise in Practice." *Qualitative Research*; 15(5): (2015): 616-632.

Sawicki, Nadia N, "The Abortion Informed Consent Debate: More Light, Less Heat", *Cornell JL

& Pub. Pol'y* 21 (2011): 19.

Schneider, Carl E. "Rights Discourse and Neonatal Euthanasia." *California Law Review* 76,

No. 1 (1988): 151-176

Schofferman, Jerome A., Marjorie L. Eskay-Auerbach, Laura S. Sawyer, Stanley A. Herring,

Paul M. Arnold, and Eric J. Muehlbauer. "Conflict of Interest and Professional Medical

Associations: The North American Spine Society experience." *The Spine Journal* 13, no.

8 (2013): 974-979.

Secretariat of Pro-Life Activities. *Assisted Suicide and Euthanasia: Beyond Terminal Illness*.

U.S. Conference of Catholic Bishops. (2014): 2.

Sedgh G, Singh S, Henshaw S et al. "Induced Abortion: The Global reality and Avoidable

Risks." Lance t (2007): 1887-1892.

Selling, Joseph. "Is a Personalist Ethic Necessarily Anthropocentric?" *Ethical Perspectives*,

6, no. 1 (1999): 60-66.

Sercu, Marij, Peter Pype, Thierry Christiaens, Maria Grypdonck, Anselme Derese, and

Myriam Deveugele. "Are General Practitioners Prepared to End Life on Request in a

Country Where Euthanasia is Legalized?." *Journal of medical ethics* (2012): 2-10.

Severs, Sjef. "Euthanasia: Law and Practice in the Netherlands." *British Medical Bulletin* 52, No.

2, (1996): 327.

Shadigian, Elizabeth. "*Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion"*, testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (September 21, 2005): 1-5.

Shale, Suzanne. *Moral leadership in medicine: Building Ethical Healthcare Organizations*. Cambridge UK: Cambridge University Press, 2011.

Sinclair, Christian T., and Richard C. Stephenson. "Palliative sedation: assessment, management, and ethics." *Hospital Physician,* Vol. 42, No. 3, (2006): 36-37.

Singer, Peter. *Practical Ethics*. New York: Cambridge University Press. 2011.

Singh, Subbash Chandra. "Euthanasia and Assisted Suicide: Revisiting the Sanctity of Life Principle." *Journal of the Indian Law Institute* 54, No. 2, (2012): 196 –197.

Slomka, Jacquelyn, Beth Quill, MaryDesvigness-Kendrick, and Linda E. Lloyd. "Professionalism and Ethics in the Public Health Curriculum." *Public Health Reports* 123, no. 2_suppl (2008): 27-35.

Smebye, Kari Lislerud, Marit Kirkevold, and Knut Engedal. "Ethical Dilemmas Concerning Autonomy When Persons with Dementia Wish to Live at Home: A Qualitative, Hermeneutic study." *BMC health services research* 16.1 (2015): 21.

Smith, Stephen W. *End-Of-Life Decisions in Medical Care: Principles and Policies for Regulating the Dying Process*. Cambridge: Cambridge University Press. 2012.

Soh, Tze Ling Gwendoline Beatrice, Lalit Kumar Radha Krishna, Shin Wei Sim, and Alethea Chung Peng Yee. "Distancing Sedation in End-of-Life Care from Physician-Assisted Suicideand Euthanasia." *Singapore medical journal*57, no. 5 (2016): 220-221.

Somerville, Margaret A. *Death Talk*. New York: McGill-Queen's Press, 2001.

Squellati, Robin. "Ethical Challenges in Health Care: Developing Your Moral Compass." *CN* 17, no. 2 (2011): 106.

Steinberg, Donald R. "Limits to Death with Dignity." *Harvard Journal of Law and Technology* 1, (1988): 129.

Sterckx, Sigrid, Kasper Raus, and Freddy Mortier. *Continuous Sedation at the End of Life: Ethical, Clinical and Legal Perspectives*. New York: Cambridge University Press, 2013.

Strinic, Vinsja, "Arguments in Support and Against Euthanasia" *British Journal of Medicine & Medical Research* 9, no. 7 (2015): 1-12.

Sugarman, Jeremy, and Daniel P. Sulmasy. *Methods in medical ethics*. Washignton DC: Georgetown University Press, 2010.

Sulmasy, Daniel P. "Informed Consent without Autonomy." *Fordham Urb. LJ* 30 (2002): 207.

Summers, Jim, and E. Morrison. "Principles of Healthcare Ethics." *Health Care Ethics*. 2nd ed. Sudbury: Jones and Bartlett Publishers. (2009): 41-58.

Swick, Herbert M., Charles S. Bryan, and Lawrence D. Longo. "Beyond the Physician Charter: Reflections on Medical Professionalism." *Perspectives in Biology and Medicine* 49, No. 2, (2006): 263-275.

Ter Meulen, Ruud. "Ethics of Care." In *The Sage Handbook of Health Care Ethics: Core and Emerging Issues*, edited by Ruth Chadwick, Henk and Eric M. Meslin, London: SAGE Publications Ltd, 2011.

Thompson, Dennis Frank. *Restoring Responsibility: Ethics in Government, Business, and Healthcare.* Cambridge: Cambridge University Press, 2005.

Tronto, Joan C. *Moral Boundaries. A Political Argument for an Ethic of Care*. New York: Routledge, 1993.

Van der Lee, Marije L., Johanna G. van der Bom, Nikkie B. Swarte, A. Peter M. Heintz, Alexander de Graeff, and Jan van den Bout. "Euthanasia and Depression: A Prospective Cohort Study among Terminally Ill Cancer Patients." *Journal of Clinical Oncology* 23, no. 27 (2005): 6607-6612.

Van der Maas, Paul J., Johannes JM Van Delden, Loes Pijnenborg, and Caspar WN Looman. "Euthanasia and Other Medical Decisions Concerning The End of Life." *The Lancet* 338, no. 8768 (1991): 669-674.

van Dijk, Hans, Marloes van Engen, and Jaap Paauwe. "Reframing the Business Case for Diversity: A Values and Virtues Perspective." *JBE* 111, no. 1 (2012): 73-84.

Vanlaere, Linus, and Chris Gastmans. "A Personalist Approach to Care Ethics." *Nursing Ethics,*18, no. 2 (2011): 161-176.

Vaughn, Lewis. *Doing ethics: Moral reasoning and contemporary issues*. WW Norton & Company, 2015.

USA, Congress. "*Congressional Record.*" Washington: *INIAP Archivo Historico*, 2009.

Wear, Stephen, and Jonathan D. Moreno. "Informed Consent: Patient Autonomy and Physician Beneficence within Clinical Medicine." In *HEC Forum*, vol. 6, no. Kluwer Academic Publishers 6, 5, (1994): 12, 323–325, 660-661.

Weingarten, Michael A. "On the Sanctity of Life" *British Journal of General Practice* 57, No. 537, (2007): 333.

Wells, Celia, Nicola Lacey, and Oliver Quick. *Lacey, Wells and Quick Reconstructing Criminal Law*. Cambridge: Cambridge University Press, 2012.

Werth, James L. *Contemporary Perspectives on Rational Suicide*. Hoboken: Routledge, 2013.

Whitehouse, Peter. "Ethical Issues in Dementia." *Dialogues Clin Neurosci 2* no 2, (2000):

164.

Wilson, Keith G, Tracy L Dalgleish, Harvey Max Chochinov, Srini Chary, Pierre R Gagnon,
Karen Macmillan, Marina De Luca, Fiona O'Shea, David Kuhl, and Robin L
Fainsinger. "Mental Disorders and the Desire for Death in Patients Receiving
Palliative Care for Cancer". *BMJ Supportive & Palliative Care,* 6, No. 2, (2014): 170.

Winter, Roberta E. *Unraveling U.S. Health Care*. Lanham, Md.: Rowman & Littlefield, 2013.

Woods, Simon. *Death's Dominion: Ethics at the End of Life*. Maidenhead: Open Univ. Press,
2007.

Woodward, Beverly. "Confidentiality, Consent, and Autonomy in the Physician-Patient
Relationship." *Health Care Analysis* 9, no. 3 (2001): 337-351.
https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?referer=https://scholar.goog
e.com/&httpsredir=1&article=1488&context=facpub.

World Health Organization. Unsafe Abortion: Global and Regional Estimates of the
Incidence of Unsafe Abortion and An associated Mortality in 20 03. 5th edition.
Geneva: WHO, 2007;
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241596121en/

Yardi, Sarita, and Danah Boyd. "Dynamic Debates: An Analysis of Group Polarization over
Time on Twitter." *Bulletin of Science, Technology & Society* 30, no. 5 First
Published September 14, (2010): 316-327.

Zahedi, F., M. Sanjari, M. Aala, M. Peymani, K. Aramesh, A. Parsapour, SS Bagher Maddah
et al, "The Code of Ethics for Nurses." *Iranian Journal of Public Health* 42, no.
Supple1 (2013): 1-8.

Zenz, Julia, Michael Tryba, and Michael Zenz. "Palliative Care Professionals' Willingness

to Perform Euthanasia or Physician Assisted Suicide". *BMC Palliative Care* 14,   No. 1,

(2015): 1.