Journal of Intercultural Management and Ethics

JIME

ISSN 2601 - 5749, ISSN-L 2601 - 5749

published by

Center for Socio-Economic Studies and Multiculturalism
Iasi, Romania
www.csesm.org

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FROM INDIVIDUAL`S RIGHTS TO PUBLIC BENEFITS – A CONFLICT OF VALUES IN HEALTHCARE

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Abstract

This article emphasizes the important differences that should be taken into consideration, when the ethical concepts are used in the analysis of the specific practical situations in healthcare. The definitions of *medical ethics, bioethics, and public health ethics* seem to resemble in their ultimate scope, but look very different in their relational interactions among stakeholders. The major differences could be attributed to the moral norms and values that guide the ethics decisions. The ethics approaches and their potential effect on human rights protection is discussed in the presented case study analysis of a legislative act on late term abortions for social reasons in the Republic of Moldova.

Keywords: Medical Ethics, Bioethics, Public Health Ethics, Late-term abortion, Human rights, Republic of Moldova

Background

The development of new scientific biomedical fields and the introduction of new technologies and innovative treatment methods expose human lives to previously unknown and more complex challenges. Emerging ethical topics are discussed more frequently in the professional literature, and many specialized bioethics commissions at the national and international levels are trying to address them. Still, novel ethical issues constantly arise with progress in medicine and biotechnology. The ethical questions affect all stakeholders, from public health administrators, to healthcare providers and their patients, as well as the society at the level of individuals and groups of people. Ultimately, ethics becomes an indispensable virtue for a proper clinical care and management of patients, and for the administrative decision-making and public health policy development.

The definitions of *medical ethics, bioethics, and public health ethics* are all part of the applied ethics in philosophical context. In many cases, the ethical values are referenced directly to *human* or *patient rights*. It is indisputable that all these definitions are very closely connected, but the distinctions between these domains seem to be a very fine line, and sometimes - confusing for decision-makers. Even more than that, they do not understand the role of these concepts in the public health policies development.

Human rights in patient care

The concept of *human rights in patient* care refers to the theoretical and practical application of general human rights principles to the patient care context, particularly to interactions between patients and providers. It applies rights principles universally to a health context or setting. However, the concept of human rights in patient care derives from universal and inherent human dignity, rather than the rights of patients as participants in a consumer transaction. It includes key patient rights to liberty and security of the person; privacy; information; bodily integrity; life; highest attainable standard of health; freedom

from torture, cruel, inhuman, and degrading treatment; participation in public policy; non-discrimination and equality (Cohen & Ezer, 2013).

Three domains of applied ethics

The consensus is that *medical ethics* applies primarily to patients care and management, the *bioethics* addresses the ethics of biomedical research, and the *public health ethics* is concerned with the societal health and well-being. Altogether, all three domains are responsible for the protection of human rights in healthcare. As much as these concepts seem to resemble in their ultimate scope, they look very different in their relational interactions among stakeholders. The major differences could be attributed to the moral norms and values that guide the ethics decisions, along with the interacting key-players involved in each of these domains. These distinctions establish the relationships among participating parties, which could have intrinsic or newly created conflicts, and, ultimately, may affect the human rights of individuals (Figure 1).

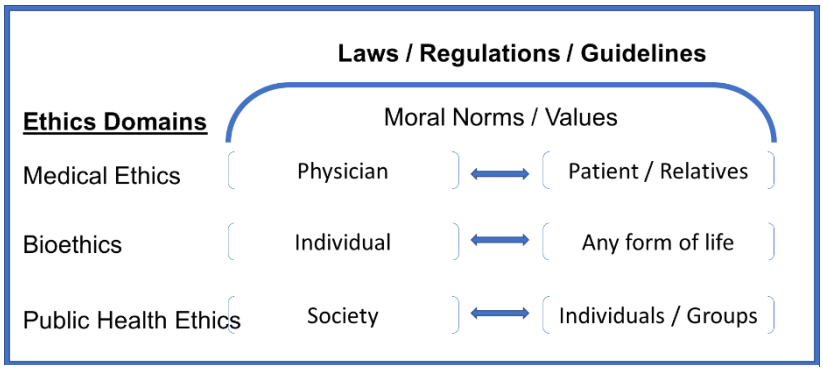

Figure 1: Distinctions between ethics domains

What is ethics?

Ethics is the theoretical discipline that concerns with the meaning of all aspects of human behavior and studies the concepts of *Good, Evil, Duty, Justice*, etc., namely people's morality. It is the consideration of how society or individuals develop the rules and principles (norms) by which to judge and guide meaningful decision-making.

Robert Solomon, one of the authors on the *business ethics* concepts (Solomon & Hanson, 1983), noted that the ethics etymology suggests its core meanings: a) *the individual nature*, including what it means to be "a good person", and b) *social norms* that govern and limit our behavior, in particular regarding what is right and wrong (which we call morality) (Solomon, 1992).

As a concept, ethics appears only when we affirm ourselves in a relationship with another person and get involved in someone else's freedom. Especially, the ethics examines this relationship by stating that you MUST do so that to respect one's freedom like your own, which would inspire the trust of others. This relation is mediated by the social rules, norms or laws, in order to allow people's coexistence and to distinguish the limits of accepted freedoms: *my freedom, your freedom, the rule*. In this way, the ethic decisions are guided by the *imperative* and *law*. The ethics has the ambition to rebuild mediation between **freedom**, which is the starting point in philosophical reflection, and **law**, as the end-point in proposing solutions (Morar, 2012).

Based on these relational arguments, the ethical reflection is necessary when certain choices are made, with a potential benefit or harm affecting others or ourselves. The subjects of ethical discussions and dilemmas encompass such definitions as health, life, human dignity, integrity and autonomy, etc., underlying human relationships in a democratic society. In the context of biomedical sciences and clinical practice, ethical reflection appears as a continuous and inevitable process, with many synergistic scopes and conflicting interests between the involved stakeholders. Trying to find a solution to ethical conflicts, prioritizing the values becomes crucial. This paper will attempt to reflect on these conflicts through the

interpretation of medical ethics, bioethics, and public health ethics, as these domains relate to the fundamental human and/or patient rights.

Medical Ethics

Since Hippocratic Oath, the medicine is promoted extensively by the existing professional codes of ethics (Byrd & Winkelstein, 2014). The basic principles of medical ethics relate to the correct behavior of the representatives of the trade, the moral qualities that should characterize them, given the social function of the profession, and are determined by the specific duties and responsibilities. For instance, in medical profession the gentleness, kindness, and empathy are the utmost expected qualities in a society that has a strict moral judgment. Therefore, these qualities should especially characterize healthcare workers in their relationships with patients.

The object of medical ethics is the field of moral relations in clinical practice. Particularly, this domain tends to regulate interpersonal relationships between doctors and patients, their relatives, along with the professional relationships between health workers and the society. Thus, the ethics triangle "doctor-patient-society" can be easily interpreted in the context of medical care. The physician establishes his own values that characterize him or her professionally and applies them in dealing with others, while respecting deontological and legal frameworks imposed by the society as the limits of freedoms for each involved party.

The core values of medical ethics are very similar to those that protect the patients' rights in general. For instance, the non-discrimination, confidentiality, and responsible (clinical) conduct are crucial principles in medical ethics, mandating an equal and fair attitude towards each patient, protection of patients' privacy and respect for their autonomy. At the same time, there are some specific conflicting categories in medical ethics, such as healthcare provider's authority, patient's trust, and perception of clinician's professionalism by patients that may entice the healthcare provider to neglect unintentionally some of the core values. For example, patients expect to have the best intentions from a clinician and entrust their fates almost unconditionally, believing that "doctors should know what is best for the patients and should care for patients". In turn, doctors encourage the patients to consent to procedures and recommendations that in doctors' opinion are needed to the patients, a so-called paternalistic model of doctor-patient relationships (Kaba & Sooriakumaran, 2007). However, doctor's social and personal commitments are not always at the highest level, and their medical competence and care for patients in circumstances such as complex diseases (i.e., cancer) or resource-limited societies with scarce diagnostic infrastructure may be objectively hindered by an incomplete understanding of diseases and lack of effective diagnostics and treatments. Psychological influence of such believes may constitute the bulk of the "placebo effect", which is related, at least partially, to the level of trust in a physician's professionalism. The trust in medical providers' professionalism makes some patients vulnerable with respect to their autonomy, biasing their decision toward doctor's suggestions or recommendations. This phenomenon is especially noted in post-Soviet societies and developing countries in general, where the paternalistic approach to doctor-patient relationship is still a social norm.

In fact, the interests of medical providers and patients are asymmetrical and not always aligned with human rights principles. In this context, the notion of dual loyalty is applied, which poses particular challenges for health professionals when the subordination of the patient's interests to state or other purposes risks violating the patient's human rights. However, health professionals are increasingly asked to weigh their devotion to patients against service to the objectives of government or other third parties. A medical provider should have high moral standards in order to minimize the asymmetry with patient's interests, and the patient should be better educated in his or her rights in order to exercise them in relationships with the medical provider. The medical ethics categories reflect the

particularities of moral atmosphere in the medical practice and play a key role in regulating professional relations. The ethical canons usually are translated into specific legislation at the national levels that reflect the major principles of human rights as individuals. Thus, human rights in patient care complement medical ethics by providing a set of legally recognized and globally accepted norms and procedures for identifying systemic issues.

Bioethics

Semantically, medical ethics is closely related, but not identical to bioethics. Medical ethics focuses on problems arising specifically from the medical practice, while bioethics addresses a subject which is much broader, dealing with moral issues initiated by the developments in biological sciences, in general. Some debatable terms, such as "life conception", may be shared by both medical ethics and bioethics. For example, the issue of the "beginning of life" is as much a philosophical and religious concept as it is a biological natural event. At first appearance being attributed to the domain of *bioethics*, the definition of the "beginning of life" has a practical meaning for *medical ethics* when considering the human rights issues, specifically, in cases of legislative and social norms of abortion, sometimes referred to as "prenatal welfare" in legal arguments (Fox, 2015). Some legislations (i.e. Europe) consider that the embryo becomes a subject of human rights after 12 weeks of gestation, while other administrative laws are based on the religious believes that "life begins at conception", resulting in a large variation in legislation on abortions among geographical regions and countries (Myser, 2008). For a physician as an individual, either situation may be unacceptable at the personal level, but the ultimate victims of the conflicting and competing interests are the pregnant women and their "unborn" fetuses (Shah & Salazar, 2014).

As a philosophical field, bioethics appears in the middle of last century, being promoted as a space for reflection and concern for the impact of speedy progress of biomedical sciences over the morality of a society. The subject of bioethics is the value of life in any manifestation and at any level of development. In a simple definition, the main purpose of bioethics is to protect the life as a naturally occurring phenomenon.

Bioethics is centered on the individual, addressing the vulnerability of the patient's life in the context of medical care, the value and respect of human life from conception (human embryo, abortion, artificial fertilization, experiments with embryonic stem cells, etc.) till death (the dignity of dying, the issue of euthanasia, medically assisted death, end-of-life support, etc.). Some additional topics of bioethics include issues on genetic engineering, identification of the risks for individuality and uniqueness of human beings, cloning and use of cells, tissues and human organs for transplantation. Bioethics examines human attitudes toward lower forms of life, especially when it concerns the inclusion of animals in biomedical and pharmaceutical experiments, irresponsible exploit of animals, along with tortures and sufferings caused by the human activity (Dubois et al., 2017).

The distinction between medical ethics and bioethics domains comes from the identification of key stakeholders involved in the act of ethical assessment. In medical ethics, these parts are identified with the healthcare provider on one side and the patient, relatives or colleagues on the other side. In bioethical analysis, the core value is the life in any form (including animals), basic concerns being protection and respect for its dignity. Moreover, bioethics reflects not only upon the individual life, legally recognized, but also on any form that is not recognized as an individual (ex. embryos), or its perspective rights in life's development (ex., use of embryos and cloning issues). Thus, there is a bias toward a generalization of benefits in bioethics vs medical ethics in which the benefits are always patient oriented.

A larger interpretation of the term of bioethics is given by a philosopher and physician of the last century, Albert Schweitzer, who has introduced a new ethical concept - "*reverence for life*" (Tan & Tatsumura, 2014). In his opinion the reverence for life should become the

world concept of contemporary society: The sense of ethics is to urge to express equal reverence for life. It is also the fundamental principle of morality. Good is what serves to maintain and develop life, evil is all that prevents or destroys life. (Schweitzer & Joy, 2006).

While the field and practice of bioethics applies philosophical principles such as autonomy, beneficence, justice, and non-maleficence to the patient care context, the human rights framework applies a complementary set of legal norms (for example, freedom, security of the person, non-discrimination) that have been developed through judicial interpretation. This legal analysis enables a more systemic approach, widening from of an individual patient-provider relationship and focusing attention on the state and health policies (Cohen & Ezer, 2013).

Public health ethics

The term "public health" refers to the whole society efforts to improve population health and disease prevention or the "society obligation to assure conditions for people's health" (Petrini, Gainotti & Requena, 2013). Public health ethics and the resulting policies emphasize primarily broader measures and interventions at the community level for prevention and prophylaxis of diseases, rather than treatment of individuals. The target group is the population as a whole (Goldsteen, Goldsteen &, Dwelle, 2015). By far, the most arguable conflicts of interests related to human rights are present in the public health ethics, ranging from whose interests are primordial, to who is to decide what is good or bad for the individual and the society (Annas & Mariner, 2016).

In general terms, the *public health ethics* defines the relationships between the majority of population or the whole society *vs.* specific individuals or groups of individuals, in many cases with special needs or interests (i.e., sharing a disease or a condition). In public health ethics, the society possesses a normative power over the community and its individuals. The *common good* is the key value applied in relation to other parts. Thus, the majority or the society, being guided by commonly accepted principles, sets limits of their normative power, applies its standards in relation with individuals, and develops the laws for interaction with individuals or other groups.

Many arguable issues and contradictions could arise in response to public health policy initiatives, developed based on the principles of justice, equity, and common good. Sometimes, the process of identifying the common good results in individuals' outcry and resistance. For example, many societies, especially from developing and resource-limited countries, are faced with anti-vaccination currents promoting a negative attitude towards state-mandated universal vaccination programs. While these programs are an important achievement in prevention of serious infectious diseases, individual's right to accept or not the intervention that concerns their health, as well as parents' right to decide about vaccination of their children is conflicting with the common good of health systems to have maximum coverage of population for prevention of diseases. In some cases, the vaccination is mandated indirectly by compulsory requests for certificate of vaccination before admitting a child into a public education institution (kindergarten or school), which could be seen as a barrier in achieving the fundamental right to education of individuals (Dawson, 2011).

The Nuffield Council of Bioethics' report *Public Health: Ethical Issues* describes a step-wise intervention that a state may use in promoting public health: "an intervention ladders"- from the least to the most coercive or intrusive measure, in which every step up the ladder requires a stronger justification to support the intervention (Nuffield Council on Bioethics, 2007). The identified moral considerations, which should be taken into account in an ethical evaluation of public health interventions, include, among others, protection of non-dominant (minority) subgroups from marginalization and stigma; justified and fair distribution of health benefits; prevention of utilitarian commitments in health policy, etc. While it may be not easy to apply these ethical principles and frameworks as general

guidelines for developing public health policies and practices, it needs to be considered that public health activities can significantly influence individual's actions. Moreover, public health policies can entirely ignore or exclude individual's right to make informed choices. For instance, imposing the compulsory quarantine for the patients with dangerous infectious diseases; or banning smoking in public places; or fluoridation of drinking water, etc. - all considered beneficial for "common good", these measures of public health interventions may be perceived unethical as limitations imposed on individual`s freedom.

Under the influence of described circumstances, it became evident the necessity for the decision makers to design appropriate and fair policies and measures, which would favor the population, viewed as a whole, or the majority of a community. However, this approach sometimes could contradict the traditional focus of medical ethics, applied on doctor-patient relationship (individual approach).

Trying to determine the balance between individual's rights to make informed choices and the power of the state to ban freedoms, we could make the reference to the *principle of injury*, originally formulated by John Stuart Mill in his essay *On Liberty* (Mill, 1869). Mill argues that the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is the only one that is meant to prevent a danger to others. Only in this case, the individual's good, physical or moral, does not prevail over the common good. Here comes another dimension to the discussion, referring to the limits of freedoms and responsibilities of individuals towards their own health versus social responsibility towards public health.

Thereby, public health ethics is complemented by human rights, as the main goal of this field is ensuring that public health interventions provide benefit and minimize harms, respect individuals' dignity and rights to the greatest extent possible, and are implemented fairly (Cohen & Ezer, 2013).

Discussion: A case study

To demonstrate the significant differences between ethics approaches mentioned above, a case-study from the author's practice in the Republic of Moldova, is analyzed below.

A 34-year old woman at 20-21 weeks of pregnancy visited the OBGYN office for an initial consultation. This was her 4th pregnancy and she is the mother of three children: 6, 4, and 1 year and 8 months old. She is a housewife from a small village and her husband is employed on temporary seasonal agrarian works. The family lives in very precarious conditions, below the poverty line under national standards. The woman complained about her family difficult financial situation and mentioned that she was not happy about one more child. As a solution, the obstetrician, in a paternalistic manner, suggested an abortion due to woman's social situation. He stated with a very cold and contemptuous attitude: "*It is enough to multiply the poverty!*"

It should be mentioned that abortion, based on social reasons, is legally supported in the Republic of Moldova (Ministry of Health, 2020). The law allows a voluntary interruption of pregnancy without any restriction within first 12 weeks. After 12 weeks and up until the end of the 21st week of pregnancy, certain medical and social situations may serve as a basis for an abortion. Upon a request from a pregnant woman, a committee consisting of medical consultants would consider the following social conditions as the justification for a late voluntary abortion:

1. Pregnant women under 18 and over 40 years of age;
2. Pregnancy resulted from a rape, incest, or human trafficking;
3. Divorce during pregnancy;
4. Husband's death during pregnancy;

5. Imprisonment or deprivation of parental rights of one or both spouses;
6. Pregnant women in the process of migration;
7. Pregnant women with five or more children;
8. Pregnant women who take care of:
    1) a child under 2 years;
    2) one or more family members with 1st degree of disability that requires care, according to the conclusion of the Medical Expertise Council on Vitality (subdivision of the Moldova's National Council on Disability);
9. Combination of at least 2 circumstances: lack of domicile, lack of financial resources, abuse of alcohol and / or drugs, domestic violence, loitering.

In terms of *medical ethics*, we could observe that the obstetrician's behavior is strongly influenced by the paternalistic style of communication, typical for post-Soviet countries. The doctor feels that he is entitled to dictate what is best for the patient, based on his own moral norms and values and without going into specific details. Moreover, the doctor will impose his own opinion as the only right solution at the moment. The paternalistic approach remains a serious problem in doctor-patient relations in the Republic of Moldova, and it is one of the reasons of frequent violations of patients' rights to consent, to be informed and to make an informed decision or choice.

Using the vulnerable state of the patient, caused by insufficient information on the available alternatives, the doctor, most likely, will convince the patient to accept his point of view. For instance, in this specific case, being scared of her health and social status, the pregnant women will give the doctor a full authority to decide for her. As a result, the principles of *medical ethics* will be seriously violated in this and similar cases. In the same time, the right of choice of this pregnant woman is violated.

In terms of *bioethics*, the value of the fetal life, which is a form of life with the prospects of its development into an individual with natural rights to exist, is neglected. At a gestational period of 20 to 21 weeks, the human fetus growths up to 26 cm long (almost 1 ft.) and weighs up to 350 grams (over 1 pound). All his organs are formed, including his fingerprints. In canonical bioethics approach, the priority should be given to a life, which cannot defend itself but has the potential to grow and to become a person with full rights. The pregnant women should make an informed decision based on her present health and social status and the moral outcomes of termination of pregnancy. From the point of view of "pro-choice" adepts, the decision should belong to a mother. On the other side, "pro-life" adepts promote the idea of banning abortions as murders *de facto*. But, banning the abortions would result in violation of women's rights, most likely leading to an increase in number of criminal abortions. The bioethics question remains unsolved in this dilemma regarding the gestation age at which we give the value to a human life in its embryonic form. The consensus of 12-week threshold is arbitrary and should not have a significant weight in decision making, specifically in physiologically healthy embryonic development. Can this value be assessed in terms of a utilitarian approach of long-term "good"? And whose "good" should have a priority? From a social justice point of view, it seems very unethical to favor the embryo development in a rich family and to ignore the right to live of an embryo conceived in the womb of a poor woman.

In terms of *public health ethics*, the legal framework to terminate a late-term abortion for social reasons is an example of a utilitarian and, ultimately, discriminatory approach. In the absence of adequate social programs that should support women with many children, widows or single mothers, the state increases the list of social indications for abortions. The decision based on any social factors to abort a fetus in an advanced gestational period of pregnancy is profoundly unethical with no evident good for a society. Addressable social situations, such as lack of a home during pregnancy, or caring for a child younger than 2

years, or having a disabled person in the family etc., are primarily an expression of despair and lack of opportunities for pregnant women, rather than thoughtful and well-considered choices in family planning. Apparently, the voluntary interruptions of late pregnancies are strongly influenced by a shortage of sensitive social programs to encourage births, rather than by well-thought and morally assessed decisions.

Combating the poverty by reducing the number of population should be an unacceptable solution, as has been shown in recent historical examples of unethical health policies (Wilkinson, 2011). In fact, in a long run, given a negative birth rate of population, such measures will affect negatively the demographic and social indicators. It is sad that policy makers mask their questionable decisions with an obscure "pro-choice" explanation of respecting the women right to decide over their bodies. Therewith, in a country where abortion is found to be the most common measure of birth control, arises the question regarding the right to information of individuals on reproductive health. The international experts reported serious violations of human rights in the Republic of Moldova, despite that the local authorities did not find their legal solutions and public policies to be unethical.

Similar cases can be encountered in other economically poor societies in which the process of public policy development is heavily influenced by the benefit of the majority and the perceived "common goods" prevail over the interests of individuals and even over their rights.

Conclusion

The fundamental rights of individuals and the principles of equity and justice are embedded into every domain of ethics, and every public health regulation and guideline should be scrutinized extensively for compliance with the current standards of ethics. To comply with the principles of ethics, the public health policies must ensure that individuals are provided with adequate information in order to make informed decisions or choices. And, at the same time, in order to respect their autonomy, they must be offered possibilities and alternatives in the decision-making process

The development of public health policies is a very complex and difficult task. These policies can significantly influence behavior and choices of individuals, members of the society. Policy makers need to ensure that in the process of development of public policies and interventions, the ethical aspects and particularities of each situation are taken into consideration in terms of protecting the individual rights and values, as well as preserving the morality of the society in general by respecting bioethical principles. Sometimes, it becomes very complicated to achieve these conditions simultaneously, because they could have too many points of divergence. The application of principles promoted by human rights in patient care seems to be the best and objective solution.

That is why policy makers need to know and understand the essence and value of ethics, bioethics principles and human rights should become a topic of continuous education of healthcare providers, policy makers, and governmental officials.

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