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Editorial: Ethics Around the Globe

EJAIB has always received a number of papers over the past 24 years from Latin America, and this issue includes a further two on medical ethics from Brazil. Lins explores the influence of Albert Schweitzer in the healthcare system, and Oliveira dos Santos et al. present results of a study of anesthesiologists' practices in delivery of palliative care. The original purpose to develop broad international dialogue was the reason for the words "and International" abbreviated by the "I" in EJAIB. This cross-cultural reflection on bioethics has been one of the rich aspects of the discourse, to have a vision beyond "EJAB", and one which can be expected to grow as the editorial office has moved with me to AUSN, which will enable broader dialogue.

This issue of *EJAIB* is delayed due to this move to USA, as I have been organizing a number of conferences around the world in my new capacity at AUSN, mainly jointly with Eubios Ethics Institute. I hope to be able to do more writing and editing now that a busy 2013 is coming to an end, and please explore the AUSN website for News from the Provost that provides updates on my activities.

The first paper in this issue is by one of my mentors from my time at Tsukuba, Professor Humitake Seki, who explores ethics in martial art with intercultural comparisons. The linkages between cultures and ideologies run deep, and the common cosmologies that people have is also explored in the paper from Kyrgyzstan by Tamara and Diethelm. May and Sass propose a check-list approach to help make ethical decisions in personalized medicine. The issues of justice in systems of healthcare in Japan, gender equality in Bangladesh, also link to the paper from Brazil.

EJAIB welcomes papers from a variety of perspectives to encourage dialogue. I hope readers will support that dialogue, send in commentaries or articles, and continue to support us.

– Darryl Macer

Ethics in the Traditional Martial Art of the Kashima Grand Shrine & in the Bible

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In Genesis of the Bible it is described that “the Tree of Life” is in the midst of the Garden of Eden, and its fruit is of such a nature as to produce physical immortality. It is also described that if Adam and Eve ate fruits of “the Tree of Life” they would become immortalized in their sinful condition, after being guilty of their eating a fruit of “the Tree of the Knowledge of Good and Evil”. It would be disastrous for those sinful beings to live forever on the earth: Then the earth would soon be a hell with sin propagating forever.

To prevent such a disastrous possibility, the Lord God drove out Adam and Eve from the Garden of Eden; and at the east of the Garden placed “Cherubim” with a “flaming sword turning every way”, in order to guard the way to the Tree of Life. Those divine commands prevented them and their offspring from possessing physical immortality. As such, Cherubim are involved in human immortality.

One of the most possible Cherub standing at the Gate of Eden with the sword, Archangel Uriel is often identified because he is characterized as a cherub and a divine intercessor between God and humankind. Archangel Michael is regarded also as a guardian angel of the entrance of the Garden of Eden, because he is the angel of death, carrying the souls of all the deceased to heaven. The most possible features of Cherubim are described in the Book of Ezekiel (1: 6-10). Each of them had four faces and four wings, with straight feet with a sole like the sole of a calf's foot, and "hands of a man" under their wings. Each had four faces: The face of a man, the face of a lion on the right side, the face of an ox on the left side, and the face of an eagle. Therefore, in order to guard the way to the Tree of Life at the east of the Garden, the movement of the dynamic axis of the flaming sword had to turn every way, and had to revolve around the center point of a united troop of Cherubim as one body.

The reason “Why this guard technique by a united troop of Cherubim must be turning a sword in all directions?” is not given in the Bible. But, as “Cherubim are intercessors”, the command of the Lord God should be transmitted to the sword while turning around the united troop of Cherubim.

When we consider why this guard technique involves turning a sword in all directions, one may speculate with special references to the “life and death” struggle with a human wielded sword as described in “the spiritually transmitted martial art in Shint" ism”. That has been conformed to the “Martiality of Divine Mystery” of the August Deity of Kashima, “*Takemikadzuchi-no-mikoto*”.

The traditional martial arts of Japan began at the Kashima Grand Shrine in the 7th century when “*Kuninazu-no- mahito*”, priestly celebrant of the Kashima Grand Shrine, attained a revelation from the August Deity of Kashima (Fig. 1). The revelation from the August Deity of Kashima enabled *Kuninazu-no-mahito* (as an intercessor) to transform the technique of “Sword of Kashima” from a religious ceremony using sword for spiritual purification, into a set of scientifically advanced techniques for human combat.

The set of techniques constitutes “*Futsu-no-mitama-no-kata*”: that is, the dynamic axis of operations for the spiritually transmitted martial art revolves around the center point of the “*Hasshinden* (Hall of eight divinities)” (Table 1).

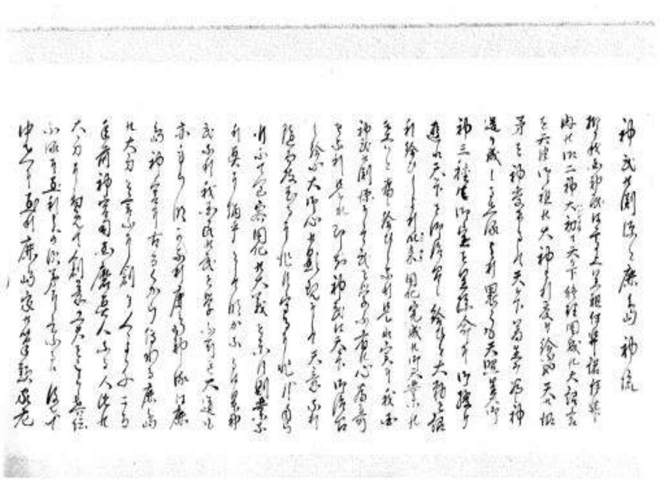

Fig. 1 Historical records on the spiritually transmitted martial art in “Certificate of Mastery of Kashima-Shinry! , reproduced by Kuni’i Zen’ya Minamoto no Michiyuki in 1961 from the original scroll described by Kuni’i Taizen Minamoto no Ritsuzan at around 1780AD in the middle of the Edo Era”

The “*Hasshinden*” originated as a sanctuary for worshiping the divinities that protect the Heavenly Sovereign. While executing every technique of the martial art of Kashima, the Eight Divinities of “*Hasshinden*” must function as a metaphysical telescope of the mind’s eye of warrior for evaluating the enemy’s virtue (Fig. 2); and then function almost simultaneously as an inner structure for protecting one’s devotion to “Acceptance and Resorption”, which supports the Divine Will by “Refuting Error to Reveal Righteousness”.

The spiral motion of the “*Futsu-no-mitama-no-kata*” through the eight divine attitudes of the *Hasshinden* can be executed with a unified motion used for drawing a circle, as is formulated by such a wave equation as the Schrödinger equation; just as when performing the Great Purification Ritual of the Nation of Japan. Accordingly, the “attitude of warrior” that performs the spiritually transmitted martial art can place one’s single-minded reliance, exclusively, onto the “attitudes of the divinities”.

The same spiral motion for the martial art of Spiritual Transmission, which supports the Divine Will, is described in the Bible Verses about “David's battle with

Goliath” from the King James Version (Samuel 17:49), showing the victory of God's king over the God's enemy: There,

“Samuel 17:49 - And David put his hand in his bag, and took thence a stone, and slang [it], and smote the Philistine in his forehead, that the stone sunk into his forehead; and he fell upon his face to the earth.”*

*The spiral motion is the sole sling technique for resulting in David's victory of “David hurls a stone from his sling to hit Goliath in the center of his forehead”.

Table 1: Attitudes of the Hasshinden’s Eight Divinities

POSITION	DIVINITY	FUNCTION OF SPIRITUAL ENERGY
First Seat	Takami-Musubi （高御産日神）	refuting error to reveal righteousness (haja kensh" ：破邪顕正)
Second Seat	Iku-Musubi （生産日神）	praises the activity of generative energy (musubi：ムスビ)
Third Seat	Taru-Musubi （足産日神）	brings an activity to its peak, overflowing capacity
Fourth Seat	Tamatsume-Musubi （玉積産日神）	concentrates spiritual energy within the body (thou shall not kill)
Fifth Seat	Kami-Musubi （神産日神）	using only the least violence to save the most lives (issetsu mansh" ：一殺万生)
Sixth Seat	Kotoshironushi （事代主神）	receptivity to spiritual oracles and inspiration
Seventh Seat	Miketsu （御食津神）	a divinity of food: i.e., energy supply
Eighth Seat	# miya-no-Me (大宮売神)	harmonious fusion of human minds (jinshin y! wa：人心融和) activity of origination and manifestation as one (kihatsu ittai：起発一体)

Facing a real combat, whether the enemy’s virtue is to be attacked or not, a warrior receives an oracle concerned with “refuting error to reveal righteousness” via an attitude of *Takami-Musubi* on the First Seat or “using only the least violence to save the most lives” via attitude of *Kami-Musubi* on the Fifth Seat of “*Hasshinden*” .

Then, at the final stage of combat, the achievement of “life or death” is attained based on the greatest moral law “Acceptance and Resorption” of divine martiality, so that a warrior receives an oracle on enemy’s virtue in such way as “praising the activity of generative energy (*Musubi*)” via attitude of *Iku-Musubi* on the Second Seat or “thou shall not kill” via the attitude of *Tamatsume-Musubi* on the Fourth Seat of “*Hasshinden*”.

To be able to embody this divine martiality in combat, the precise evaluation of enemy’s virtue during the phase of preemptive attack is most crucial in either way as the physical strategy of “activity of origination and manifestation as one” or the psychological strategy of “harmonious fusion of human minds”; Consequently, such attitude of *! miya-no-Me* on the Eighth Seat of “*Hasshinden*” (Fig. 3) must initiate to conform to the “attitude of warrior”.

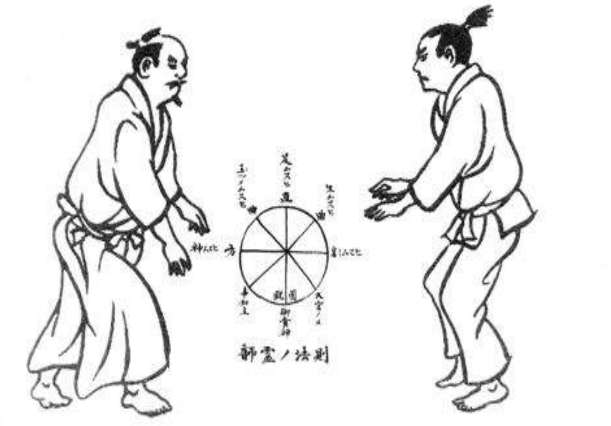

Fig. 2. “Hasshinden” as a metaphysical telescope of the mind’s eye of warrior for evaluating the enemy’s virtue

Fig. 3. The attitude of *! miya-no-Me* (the right side) on the Eighth Seat of “*Hasshinden*”, drawn by *Utagawa Kuniyoshi* (*Ichimu D" jin* [1860]: *Nihon-kaibyaku-yuraiki*, Vol. 2, *Suwaraya Mohei* Publisher)

With tardy physical appearance of attracting “harmonious fusion of human minds” of *! miya-no-Me*, a warrior gathers all the metaphysical information about “Life or Death” from the opponent’s reaction, and it is possible by attacking first prior to the opponent’s “take the offensive”.

Let us compare the expression: "You never attack first in karate". This performance of divine transmitted martial art can be performed by depending absolutely on “seizing the initiative of the opponent’s mental movements”.

The strategy at an initial stage of this martiality is based on the same philosophy and morality as the “rule of virtue” of Taoism (Lao Tzu [6 c. BC]: Tao Te Ching, LXI); that is,

“A great nation flows down to be the world’s pool, as the female to be under heaven.

In stillness, the female constantly overcomes the male, as in stillness she takes the low place.

Therefore, in stillness, a great nation lowers itself and wins over a small one.”

In striking contrast to the divine martiality, the combat arts of all other non-spiritual traditions without reliable backgrounds of historical and religious evidence are in linear motion; both the kinetic and ethical constructions of this motion are based solely in joy of “the felling an enemy and destroying evil” during limited time of fighting to spare for the “refuting error to reveal righteousness”, the ethical embodiment of divine martiality of “the struggle for existence” is technically impossible for any great master of martial art.

As the divine martiality is of the Will of Heaven, its manifestation exists neither in attack nor in defense but must operate of itself based on the paradigm that reveals the great moral law of “Acceptance and Resorption” by exorcising the attitudes of “Ten Evils ”: 1) endurance, 2) overconfidence, 3) greed, 4) anger, 5) fear, 6) doubt, 7) distrust, 8) hesitation, 9) contempt, and 10) conceit. Therewith the divine martiality, a warrior is able to approach combat from a great position of “absolute impartiality of the physical and moral rectitude” with the delight naught in unavailing joy of “felling an enemy and destroying evil”.

Such the great moral law of “Acceptance and Resorption” cherished by the “warrior of virtue” represents an approach not only to “Life” but also to “Social Interaction of All Forms”.

The universe has continuously evolved from the time of its creation until the present day. Since human appearance, the “divine intent” of the Lord God described in “The First Sin and Its Punishment” in Genesis must be the ethical guide for this evolution: Whereby “divine dynamics” that propel this evolution places humankind for keeping desirable the Biosphere, and Cherubim with the revolving sword could be a symbolized “ethical strategy of social interaction of all forms ” above an evolutional principle of “survival of the fittest upon the struggle for existence”.

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The Check-list Approach in Personalized Medicine

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Abstract

Modern medicine, based on enormous progress in science and its applications, has lost dimensions of individualized treatment and compassion which traditionally were an essential part of physician’s service over the millennia in Eastern and Western cultures. Today diseases and symptoms, rather than persons, are treated, based on objective quality norms and inflexible payment schemes rather than the rather than persons. We present a checklist model for personalized health care, which has been successful in teaching and practice to reclaim lost territory in treating patients as persons.

The Quest for Personalized Treatment and Care

Quality medical care traditionally included more than treating a particular disease; professional medical care treats the patient as a fellow person. In clinical practice one size does not fit all; clinical quality standards and reimbursement schemes are general, but patients are different. The ‘best for the patient as the prime rule‘– aegroti salus suprema lex – needs to take both, the medical status and well as the value status of the patient, into account by integrating differential ethics into differential diagnosis, prognosis, and treatment. Not only citizens in modern pluralistic societies have different preferences and understandings of the quality of life and its goals of life; Galen, personal physician of Roman Emperor Augustus 2000 years ago, reminded his fellow professionals ‘non homo universalis curatur, set unus quique nostrum’: it is not the universal person we are to treat, it is an individual, unique, our patient! Providing this type of quality and patient-oriented care is particularly difficult in times when financial schemes are inflexible and objective, and do not leave much room for individualized care.

Confucian physician Yang Chuan, 1700 years ago requested that the prospective patient must be smart to choose her or his physician carefully based on virtues which include more than technical expertise: ‘Trust only those physicians who have the heart of humanness and compassion, who are clever and wise, sincere and honest’ [Sass 2007]. Paul Ramsey, theologian and ethicist in the early days of medical ethics facing great successes of scientific medicine, published his influential book ‘The Patient as Person’ (Boston 1973). 40 years later the European Association of Centers for Medical Ethics (EACME) held a conference *“Personalized Medicine”* in Bochum, Germany (September 2013).

Modern health care settings carry additional challenges: the institutionalization of medicine and the increased diversification of worldviews and personal values and wishes among providers and recipients. In the new century of globalization, we find Buddhists in Berlin, Muslims in Paris and Bochum, Christians in China, and non-believers in Beijing, Basel, Rome or New York. Physicians are not experts in worldviews. Among religiously affiliated people some are fundamentalists, some very liberal, some just loosely affiliated. Also, quite a number of patients are not used or ever had an opportunity to make independent decisions in their everyday lives. We have both, globalization of previously geographically based cultures and attitudes, and individualization in personal cultures towards traditional and modern worldviews. – Today, medicine and health care is widely provided in institutional settings, in cooperation with physicians, nurses, technicians, and administrators. Thus, treatment and care are provided by quite a number of stakeholders. Hospitals, Nursing Homes, Health Care Insurers, and Research Institutions are corporate persons with a distinct corporate profile and in need of a corporate ethics profile as good neighbors.

The Checklist Approach

In 1987, the founders of the Bochum Center for Medical Ethics (ZME) Hans-Martin Sass, an ethicist, and Herbert Viefhues, a physician, developed an open checklist for good medical and moral personalized treatment, based on an instrument which was very well known to physicians in exploratory diagnosis: a checklist, short and based on previous experience and an obligation for best possible treatment. Checklists are used elsewhere in technical procedures such as car maintenance, quality control of products and services of different kind, in assessing customer satisfaction, and in many other fields of personal and professional life. In medicine, medical checklists are routinely used by family practitioners and clinicians to collect basic medical and laboratory data of patients and to note details of prognosis, treatment and prescriptions, therapeutic or chronic improvement; they are used by hospitals at time of admission and later to document clinical patient data, also in research to document patient/subject’s reaction. Health care experts and teams are well experienced and comfortable with using all kinds of checklists, so the introduction of a checklist for personalized care was the logical choice. In applied ethics, such as in clinical ethics and hospital care, one cannot distinguish clearly between theory and practice; both are intertwined and ‘one cannot competently engage in education or policy development without a competency for case review’ [Blake]. Checklists also are not only useful for documentation and review; they also guarantee that a wide range of issues is recognized rather than only the few with most intriguing details of a particular case. Checklists need to be short, allow for precise documentation, and eventually be complemented by special additional checklists such as checklists documenting laboratory blood tests or sonograms.

The Bochum checklist integrates information about the ‘medical status’ and the ‘value status’ of the patient and subsequent decision making into one instrument. A good medical-ethical checklist needs to be open to different visions of the world and of individual wishes held by patients; and physicians and other health care experts also need to evaluate their medical and moral options as well. Ethics without expertise is ineffective; expertise without ethics is blind. Traditionally, checklists for patient’s values and wishes were not necessary traditionally as the family doctor (a) knew his/her patients and their families very well, (b) limited medical knowledge did not allow for a wide range of different treatments, and (c) physicians could assume that patients were representatives of a consistent moral and cultural environment having quite similar moral, religious, and cultural views and expectations from medicine and their doctors.

Checklists have to be clear-cut, short and precise. The Bochum checklist in its basic form presents three sets of questions: (1) medical status; (2) value status; (3) treatment decisions. Physicians are well trained and experienced with diagnosing the medical status of a patient, often in complex forms of differential diagnosis; this checklist asks them to use the same precision and well-defined terms in diagnosing the wish-and-value status. In order to find a well-argued answer, we ask to present a written summary at the end of both sets of questions. Ethics terminology often is not as precise and scientific language, therefore we found it important to start with scientific issues and move thereafter to more complex value-and-wish issues. Similarly, treatment decisions and their routine reviews also have to be written down. - Additional checklists were developed and widely tested empirically using dozens of cases from Bochum hospitals; the first 3 additional checklists offered help for special situations in (1) long term treatment (2) considerable social impact, and (3) medical research. A special sub-list was developed for phase 1 cytostatica research. Thereafter other checklists were asked for (4) in psychiatric intervention, (5) in neonatology and pediatrics, (6) in the care for dying, and (7) in considerable moral, cultural and religious differences among stakeholders and (8) in team training and in the development of a corporate profile.

Learning and Training – Integrating Expertise with Ethics

The Bochum checklist was and is widely used in teaching preclinical and clinical medical students, in training multidisciplinary teams in hospital wards and in hospitals, also ethics consultation groups and corporate leadership for devising and reviewing the corporate profile and special traditional or new activities. In particular, in case discussions within care-and-treatment teams representing different professions, we found it important to develop a common language in using these checklists. In other situations we have asked medical and nursing students as well as care teams to develop their own short checklist of a particular case; this was a particular effective approach in learning and interactive training. Some department teams have used the checklist approach to write down standard answers for routine questions and issues in a particular ward or department. In the educational setting we have encouraged the students to bring cases for evaluation and to also check the validity and practicality of checklists used. In institutional training sessions we have avoided to use cases from within the house in order to avoid potential embarrassment of persons, who had been involved, having been careless or made mistakes. There is nothing sacred about the checklists we have used and encouraging students, clinical experts and Clinical teams to develop their own specific checklists is an interactive contribution to livable and productive casuistry.

Of course, this checklist approach is a model of so called soft-paternalism and not an expression of the Georgetown model of the four principles – autonomy of the patient, non-maleficence, beneficence, justice (Beauchamp and Childress). It shares with the Georgetown model the *'primum nil nocere'* – first do no harm – principle, i.e. the requirement of balancing potential harm with potential benefit. But it puts a high emphasis on compassion as an instrument for personalized care and on professional expertise. When Sass introduced the Bochum checklist at the Kennedy Institute of Ethics, the question 'To what degree should the physician permit the patient to determine the treatment plan?' was particularly criticized. In the meantime, medical ethicists and responsible health care experts, also in the USA and not only in Europe and Asia, have a more differentiated and positive understanding of 'soft paternalism' as one of the professional virtues in treating the frail and the sick.

The original checklist for personalized healthcare was developed more than 25 years ago in Europe and has found a place in medical-ethical teaching and in clinical medicine review and consultation around the world. The basic principles of competent and compassionate care are similar in all cultures independent of their religious or philosophical or customary tradition. Translations exist in many languages and are used in clinical training and medical education, in English (Stuart Spicker), Brazilian (Juan Carlos Batistiole), Chinese (Qiu Renzong), Croatian (Ana Borovecki), Dutch (Henk ten Have), Italian (Antonio Autiero), Japanese (Akio Sakai), Spanish (Jose-Alberto Mainetti), Swedish (Erwin Bischoffsberger SJ), and Turkish (Ilhan Ilkilic). Basic principles of competent and compassionate care are similar in all cultures independent of their religious or philosophical or customary tradition and they can be dealt with in one single non-ideological and open questionnaire. However, different cultures have their own values and principles which are more easily referred to than to imported principles. Tai has referred to 5 classical virtues in Asian culture: 'Compassion' as a basic human virtue in all situations, 'Righteousness' in doing things right and doing the right things, 'Respect' for fellow humans in all social interactions, 'Responsibility' in personal and professional actions, and 'Ahimsa' as respect and reverence for life and non-violence. He recommends using the three classical Confucian parameters for applying values and virtues to concrete situations: Cheng, Li, and Fa. 'Cheng' requires situational action and ethics. 'Li' requires reasonableness and propriety, also the respect for stable norms and expectation in society. 'Fa', lawfulness in all situations, is a principle of last resort, against which actions. He successfully has used this basic checklist for mixed committees of health care professionals in Asian cultures: '1. Identify the issue. - 2. Speak with nurse and family if request comes from physician or vice versa. - 3. See the patient and allow the patient to speak without interruption. - 4. Ask open-ended question. - 5. Talk with the physician. - 6. Prepare an ethical analysis. -7. Provide recommendations.' [Tai, p. 122-128].

Discussion

Open checklists for personalized and patient-centered medical treatment and care [May, in press] have been successfully used for over 25 years as a tool in educating students in medicine and nursing, in guiding interdisciplinary teams in hospitals and nursing homes, and in supporting health care institutions and health insurances in shaping and reviewing their corporate profile and in training staff and executives in improving competence and compassion. It is recommended, that students and groups and individuals in treatment and care are encouraged to develop their own questionnaires in interactive learning, training, and reviewing, and in professional treatment and care.

Bochum Checklist For Patient-Oriented Clinical Care

Integrating medical status and value status in patient-oriented treatment and care

I. Differential diagnosis of the medical status

The evaluation of the medical-scientific diagnosis follows these traditional patterns.

General considerations: What is the patient's diagnosis and prognosis? - What type of treatment is recommended regarding the diagnosis and prognosis? What alternative treatments could be offered? What are the anticipated outcomes of these various treatment options? - If the recommended treatment is neither offered to nor accepted by the patient, what is the prognosis?

Special considerations: Will the preferred medical treatment be helpful to the patient? - Will the treatment selected lead to a positive prognosis in the particular case? If so, to what degree? Could the selected treatment harm or injure the patient? To what degree? - How can benefits, harms, and risks be evaluated?

Medical practice: Are any other medical treatments equally adequate? - What consideration should be given to (1) the most recent medical advances due to biomedical research as well as (2) the physician's extensive clinical experience? What relevant facts are unknown or unavailable? Are the terms employed correctly, and are they precise? –

Summary: What is the optimal treatment after considering all the available scientific-medical knowledge?

II. Differential ethics of the value-and-wish status

The diagnosis of the value status of the patient follows three principles:

Health and well-being of the patient: What harm or injury may arise as a result of selecting a specific [single] method of treatment? - How might the treatment compromise the patient's well-being, cause extensive pain, or even shorten his/her life? - Might it cause physical or mental deterioration? - Might it tend to produce fear or grave anxiety in the patient?

Self-determination and the patient's autonomy: What is known about the patient's values, wishes, fears and expectations? - What is the patient's understanding of intensive or palliative treatment as well as resuscitation criteria? - Is the patient well-informed about diagnosis, prognosis, and the various treatment options available for him/her? - How is it possible to serve the patient's preferences in formulating the treatment plan? - To what degree should the physician permit this patient to determine the treatment plan? - Who else, if anyone could or should make decisions on behalf of a patient and his/her best interests? Must the patient agree with the chosen therapy?

Medical responsibility: Have any conflicts surfaced between the physician, the patient, the staff, or the patient's family? - Is it possible to eliminate or resolve such conflicts by selecting a particular treatment option or plan? - How can one work to assure that the following values will be reaffirmed? - (1) the establishment of mutual trust between patient and physician; (2) the principle of truth-telling in all discussions; - (3) the respect for the patient's privacy and the protection of his/her confidentiality? - What relevant facts are unknown or unavailable?

Have the salient ethical issues been adequately formulated, clarified, and addressed within the physician-patient relationship?

Summary: What kind of treatment is optimal giving thorough attention to the salient and relevant clinical ethical issues?

III. Treatment of the Case

What options (alternative solutions) are available in the face of potential conflict between the medical-scientific and the medical-ethical aspects? - Which of the aforementioned scientific and ethical criteria are most affected by these alternative options? - Which options are most appropriate given the particular value profile of this patient? - Who, if anyone, should be consulted to serve as an advisor to the physician? Is referral of the patient necessary for either medical or ethical reasons? - What are the moral (in contrast to the legal) obligations of the physician with regard to the chosen treatment? - What are the moral obligations of the patient, staff, family, health care institution and system? - What, if any, are the arguments for rejecting the selected treatment? - How would or should the physician respond to these arguments?

Does the treatment decision require achieving an ethical consensus? - By whom and with whom?

Why? - Was/Is the treatment decision adequately discussed with the patient? - Did he/she agree?

Should the decision process be reassessed and the decision actually revised?

Summary: What decision was made after assessing the scientific and ethical aspects of the case? How can the physician most accurately represent the medical-ethical issues and the process of evaluating the medical and ethical benefits, risks, and harms?

Selected Supplementary Checklists for Special Situations

1. Long-term Treatment

Will the chosen medical treatment and its ethical acceptability periodically be reconsidered? Is the treatment in line with quality standards in medical treatment and care and medical ethics? - What clinical or ethical factors must be reviewed during on-going treatment? - How do patients react to modifications in treatment strategy? - In case where the prognosis is dim, how should the physician decide whether the patient should receive intensive or palliative treatment? - Is it possible to appropriately satisfy the patient's explicit wishes, demands, as well as his/her tacit intentions, and to be reassured that they have been seriously considered?

2. Considerable Social Impact

What are the anticipated costs, personal and material, to the patient, the family, the health care institution, and society? - Are the patient, relatives, and community able to bear these costs? - Will the costs of the social [re]integration of the patient, his/her life style, personal development, and recuperation be adequately met? - How do the answers to these questions of cost bear on the medical-scientific and medical-ethical considerations?

3. Therapeutic and Non-therapeutic Research

Has the research protocol and design taken the medical-ethical aspects under full consideration? - Is the research necessary? - Did the patient provide a truly informed consent in order to be entered into the protocol? - Who is responsible for providing adequate and thorough information to the patient subject and to assure that it is adequately understood? - What reasons might explain why a patient subject did not give a fully informed, competent, and voluntary consent? - What procedures were initiated to avoid discriminating against a patient [subject] when requesting his/her participation in a research protocol? - What mechanisms are in place to respect and act on a patient's right to withdraw from participating in a research protocol at any time? - Was the experiment fully explained to the patient [subject] in clear and fully comprehensive language? –

3.1. Cytostatica phase-1 research as an example for an additional checklist:

1. Is the scientific definition of efficacy as expressed in terms of remission or no-change in conflict with the patient's definitions of quality of life?
2. Is the patient aware of a possibly scanty prognosis for full recovery? What does the patient expect from the trial? What does the researcher expect?
3. Can and will quality of life issues be dealt with separately from medical research issues?
4. Has the patient been offered the best available

palliative care? Has he/she been made aware that best palliative and quality-of-life support will continue even if she/he withdraws from the trial?

4. Psychiatric Intervention

1. Is intervention indicated, given this disease and its risks? Who decides?
2. Are concepts of quality of life of this patient known? Why are they not used in deciding about treatment?
3. Has the personal profile of this patient been modified by medication or intervention? Can it be reconstructed or supported? - 4. What are the risks, disadvantages and advantages of institutionalization? How can institutionalization be avoided? - 5. Is paternalistic treatment mandated at all? Why? How long? Who makes those decisions? - 6. Use or develop a specific ethics checklist for this disease! - 7. How can it be secured that decisions on intervention will be periodically and ad hoc reviewed?

5. Neonatology and Pediatric Care

1. Who defines the ‘interest’ of the child and how?
2. Can this child be involved in the decision-making process?
3. What are the parents’ values, wishes, fears?
4. Are there any special actual and future care-giving dimensions?
5. Will they be able to care for a severely handicapped the child?
6. Which financial organizational or consulting services are available?

6. Care for the Dying

1. Does this patient request palliative care even at the expense of prolonging life?
2. Does this patient request medical treatment of symptoms associated with the process of dying?
3. Are the wishes of the patient clear? How does he/she express their wishes?
4. Can the physician justify not following the wishes of the patient? Which available options in medical, palliative, and nursing care are the most appropriate?

7. Considerable Moral, Cultural or Religious Differences

1. Is the intended treatment and care acceptable to the values of the patient?
2. Is the treatment or care asked for by the patient (or her/his family or guardian) acceptable to health care providers, teams and to the institution?
3. What are the differences and who could be brought in to reduce or solve controversies?
4. Is it acceptable to experts, teams and institutions to recommend other experts or institutions to the patient? – Summarize major points of your decision; review those after treatment of the case.

8. Corporate Profile: Clinical Training and Public Profile

1. What are the most essential virtues/principles for your institution and its specific wards?
2. Which role play the following virtues/principles: communication, cooperation, competence, compassion, cultivation.
3 Are they of different importance in special fields of your service?
4. Is there a difference between personal or collective virtues as character traits and as legal, moral or cultural principles?
5. How would such a list of virtues/principles be different in special wards of your institution?
6. Which of these principles/virtues need more training?
7. Which principles/virtues should be addressed in public relations to demonstrate that your ward/institution is a good and reliable corporate neighbor?

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The ‘Bochum Checklist’ can be downloaded from www.ethik-in-der-praxis.de in different languages.

A ‘Virtual Training Course in Clinical Ethics’ by Hans-Martin Sass, using the checklist method, is also available in www.ethik-in-der-medizin.de in English language.

How can humans live without harming other living organisms?

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1. Introduction

Many, if not most cultures attempt to live in harmony with nature as far as possible, and they address this question seriously. One exception is globalized capitalism, one of which aims seems to be accumulation of wealth associated with ruthless exploitation of nature. But within this system resistance has emerged, striving for greater sustainability in agriculture and economy.

Traditional, especially animistic cultures see Nature (earth, plants, animals, rivers, mountains etc.) as an integral part of human existence that is endowed with its own rights and has to be honored and preserved. Human necessities like food, clothing, housing or religious rites have to be obtained with as little harm to nature as possible. Consequently, the ultimate goal may be summed up as follows: life in harmony with nature should consume only what Nature gives voluntarily.

2. The concept of Nature in Kyrgyz culture

We here take Kyrgyz culture as an example of how a traditional way of life deals with the problem to harmonize nature with human needs. Kyrgyz are nomadic people of Central Asia. They followed the ancient idea of unity of humans with Nature that originated in Tengrianism. The Tengrianism is the philosophic-religious doctrine based on the cult of the Sky – the Tengri. Tengrianism starts with the essence of orderliness in space which includes balanced preservation of Nature. For preservation of this balance it is necessary to give anything to Nature before taking anything from it. It was for example, not permitted to throw away or dump rotten food because then this person had dared to take superfluous amounts from Nature.

The nomadic consciousness perceives the world being represented as an uniform internally intelligent Whole, that covers all objects and events of reality. All elements possess equal value in this unity. The nomad considered that all life is useful, because it was created by Nature. Disappearance of any kind of animal or plant can break the balance and order in the Whole; than comes chaos and «the world will turn over».

Relations of people with the Nature were based on respect and were considered rather as interdependence than as its exploitation. This allowed the Kyrgyz to live on the earth a millennium without negative consequences for environment.

From old times the Kyrgyz believe in existence of spirits-patrons of each mountain, rivers, lakes, roads, etc. It was supposed to approach spirits of districts respectfully, to make a sacrifice and ask the permission for a journey or good luck in a craft. The sacrifice was made always in certain places usually at lonely trees named *Mazar*. The sacrifice used to be ribbons or strips of a fabric that became attached to trees. There are still many such places in Kyrgyzstan. Till now ribbons are tied to trees on mountain passes, at dangerous river crossings etc.

The ancient idea of unity of human with the Nature is expressed in legends and eposes. The small epos "*Kozhozhash*" can serve as example (se addendum).

3. Food: a biological necessity

All organisms have take up food for gain of nutrients (elements, molecules) and to a great part also for gain of energy. In Nature two ways of getting nutrients and energy are realized:

a) Autotrophic organisms get all nutrients from soil, water or air, largely in the form of inorganic molecules (ammonia, nitrate, sulfate, phosphate, metal ions etc.). Energy is derived from sun light (plants, phototrophic bacteria) or from chemical reactions (chemolithotrophic bacteria: oxidation of e.g. hydrogen, ammonia, hydrogen sulfide, or reduction of e.g. nitrate, sulfate). Killing and cannibalism are not necessary.[1]

b) Heterotrophic organisms (humans, animals, fungi, many bacteria) have to feed on organic matter which had been produced by other organisms, in first instance by autotrophs. No killing is necessary, when feeding on dead organic matter (many fungi, carrion eaters). But all other organisms have to inflict damage on plants or animals, up to killing them or devouring pre-offspring (seeds, grains, eggs, etc.).[2]

3.1 Vegetarianism: a way out?

Vegetarians maintain that harming animals is not permitted whereas harming plants is. Destruction of seeds and parts of plants (leaves, roots…) is allowed and considered necessary. One of the arguments is not to inflict pain. Vegetarians consider pain to be restricted to animals. Certainly the specific pain experienced by e.g. wounded humans or beaten dogs is based on the existence of a nervous system, that is absent in pants, fungi and lower organisms. Nerves electrochemically transfer unpleasant signals (beating, burning etc.) to the brain, where they are converted into the sensation of pain and elicit reactions of defense.[3] Although lacking a nervous system plants definitely have ways to transduce dangerous signals from e.g. wounds to specific centers (cells, organs) and then induce appropriate defensive or healing measures (León et al., 2001). These signals must be considered as "unpleasant", and plants try to avoid them. Some plants after their reception even warn neighbors of imminent danger so they can take preparative actions. The warning signal frequently is the

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[1] http://en.wikipedia.org/wiki/Autotroph
[2] http://en.wikipedia.org/wiki/Heterotroph
[3] http://pain.about.com/od/whatischronicpain/a/feeling_pain.htm

gas ethylene (Baldwin et al., 2002).

Thus plants obviously resent removal of essential parts (leaves, roots) of their bodies, although they do not audibly protest. Likewise we can safely assume that they generally do not agree with consumption of their descendants (grains, seeds).

Apart from the unsolved question whether or not plants experience an unknown equivalent of pain, it seems questionable whether destruction of plant parts or devouring their offspring really is ethically more tolerable than e.g. eating eggs.

3.2 Voluntary donations of plants

Due to their sessile life style plants have invented ingenious ways to disperse their embryos (seeds).[4] Aims are to avoid young competitors rooting close by, and to colonize new niches far away. Some plants construct seeds which easily can be carried away by wind (e.g. dandelion), others have invented machineries to catapult the seeds as far away as possible (e. g. small-flowered bittercress). The most widely distributed strategy makes use of animals as carriers. Fruits of these plants either stick to the carriers or are intentioned to be devoured by animals as means of propagation and distribution of the future population. The seeds are embedded in tasty textures which are meant to attract animals and be eaten. The seeds then should pass the intestinal tract unharmed and be excreted at a place far away from the parent.[5]

If not consumed by animal carriers, the mature fruits drop to the earth nearby and decay to liberate the seeds. Well known examples are: cherries, apples, oranges, avocados, tomatoes, cucumbers, olives. Consuming these fruits and liberating the seeds far away can be considered as a culinary symbiosis and helps both partners.

Other groups with an exploitable strategy are the fungi. Their fruiting bodies are built for the production of thousands or millions of spores that after maturation dissociate and are dispersed by the wind.[6] Consuming the fruiting bodies entirely with immature spores in the above discussed context harms the organism. But if we remove the spores from a ripe body, consumption should be tolerable. Fruiting bodies after dismissal of spores are not essential to fungal physiology, they decay like plant fruits. The essentials of fungal life are concentrated in the mycelium in the soil.

Milk and its products are a special topic: they may be indispensable as vitamin source; but cows can be considered to be harmed indirectly by deprivation of calf food. Overproduction for human consumption could be considered as enslavement of the producer.

4. Conclusion

If we strive towards a life with as little harm to nature as possible, consumption of donations from the plants and fungi should be the first choice, if a balanced diet can be achieved this way. In the culinary symbiosis outlined above the seeds of fruits (of course, seedless varieties are not permitted!) should be distributed in the environment first before consumption without remorse.

These considerations did not touch the controversial matters of fuel and fibers, which have to be discussed elsewhere.

Addendum: The Kyrgyz epos "*Kozhozhash*".

There was a belief in existence of spirits-patrons of wild animals in the Kyrgyz ancient mythology. It is considered one of such spirits *Kajberen*, an anthropomorphic being in the form of a sacred animal, a female of mountain goat *Sur echki*. The human can hunt on its numerous posterity, it has the right to be fed for the account of posterity of *Sur echki*, but should not break that extreme line when hunting becomes not a craft for a sort survival, and injurious destruction for the sake of passion or human self-interest.

The skillful and successful hunter who has managed to rescue the relatives from starvation during long winter and cattle-plaque has a dream in which, after successful hunting for wild goats, he appears at top of an unapproachable rock. He feels fear and asks the wife to interpret a dream. She advises to him not to hunt any more as his life is threatened with danger. Despite of it *Kozhozhash* decides to continue hunting for posterity of the Grey goat.

Opposition between the hunter and a sacred animal amplifies after *Kozhozhash* completely exterminates young posterity of the *Sur echki*.

The Grey goat asks *Kozhozhash* to leave in live her spouse *Alabash*. However, the grown exited hunter kills him also, having undermined thereby possibility of a continuation of the family of the *Sur echki*.

It is remarkable that in the epoc intense dispute between the hunter and an animal that testifies to absolute belief in special qualities of the sacred animal appears, capable to talk to the person and to express the feelings.

The *Sur echki* swears to revenge *Kozhozhash* for destruction of the posterity, and the hunter swears not to calm down until catching his opponent.

Finally, the *Sur echki* entices the hunter on a slope of an unapproachable rock and leave him there to die of hunger and cold. Without having taken out sufferings, *Kozhozhash* rushes from a rock down and perishes.

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[4] http://en.wikipedia.org/wiki/Seed_dispersal

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Neo-Socratic Dialogue on Fairness in the Healthcare System

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Abstract

As public values change and diversify, a wide range of attitudes focused on basic aims of healthcare will develop. Yet, few opportunities exist between professionals and patients to discuss various healthcare issues and concerns. In this study, we used the Neo-Socratic Dialogue (NSD) method and established a forum to discuss fairness in the healthcare system among participants with diverse backgrounds. Participants in three sessions, based on case studies concerning elderly healthcare service, basic coverage, and rationing of care, achieved a consensus on the following principles: healthcare service should fulfill patient’s health needs; certain services should be equally provided to every patient; everyone should support the healthcare system; and patients and professionals are responsible for establishing a fair healthcare service. All groups supported the egalitarian system of healthcare in Japan and suggested necessary improvements. The NSD facilitated to formulate shared ethical principles and responsibilities among healthcare professionals and the general public.

Keywords: Neo-Socratic Dialogue, healthcare, fairness, philosophical discussion.

Introduction

Japan has a low-cost universal healthcare system with the highest life expectancy worldwide. However, national healthcare expenses continue to rise due to a rapidly aging population. In addition, Japan’s healthcare system suffers from a shortage of doctors, especially in the areas of emergency care, obstetrics, and pediatrics. Patients, for example, are sometimes denied emergency service by several hospitals before they receive treatment. Regional disparities exist regarding physician and hospital availability in the present healthcare system (1). Issues such as “convenience-store consultations,” a term that describes patients that drop by emergency outpatient services even when their symptoms are neither serious nor urgent, remain to be solved. “Monster patients,” or patients who use abusive language and are violent, are also seen. Unfortunately, the media’s extensive coverage of medical accidents has generated public distrust of Japan’s healthcare system. Disputes and lawsuits are feared and have resulted in defensive medical treatment and/or refusal to provide treatment by healthcare professionals. Therefore, Japan’s healthcare situation, also referred to “collapse of healthcare,” needs immediate reforms (2).

As public values change and diversify, a wide range of attitudes focused on basic aims of healthcare will develop. Few opportunities between professionals and patients exist to discuss the various healthcare issues and concerns. Nevertheless, these issues need to be addressed with a particular focus on the future of Japan’s healthcare system. Thus, it is vital to explore these concerns, and to create and test a communication model that will help generate a mutual understanding and consensus.

In this study, we used the Neo-Socratic Dialogue (NSD) method and established a forum to permit discussion of issues, principles, and values associated with healthcare among participants with diverse backgrounds. We had previously conducted NSDs on respective rights and responsibilities of healthcare professionals and patients. In prior studies, participants agreed that “receiving and providing the most suitable care” were both the right and responsibility of patients and healthcare professionals (3). In the present study, we conducted NSDs focusing on fairness in the healthcare system, a central principle behind healthcare ethics. In addition, we asked participants to assess their experience, and we validated the method beyond the content of each discussion.

Methods

NSD is a method which promotes philosophical dialogue among small groups of approximately seven people. This method was formulated by Leonard Nelson (1882-1927), and is presently used in Germany, England, and Holland for philosophical training, dialogue-based education, problem discovery, and for establishing consensus (4-5). In 1999, the method was introduced in Japan and has been in use since then. Recent attempts have been made to apply NSD to ethical and social discussions spanning the medical and healthcare fields (6-8).

NSD typically starts with a general question. Relevant case studies are then gathered from each participant, and one is selected for further investigation and discussion. Participants then corroborate judgments and actions associated with the people in each case study, and abstract the underlying principles and values. Finally, a consensus is formulated around the initial question. To ensure the success of any given dialogue, participants are asked to conform to specific rules, which include speaking clearly and listening carefully to other participants. Participants are also provided with appropriate standards to help select a case study suitable for dialogue. In the present study, a series of dialogues was divided into six 90-minute sessions conducted in a period of one and a half days. These sessions were carried out by three groups during 2009 and 2010 in Tokyo, Kumamoto, and Osaka. The general question chosen for the dialogues was: “What is fairness in healthcare?” Seven participants were selected per group and recruited among acquaintances of researchers that contributed to the study. The following participants were included in each group: two participants representing the general public; an ethicist or bioethicist; a participant with a legal background, participant representing the mass media, or sociologist; a physician; a nurse; and an additional healthcare professional. During the discussions, a facilitator wrote the main points on a flip chart, while a transcriber recorded participant statements on a computer terminal. This study was authorized by a General Research Ethics Review under the auspices of the Faculty of Medical and Pharmaceutical Sciences at Kumamoto University (Ethics No. 282, issued September 20, 2008).

Table 1: Participants

Total 19 participants (7 males, 12 females)
First NSD (June 2009, Tokyo) 7 (2 m, 5 f): An ethicist who takes care of his old parent, two journalists, the president of a medical consulting company, a doctor, a nurse, and a pharmacist.
Second NSD (February 2010, Kumamoto) 6 (2 m, 4 f): Two social activists and a bioethicist, (all three of whom participated for one day) a jurist, a doctor, and a nurse (all three of whom participated for the entire day-and-a-half).
Third NSD (March 2010, Osaka) 6 (3 m, 3 f): A social activist, an ethicist, a sociologist, a nurse, an occupational therapist, and a psychoanalyst. (A doctor partly sat in to observe)

Table 2: Case study categories (number of cases)

	1st	2nd	3rd	**Total**
Elderly healthcare services	1	4	1	**6**
Basic coverage		3		**3**
Rationing of care		2	2	**4**
Favorable treatment resulting from money, gifts, connections, etc.	5	8	5	**18**
Informed and family consent	2	1	7	**10**
Regional disparities		3		**3**
Psychiatry		2		**2**
Miscellaneous	4		2	**6**
Total	12	23	16	**52**

Results

A total of 19 people participated in the NSDs summarized in this study (Table 1). Fifty-two case studies were presented in response to the question: “What is fairness in healthcare?” These case studies were further categorized into 13 groups (Table 2).

3-1. First NSD: Elderly healthcare service

Participants from the first group chose the following case study as an example which represents the present healthcare system:

Case Study 1: Elderly patient who did not leave the hospital

Case Study Contributor: Nurse and bed-control manager

Case Summary: This case regards a male patient in his 80s who lived with his wife and received a pension. The patient also had a son and a daughter. The patient developed difficulty breathing and arranged a visit by his doctor, who decided to hospitalize him. However, the local hospital refused to admit the patient because only one doctor was present that night. Therefore, the patient was referred to me, a bed-control manager at an acute hospital located in the region. The patient arrived by ambulance even though he was able to walk. The initial diagnosis was possible pneumonia, with an estimated hospital stay of one week. The patient appeared disheveled and his overall condition was poor. During his stay, he developed lethargy with occasional delirium. After a week, the patient’s wife repeatedly requested for him to be moved to a shared room that was free of charge. X-ray and bronchoscopic examinations conducted by a physician revealed cancer in the patient. Although the physician was not in favour of treatment, the patient’s wife requested chemotherapy. However, the patient himself was not informed. I myself considered the treatment unnecessary, but at the same time the patient had the right to be treated. Once the therapy ended, the hospital asked the patient’s family to take him home, but they refused and argued that his health had declined. A social worker was appointed to look for a care facility, but was unable to locate one that met the family’s economic possibilities. At the same time, the family was not willing to relocate the patient to a distant facility nor were they willing to pay for a private room. The family began to visit less to avoid a discharge request. When the physician finally demanded a discharge, the wife pleaded with him and asked if the patient could stay. The patient’s daughter stated, “I know he cannot stay here, but it would be a burden for my mom to visit him if he were relocated to a distant facility. I also want my dad to receive the best possible treatment.” The patient’s health insurance co-payment was about 60,000 yen (~600 USD) per month, which basically meant that the hospital was cheaper compared to other healthcare facilities. Furthermore, the hospital was close for the family and provided the necessary care for the patient. Unfortunately, after staying for about 200 days, the patient died in hospital. The patient’s wife was satisfied with the outcome. However, attending nurses were frustrated because they had wasted time and effort with the patient. After this experience, I only assign private rooms to elderly patients that have to stay long.

Participants identified the judgments and actions of this case study that related to fairness in healthcare. A central judgment and reason were formulated as follows:

Judgment: The bed-control manager felt that the patient’s family was selfish and that it was unfair for the patient to stay at the hospital.

Reason: Healthcare facility guidelines should be strictly followed in order to provide services based on patient need.

The case contributor stated that she could not hospitalize acutely ill patients if other patients occupied beds for a longer period of time than needed. Moreover, a participant pointed out that the bed-control manager was responsible for the medical fees paid to the hospital by the Diagnosis Procedure Combination-based payment system. However, not all group participants supported the judgment. Opponents argued that the patient's long-term hospital stay, although unfair and a breach of healthcare facility guidelines, was justifiable since the family was unable to find an affordable facility. They attributed the lack of affordable facilities to the current Japanese healthcare system, which suffers from a shortage of facilities, and which offers costly care of poor quality. Participants recognized both sides of the argument and strived to answer the question regarding fairness in healthcare. Answers to discussed concerns were established as follows:

Answers:

- Healthcare services should be provided according to patient need.
- It is not possible to meet every patient's need.
- The healthcare system functions only if supported by everyone.
- Everyone should follow the rules of the healthcare system.
- Everyone should be informed and taught how to support the healthcare system.
- The healthcare system requires improvements before people can trust and support it.

3-2. Second NSD: Basic care coverage

Participants in the second group chose the following case study associated with public health insurance coverage:

Case Study 2: Doctor who ignored a patient's concern regarding her post-operative scar

Case Study Contributor: Medical student

Case Summary: A housewife in her 40's was hospitalized requiring surgery due to possible malignancy in the kidney. The patient was informed prior to surgery that if there was a malignant tumor the kidney would be removed. An optimistic prognosis was given, but no specific information about a post-operative scar was provided. A week later, the surgery was performed and the patient's kidney was removed. Following the surgery, the patient was given a favorable prognosis, but again no explanation about a post-operative scar was provided. Two days after the surgery, the patient was shocked to see a 12 cm scar and stated, "The scar is unexpectedly large. I cannot go to hot springs anymore." However, she did not mention any of this to her doctor. As a medical student at that time, I wrote down the patient's words on the medical chart and asked the doctor about referring the patient to a plastic surgeon. The doctor responded, "It is unnecessary to spend money and human resources in a public hospital, especially since the patient is married and has children. Please tell her nicely." Yet, I was unable to tell the patient, but did suggest that she visit another hospital to consult a plastic surgeon. No one at the hospital did anything to address the patient's concerns about the post-operative scar. I could tell that the patient was upset about her scar up to the day she was discharged. I also talked to my mentor about the patient's situation, but he did not follow up with this case. I lost contact with the patient after she was discharged from the hospital.

Participants in this group identified the following judgments and actions of the case study relating to fairness in healthcare:

Judgments: The patient hoped to get her scar treated; yet, her doctor considered it to be unnecessary. Other healthcare professionals at the hospital also agreed with the doctor. The patient was not informed about a post-operative scar. The case contributor felt that the patient's concerns should have been addressed.

This last statement was selected as the main judgment of the study, and the following reason was provided:

Reason: Healthcare professionals should be sympathetic towards patient's health needs, and should provide the best possible care while taking resource availability into consideration.

Participants in this NSD group established the following answers to the question regarding fairness in the healthcare system:

Answers:

- Healthcare professionals should consider the patient's wellbeing, and should be sympathetic toward patient needs.
- Patients should be informed about their conditions, basic service options and be given time to consider each option.
- Fairness is commonly accepted to mean equality rather than freedom, self-determination, and contract.

Participants concluded that sex, age, marital status, and scar location should not be deciding factors for plastic surgery referrals. Moreover, the medical team should have informed the patient about her condition and options once the scar had healed (i.e., plastic surgery at her own expense).

3-3. Third NSD: Rationing of nursing care

The following case study was chosen to discuss rationing by the third group:

Case Study 3: Rationing of nursing care

Case Study Contributor: Nurse

Case Summary: My colleague and I were supervising a ward at a hospital during the night shift. The ward had 50 beds with terminally- and acutely-ill patients mixed together. A terminally ill male patient in his 50s suffering from stomach cancer called for help from his private room. When I went to answer his call, the patient told me that he could not sleep and that he felt cold. My assessment was that the patient was feeling anxious. After consulting with my colleague, I provided the patient with a footbath and massage. In addition, I gave the patient a cup of ice cream and had one with him by the bedside. The patient thanked me and closed his eyes. The total amount of time I spent with the patient was about half an hour, which I thought was timesaving in the long run. In fact, I would do this for any patient in the ward provided no emergencies require my attention. The hospital's nursing policy is to provide superior patient care, but this policy is not carried out in practice. Moreover, the ward's head nurse allows personnel to act on their own with no prior permission. Having said this, I proceeded with what might be considered by others as unorthodox, and documented my actions on the nursing record. I believe that it was best to consult with my colleague before proceeding. Perhaps another colleague might have suggested giving the patient an electric blanket. I dedicated extra time to this particular patient, and I would do so for any patient in the ward.

Participants made the following observations about the nurse's judgments and actions:

Judgments: Work at the hospital ward was very busy. The nurse was working in a ward where patients with different diseases were mixed together. The nurse received an unusual request from a terminally ill patient. The nurse determined the amount of time she could dedicate to the patient. The nurse consulted with her colleague. The nurse reached an agreement with her colleague about spending time with the patient. Patients in other rooms did not see nor complain about the nurse's actions. The nurse dedicated time to one patient. The nurse provided a kind gesture to the patient, and indirectly contributed to the wellbeing of other patients, colleagues, and the ward. The nurse made an effort to improve healthcare quality at the hospital. The nurse carried out an unorthodox act other colleagues might disagree with. The nurse lacked discretion.

Participants concluded that the nurse's judgments and actions had been mostly fair. The following reasons for this conclusion were:

- Every patient should receive proper care according to their health needs.
- The nurse's actions improved healthcare quality and were educational; however, such practices are difficult to standardize.
- The nurse balanced her responsibilities at the ward and executed them.

During the discussion session, participants highlighted several aspects from the case study that were unfair. For example, participants argued that some professionals and patients might disagree with the nurse's actions. The following answers were established regarding fairness during rationing of nursing care:

- Patient's health needs should be a priority of healthcare professionals. Furthermore, professionals should respect patients, treat them as individuals, and do the best to meet their needs.
- A balance between procedures and outcomes should be established given limited resources.
- Nursing professionals should establish a nursing philosophy and educate others. However, nursing is an art and not a science, which makes it difficult to standardize.
- Nurses should be held accountable for their actions and understood by hospital managers, patients, and society.

3-4. NSD Evaluations

At the end of each discussion, participants were asked to fill out an evaluation sheet regarding their experience with the NSD (n=16). The evaluations showed a similar tendency for all three NSDs, with an overall evaluation averaging between "excellent" and "good." Participants from each group strongly agreed with the following statements: "We had a fruitful discussion," "I understood others' opinions," and "Other participants referred to my argument." In contrast, some participants were uncertain about the following points: "I convinced others of my opinion," and "My opinion has changed." In addition, several participants described the NSD as a forum where topics could be discussed separate from personal interests. One participant also pointed out that by listening to others her own position on a particular matter became clear.

However, participants mentioned several disadvantages with the NSD including influences from discussion facilitation, participant recruitment, case study selection, and time-consuming discussions. One participant also stressed that the level of expert knowledge to be communicated to other participants was unclear. Furthermore, concerns were raised regarding the need to verify results and the applicability of NSDs in real life problem solving situations. Finally, several participants stated that accountability was a heavy burden for healthcare professionals, which could negatively affect patient care.

4. Discussion

Participant answers regarding fairness in healthcare can be summarized as follows. Distributive justice: Quality health service should be provided according to patient's health needs. Limitation of resources: Not every patient need can be met because of limited healthcare resources. Decent minimum of healthcare: Everyone should be treated with sympathy and provided information, healthcare service options, and the necessary time to consider every option. Procedural justice: Health service procedures and outcomes should be accountable, informed, and accepted by each party involved. Responsibility and improvement: Healthcare professionals and patients have the responsibility to maintain fair healthcare service. In addition, such services need to be improved to provide people with better quality service.

Although not novel, these principles allowed participants with diverse backgrounds to reach a consensus about guidelines required to establish a fair healthcare system (9). The first and third NSD group concentrated on procedural justice and responsibility, while the second group focused on the principle of decent minimum of healthcare. In general, all groups supported the egalitarian system of healthcare in Japan, which provides universal access and a decent minimum of healthcare. During the NSDs, the following problems with respect to the present healthcare system were identified and discussed: elderly healthcare requires improvements; the decent minimum of healthcare should be more efficient; and healthcare services should be more accountable. A multi-disciplinary expert group had once proposed shared ethical principles for all healthcare providers (10). However, it is more important to formulate shared ethical principles and responsibilities among healthcare professionals and the general public, which was facilitated by NSDs.

The questions of whether unfair treatments are ever acceptable and whether accountability would place too much of a burden on healthcare providers were not fully discussed. However, participants in the first group were generally for protecting people who are unable, financially or otherwise, to follow the rules of the healthcare system. Participants in the third group believed that the nurse in the case study provided better care than she was responsible for, but that she could not be held fully accountable for it. Important to keep in mind is that these principles need to be considered in various contexts of healthcare.

Although participants were mostly in favor of the NSD, several limitations were noted. The case studies illustrated here may not be sufficient to answer the general question regarding fairness in healthcare. In addition, discussions may have been biased given the limited number of participants, their diversity and ability, and the allotted discussion time. Therefore, more detailed information is necessary in order to formulate policies regarding healthcare, especially those that relate to the elderly.

Conclusion

We used the NSD method to promote discussions and achieve a consensus among participants with diverse backgrounds regarding fairness in healthcare. The following principles can be concluded from this study: healthcare service should fulfill patient's health needs; certain services should be equally provided to every patient; everyone should support the healthcare system; and patients and professionals are responsible for establishing a fair healthcare service.

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Women's Opinions and Experiences Regarding Pursuing a Professional Life: A Micro Level Study of a Mahalla in Rajshahi City Corporation, Bangladesh

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Abstract

Women's participation in higher education is quite low in Bangladesh. Their participation in different professions is even lower. Various types of barriers are faced by women in their families, communities and broader society in acquiring higher education and in pursuing different professions. This paper attempts to find the proportion of women who had acquired education up to the S.S.C. level (or higher) in the study area, discover those who were engaged in some kind of professional activities among them and then reveal the opinions and experiences of those working women in entering and continuing a professional life. 44 out of 54 S.S.C. (or higher degree) holder women belonging to 150 households residing within the study locale were respondents of this study. 80% of these respondents held either a bachelor's or a master's degree. Only 7 of the respondents were housewives, 28 (64%) were engaged in some kind of profession, and most of others were students. The respondents thought that in acquiring higher education and pursuing different professions women faced problems related to family approval, and financial support. Unavailability of day care centres barred mothers from materializing their dreams of doing well in higher education and pursuing challenging professions.

Keywords: Women, Higher education, Professional life, Socialization, Family approval.

Introduction

Higher education is essential for training up future professionals, administrators, scientists, and apt businessmen in a country, and hence it plays a crucial role in its socio-economic development (Khatun 2003). Women gained opportunity to enroll into higher education not before the 1850s (Lie and O'Leary 1990). Even today, those women who do gain access to higher education seldom get the chance to enter lucrative fields of study, or selective colleges that lead them to higher paying jobs. In the USA, “males are much more likely to enter fields of study with higher economic returns than are females” (Davies and Guppy, 1997).

Higher education brings about some important positive outcomes, namely, quality education of children, elevated age of getting married (of women), greater acceptance of birth control methods, higher status of women and their development and acquisition of qualifications to work in the productive sector (Khatun 1998). “The level of female education is an important indicator not only for raising the status of women in the society but also for increasing the ability of a country to use its human resources effectively for national development” (Begum 1994). Although women in developed countries like the UK, USA and Canada are almost equal or even higher in proportion in comparison to men in attaining higher education (Ballantine 1993, Sutherland 1994, Astin and Malik 1994; Bellamy and Guppy 1990, Davies and Guppy 2006), participation of women at tertiary level of education is quite low in Bangladesh. Country profile data of the UN shows that during 2005-2010, female students’ proportion at third level of education stood at 35.1% (UN data 2011). Their participation in different professions was even lower. In 2005, only 22% of the non-agricultural service holders were women (Islam 2007). In 2005, only 1.35% of the important posts of the secretariat (secretary, additional secretary, joint secretary and deputy secretary) were held by women (Mannan and Mary 2006, p. 92).

The main reason for this poor representation is the preconception of the people in society that it is men’s responsibility to earn a living and women need not/should not be involved in paid jobs. This ideology discourages women to acquire higher education, as a result of which they are left lacking in required qualifications to enter different professions and remain economically and socially dependent on men. The implication of such ideology is that if there is a man available for a particular job, employers seldom hire a woman (Rahman and Otobe, 2005). Moreover, women are paid less than men as remuneration for performing the same tasks. Marzia Fontana (as cited in USAID 2006, p. 54) has shown the gender wage gap in Bangladesh in the year 2000—among those working males and females who had completed 10 schooling years or more, females earned only 72% of what males earned. Careers of women are constricted owing to their preference for convenient locations, flexible work-hours and longer vacations to make a balance between their professional and household responsibilities (Khan 1993).

Various types of barriers are faced by women in their families, communities and broader society in acquiring higher education and in pursuing different professions, which include discriminatory socialization within the family, placing greater importance on educating sons, security problems for girls regarding residence and traveling while studying in universities, greater costs for girls’ higher education in terms of communication, movement, clothes etc., session jam in universities etc. (see Bhoumik 2007, Begum 2002, Akmam 2004, Mannan and Mary 2006) .

Socio-economic conditions of a woman’s family and the encouragement and support she receives from her family members affect her academic performance (Akmam 1995). However, it is usually observed that instead of putting primary emphasis on their daughters’ securing a high status-lucrative job, parents are more concerned about finding a well-established husband for them, who will be of higher educational and professional qualification (Begum 2002). Often “the most desirable outcome for investing in lengthy education for daughters in the eyes of most families may well be that these women never need to enter occupations for which they are trained because they have married men with stable jobs and adequate income” (Papanek 1985: 341). As parents cannot expect any financial gain from their daughters’ income, it is rational that they would place a lower emphasis on educating their daughters up to university level (Hill and King 1993).

Objectives of the Study

This paper is based on a micro level study that attempts to find out the proportion of women who had acquired the S.S.C. level of education or higher within a residential area of Rajshahi City Corporation, discover those who were engaged in some kind of professional activities among them and then reveal the opinions and experiences of those women in entering and continuing a professional life. More specifically, its objectives are:

(1) To find out socio-economic conditions of the families of the respondents, which greatly influences their achievements in higher education and pursuing a professional career;

(2) To discover attitudes/opinions of the respondents regarding women’s attainment of higher education and their pursuing different professions;

(3) To learn about the attitudes/opinions of the families and communities of respondents regarding women’s attainment of higher education and their pursuing different professions (as experienced by the respondents in their lives);

(4) To know about the attitudes/cooperation of colleagues of those respondents who were pursuing a profession (as experienced by the respondents in their lives);

(5) To understand the nature of the hurdles encountered by women in continuing and developing their professional career.

Methodology of the Study

Social survey and case study were the methods used in this study. Respondents were women with an S.S.C. or higher academic degree living in an area named Purba Para of Mohishbathan mahalla within ward # 5 of Rajshahi City Corporation. Women with academic qualification mentioned above in *all* the households (150) residing within the study area were included in the study.

Sampling Technique and Sample Size

It was expected by the authors that on an average there would be at least one female within each household educated up to at least S.S.C. level or higher among the 150 households residing within the study area. As such the assumed number of respondents was around 150. However, within all the 150 households only 54 women living in 41 of the households were found to be holding an S.S.C. or a higher degree during the field-work period (October 15 to November 10, 2011). Upon being humbly approached to answer the questions for the current research work, only 44 of these women (residing in 34 households) agreed to be respondents of this study. Shortage of time, ignorance about the importance of these studies, lack of interest in sharing personal/family affairs with strangers or even sheer laziness could have made the prospective respondents refrain from participating in this study. As a result, although a total enumeration of all the women holding an S.S.C. or a higher degree in the study area was intended for the study, the actual number of respondents turned out to be quite small. The time limit of completing the study (originally carried out to be presented at a conference on December 2, 2011) prevented the authors from taking a larger locality as the study area. Therefore, a small sample size remains a limitation of this study.

Collection of Data

Mainly face to face interviews using a questionnaire containing open ended and closed-ended questions was adopted as the technique of data collection. The questionnaires were developed on the basis of the objectives of the study. Care was taken in setting the language of the questions so that the respondents would not feel embarrassed. Two of the female authors of this study conducted the interviews themselves. Both had previous experience of carrying out social research. In some cases respondents took the questionnaires and filled them in during their free time. The filled in questionnaires were collected by the researchers later on. Some respondents did not answer all the questions. The efforts of the authors to get the missing information (in the incomplete questionnaires) became futile in the face of disinterest shown by the respondents. It appeared that they did not realize the importance of their participation in the study and did not wish to give any more time for this purpose. The filled-in questionnaires collected from the respondents were edited before processing.

Processing and Analysis of Data

SPSS software package was used to process and analyze the data.

Socio-economic condition of the respondents

Table 1 shows the age of the respondents, which reveals that most of them (n=28, 64%) were under 40 years of age. Table 2 portrays the educational level of the respondents. In it we find that more than 52% of the respondents were postgraduates. Only one respondent had stopped studying after acquiring S.S.C. and only six (14%) had given up their studies after crossing the H.S.C. level. In the survey it was found that more than 93% (n=41) of the respondents were Muslims, while 2 (4.5%) were Christians and 1 belonged to Hindu faith (2.3%). Table 3 shows that most of the respondents were married (n=27, 61%); 14 (32%) were unmarried, 2 (4.5%) were widows and one (2.3%) was a divorcee.

Table 1: Age of the respondents

Age (in years)	No. of Respondents	Percent
<20-30	17	38.64
30-40	11	25
40-50	12	27.27
50-60	3	6.82
>60	1	2.27
Total	**44**	**100.0**

Table 2: Educational level of the respondent

Education Level	No. Respondents	Percent
SSC	1	2.3
HSC	6	13.6
Studying at Graduate level	2	4.5
Graduate	12	27.3
Post Graduate	22	50.0
Post Graduate+B.Ed	1	2.3
Total	**44**	**100.0**

Table 3: Marital status of the respondents

Marital Status	No. Respondents	Percent
Married	27	61.4
Unmarried	14	31.8
Widow	2	4.5
Divorced/Separated	1	2.3
Total	**44**	**100.0**

The data presented in Table 4 indicate that most of the respondents were service holders/business woman (n=28, 64%)—i.e., engaged in income generating activities. Seven of the respondents (16%) were housewives, not engaged in income-generating activities. Only one respondent identified herself as unemployed—meaning that she still was not married, nor was she a student or an income earner. The respondents were asked about types of their families and residences. The survey reveals that most of them belonged to nuclear families (n=35, 80%), and the rest were members of joint families (n=9, 21%). All the unmarried respondents (n=14, 32%) lived in their parental homes. Table 5 reveals that only five (11%) of the married respondents lived jointly with their in-laws, while most of them lived separately with their husbands (n=23, 52%). Two (4.5%) of the respondents were students and lived in hostels or messes in Dhaka. During the field work period of the study they were present at their parental homes. The field data also reveals that almost 80% of the respondents' families lived in their own houses (n=31, 80%), while others lived in rented houses (n=13, 21%).

Table 4: Occupation of the respondents

Occupation	No. Respondents	Percent
House wife	7	15.9
Service Holder	27	61.4
Business Woman	1	2.3
Student	7	15.9
Housewife+Student	1	2.3
Unemployed	1	2.3
Total	**44**	**100.0**

Table 5: Place of residence

Place of Residence	No. Respondents	Percent
Father's house	14	31.8
In-law's-house	5	11.4
With Husband	23	52.3
Mess/Hostel	2	4.5
Total	**44**	**100.0**

Table 6: Sources of income

Sources of Income	No. Respondents	Percent
Service	35	79.5
Agriculture	1	2.3
Business	4	9.1
Service and Business	2	4.5
Service and Agriculture	2	4.5
Total	**44**	**100.0**

Table 6 shows that most of the respondents' families earned their living through their services (n=35, 80%). Two of the families' income earners were both service holders and businessmen. The survey data reveal that more than 63% (n=28) of the respondents' families had two income earners. Seven (16%) of the respondents' families had three income earners and nine (21%) had a single income earner. Number of family members also tells us a lot about a family. The survey findings show that in 82% (n=36) of the respondents' families, number of family members was limited to five. Only three (6.8%) had more than seven members. Five (11%) of the respondents' families had 6-7 members. Table 7 shows average yearly income of the respondents. Almost 50% (n=21, 48%) of the respondents' families earned less than Taka 200,000 per year. Fifteen of the families (34%) earned in between Tk. 200,000 to Tk. 300,000, which means that more than 81% of the respondent families earned Tk. 300,000 or less per year.

Table 7: Average yearly income of the respondents' households

Yearly Income (in Taka)	No. Respondents	Percent
<200,000	21	47.7
200,000-300,000	15	34.1
300,000-400,000	2	4.5
400,000-600,000	5	11.4
>600,000	1	2.3
Total	**44**	**100.0**

Respondents' Opinions and Experiences Regarding Women's Education and Profession

All respondents were of the opinion that education enriches our lives both financially and emotionally and that an educated woman could contribute to her family and society in a much more efficient way than an uneducated woman using knowledge gained through education. There were marked differences in the life styles of educated and non-educated women. Educated women were more efficient in child-rearing; they were able to make appropriate decisions quickly and contribute more to solving different problems that arise in the family. However, as the survey data reveal, most of the respondents (n=40, 91%) believed that women faced many problems in pursuing higher education—namely, barriers from the family (n=39, 89%), and barriers due to financial reasons (n=34, 77%). Thirteen (30%) of the respondents themselves faced financial and familial barriers in pursuing education.

Regarding pursuing of a profession, only 23 (52%) believed that women were able to pursue any profession. The rest were of the opinion that not all jobs were suitable for women due to their physical weakness (n=8, 18%), lack of security (n=16, 36%), lack of cooperation from family and society (n=8, 18%), and lack of suitable work environment (n=14, 32%). Twenty-five (57%) of the respondents thought that women are capable of working efficiently in all types of professions. However, 12 (27%) of the respondents thought that women were most efficient in household jobs, 2 (4.5%) thought they were best fitted for desk work and household tasks, 4 (9.1%) thought that women could work most efficiently in only desk jobs, and only one (2.3%) thought that women could work well at field level. The respondents were asked again, about the work they thought were not approved by society to be done by women. In response, 16 (36%) mentioned that field-based work done by women was not socially acceptable, 6 (14%) believed that media, film and defense were the work areas which were not approved by society to be a woman's work arena. Another 5 (11%) mentioned the defense and field-based work as not approved by society to be done by women. Three (6.8%) have mentioned that jobs which required physical strength were not socially acceptable as women's job. Another respondent said that women working in the defense and as sales girls were socially despised. Still another respondent said that women working in the media and in the defense were socially looked down upon.

The survey reveals that all except one respondent (98%) believed that all women should have the opportunity to choose their own profession. One respondent thought that women should not choose their own profession because they could make wrong decisions; there could be family disturbances due to their decision making; and because they thought that women lacked the confidence to make correct decisions.

All the respondents said that support from family was essential for a woman to continue her studies. In describing their own experiences, almost all the respondents said that they received ample support from their families. However, 2 said that they experienced heavy loads of household chores and lack of financial support from their families while attaining their higher studies.

All except one of the respondents enjoyed support of their parental families regarding continuation of their professions/jobs. Table 8 portrays the type of job viewed as most suitable for women by the respondents' families. Teaching was the profession chosen by 73% (n=32) of the respondents' families. Only 6 (13.6%) of them have said that their families would accept any profession to be pursued by their female family members. All except one respondent enjoyed full support of their parental families in continuing their professions and building their careers. All said that their jobs had contributed to the development of their family members.

Table 8: Most suitable profession for women according to respondents' parent's families

Acceptable professions	No. Respondents	Percent
All professions	6	13.6
Teaching	32	72.7
Administrative work	3	6.8
Desk jobs	1	2.3
Teaching or desk job	2	4.6
Total	**44**	**100.0**

In their own lives, most of the respondents (n=39, 89%) enjoyed positive attitude of their neighbours regarding their attaining of higher education. Their neighbours had encouraged them in doing well in their studies (n=31, 71%). The neighbours also showed a positive attitude towards them to engage in income generating activities. The field data reveal that neighbours of almost all of the respondents engaged in different professions were benefited by the jobs they were engaged in.

Regarding environment of the work place, most of the respondents (n=37, 84%) have opined that the environment of their workplaces should be safe, healthy and cooperative. One of the respondents wanted her work environment to be challenging as well. Among the 28 respondents who were engaged in different professions, six (21%) thought that they had been deprived on account of their gender. The opportunities they were deprived of included higher training, visits abroad and promotion.

All except one respondent received necessary cooperation from their colleagues. Twenty (74%) have said that they got cooperation from their male and female colleagues equally. Friendly relations with colleagues were reported by 21 (75%) of the respondents engaged in different professions, while 7 (25%) spoke of formal relationships. All of these respondents have said that their colleagues helped them a lot during their periods of distress. Only four respondents have reported that they had seen their female colleagues to be harassed by male colleagues. None of them however, had admitted to be harassed themselves.

The respondents were asked about the types of problems that women face in continuing and developing their careers, as they had observed in their own lives and in the lives of other women. Their responses are found in Table 9. One respondent spoke of emotional problems, another mentioned physical problems, three (6.8%) have mentioned family problems, and 10 (23%) considered gender discrimination as the problems faced by women in continuation and development of their careers. However, most of the respondents (n=28, 64%) opined that all the problems mentioned above were experienced by women aiming at developing their careers.

Having to bear full responsibility of maintaining the family—i.e., doing the household work, rearing children--is the most important barrier in a career woman's life in pursuing her profession. If her husband shares the household work, it makes things easier for everyone. In fact it is very difficult for a woman to continue her profession without support of her husband or other family members in carrying out the reproductive works in the household. In Table 10 we find that more than 50% (n=16, 57.1%) of the respondents with professional careers received help of their husbands in household work, 8 (29%) did not receive such help. Four of the respondents did not respond on this issue.

Table 9: Problems faced by women in continuing and developing their careers

Types of problems	No. of Respondents	Percent
Emotional problems	1	2.3
Physical problems	1	2.3
Family problems	3	6.8
Gender discrimination	10	22.7
All mentioned above	28	63.6
Emotional problems and gender discrimination	1	2.3
Total	**44**	**100.0**

The respondents of this study were asked whether they fell behind their male colleagues in developing their careers. In response, only five (18%) answered in the affirmative. The rest said that they did not fall behind their male colleagues. They were also asked about the reasons for which women fell behind their male colleagues in developing their careers. The reasons they mentioned were: (1) males were thought to be as more industrious and efficient, (2) males were more acceptable, (3) there was wider freedom in work for male workers, and (4) greater involvement of women in domestic chores. The survey results portray that among the 44 respondents 39 (89%) believed that a woman has to work harder to prove herself equal to her male colleagues in similar professions.

Table 10: Whether husband helps in household work

Whether husband helps in household work	No. of Respondents	Percent
Yes	16	57.1
No	8	28.6
No response	4	14.3
Total	**28**	**100.0**

All but one of the respondents believed that all women should take part in income generating jobs. The respondent who was against women's income earning thought that it would hamper peace in the family and cause trouble in child rearing. Respondents were asked about the attitude of greater society (within which they lived) regarding women's pursuing higher education and professions. Most of them (n=34, 77%) thought that the attitude of society in general was not sufficiently supportive, 2 (4.5%) thought that attitude of society was rather conservative, 4 (9.1%) thought that society's attitude towards women's participation in higher education and different professions was liberal and another 4 (9.1%) thought that the society extended very much cooperative attitude towards women. Most (n=28, 64%) of the respondents said that the society must assume a constructive, cooperative and liberal role in encouraging women's participation in higher education and in giving them greater freedom to choose their own professions. Almost all of them (n=43, 98%) thought that women should take part in development process of the country, as they also had some liability in developing the nation (n=26, 59%). Also, women should work to expedite the development process in the country and make themselves self-confident (n=9, 21%).

In the survey it was found that among the 30 respondents who were married (or widow/divorcee), 21 (70%) got married while they were still students. Thirteen (62%) of them have said that their in-laws were very cooperative regarding continuation of their studies. However, 8 (38%) have said that their in-laws were rather neutral regarding their pursuing of higher education. Among the husbands, 19 (91%) were cooperative, the rest were not cooperative. All the respondents believed that support of in-laws was necessary for continuation of education of a married woman. Five of the respondents said that they were forced to put an end to their studies after marriage, as it was not approved by the members of their husbands' families (n=3, 60%), and because there was no one else to look after their children (n=2, 40%).

The respondents were asked whether their husbands' families made any discrimination between their daughters in law and their own daughters regarding pursuing higher education. Six of the married women experienced such discrimination—where their parents-in-law favoured their (the respondents') sisters-in-law. Nineteen (68%) of the married (income earning) respondents have said they enjoyed cooperation of their husbands and in-laws' families in continuing their professions. Sixteen (57%) of them said that they enjoyed greater importance and higher status in their in-laws' families than those women who were not engaged in any profession. Nineteen (68%) of the married (income earning) respondents thought their professional careers had contributed to the betterment of their in-laws' families. Among the 28 married working respondents, nine (32%) felt that their involvement in professions had brought about some negative impact upon their children. The reason for this feeling was that they could not allot sufficient time for their children for which they (children) could not be guided properly to turn out to be worthy citizens.

In the above, opinions and experiences of the respondents on an aggregate have been shown. Four of the respondents' life stories have been chosen to be presented as case studies, which are written briefly below. These respondents were asked about their aims in life during their student life (before marriage), about their families of origin and families of procreation, especially family-attitudes related to their acquisition of higher education and pursuing of a profession, the response of their husbands in this regard, the attitude of their colleagues towards them while working together, the hurdles they had to encounter in their acquisition of higher education and pursuing of a profession and about their lives in general.

Case Study 1

Mehenaz Mustarin (40 years) was working as an officer for an NGO named Manabsheba Abhijan at the time when this study was carried out. She completed her honours graduation at University of Rajshahi in 1995. Then she got married and gave birth to a son in 1998. After a break of study, she received her master's degree in 2000. Mehenaz lost her father during childhood. Her mother had to struggle to raise her. Watching the struggle of her mother, Meherin also came out to be an industrious woman. She had hopes of working as a high government official. However, her family situation—getting married before completion of master's degree, giving birth to two children and household responsibilities barred her from realizing her dream. Although her husband gave her full support, she refrained from striving for a high profile career. Now that her children have grown up considerably she has been working for an NGO since 2008. She has full support of her family regarding continuation of her career. However, she still has a feeling of dissatisfaction emanating from not being able to become a high ranking government official.

Case Study 2

Begum Fatima was born in 1947. She passed the S.S.C. examination in 1966. Living in a family with a step mother, she did not have the opportunity to continue her studies for long. She got married in 1966 and gave birth to her first child in 1967. Her husband died in 1971, when she was pregnant with her second child. With help of her father, Fatima once again began her studies and passed the H.S.C. examination in 1972. After passing the H.S.C. Examination, she joined a government primary school as a teacher. Although Fatima's in-laws did not encourage her much regarding continuation of her studies, they supported her in continuation of her job. This job contributed significantly in maintaining her family and raising her children. Personally she believes that all women should pursue higher education and take part in income generating activities. Currently she is living a retired life at her own residence.

Case Study 3

Tahera Akhtar Jahan (48 years) earned her S.S.C. in 1977, and completed her master's degree in botany in 1986 from University of Rajshahi. She got married when she was still a student. She also gave birth to a daughter during her study period at the university. However, she was able to continue her studies with the encouragement and support of her husband. Incidentally, Tahera got the opportunity to teach at a school named Queen's International School in Domar in 1991. Unfortunately, she could work there for only one year as she had to move from Domar, due to transfer of her husband who was a government official. After leaving Domar, she got more involved in her household work and rearing of her children, which barred her from getting a new job. Currently she is not involved in any income generating work, but she has educated her daughter up to post-graduate level and extends as much support as possible to her, so that she (Ms. Tahera's daughter) can pursue a professional life.

Case Study 4

Anjana Gomez (33 years old) is a socially conscious lady. Personally she believes that education enriches a person's life and that all women should get involved in income generating activities. Anjana passed the S.S.C. examination in 1994 and in 2002 got her bachelor's degree. While she was a master's level student, she got married. Due to lack of support from her husband and in-laws' family she could not continue her studies, in spite of having personal desire to complete her post graduation. However, she worked for some time as a field organizer for an NGO named CARITAS. Anjana's husband also works there. Unfortunately, Anjana could not continue her job, as she did not have the necessary support from her family. It is to be mentioned that Anjana lives in a joint family and her mother in law is still working. She has to shoulder all the household responsibilities. She believes that she could have continued her job if she had the support of her family. Anjana is aggrieved for not being able to continue her job. She earnestly hopes that all willing women be supported in order to lead a professional life.

Discussion

Attempts have been made in this paper to learn about women's experiences in pursuing different professions in an urban setting in Bangladesh. In this section we shall discuss some of the important findings of this study. In order to pursue a profession a relatively higher level of education/training is required. The first striking finding of this study was that there were only 54 Secondary School Certificate (SSC) holder women to be found within 150 households residing in Purba Para of Mahishbathan mahalla of Rajshahi City Corporation. However, it was also observed that among the 44 respondents who had achieved an education level of S.S.C. or higher, most (80%) were either bachelor's degree or master's degree holders. More than 52% of the respondents were post-graduates. Only one respondent had stopped studying after acquiring S.S.C., and only six (14%) had given up their studies after crossing the H.S.C. level. Thus those who were able to pass the hurdle of the H.S.C. Examination were very likely to reach up to the post graduate level. One of the reasons for the small number of S.S.C. holders within the study area was that many of the women with the education level mentioned above, having their parental homes within the study area were living elsewhere during the period of data collection owing to different reasons, such as having been married somewhere else, or studying/working at other places.

In the results of the study, we have also seen that most of the respondents (n=28, 64%) were under 40 years of age, which portrays that with the passage of time more women in the study area were likely to complete their studies up to at least the S.S.C. level. Most of the respondents were involved in income generating activities. Only 7 of the respondents were housewives, and 28 (64%) were engaged in some kind of profession. Among the service holders were teachers, NGO workers, a nurse, a lawyer and a doctor. Eight (18%) of the respondents were students, preparing themselves to enter a profession. Only one respondent identified herself as unemployed—meaning that she still was not married, nor was she a student or an income earner. This finding is encouraging. The authors tried to relate respondents' participation in professional activities with their level of education. It was found that among the 7 housewives, one had studied up to the H.S.C. level, three held bachelor's degree and another three held master's degree. They were asked why they did not engage themselves in income generating activities. The reasons they showed were that they had no one else to take care of their children during working hours. Another reason was that their husbands' jobs were transferable. So they had to leave their jobs in order stay with their husbands. Thus educational level of the respondents and their engagement in income generating activities do not appear to be related in this study.

The respondents identified many obstacles that bar women from attaining higher education-- problems related to family approval, and problems related to financial support. After marriage it is often difficult for women to continue their studies—they need approval and cooperation of their husbands and in-laws, which is not always provided by the persons concerned. If children are born to a woman during her studies it is very difficult for her to continue studies and do well in her examinations. Unavailability of day care centres bar mothers from materializing their dreams of doing well in higher education and pursuing challenging professions. Some working mothers have a feeling of guilt for not being able to spend sufficient time for their children. This feeling often prevents them from trying their best to develop their careers.

Twenty one of the respondents thought that not all jobs were suitable for women. Their ideas mainly reflected the ideas of their families which were inculcated into them during their childhood socialization. The type of job viewed as most suitable by the women's families is a crucial factor in determining their life patterns. A family would educate their female children to the direction of professions which it thought would be suitable for these children to enter. Only 6 (13.6%) of the respondents have said that their families would accept any profession to be pursued by their female family members. According to the families of 32 respondents (73%) the most suitable job for women was teaching. As such it is very likely that these families would educate their daughters in a direction which would lead them to become teachers, rather than becoming doctors, engineers, journalists, architects, scientists, NGO workers etc. Most of the respondents who were able to continue their jobs received approval and cooperation of their families of orientation, and families of procreation. Lack of approval and cooperation pose a great problem to women who wish to pursue a profession in Bangladesh. Most of the respondents spoke of receiving cooperation from their male and female colleagues at work and having friendly relationship with them. Some of them were deprived of due promotion, overseas visits and higher training on grounds of being a woman, which slowed steady advancement in their careers. Almost all the respondents thought that women had to work more to prove themselves equal to men.

The findings of this study regarding barriers identified and encountered by the respondents of this study in pursuing their careers have very much in common with the findings of Rahman and Hossain (2006) and Khanam (1998). In their study on problems faced by working women, Rahman and Hossain (2006) have identified the following as the most common problems: (a) problems of maintaining a family along with working outside; (b) non-existence of day-care centres for baby–sitting, or arrangements for bringing babies to the workplace; (c) partial attitudes of authorities in recognising women's qualifications in getting promotions; (d) subtle situations of harassment; (e) onlya few holidays, especially in private organizations; (f) non-cooperative and hostile behaviour of male colleagues; (g) problems related to commuting to the workplace and coming back home; (h) absence of suitable restrooms in work places, (i) lack of support from husband etc. Khanam (1998) has mentioned the following barriers that obstruct creation of equal opportunities in workplaces for women: (1) prejudice against women in society; (2) low participation of women in public and private sectors; (3) low participation of women in higher education; (4) disinterest of women in jobs that require skilled professional efficiency; (5) unwillingness of employers to employ women in certain jobs, e.g., jobs that require working at odd times, going to remote places, operating heavy machinery etc. (6) women's preference for lower paid/lower status secure jobs to remain close to home; (7) non-congenial atmosphere in the workplaces; (8) not strictly maintaining the quota reserved for women; (9) lack of bargaining capacity of female workers to fulfill their demands; (10) lack of awareness of women workers regarding their rights and labour laws.

Conclusion

The findings of this study make us optimistic regarding women's rate of participation in the economy and in nation building activities. However, more should be done in order for women to gain greater access to higher education. As Khan (1995, p. 80) has suggested "[u]nless a significant breakthrough can be made in the area of female education and specially at the higher level no effort to increase the representation of women in the civil service will succeed." Changes in attitudes of people and cooperation from all relevant corners of the society and the state is required to create an environment in which women's capabilities can be utilized fully towards the development of Bangladesh. To this end, in conclusion to this paper we recommend the following:

(1) Steps must be taken by the state, NGOs, civil society and the media to bring about changes in the attitudes of the people so that the socialisation process that takes place within the family and greater society is *not* gender biased. All must have the understanding that both males and females have potentials to perform almost all kinds of jobs, and so both boys and girls should be given the opportunity to attain higher education in the area of their aptitude;

(2) The government and greater society must come forward to financially help brilliant girls to attain higher education;

(3) Women have to be made aware of their duties towards to the greater society as well as to their children, their families which will encourage them to be engaged in income generating development activities;

(4) Both male and female members should consider it their duties to perform their share of household chores;

(5) The social system must be gradually changed so that loads of household work is reduced—for example, arrangements could be made to provide lunch to workers at their work places (and to children in their schools and day care centres), so that lunch need not be cooked at home;

(6) Organisations must be established and run to take care of babies in order to enable parents to work without being too much anxious about their children; Organisations could make arrangements for baby sitting in close proximity with mothers that would allow them to breast-feed their babies if required.

(7) Special facilities should be provided in government and private sectors so that husband and wife could work in the same city;

(8) Living in joint families with cooperative attitudes of all could help women pursue and develop their careers.

(9) Congenial environments for women at work must be created and arrangements must be made to ensure their safe commuting from home to work and from work to home;

(10) Working women should be aware of the laws that are in place to protect their rights and use them in their favour;

(11) Strict maintenance of quota for women in all organizations should be ensured.

(12) High moral standards and congenial physical and behavioural atmosphere must be maintained at all work places.

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Ethical Issues of Wireless Sensor Networks in Environmental Applications

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Introduction

We are degrading our environment and consuming its resources at unsupportable rates. Our rivers and lakes are polluted with industrial wastes, agrochemicals, petrochemicals and untreated sewage. Hence we have to learn to live more sustainable and with less impact on our environment so that the prospects for future generations are bright. For this, monitoring our environment becomes mandatory. Effective monitoring can be done with the application of Wireless Sensor Networks (WSN). They are a new technology for gathering data about the natural world. This technology is just one small part of a complex system which includes internet links from WSN to a server, databases, and web presentation tools. The national challenges of our country include land degradation, water shortage and climate change. These challenges involve many numbers of unpredictable events and difficult outdoor conditions.

Applications

Wireless Sensor Networks are used in a wide range of application areas including office and home, control and automation, logistics and transport, healthcare, security and surveillance, tourism, training, education and entertainment, agriculture and environmental monitoring. Some of the popular applications include wildlife monitoring, bushfire response, industrial quality control, and observation of buildings, distributed robotics, traffic monitoring, defense, intelligent communications and examining heart rate of patients.

WSNs can be applied in agriculture also for precision agriculture, machine and process control, building and facility automation and traceability systems. This technology enables large scale monitoring of forests and waterways providing sensor measurements at high temporal and spatial resolution. WSNs find applications in monitoring microclimate, cattle, ground water quality, testbed, virtual fencing, rainforest microclimate, water quality at different depths, environmental impact and biodiversity.

Ethical issues

In cattle monitoring, the positions of cattle over time and soil moisture have to be recorded. Pastures will grow more where soil moisture is plenty. When WSNs were used, it was difficult to manage a remote network and when solar power was greater it led to overcharging of the batteries which reduced their lifetime much. Such disposed batteries pose environment threats. In groundwater quality monitoring, salinity, water table level and water extraction rate at different bores are determined using WSN technology. As the sensor nodes are kept in the field, they may be subjected to physical damage.

Virtual fencing using WSN technology is applied for cattle control. It requires sensing of position, velocity information and activation. Activation involves the application of audio and mild-electrical stimuli which may be against animal ethics. WSN technology is also used for rainforest monitoring for restoring biodiversity. But these regions are with limited solar energy and adverse and dynamic radio environments. In the dense canopy, sunlight penetration is very less. As the sensor nodes are deployed away from the energy grid, supply, storing and replenishing energy became very difficult. The core components of sensor network nodes like the microcontroller, radio, flash memory, transducers and other peripherals have different patterns of power consumption. Radio propagation through dense and wet forest is also poor and the links of forest nodes would breakdown after heavy rains.

WSN technology is also employed in Lake Water quality monitoring to measure vertical temperature profile at different points and to provide data about water mixing for predicting algal blooms. Wireless communications over water was difficult due to multi-pathing in which radio waves reflected from water surface interfere with waves traveling directly. WSN technology can eliminate the need for external infrastructure like cell towers and satellites. But they involve high cost as network nodes are exclusively programmed by experienced software experts and maintenance costs are also high. Delivery of data over multiple node hops is also very difficult and when the sensor networks are integrated with the internet security problems also emerge.

When WSN technology is used for herd control, there might be health effects on animals. The implanted nodes may result in food contamination. The environment gets polluted due to loss of batteries or the disposal of used batteries. The autonomy of animals may be greater than with fixed fences, but animal welfare may be affected. Generally monitoring systems generate alerts for deviating or dangerous situations. If these alerts are false positive alarms, they result in extra work. False negative alarms also result in serious consequences.

If private data are exchanged, within the chain, privacy issues will arise. If accidents occur due to system failures, they can affect humans and animals. If the system underwent malfunction, it is difficult to assign responsibilities. Malfunction of the system may create negative impact on the willingness of the users and on the public opinion.

With all these issues, WSN technology can be used with modifications after solving privacy, security and energy issues. Nodes with multiple sensing nodes and diverse configurations can be deployed with adaptive power management strategies. A combination of technologies which suit specific environmental sensing applications can be implemented.

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Albert Schweitzer's Ethical and humanistic reflections in Brazilian healthcare

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Abstract

Health care assistance in Brazil has followed the biological model paradigm. This model of assistance has a negative impact on the physician-patient relationship and leads to a progressive loss of patients' autonomy. The supremacy of Cartesian objective science has taken the place of the study of humanities traditionally inherent to medical practice. In this context, Albert Schweitzer's reflections on Reverence for Life and human dignity may be applied in healthcare. We aimed to describe the humanistic physician education in Western history; to address the importance of ethical-humanistic reflections in healthcare; and to discuss how Schweitzer's philosophy may facilitate the critical analysis of principlism. Ethical and humanistic training is necessary in the Brazilian healthcare education. Albert Schweitzer's philosophy can be an educational tool for healthcare students to understand the application of bioethical principles in multiple perspectives.

Introduction

The paradigm of health care assistance in Brazil has been characterized by the biological model, with emphasis on specialization and on the healing processes (Pagliosa and Da Ross, 2008; Flexner, 1910). This model of assistance influences negatively the physician-patient relationship and determines a gradual loss of patients' autonomy in the healing process and of their own capability to deal with suffering (Foucault, 2008). This scenario was consequent to the increasing use of the Cartesian method in medical science and the interpretation of disease as an objective phenomenon (Pesotti, 1996). The supremacy of Cartesian objective science progressively has taken the place of the study of humanities traditionally inherent in medical practice.

According to Schweitzer, the age of the Enlightenment and of rationalism had generated rational ethical ideas, defining the development of the individual versus the fullness of human dignity. Those ideas concerned the interaction of material and spirituals aspects of humanity and appealed to a closer contact with reality, modifying positively the conditions of existence. The rupture in this process might have occurred in the middle of the Nineteenth Century, when the mutual understanding of ethical ideal and reality became increasingly apart. The main consequence of this process was the philosophers' renunciation of their duties. Philosophy, without its creative spirit, was practically the history of philosophy with no relation to reality (Schweitzer, 1976, p. 30-35). For Schweitzer, not only the weakening of the ability to think plays a decisive role in the decline of civilization, but other secondary factors that manifest themselves on the spiritual and economical level play a role as well. A thinker should be able to design a rational ideal and give the appropriate form, being independent to realize his ideal in favor of the community (Schweitzer, 1976, p. 39).

The enormous progress of science and its applications involves the limitation of the scope of the individual to a specific and restricted area. This results in a work organization based on the combination of individual performance, achieved through specialization, which reduces men to nothing more than fragments of themselves. The human alienated, overworked, depersonalized, and fragmented is also exposed to the danger of falling into dehumanization (Schweitzer, 1976, p. 43-45). In this scenario, Cartesian Science and objectivity became more intense in medical practice.

In this context, Albert Schweitzer's reflections about Reverence for Life and human dignity can be applied in healthcare education. The Ethics of Reverence for Life may open discussions on the universality of ethics, especially in situations where conditions of vulnerability are exacerbated by circumstances of poverty. The ethics in question is represented by a rational act that exceeds the responsibility to protect humankind, to include the planet as a whole. This reverence is revealed in the understanding of human's will to live and the limits and finitude of human existence. Resignation is a consequence of this understanding: the conscience that man does not have control of all events in life awakes the sense of resignation and the responsibility for life in all its diversity.

Schweitzer's ethical theory had a particularity: its connection with practice in a multicultural environment. For this philosopher, the ethical values were not mere abstract thoughts but should be manifested in practical life. As a theologian, musician, philosopher and medical doctor, Schweitzer had constructed the basis of his ethical argument in practical love and altruism, as well in the thoughts of occidental and oriental civilizations. Having already excelled in a brilliant academic career in the age of thirty, he decided to study medicine to serve the native people in Africa, as a physician, during his life. In Africa, he built a hospital in Lambaréné, Gabon, where he could maturate his philosophical thoughts in connection with his practical life. For Schweitzer, spirituality and rationality were essential to guide all necessary ethical reflections applied to the development of sciences in order to defend the highest humanity interests. The ethics of reverence for life is manifested when the will to live is driven to the will to act with responsibility in favor of living beings. In situations of ethical dilemmas in clinical practice, the physician's decision must be based on responsibility displayed as an act of reverence for patient and family in their particular situation. Most of the time, the decision also generates a sense of guilt, as a consequence of the impossibility to act positively in favor of all subjects' claims since there are complex value conflicts involved.

This paper has the following objectives: to briefly describe the humanistic physician education in Western history; to address the importance of ethical-humanistic reflections in healthcare; and to discuss how Schweitzer's philosophy may facilitate a critical analysis of the principlism.

Humanistic physicians in History

In the pre-Homeric period (XII century BC), the practice of medicine in Western civilization was part of the priestly office. During this period, the art of healing was performed by the priest through magic diets, impositions of hands and propitiatory rites. In this context, the priest dictated the moral rules emanating from theological and anthropological conceptions of man. The awareness of the fragility of life and human finitude allowed the understanding of adverse health conditions such as immanent phenomena in existence (Pesotti, 1996).

In the further development of Western civilization, the narratives of mythic discourse became insufficient to explain fundamental questions of man, about the world and about life in society. This led to the birth of Hippocratic medicine (IV century BC) and of Socratic Philosophy. Hippocratic medicine became separated from magical-religious practices, as Hippocrates understood disease as an organic phenomenon resulting from the interaction of Human Nature with the environment. From the ethical observation of organic phenomena and their interaction with the environment emerged the biopsychosocial conception of disease, increasing patients' autonomy on the healing process. Hippocratic medicine was enriched by the new knowledge of Galen a II. century AD physician who maintained the same interpretation of disease. Galen, as a humanist physician came to influence Western civilization for centuries and his approach remained the basis for many fundamental principles of medicine until the nineteenth century (Cotardière, 2010).

Many historical events had contributed to the depreciation of humanities in medical knowledge: the social and political changes at the end of feudalism, the emergence of the bourgeoisie, the Protestant Reform and as well the development of Galileo Galilei's empirical method. The seventeenth century proposed the initial questioning of the human attitude towards nature and Francis Bacon in *Instauration magna* (1623) advocated empiricism as a fundamental rule in research. Later, René Descartes wrote *Discourse on the Method* (1637) and the *Treatise on Man* (published posthumously in 1664) and suggested the principles of mechanistic theory and physiology to be applied to all living beings. In addition to the development of the Cartesian method, the study of cadavers, the discovery of the circulation, the development of microscopy techniques revealing the microorganisms as the cause of many diseases, enabled the separation of humanities from biological sciences (Cotardière, 2010).

In this context, disease came to be interpreted as an objective phenomenon and medicine as the healing way through technological advances. There was no longer room for a social and anthropological conception of disease. Those phenomena were accentuated with the implementation of the Flexnerian model and the influence of industry on healthcare education and clinical research (Bordeheimer, 2000; Engel, 1978).

Ethical-humanistic reflections on healthcare education: a way to understand human suffering

The Flexnerian model of healthcare education was criticized by Foucault (2008) when he established an opposition to the hospital-centered model. According to Foucault, the disease process belongs to life as a natural phenomenon and social relationships are essential to human health. The affection and common desire of healing in those relationships act in complicity, helping nature to fight against disease processes; while in the hospital-centered model, diseases are distorted and patients' social and cultural potential to collaborate on healing process of diseases are extremely reduced.

Since the 1970s, biomedicine has understood pain as a reflex phenomenon something which made the psychic sphere become of less importance. Treatment of pain and suffering are frequently reported as inadequate in patients with chronic diseases, including cancer (Peretti-Watel et al., 2012). In many cases of chronic pain treatment, there is the exclusion of patients who do not comply fully with the diagnostic criteria, of patients who do not adhere to treatment and of distrusting patients (Pessini, 2002).

The Flexnerian model still predominates in Brazilian healthcare education. Despite having contributed in important ways to the development of medicine, this model does no longer meet the needs of Brazilian healthcare assistance. Emphasis in the undergraduate training of physicians on technological advances combined with a lack of humanistic training have led to a biological interpretation of disease becoming prevalent. In the majority of cases, public hospitals are the medical students' arena for learning under medical supervision. Most academics deal with vulnerable patients in conditions of poverty with reduced access to education and health. Many of these patients suffer from social diseases that do not fulfill diagnostic criteria, something that might exclude them from biomedical treatment. Moreover, the hospital-centered model represents a high cost to the Brazilian health care system and has proved ineffective with regard to addressing the population's health care demands and needs, generating a crisis in public health assistance (Nogueira 2009; Lampert, 2002). Kühn (2011), in *The Structure of Scientific Revolutions,* describes the paradigm shifts as a way to open new approaches in science. Analogically speaking, the current crisis of the public health care assistance model has led to the detection of anomalies provoking paradigms shifts. Similarly, it is observed that healthcare education in Brazil undergoes a continuous reform process, reconstructing its field on the observation of the paradigms shifts: its model of healthcare education does not meet the demands of society and the state in health assistance (Nogueira, 2009; Scherer, Marino and Ramos, 2004).

The inclusion of humanities in the healthcare curriculum has a central role to play in the training of healthcare students. When applying teaching and learning methodologies from the humanities focus must be on students and must allow them the recognition of human nature with its virtues and defects. The use of case studies may stimulate reflections and help to link theory with practice and, as a consequence, healthcare students may develop their own values when analyzing conflicting situations in their practice (Lampert, 2002).

The educational reform should be initiated and promoted by the teachers themselves. One of the major difficulties in current educational change is the resistance of educators with regard to the new model. The active methods allow the exchange of experiences and collective thoughts that lead to alterity not only in relation to the student but also in the teacher translating the teaching-learning as an effective two-way learning (Lampert, 2002). The humanistic approach to healthcare education should prepare healthcare students to identify the anthropological aspects of disease, enabling them to face a practice reality that deals with contrasting phenomena of death, life, justice and inequality.

The philosophy of Albert Schweitzer: a useful tool in addressing the principles of bioethics.

Although the principles of bioethics were born in a sociocultural context other than the Brazilian society, these principles are widely applied today in biomedical research, in clinical practice and in healthcare education (Beauchamp and Childress, 2002). It is difficult to uphold absolute rules in the realm of health care, due to the many variables involved in clinical dilemmas. Bioethics principles should therefore not be applied as dogmatic rules. I believe Albert Schweitzer's philosophy can help to expand the application of these principles in the Brazilian context, especially with respect to reverence for life, dignity, integrity, vulnerability and global solidarity.

The ethics of *Reverence for Life* was developed as a result of the practical experience of the physician and philosopher Albert Schweitzer. According to Schweitzer, the rational fact that every human being is a life that wants to live among other lives that have the same desire to live and flourish, is the moral guideline that generates a deep respect and reverence for life in general (Schweitzer, 1976, p. 166). From his understanding follows that good deeds are those which preserve life and promote their development in its fullness, while amorally evil act is an act that damage or destroy life, or inhibits its physical and spiritual capacity to flourish. Those perspectives are included in the definition of health by the World Health Organization (WHO, 1946).

The ethics of *Reverence for Life* acknowledges that that the capacity of thinking and reflecting upon the condition of existence is inherent to humans, and that only man is able to understand that all forms of life have a will to live and strive for its fulfillment. This understanding of life's complexity and of all life-forms strive for fulfillment only human beings are able to grasp, something which imbues man with a special responsibility to respect and preserve not only human life but all forms of life (Schweitzer, 1976, p. 167-168). The ethics of *Reverence for Life* can be a useful normative framework for addressing health conflicts in healthcare education. A transdisciplinary approach with active educational methods, as for example case studies, may facilitate the application of those ethical principles in circumstances of socioeconomic disparity, poverty and cultural diversity.

The principle of respect for autonomy determines the moral obligation to recognize human beings as ends in themselves. Consequently, individuals should not be treated as a mean-to-the-end by health professionals who deal with conflicts of interest not only in research, but also in clinical practice. Immanuel Kant described autonomy as a rational freedom of the individuals to decide their own end. From this follows that a patient has the capacity to act as a rational agent in making voluntary and informed decisions. This principle encompasses fundamental moral values such as truth, privacy, confidentiality and freedom (Beauchamp and Childress, 2002).

However, the principle of autonomy at its accompanying values may conflict with other principles in certain situations, requiring a multidisciplinary approach when dealing with ethical dilemmas. Consent or informed consent is an ethical tool used in research and clinical practice to safeguard the autonomy of patients and research subjects. All constitutive elements of this instrument should be observed in order to accomplish its moral end. These elements, among which counts capacity, voluntariness, information, recommendation, understanding, decision and authorization, should not be neglected, but handled properly so as to protect the individuals integrity.

For Beauchamp and Childress (2002), understanding and consenting to health care procedures applied in research requires some specificity: the research subject should have legal capacity to give consent in a truly voluntary way and should be provided with information about research risks and benefits. In a context of vulnerability, caused by circumstances of poverty, lack of access to health and education, illiteracy or caused by unequal power relations, health care professionals, researchers, educators and students should exercise their practice within a universal dimension of morality as proposed by the ethics of reverence for life. In research, such an awareness requires of the power holders the responsibility to respect the autonomy of research subjects, not the least in circumstances of vulnerability and inequality.

The principle of beneficence is understood as the duty of health care providers or of researchers to benefit the patient or subject of research, taking positive actions to prevent harm to them. This principle encompasses fundamental moral values such as altruism, compassion and kindness. While for Schweitzer compassion as a deep sympathy for the suffering of another is limited, love encompasses all the moral values of beneficence and involves the sharing of suffering, joy and efforts with the ailing individual (Schweitzer, 1976, p.168).

It is important to acknowledge that also beneficence is a limited duty when considering other principles. As the principle of beneficence aims to protect and benefit patients, it may conflict with the principles of justice and of autonomy (Beauchamp and Childress, 2002). In order to deal with conflicts related to cultural sensitivity, the ethics of Reverence for Life can be applied with some concerns of responsibility and respect. Those concerns are fundamental to realize the transposition of the individual's will to live for the universal scope, because it may also generate conflicts since each individual alone has a representative universe (Schweitzer, 1976, p. 169-170). If two patients need treatment at the same time, some criteria of urgency need to be applied to decide who should be helped first.

In certain circumstances, paternalism is allowed when there is the duty to preserve and protect the patients' life. A classic example would be the need to provide a child of Jehovah's Witness (JW) parents with blood transfusion in a situation of imminent risk of death. The normative ethics guides the physician to inform the court and save the child with blood as a paternalistic attitude in defense of life. Schweitzer's ethics leads to a less reductionist view of this dilemma, when there is the possibility of elective treatment. For this reason, the conduct with JW patients should be discussed and informed before any surgical procedure takes place. Understanding the symbolic universe of human beings in health care assistance is fundamental. In some cases, treating and preserving JW individuals' life may, at the same time, represent a social death for them. As a consequence, researchers and physicians have developed alternative methods of treatment and have the responsibility to educate and inform patients about these possibilities.

The fundamental principle of nonmaleficence, described by Hippocrates, concerns the moral obligation of physicians not intentionally to create harm to the patient, as for example through omission acts that can be characterized as negligence. This principle differs from beneficence that requires a positive act benefitting the patient. This principle states that physicians should not practice futile therapeutic measures and that they should provide a proper standard of care that minimizes or avoid the risk of harm. According to Schweitzer, the action of a human being towards another life is immanent to his own life. The principle of nonmaleficence becomes naturally exercised when the subject of the action has understood that he is object of the practiced act in the universal sphere (Schweitzer, 1976, p.170).

There is a lack of social consensus with regard to the principle of justice. The definition of justice introduced by Aristotle more than two thousand years states that "equals should be treated equally and unequals, inequality". In the field of health care, this means that patients should be treated equally, unless they differ in some relevant ways that should be considered in the specific situation in which they are involved (Beauchamp and Childress, 2002). We can take, as a practical example, the change of criteria with regard to allocation of resources for liver transplantation in Brazil. Currently, the priority for liver transplantation is established by the model of end-stage liver disease (MELD) considering the severity of the disease. When the priority was defined by arrival, many patients with severe disease died without the possibility of transplantation. Using the MELD score the priority has been given to an eligible and potential recipient approaching imminent death without a transplant. In this situation, patients with more severe disease could be prioritized and scarce health care resources could be used for such cases of urgency even if more medical benefit could have been obtained by giving the organ to a healthier patient. Schweitzer criticizes the idea that human life is more important than any other life form, because it is not possible to make any value comparison between different life forms. However, in practice, Schweitzer states that in many situations there is the obligation of making choices by humans' beings and, sometimes, arbitrarily decide who must be saved or not, as in the case exemplified. The ethics of Reverence for Life not only finds solutions to theoretical problems, but also provides guidance for practice. The ethics of Reverence for Life insists on the respect for individual and collective desire to live, comprising the understanding of human nature which results in spiritual freedom translated into resignation, sincerity and respect for others (Schweitzer, 1976, p. 171-174).

Conclusions

A humanistic approach to training healthcare students can be useful in the Brazilian education in order to comply better with current the healthcare demands. Albert Schweitzer's philosophy and ethics of reverence for life can enable healthcare students in their training to apply bioethical principles under multiple perspectives, and help them to better understand the patient's perception of the universe, especially in situations of vulnerability.

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Evaluation of the Provision of Palliative Care Among Anesthesiologists in Brazil

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Abstract

The objective of this study was to evaluate the knowledge of Palliative Care (PC) among anesthesiologists of João Pessoa city. The research was of a descriptive nature, quantitative, by means of an individual questionnaire, composed by objective questions. The sample was of 95 anesthesiologists belonging to the Anesthesia Society of the State of Paraíba (ASSP). The data obtained were analyzed and processed using the program SPSS version 19.0. From the 126 anesthesiologists requested to participate in the study, 95 answered the questionnaire. Of these, 65 (68%) were male and 30 (32%) were female. Sixty two (65%) of anesthesiologists reported the quality of life as the term that best expresses the (PC) and 54 consider the combination of assistance home/hospital the most convenient for the care of the patient that requires (PC). It was observed that 83% (n=79) from the searched anesthesiologists didn't receive training to deal with the patient that requires (PC), and when the death of a patient happens, 88% (n=84) comment with their anesthesiologists colleagues. Most of those interviewed (n=46) disagree with the practice of euthanasia. Regarding the self perception about the grade they attribute to their own knowledge on palliative care, in a scale from Zero (0) (no knowledge) to ten (total knowledge), it was observed a majority of the average response of 5 (n=28). It is necessary to have reflection in this area of care with anesthesiologists to offer the patient measures that provide the quality of life that reduce their suffering.

Keywords: Palliative care; Anesthesiology; Terminal care; Terminally ill.

Introduction

Palliative Care (PC) aims to assist hopeless patients. Considering the process of dying as inevitable and natural, it is based on therapies that seek to provide, in time a decent quality of life and reduce the symptoms caused by the disease while respecting individual rights[1].

The World Health Organization (WHO) defined PC as "the active total care patients whose disease no longer responds to curative treatment." In this sense, it is an approach that seeks to control the symptoms of physical, psychological, social and spiritual. Therefore, your goal is to provide a better quality of life for patients and their families [2].

The concept of CP has changed over time as the care philosophy was developing in healthcare environments. Traditionally, they were seen as procedures only at death, but currently are offered from the early stage of terminal illness determined progressive, advanced, and incurable until the last moments of life.[3, 4, 5] Therefore, interventions are aimed at patients who are in a state of end of life, to relieve unpleasant symptoms caused by incurable disease. In summary, palliative care is centered on the patient's right to live out their remaining days and die with dignity. It is an interdisciplinary field of care total assets and integrals. Specifically in the field of anesthesia, the expansion of palliative care is even more recent. The challenges of the anesthetist attending the patient requiring palliative care have been increasing due to the growing progress made with new techniques of analgesia and sedation were created and developed [6,7].

Thus, considering the above, the aim of this study was to evaluate the knowledge about palliative care among anesthesiologists in the city of João Pessoa - Paraiba - Brazil.

Materials and Methods

The research, of exploratory, descriptive character and with quantitative approach, was prepared in accordance with the ethical recommendations of Resolution CNS / MS 196/96 and approved by the Ethics Committee in Research of the University Hospital Lauro Wanderley - UFPB with Case No. 359 / 09. Participants - 95 Anesthesiologists Anesthesia Society of the State of Paraíba (SAEPB), who conduct their professional activities in the city of João Pessoa - agreed to participate voluntarily in the study and signed an informed consent form (ICF).

Data were collected through a structured questionnaire consisting of closed questions, multiple choice type. To analyze them, we employed the statistical program SPSS (Statistical Package for the Social Sciences for Windows), version 19.0, and the chi-square test with simulated Monte Carlos. Descriptive data were expressed as percentages, mean and standard deviation.

Table 1: General characteristics of the sample

Variables	*N*	*%*	
Gender			
Male	**65**	68.4	
Female	**30**	31.6	
Marrital status			
Single	19	20.0	
Married/ Stable Union	62	65.3	
Divorced/Separated	12	12.6	
Widow	2	2.1	
Age (years)			
25 to 30	7	7.4	46.6 ± 11.7
31 to 40	21	22.1	
41 to 50	25	26.3	
51 to 60	24	25.3	
Religion			
Catholic	70	73.6	
Protestant	13	13.7	
Spiritualist	3	3.2	
Believe in God	6	6.3	
Others	3	3.2	
Religious practitioner			
Practitioner	60	63.2	
Non practitioner	31	32.6	
No answer	4	4.2	

Results

Of the 95 of anesthesiologist doctors who participated in the survey, 65 were male and 30 were female. The questions / answers of the participants are summarized in Tables 1-4.

Table 1 shows the general characteristics of the study participants: gender, marital status, age, religion and practicing religion. 68% of participants were male (n=65), and only 32% female (n=30). Regarding marital status, 65% were married, with (n=62). The lower portion of the sample was composed of individuals widowed, with 2.1% (n=2) of the total. The majority of the sample was between 41 and 50 years (26%) with an average of 47 years. It was observed also that only 7.4% (n = 7) were aged between 25 and 30. Regarding the religious condition, the larger sample groups are Catholics (70%, n = 70) and Protestants (14%, n = 13). On the question of whether professing any religion, the majority (63%, n = 60) responded affirmatively.

Table 2: Data regarding questions: Word that expresses Palliative Care (PC), where to attend the patient who requires PC and if they received preparation (n= number of Anesthesiologists)

Variable	**n**	**%**
Words that express palliative care		
Pain	2	2.11
Family	1	1.05
Death with dignity	24	25.26
No answer	2	2.11
Ortothanasia	4	4.21
Quality of life	62	65.26
Total	**95**	**100.00**
Where should be the patient who requires palliative care		
House	35	36.84
House/Hospital	53	55.79
Hospice	3	3.16
Hospital	3	3.16
No answer	1	1.05
Total	**95**	**100.00**
Received preparation for dealing with patients who require palliative care?		
Yes	16	16.84
No	79	83.16
Total	**95**	**100**

Table 3: Positioning data in relation to the practice of euthanasia regarding the gender

Gender	**Positioning in relation to the practice of euthanasia**								**Total**
	Do not know		Agree		Disagree		No answer		
	n	%	n	%	n	%	n	%	
Female	8	38.1	4	14.8	17	37.0	1	100.0	30
Male	13	61.9	23	85.2	29	63.0	0	-	65
Total	21	22.1	27	28.4	46	48.5	1	1,0	95

Table 4: Data relating to knowledge about palliative care from 0 to 10 regarding the gender

		Note that the researchers attribute to their knowledge about palliative care									**Total**
		2	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Gender	Female	1	3	3	10	6	5	2	0	0	**30**
	Male	1	3	3	18	12	20	5	2	1	**65**
	Total	**2**	**6**	**6**	**28**	**18**	**25**	**7**	**2**	**1**	**95**

According to Table 2, we can see the answers to questions regarding: Word expressing PC and where to meet patient requiring PC. Thus, it was found that, in the participants, the word that best expresses the palliative is quality of life (65%, n = 62). When asked where to patient care that requires palliative care, the majority (56%, n = 53) responded home / hospital. For most of the subjects (83%, n = 79) failed preparation for dealing with patients who require palliative care.

Table 3 summarizes the data obtained on the position in relation to the practice of euthanasia. The survey showed that 29 (63%) of those interviewed were male and 17 (37%) females disagreed with the practice. The chi-square test suggests that there is no association between the data. So sex does not interfere in the practice of euthanasia.

With regard to data concerning the perception of anesthesiologists regarding knowledge about palliative care, a scale of 0 to 10, the results showed that Note 5 (n = 28) had the highest score, an average of 5.8 and a median 6.0, the standard was 5, and the standard deviation of 1.54. Thus indicating a significance level of 0.755 hence most of the sample gave a score ranging between 4 and 7, to one standard deviation of 1.54. The chi-square test suggested no association between the gender and ranking (Table 4).

Discussion

Discussion of the topic of palliative care requires the completion of a reflective exercise that involves family, caregiver, death and patient autonomy, among others. The response rate to the questionnaire was 75%. Of 126 anesthesiologists, 95 responded to the questionnaire. The majority (68%) were male. This is explained for historical reasons, as anesthesiology, over time, has been carried out mostly by men.

Regarding the question that sought to identify the proper word to express palliative care, it was observed that 65% believe the term "quality of life" as it lends itself best to define palliative care among those surveyed. According to Sawada et al[8], the patient is in the terminal phase of life and chemotherapy treatment is decreasing functions of physical, emotional, cognitive and social, for in that final moment of the disease increases the symptoms of fatigue, nausea, vomiting, pain, insomnia, loss of appetite and diarrhea. Therefore, the measurement of quality of life (QoL) of the patient terminal is so difficult.

The World Health Organization defines QOL as "an individual's perception of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." This definition includes six main areas: physical health, psychological state, level of independence, social relationships, environmental characteristics and spiritual standard. Therefore, the quality of life is an eminently human notion, which has been understood as the degree of satisfaction found in family life, loving, social, environmental and aesthetic itself existential.[8, 9]

The anesthesiologist who works in palliative care searches to soften or lessen the discomfort felt by the patient and / or family, and since we have the privilege of being close to someone who is dying, this contact can turn into a source of comfort for those who shows the inevitability of death. Given this circumstance, seek to provide palliative care to patients and their family a better quality of life in the time remaining to the patient. [8,9]

Anesthesiologists recognize that among the options for the care of the patient requiring palliative care, the preferred combination is home / hospital (55.8%, n = 53). This choice is also enhanced by the medical caregiver who understands that the combination home / hospital is the most complete. This means a change as the usual place of death and requires the creation and implementation of effective programs and integrated with hospitals to provide such care. Thus, today the trend is that patients reverse the location of your care. That seems to be due to the fact that patients increasingly prefer to stay at home with family and people you love. The conduct to adopt, before the patient in the process of inevitable death, will always be controversial, so it is necessary to question whether it is worth removing the patient from home and transport him to the hospital to die.[10]

Almost all anesthesiologists surveyed (83%, n = 79) stated that they had not been prepared to deal with patients who require palliative care. Based on these considerations, studies in several countries show a gap in the training of health professionals in relation to palliative care, as well as the consequent need this training.[11,12] Probably, the adoption of futile measures occurs through ignorance of the professionals on the subject.

In Brazil, there are numerous challenges to overcome, among them is a possible deficiency in the process of training of health professionals in relation to the finitude of life. Therefore, we need to change the mindset of the professionals who are not always willing and open to accept a new change and break paradigms. This means adopting a way of caring for terminal patients less technically and more humanly. Given the above, we are led to believe that you need to perform hard work in terms of changes (personal, social and human), of handsets from makers that shape professional with excellent technical preparation and no emphasis on humanistic [13, 14].

Through advances in technology, the demand for technically skilled professionals and will always be growing at the expense of concern with the human soul. This phenomenon of the advancement of technology has led to the Medical segment increasingly offering, besides the specialties, subspecialties, which makes HR professionals to confine themselves to certain segments of the body and forget the completeness of being man as endowed with body and soul, and therefore, your health care provider should from a holistic and [14].

Although palliative care are little known among anesthesiologists, this approach is relevant for this group of professionals who often assist the patient in their last moments of life. Thus, these professionals should value the autonomy of the patient and be aware that it is essential. In this context, those who act as caregivers are also in a situation of fragility when faced with a patient without therapeutic possibilities [15].

About euthanasia, anesthesiologists studied positioned themselves as follows: 46 disagreed with that act, 27 agreed, and 22 did not answer or did not know. Euthanasia is not accepted in most societies, as it is considered as reprehensible ethical conduct. However others consider the anticipation of someone's death as an act of mercy, without any personal gain. From the perspective of Cabral, the word "euthanasia", of Greek origin, was introduced by Francis Bacon, in his *Organon* (1623). Etymologically, it means "good death", ie gentle death, peacefully, without suffering. It is the medical procedure that aims to eliminate the pain and indignity of terminal illness, through the direct induction and activates the death of its bearer [16,17].

It became clear through this work, that the knowledge of palliative care is inadequate, which can be explained as a failure during the years of medical training, during which little is said of the death. Therefore, anesthesiologists should be prepared for how to deal with the challenges that arise in the field of patient care that requires palliative care.

In this perspective, we have to take care of medical training, through reflection and discussion around the process of training and development. Thus, it is important to recognize that it is necessary to train professionals to work in the specific field of hospice care. This is a way to contribute to improving the delivery of health care by professionals in this area, since these are conflicts that doctors dealing with terminally ill patients face.[18]

Conclusion

Palliative care is a philosophical field still under construction. This practice is a challenge for anesthesiologists, since science is dazzling technical education. The medical assistance to the patient in need of palliative care requires the adoption of measures to give up a cure but to relieve suffering, when resources are exhausted therapy. So it is exceedingly important to promote reflections on palliative care with anesthesiologists who care for patients in the final moments of life.

With the analysis of the data, we can infer the following considerations of the study: the word that expresses palliative care, in view of anesthesiologists, is the quality of life, patient care requires that palliative care should be a combination of home and hospital care, and that the majority of respondents received no preparation for caring for terminally ill patients. The data presented in this research can contribute to understanding that we need to enhance the anesthesiologist caregiver in the process of patient care that need palliative care.

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Conflicts of interest: None

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