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CHAPTER 11

Community/Public Health Nursing Ethics

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To be a [person] is, precisely to be responsible. It is to feel shame at the sight of what seems to be unmerited misery. . . . It is to feel, when setting one's stone, that one is contributing to the building of the world.

—ANTOINE DE SAINT-EXUPERY, *A GUIDE FOR GROWN-UPS: ESSENTIAL WISDOM FROM THE COLLECTED WORKS*

OBJECTIVES

After reading this chapter, the reader should be able to:

1. Distinguish a moral community from a population.
2. Apply different ethical approaches to specific community/public health (C/PH) nursing issues.
3. Discuss health care disparities and identify populations at risk.
4. Analyze communicable disease-related ethical issues.
5. Identify ethical issues and questions that are outcomes of the human genome project.
6. Explain what it means for a nurse to be a servant leader.
7. Discuss the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001) in relation to C/PH nursing.

KEY TERMS

Moral community
Social justice
Service learning
Precautionary principle
Health disparities
Servant leadership
Communitarian ethics
Just generosity

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Introduction

In their own way, community/public health (C/PH) nurses are contributors to the building of the world. Although the terms *community health nursing* (CHN) and *public health nursing* (PHN) ideally are differentiated, the terms generally have not been distinguished in this chapter. However, the greatest content emphasis in the chapter is focused on PHN. "Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population" (American Public Health Association, PHN Section, 2007, Para 1). "The practice is population-focused with the goals of promoting health and preventing disease and disability for all people through the creation of conditions in which people can be healthy" (American Nurses Association [ANA], 2007, p. 5). The following eight principles outlined in the ANA's *Public Health Nursing: Scope and Standards of Practice* distinguish PHN from other nursing specialties. Because of the nature of the content of these principles, PHN, like all types of nursing, is inherently ethical in nature.

1. *The client or* unit of care *is the population*.
2. *The primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole*.
3. *The processes used by public health nurses include working with the client as an equal partner*.
4. *Primary prevention is the priority in selecting appropriate activities*.
5. *Public health nursing focuses on strategies that create healthy environmental, social, and economic conditions in which populations may thrive*.
6. *A public health nurse is obligated to actively identify and reach out to all who might benefit from a specific activity or service*.
7. *Optimal use of available resources to assure the best overall improvement in the health of the population is a key element of the practice*.
8. *Collaboration with a variety of other professions, populations, organizations, and other stakeholder groups is the most effective way to promote and protect the health of the people*. (pp. 8–9)

The fundamental purpose of C/PH nursing is consistent with the purpose articulated by the U.S. Department of Health and Human Services (DHHS, 2000) in *Healthy People 2010,* the nation's public health agenda. The purpose of this national agenda is "promoting health and preventing illness, disability, and premature death" (p. 1). The goals of C/PH nursing are likewise consistent with the goals of *Healthy*

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People 2010 to "increase quality and years of healthy life" and to "eliminate health disparities" among the public (p. 2).

Population is the term used to describe the recipients of the health promotion and disease and disability prevention care that is the primary focus of C/PH nursing. In this chapter, a population is defined as a group of people who share at least one common descriptive characteristic but who do not necessarily have a collective commitment to a common good. The name used to denote a population is often related to the common characteristic(s) of the people who make up the population, such as male alcoholics or pregnant teenagers. People within populations may or may not interact or share in a collective dialogue.

The word *community* means different things to different people (see Box 11.1). A community is a group of people who have a shared interest in a common good, and members of the group have the potential to share in a collective dialogue about their common good. Membership in the community forms some part of each member's identity. The sharing in a commitment to promote the community's well-being, which transcends individual interests and goals, makes personal relationships within the community moral in nature. A **moral community** is formed by members who care about collectively alleviating the suffering and facilitating the well-being of other members of the community and who may take action in doing so. Individual persons may be active or inactive members of a moral community.

A moral community can be as large as the global community whose members are generally committed to the common good and prosperity of the inhabitants of the earth or as small as a community of senior nursing students at a university. The common good of a community of nursing students might be the collective concern of obtaining professional nursing licensure while maintaining individual physical and psychological well-being. The student community accomplishes its goals through the members' shared commitment to providing emotional support to community members and to helping one another move toward the successful completion of the National Council Licensure Examination (NCLEX). An even smaller community is a family that is committed to common goals beyond the individual personal goals of family members.

Members of a community may or may not share close geographic boundaries; however, if members of a community share some type of geographic boundaries, the primary moral connection among the members is not based solely on that geography. Nurses, patients, and other people in society are usually members of more than one community. A nurse is a member of the community of registered nurses who are collectively committed to the common good of alleviating patients' suffering and promoting

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Box 11.1: Highlights From the Field: Community

Community. A word of many connotations—a word overused until its meanings are so diffuse as to be almost useless. Yet the images it evokes, the deep longings and memories it can stir, represent something that human beings have created and recreated since time immemorial, out of our profound need for connection among ourselves and with Mother Earth.

Forsey, H. (1993). *Circles of strength: Community alternatives to alienation*. Philadelphia: New Society, p. 1.

patients' well-being. The same nurse also may be a member of a faith community; a member of a geographic neighborhood community, which is interested in the common good and safety of the neighbors; and a member of a parent-teacher organization, which is committed to the common good of a population of children.

Ethical Approaches to Public Health

As it is with all sorts of ethical considerations regarding nurses' personal and professional beliefs and behaviors, it is difficult to limit one's philosophy to only one ethical theory or approach in public health practice. At varying times and in varying situations one of a number of important ethical approaches and theories may help guide nurses' actions and the development of public health policies.

According to the ANA (2007), public health nurses must adhere to the ethical principles outlined in the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001), the *Principles of Ethical Practice of Public Health* (Public Health Leadership Society, 2002), and the *Environmental Health Principles and Recommendations for Public Health Nursing* (APHA, 2006) (see Boxes 11.2 and 11.3). C/PH nurses are charged with honoring "the diverse values, beliefs and cultures present in the population served" (ANA, 2007, p. 9) and providing information necessary for members of populations to discuss health care choices and make noncoerced health care decisions. Because of the scope of C/PH nursing, ethical practice is especially focused on social justice and the rights of various populations. The ANA noted that the precautionary principle is a good guide to use in supporting social justice and populations' rights.

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Box 11.2: Highlights From the Field: Principles of the Ethical Practice of Public Health

1. Public health should address principally the fundamental causes of disease and requirements of health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.

Public Health Leadership Society. (2002). *Principles of the ethical practice of public health*, p. 4.

For a complete list of principles go to http://www.apha.org/codeofethics/ethicsbrochure.pdf

The Precautionary Principle

The concept known as the **precautionary principle** is based on the German word, *vorsorgeprinzip*, which means the principle of forecaring. The word *forecaring* conveys more than being cautious. It means that one uses foresight and preparation, and it is aligned with the principle of "first do no harm" (nonmaleficence) and the adage "better safe than sorry" (Science & Environment Health Network [SEHN], n.d. a). In 1998, a multinational, multiprofessional group met for a conference sponsored by the SEHN at the Wingspread headquarters of the Johnson Foundation to discuss using the precautionary principle as the basis of international agreements, especially those related to the environment and health. The participants at the Wingspread conference developed a statement to guide actions by governmental and nongovernmental agencies. The group stated: "When an activity raises threats of harm to the environment or human health,

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Box 11.3: Highlights From the Field: *Environmental Health Principles and Recommendations for PHN*

1. Environmental health is integral to the role and responsibilities of *all* public health nurses.
2. The *Precautionary Principle* is a fundamental tenet for all environmental health endeavors.
3. Environmental justice is a right of all populations.
4. Collaboration is essential to effectively protecting the health of all people from environmental harm.
5. Environmental health advocacy must be rooted in scientific integrity, honesty, respect for all persons, and social justice.

American Public Health Association, Public Health Nursing Section. (2006). Environmental health principles and recommendations for public health nursing, p. 5.

For a complete list of principles go to http://www.astdn.org/downloadablefiles/Principles%20and%20Recommendations%20Document_4-06.doc

precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically" (Para 1).

According to SEHN (n.d. b), "the key element of the principle is that it incites us to take anticipatory action in the absence of scientific certainty" (Para 1). Advocates of using the precautionary principle contend that we should not wait until we have "certain evidence" from traditional science to show the causal connection between various actions or toxins and their effects. Minimum standards for citing evidence of cause and effect relationships via traditional science are usually very high (SEHN, n.d. a). The type of science needed to support the precautionary principle has been called *appropriate science*, as distinguished from *traditional science* (Kriebel, Tickner, & Crumbley, 2003). Appropriate science is based on the context of the problem at hand rather than requiring that scientific pursuits be forced into a preconceived idea of necessary rigor.

People who oppose the precautionary principle contend that if science has not provided certain evidence that a particular activity or substance is harmful to humans

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and/or the environment, then the activity or substance is assumed to be safe until shown to be otherwise. However, proponents of using the precautionary principle answer with the argument that by the time harmful causal relationships are established as certainty, much damage already may have occurred. An example cited by proponents of the precautionary principle is the harmful connection between smoking and lung cancer. "Smoking was strongly suspected of causing lung cancer long before the link was demonstrated conclusively" (SEHN, n.d. a, Para 3). Fortunately, many smokers had stopped smoking based on precautionary measures rather than waiting on scientific certainty to confirm the harmful effects.

Today, there is evidence that the incidence of chronic illnesses, birth defects, infertility, cancer, Alzheimer's disease, and autism are increasing while certain causal links to these conditions are lacking. Advocates of using the precautionary principle strongly propose that society should limit exposure to potentially harmful substances even before those substances are shown to have direct causal links to human health problems.

For C/PH nurses to practice ethically, it is recommended in the ANA's (2007) *Public Health Nursing: Scope and Standards of Practice* that public health nurses use the precautionary principle. As a follow-up to the Wingspread conference, another community of philosophers, scientists, and environmentalists, called the Blue Mountain group, met to discuss the ethics that underlie the precautionary principle. This group's consensus was that the precautionary principle is an integration of science and ethics (Raffensperger & Myers, 2001). Whereas traditional science tries to separate evidence from values, the precautionary principle supports the integration of the two, and the precautionary principle is "an ethic of survival" (Para 8). The Blue Mountain group contended that emotions and "values such as compassion, sympathy, gratitude, and even humor are based on sound instinct" (Para 8). Societal values become societal actions. The group argued that people must live in a positive reciprocal relationship with nature as well as with one another if society is to survive.

Kantian Ethics (Deontology)

Kantian ethics emphasizes that all rational persons are autonomous, ends-in-themselves and worthy of dignity and respect. (See Chapter 1 for a more complete discussion of Kantian ethics.) Kantianism is highly valued in Western medicine because of the focus on individual rights and informed consent. In the U.S. health care system and in Western bioethics, the choices of rational individuals are generally respected. However, in public health, practitioners often must balance the rights of individuals with the rights of populations and communities. Sometimes, navigating this delicate

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balance can be controversial or generate dilemmas, such as considering appropriate actions when a person with a stigmatizing communicable disease may jeopardize the health of other people. This situation results in a need to balance respecting the autonomy and protecting the confidentiality of one person while trying to protect the safety of other persons.

Utilitarianism (Consequentialism)

As discussed in Chapter 1, utilitarianism is an ethical approach based on maximizing the good or moral consequences of one's decisions and actions. Although there are variations in utilitarian theories, when utilitarianism is used in health care, the goal or intended consequence generally is to produce the greatest good for the greatest number of people. Because of the emphasis on population-focused care, utilitarianism is one of the most widely used ethical approaches in public health practice. The second distinguishing element of public health nursing outlined in the ANA's (2007) *Public Health Nursing: Scope and Standards of Nursing* is that "*the primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole*" (p. 8). This directive for public health nurses is a classic example of utilitarianism.

Communitarian Ethics

There is no power for change greater than a community discovering what it cares about.

—MARGARET WHEATLEY, *TURNING TO ONE ANOTHER*

Communitarian ethics is based on the position that "everything fundamental in ethics derives from communal values, the common good, social goals, traditional practices, and cooperative virtues" (Beauchamp & Childress, 2001, p. 362). Communitarian ethics is relevant to moral relationships in any community, and this ethical approach is particularly useful in the practice of PHN because of the focus on populations and communities rather than on the care of individuals.

The notion that communitarian ethics is based on the model of friendships and relationships that existed in the ancient Greek city-states described by Aristotle was popularized in modern times by the philosopher and ethicist Alasdair MacIntyre (1984) in his book, *After Virtue*. In general societal ethics and in bioethics, the valuing and consideration of community relationships has come to mean different things to different people (Beauchamp & Childress, 2001). Communitarian ethics as an ethical approach is distinguished because the epicenter of communitarian ethics is the commu-

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nity rather than any one individual (Wildes, 2000). Populations, in general, and moral communities, in particular, also are the starting points for C/PH nursing practice.

The value of discussing and articulating an approach to communitarian ethics lies in the benefit that can be gained through illuminating and appreciating the relationships and interconnections between people that are often overlooked in everyday life. Although personal moral goals, such as the pursuit of personal well-being, are significant, the importance of forming strong communities and identifying the moral goals of communities must not be neglected in order for both individuals and communities to flourish.

An important distinction that legitimately can be drawn between communitarian and other popular ethical approaches, such as deontological or rule-based ethics, is based on communitarian ethicists' proposal that it is natural for humans to favor the people with whom they live and have frequent interactions. Kantian deontologists base their ethics on an impartial stance toward the persons who experience the effects of their morally related actions.

However, using a communitarian ethic and valuing partiality as a way of relating to other people does not have to exclude caring about people who are personally unknown to moral agents. Although it is often easier for people to care about and have compassion for people who are relationally closest to them, it is not unrealistic to believe that people also can develop empathy or compassion toward people who are personally unknown to them. Such behavior and expectations are an integral part of Christian and Buddhist philosophies, for example. Accepting the notion that humans usually are more partial to people with whom they are most closely related, while at the same time believing that it is possible to expand the scope of their empathy and compassion to unknown others, broadens the sphere of morality in communitarian ethics.

Nussbaum (2004) suggested that people often develop an "us" versus "them" mentality, especially when violence occurs among various groups and significant ethnic and cultural differences separate them. People are able to generate sympathy, or fellow-feeling, when they hear about epidemics, disasters, and wars occurring on continents that are far away, but it is often difficult for people to sustain their sympathy for more than a short period of time after media coverage diminishes. People tend to stop and notice the needs of other people and then soon turn back to their own personal lives. According to Nussbaum, humanity will "achieve no lasting moral progress unless and until the daily unremarkable lives of people distant from us become real in the fabric of our own daily lives" (p. 958) and until people include others that they do not know personally within the important sphere of their lives (see Box 11.4). C/PH nurses

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Box 11.4: Highlights From the Field: The Delusion of Separateness

A human being is a part of the whole called by us universe, a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest, a kind of optical delusion of his consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to enhance all living creatures and the whole of nature in its beauty.

Albert Einstein. (1930). *What I believe.* Retrieved August 20, 2007, from http://home.earthlink.net/~johnrpenner/Articles/Einstein3.html

must broaden their scope of concern to consistently include people affected by health care disparities, diseases, epidemics, and the impact of ethnic violence and wars all over the world, not only when issues are highlighted in the media.

"All communities have some organizing vision about the meaning of life and how one ought to conduct a good life" (Wildes, 2000, p. 129). C/PH nurses have an important role in bringing populations and communities together to work toward a common humanitarian good. Transforming a community from an "us" versus "them" mentality to one that seeks a common good is possible through education (Nussbaum, 2004). "Children [and people] at all ages must learn to recognize people in other countries as their fellows, and to sympathize with their plights. Not just their dramatic plights, in a cyclone or war, but their daily plights" (p. 959). This need for empathetic understanding also is important in one's own country, state, city, town, or neighborhood. Many people of all ages are suffering in the United States and throughout the world because they lack adequate health care, proper food, a sanitary environment, and good housing.

The education of communities often occurs through role modeling (Wildes, 2000). Members of communities learn about what is and is not accepted as moral through personal and group interactions and dialogue within their communities. Narratives are told by nurses about the lives of exemplars, such as Florence Nightingale and Lillian Wald, to illustrate moral living. By her efforts to improve social justice and health protection through environmental measures and her efforts to elevate the char-

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acter of nurses, Nightingale exhibited moral concern for her local society, the nursing profession, and people remote from her local associations, such as the population of soldiers affected by the Crimean War. Likewise, Lillian Wald was an excellent role model for members of communities because of her efforts to improve social justice through her work at the Henry Street Settlement. When learning from the example of Nightingale and Wald, communitarian-minded C/PH nurses are in an excellent position to educate the public and other nurses and health care professionals about why they in many ways should assume the role of being their brothers' and sisters' keepers.

Ethical Reflections

- To what communities do you belong? What can be identified as the common good of each of these communities?
- Have you noticed "us" versus "them" thinking among members of the nursing community? Among members of the larger community of health care professionals? If so, what effect has this thinking had on relationships among members of the particular community?
- Can a community exist when there is "us" versus "them" thinking among the members? Why or why not?
- What patient populations might be particularly susceptible to having people approach them as "us" versus "them"? What evidence did you use for your answer? How can nurses change this type of separatist thinking?

Social Justice

As discussed in Chapter 1, **social justice** is related to the fair distribution of benefits and burdens among members of a society. However, in our U.S. society, market justice is the dominant model (Beauchamp, 1999). Market justice is based on the principle that the benefits and burdens of a society should be distributed among its members according to the members' individual efforts and abilities. In a market-justice system, money for health care tends to be invested in technology and curing diseases rather than in health promotion and disease prevention.

Major public health problems usually are concentrated among a small minority of the U.S. population. For social justice to be achieved, members of U.S. society who are not directly experiencing problems such as a lack of access to health care, poverty, poor quality of housing, and malnutrition may have to significantly reduce their share of societal benefits and increase their share of societal burdens. Therefore, public health and

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social justice involve important ethical decisions about how members of societies choose to distribute their resources and provide for the well-being of their fellow citizens.

Health Disparities

If we gloss over the difficulties that people face in their communities, we cannot hope to build a better world.

—Helen Forsey, *Circles of Strength: Community Alternatives to Alienation*, p. 50

Health disparities are inequalities or differences in health care access and treatment that result in poor health outcomes for persons and populations. Health disparities occur because of some characteristic(s) of the persons or population affected. After the first goal of aiming to "increase quality and years of healthy life" (U.S. DHHS, 2000, p. 8), the second goal of *Healthy People 2010* "is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (p. 11). Eliminating health disparities is a moral issue for C/PH nurses because social justice and communitarian ethics are based on building flourishing communities that support the common good of all community members.

According to nurse anthropologist Lundberg (2005), "social and cultural factors give context and meaning to health, illness, and injury. The experience is more than that of the patient. It also reflects the worldview of the individuals helping the person in distress" (p. 152). A major concern of bioethicists is the recognition that people's health and access to health care is adversely affected in proportion to their lack of power and privilege in a society (Sherwin, 1992). Consequently, poverty and the placement of people within the margins of society are key factors in the determination of public health. When any community members are suffering or are in need, all people in the communities are affected, even if it is in imperceptible ways. One must only think about the hypothetical Net of Indra (see Box 1.3 in Chapter 1) to imagine how this situation might be a reality.

The aim of the *Healthy People 2010* (U.S. DHHS, 2000) agenda is that "every person in every community across the Nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health" (p. 16). Racial and ethnic minorities suffer serious health disparities in regard to access to care and health outcomes. The DHHS has selected six target areas of focus to try to minimize disparities among minorities (Centers for Disease Control [CDC], 2006a). The six areas of emphasis are infant mortality, cancer screening and management, cardiovascular dis-

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ease, diabetes, HIV infections/AIDS, and immunizations. Several of the many specific examples of health disparities experienced by minorities include a black-to-white infant mortality ratio of 2.5 to 1, diabetes being 2.6 times more likely to be diagnosed in American Indians and Alaska Natives than in non-Hispanic whites, and the influenza and pneumococcal vaccine being less likely to be received by people age 65 and older who are Hispanics and African Americans than by non-Hispanic white people.

C/PH nurses need to play a role in helping members of communities to collectively accept their responsibility for their own health and to develop the capacity to help themselves in resolving problems that lead to health disparities. One coordinated plan to address public health disparities involves four phases or themes: community participation, community mobilization, commitment to social justice, and the leadership challenge (Berkowitz et al., 2001).

C/PH nurses can support members of communities by participating in the validation of suspected problems through investigation and research and by building partnerships to collaborate on policy development. C/PH nurses facilitate community mobilization by educating members of the community about health promotion and health protection measures that would be likely to improve the lives of people in the community. Teaching people in the community about how to begin grassroots political efforts to obtain needed resources is an important advocacy role of C/PH nurses. Being committed to social justice requires C/PH nurses to speak out about health disparities to other nurses and health care professionals, to a wide group of community members, and to politicians about health disparities (see Box 11.5). In helping communities to increase participation, mobilize action, and expand social justice, the leadership challenge for C/PH nurses is to "act as a resource, consultant, facilitator, educator, advocate, and role model" (Berkowitz et al., 2001, p. 53).

A widely accepted approach to organizing communities in efforts to address their health disparity and social justice problems has been based on the thought that health care professionals must appeal to the self-interest of the community and its members (Minkler & Pies, 2002). However, Minkler and Pies argued that this traditional approach often only further divides groups of people by furthering the notion of individualism and separateness that is already a divisive way of thinking in Western societies. This approach does not support a community's interest in a common good.

Minkler and Pies (2002) adapted a feminist approach to social change as an agenda for trying to eliminate disparities in the equitable distribution of community resources. Historically, feminist philosophers and activists have approached their agenda in terms of the disparities experienced by women. Therefore, a feminist approach often can be applied with other marginalized populations. This approach

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Box 11.5: Highlights from the Field: Three Parts of a Legislative Meeting

During meetings with legislators, nurses can use the following guidelines:

1. **Hook**: Briefly explain who you are.
2. **Line**: Briefly explain your issue and why you care about it. Present a strong argument, a personal story, or both. Try to put a face on your issue.
3. **Sinker**: Clearly present your specific request and try to get a commitment. It is very important to stay focused on your message and to listen attentively to feedback.

Other suggestions:

- Plan for the meeting to last no more than 15 minutes.
- Arrive 10 to 15 minutes early for your appointment.
- Before the meeting, assign responsibilities among your colleagues to carry out during the meeting, such as deciding who will begin and end the meeting.
- Rehearse your talking points before the meeting.
- Exchange business cards during the meeting.
- At the end of the meeting, thank everyone who met with you or helped schedule the meeting. Send a thank you note shortly after the meeting.

Christopher Kush. (2004). *The one hour activist: The 15 most powerful actions you can take to fight for the issues and candidates you care about.* San Francisco: Jossey-Bass.

can be used to build a bridge that connects local community efforts to eliminate disparities with efforts that can be used to address more global social concerns. Nurses and other health care professionals working with community members who are involved in becoming organized to facilitate change can ask:

(1) Does [the community's organizing effort] materially improve the lives of community members and if so, which members and how many? (2) Does [participating in the organizing process] give community members a sense of power, strength and imagination as a group and help build structures for further changes? and (3) Does the struggle . . . educate community members politically, enhancing their ability to criticize and challenge the system in the future? (Minkler & Pies, pp. 132–133)

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Ethical Reflections

- What is meant by the term *marginalized populations*? Identify populations that may be marginalized in regard to health disparities and discuss why this may be so.
- Reflect on and discuss why appeals to self-interest in addressing health disparities might divide people and communities.
- Review critical theory in Chapter 1. Why is this theory relevant to the issue of health disparities? Provide one example of how a public health nurse could use critical theory in addressing health disparities in a specific population.
- Identify issues and problems that PH nurses might address via a meeting with a state or national legislator.

Virtue Ethics: Justice and Generosity

To a [disciple] the Master said, "I fear you are doing more harm than good."
"Why?"
"Because you stress only one of the two imperatives of justice."
"Namely?"
"The poor have a right to bread."
"What's the other one?"
"The poor have a right to beauty."

—Anthony De Mello, *One Minute Nonsense*

Pieper (1966) proposed that "the subject of justice is the 'community'" (p. 70). Justice can be viewed in terms of what rights or resources should be accorded or distributed to persons or populations or what is their due. However, there is another conception of justice that is communitarian in nature (see Moral Ground Model in Chapter 2). This approach is based on virtue ethics and emphasizes the virtue of **just generosity**, which is a conception of justice that highlights human connections and not separateness. Indebtedness is the hallmark of this type of justice, and although the concept of justice as a stand-alone virtue is important to public health ethics, the combination of the virtue of justice with the virtue of generosity expands the scope of justice.

People are accustomed to thinking of justice in limited terms, and they are accustomed to separating the individual virtues of justice and generosity. Thinking and acting in terms of the comprehensive virtue of just generosity sometimes requires the use of one's moral imagination to envision "what could be." Whereas justice involves giving others what they are due, generosity involves giving to people from a source

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that is somehow personal. Fusion of the single virtues of justice and generosity into a combined activated virtue is important for people in facilitating the development of flourishing communities, both communities as large as the global community and communities as small as families.

Cultivation of the virtue of just generosity is based on a person's motivation to actively participate in a community-centered network of giving and receiving. Persons, including nurses, who exhibit the virtue of just generosity do not give merely in proportion to what an individual receiver or community is perceived as being due, but instead they give to persons or communities based on the receivers' or communities' needs. The giver believes in and does more than dispassionately allocate or distribute resources. The person or group that possesses just generosity gives from resources that in some way touch the giver(s) personally, which may not necessarily involve the giving of something that is material or tangible but often involves what might be called giving from the heart.

Salamon (2003) in her book, *Rambam's Ladder*, adapted the Jewish physician and philosopher Maimonides's (1135–1204) "ladder of charity" for contemporary use. Salamon's book provides a meditation on generosity and underscores that an awareness of the need for giving has become more important than ever in a post-9/11 world. Salamon's ladder of charity starts, as did Maimonides's ladder, with the bottom rung representing the least generous motivation for giving and progresses to the top of the ladder with the top step being what Salamon proposed to be the highest form of giving. The eight steps of the ladder are as follows, beginning with the lowest:

1. Reluctance: To give begrudgingly.
2. Proportion: To give less to the poor than is proper, but to do so cheerfully.
3. Solicitation: To hand money to the poor after being asked.
4. Shame: To hand money to the poor before being asked, but risk making the recipient feel shame.
5. Boundaries: To give to someone you don't know, but allow your name to be known.
6. Corruption: To give to someone you know, but who doesn't know from whom he is receiving help. (For example, this occurs when people are concerned that the "middlemen" distributing the gifts are not trustworthy.)
7. Anonymity: To give to someone you don't know, and to do so anonymously.
8. Responsibility: At the top of the ladder is the gift of self-reliance. To hand someone a gift or a loan or to enter into a partnership with him or to find work for him so that he will never have to beg again. (Salamon, 2003, Introduction)

C/PH nurses can use the ladder of charity as a gauge of the type of giving that occurs within communities while keeping their eyes focused on aiming for the top step of the

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ladder. C/PH nurses do not directly give money to people and usually do not give material resources to them. Nurses' services to individuals, families, communities, and populations can be substituted for monetary or material giving in the steps of the ladder. Salamon (2003) herself recognized that monetary giving is not always the primary means of generosity. However, depending on their particular jobs, C/PH nurses are sometimes responsible for coordinating and distributing gifts and donations to populations.

Nurses might ask themselves whether or not they give begrudgingly during their work. Do they work from the motivation of a generous servant, hoping to affect the well-being of a population or community who will not know how the nurse's services have positively affected them and their health? Must individual and community recipients of the services of C/PH nurses directly ask for each of their specific needs to be met? Do nurses use their moral imaginations and anticipate needs, reflecting and acting based on the "big picture" of "what could be" that may not be readily apparent to them unless they suspend their initial judgments? When the practice of just generosity is consistent with the top step of the ladder, C/PH nurses enter into community partnerships and teach other people to be responsible for helping themselves and their communities so that community members and, ultimately, whole communities become self-reliant whenever possible.

Ethical Reflections

Discuss the following situations and apply ethical theories and approaches discussed in this section of the chapter. If needed, refer to other chapters in the book, read ahead in this chapter, or search the Internet for more information. What theories or approaches are applicable in each situation? Could more than one approach be useful? What do you believe are the most ethical actions or positions in these situations? List and discuss as many relevant issues and considerations as possible. What additional information might you need to make your decisions? Specifically, how and where would you obtain this information?

- You are a school nurse in Mississippi. A mother does not want her school-aged child immunized for chickenpox before entering the school where you work. The child was not previously immunized and has not had chickenpox.
- Your clinic patient was newly diagnosed as being HIV positive. The patient refuses to tell his diagnosis to his sexual partner. Also, the patient tells you that he does not want you to report his status to the state health department.
- Your rich friend who owns a business and has health insurance tells you that he doesn't want to pay extra taxes so that all people in the United States will have access to basic health care.

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- You are the tuberculosis (TB) nurse at the county health department. You regularly make home visits for directly observed therapy (DOT) for a woman with TB. The woman is frequently not home when she knows that you are coming to her house.
- You are a nurse working at the county health department. You learn that a rich developer is planning to build low income housing on an old landfill that was used by a chemical company. The developer has stated that there is no evidence that chemicals at the landfill will harm anyone.
- You are a nurse working at a mission in Africa, and you are participating in an HIV/AIDS research study with several doctors. The research is aimed at identifying whether circumcision reduces the transmission of HIV between heterosexual couples. During the study it becomes apparent that transmission is significantly reduced when males are circumcised. However, the doctors do not want to stop their study even though they believe that participants in the control group may unnecessarily become infected during the course of the study.
- Your colleague tells you that she doesn't ever want to work with a population of elders. She states that she becomes frustrated with the physical and emotional dependency that sometimes develops in this population.
- You are an elementary school nurse. Many of the children at the school are ethnic minorities living in single-parent families. The population of children at the school has a high incidence of health-related problems as compared to the children at the private school where your nurse friend works. You frequently are frustrated because you do not see the children's mothers trying to break their cycle of poverty. You consider quitting your job.
- While working as an occupational health nurse at a local industry, you discover that your employer is willingly pushing the limits on air and water pollution standards. Your supervisor tells you that it would cost too much money to reduce the pollution.
- Your nonsmoker friend tells you that she is angry because she has to pay health care costs for tobacco users. She states that tobacco use is one of the leading causes of diseases requiring major expenditures of health care dollars and that the smoking-related expenditures cause her cost of health care to rise. She complains that smokers are "choosing their own health" and should not receive federally funded health care through Medicare and Medicaid programs. How do you respond to your friend? Do you believe that people often choose their own health? If so, what are the ethical implications? If not, explain the justification for your position.
- You are an elementary school nurse. You are informed that the school cafeteria will begin including food from cloned animals. This type of food has not been tested exhaustively by the FDA. The school superintendent does not want to publicize the addition of the new food sources at the school.

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Communicable Diseases

Public health advances in the 20th century dramatically decreased morbidity and mortality from infectious diseases in the United States; because of this progress, national health officials began to lose interest in funding and promoting research directed at infectious disease treatment and control (CDC, 2003). However, people in the government, health care systems, and the general public have begun to recognize that humanity's fight against infectious diseases is never ending (Markel, 2004). In her book about the global collapse of the public health care system, Garrett (2000) stated "we now live in comfortable ignorance about the health and well-being of people in faraway places. But in truth we are never very far away from the experiences of our forebears" (p. xii).

Societies are still tormented by diseases that have affected the public's health since ancient times, while the threat of new infections looms ominously in the future. "Together, malaria, tuberculosis and AIDS killed 5.7 million people in 2004, accounting for about one-tenth of the world's deaths" (World Health Organization [WHO], 2006b, Para 1). Some people in the United States try to avert their eyes from the global scourge of malaria, tuberculosis (TB), and AIDS, but due to media coverage of communicable disease threats such as pandemic influenza, it has become more apparent that no one in the United States or elsewhere around the world should feel safe from mass casualties involving infectious diseases. C/PH nurses will be at the epicenter of the health care system if a highly contagious pandemic occurs. C/PH nurses also must take a prominent role in current epidemics such as malaria, TB, and AIDS. The words of the poet John Donne (1962) provide a good representation of how infectious diseases that affect the global community are related to ethics in nursing:

No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were. Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee. (p. 1107)

Paul Farmer (2001), a physician at Harvard Medical School who also travels to central Haiti to work at the Clinique Bone Sauveur, advocated that "we can no longer accept whatever we are told about 'limited resources'" (p. xxvi). Health care professionals must challenge the often repeated mantra that resources are too limited to fund programs to treat epidemics. According to Farmer, "the wealth of the world has not dried

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up; it has simply become unavailable to those who need it most" (p. xxvi). He proposed that people must ask to be shown the data that support the truth of statements that there are fewer resources for public health than there were when effective therapies were not available to treat many diseases. "Our challenge, therefore, is not merely to draw attention to the widening outcome gap, but also to attack it, to dissect it, and to work with all our capacity to reduce this gap" (p. xxvi). Health care professionals and the public must make it clearly known that they are not willing to idly watch when the wealth of nations is being concentrated within limited populations and programs while, on a mass scale, people in other populations die of treatable diseases.

Ethical Reflections

- Do you believe that there are enough resources to treat diseases in populations severely affected by health disparities? On what evidence do you base your position?
- What can nurses do to become more aware of people's access to health care and how health care resources are distributed in poor countries? What can nurses do to try to improve health care access for people in poor countries that are far from the nurses' own homes?
- Is being aware of the state of health care and epidemic diseases in poor countries a moral issue? Why or why not?

Malaria

Malaria, which means "bad air," has been a problem for humans for over 4,000 years (CDC, 2004). Globally, the annual human burden of malaria is very high with malaria causing 1.1 million deaths, most of which occur in children under 5 years old, and 300-500 million total malaria cases (WHO, 2002). The social and economic burden also is very high in endemic countries. "Those at greatest risk of malaria are poor people, and populations that are marginalized, such as ethnic minorities and people displaced as a result of civic unrest" (p. 1). If corrective actions are not taken, trends over the last several decades indicate that the impact of malaria will continue to worsen.

Issues contributing to the rising burden of malaria include the following:

- Inadequate ability to treat the disease because of poor drug availability and drug resistance.
- Inadequate availability of effective and affordable insecticide-treated bed nets. The WHO has now resumed recommending the use of DDT-treated bed nets. This action reversed the WHO's 30-year policy of discouraging the use of DDT in try-

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ing to control malaria because of fears about DDT's impact on human and animal health. The WHO now has proposed that DDT is the most cost-effective alternative for indoor spraying to prevent malaria.

- User ignorance in regard to effective treatment tools.
- Poorly coordinated partnerships and approaches to epidemiological systems.
- War, social unrest, and poverty. (British Broadcasting Corporation News, 2006; Lobe, 2006; WHO, 2002)

Partnerships among members of the global community that have resources to combat this deadly disease will be needed to help poor populations that are suffering and dying needlessly from malaria. It is morally incumbent upon C/PH nurses to understand the human and economic burden of malaria and to advocate for adequate prevention and treatment of this serious disease.

Ethical Reflections

- The use of DDT to prevent malaria has been controversial. Go to the Internet and locate evidence that supports and evidence that contradicts the benefits of using DDT. What is your position about this issue? Discuss the precautionary principle in relation to the use of DDT.

Tuberculosis

"TB, with AIDS, is the leading infectious cause of adult mortality in the world, causing between 1.5 and 2 million deaths per year" (WHO, 2006c, Para 2). Almost one third of the global population (2 billion persons) is living with TB infection, and the annual infection rate continues to climb. By 2020, TB is expected to remain as one of the top 10 causes of adult mortality in the world. The only other infectious disease expected to remain on this list is HIV. "One estimate suggests 171 million new [TB] cases and 60 million deaths over this period in the 'best case scenario,' and 249 million new [TB] cases and 90 million deaths in the 'worst-case scenario' (Para 3).

Tuberculosis is airborne, and this makes the treatment of TB a major public health concern in terms of infected persons' infringement on the well-being of noninfected persons. People infected with TB who lack the capacity or desire to adhere to recommended treatment are an ongoing moral problem (Beauchamp & Childress, 2001). Freedom and autonomy are, of course, to be supported whenever possible; however, when persons infected with TB do not voluntarily adhere to treatment, it is ethically and legally obligatory to mandate treatment because of health threats to others.

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Directly observed therapy (DOT), in which persons are directly observed while taking their TB medications, is one means of ensuring that affected individuals adhere to their treatment regimen. The international community has responded to the problem of the spread of TB with coordinated efforts to control it through DOT. The least restrictive and least intrusive measures for reaching treatment goals should be given priority, but if measures like DOT are not effective, detention and quarantine are ethical and may be required for the public's safety (Beauchamp & Childress, 2001).

Ethical Reflections

- Search the Internet and review the case of the American attorney, Andrew Speaker, who was infected with TB.
- List and discuss the ethical issues involved with Mr. Speaker's case.
- What are the various ethical theories or approaches that can be applied to the case? Explain. Remember to consider different perspectives.
- What is your position about the ethics surrounding the case? Be sure to provide a clear position and support it. Include one or more ethical approaches as part of your justification.

HIV/AIDS

AIDS-related illnesses killed 2.9 million people in 2006 (WHO, 2006a). Unfortunately, the previously stable or declining HIV infection rates in some countries now seem to be reversing. The AIDS epidemic is continuing to grow worldwide and there is a resurgence in new HIV infection rates in some parts of the world. A 2006 update revealed that there were 4.3 million new HIV infections, and it appeared that there may have been a 50% increase in infections between 2004 and 2006 in Eastern Europe and Central Asia. Evidence shows that HIV prevention programs produce positive outcomes if the programs are focused and sustained; but in North America and Western Europe, these programs have not been sustained and new HIV infections have remained level.

Ethical Reflections

- Imagine that you are a nurse participating in a research study with a pharmaceutical company that develops drugs to treat HIV/AIDS. You and your professional colleagues discuss that the experimental drug being researched seems to be causing severe adverse reactions in a few of the patients with AIDS and even may have caused one or two deaths.

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The "line" that is delivered by the primary investigator is that AIDS patients already have a shortened lifespan. He states that although the drug may cause adverse reactions in a few patients, overall he is hoping for "the greatest good for the greatest number of patients." How do you feel about this position? Is it ethical? Why or why not? What would you do if you were helping to conduct this research?

HIV Testing

In 2006, the CDC (2006b) published major revisions to its HIV testing guidelines, and the new recommendations include routine HIV testing for patients in all health care settings. Because basic screening for treatable conditions is a common public health secondary prevention tool, it is believed that early identification of HIV infections will lead to better health outcomes. Also, risk-based screening is less effective now because the mix of people becoming infected with HIV is changing to persons who are frequently unaware of their high risk status—racial and ethnic minorities, people less than 20 years of age, non-metropolitan-area dwellers, and heterosexuals.

Major revisions in the CDC's (2006b) guidelines are contained in Box 11.6. The CDC's position is unchanged in its continued advocacy for voluntary, noncoerced agreement for testing, for no testing without a patient's knowledge, and for access to clinical care and counseling for persons whose tests are positive. However, the CDC now advocates that screening should be provided in a manner similar to other diagnostic testing without special pretest prevention counseling.

However, even when it is voluntary, HIV testing carries with it certain risks and benefits. Since the emergence of HIV, the policy issue that has generated the biggest ethical concern is how to protect the public while respecting individual rights and privacy (Beauchamp & Childress, 2001). Psychological well-being and the opportunity to prevent future infection are among the benefits to people whose test results are negative. For people whose test results are positive, benefits include "closer medical follow-up, earlier use of antiretroviral agents, prophylaxis or other treatment of associated diseases, protection of loved ones, and a clearer sense of the future" (p. 298).

People who are seronegative have no significant risks from testing; however, the psychological and social risks are significant for people who are seropositive (Beauchamp & Childress, 2001). People who are HIV positive are at a high psychological risk for anxiety, depression, and suicide and are at a high social risk for "stigmatization, discrimination, and breaches of confidentiality" (p. 299). It is the ethical responsibility of health care professionals and other people in society to try to minimize

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Box 11.6: Highlights From the Field: New HIV Testing Guidelines

- Screening after notifying the patient that an HIV test will be performed unless the patient declines (opt-out screening) is recommended in all health-care settings. Specific signed consent for HIV testing should not be required. General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing.
- Persons at high risk for HIV should be screened for HIV at least annually.
- HIV test results should be provided in the same manner as results of other diagnostic or screening tests.
- Prevention counseling should not be required as a part of HIV screening programs in health-care settings. Prevention counseling is strongly encouraged for persons at high risk for HIV in settings in which risk behaviors are assessed routinely (e.g., STD clinics) but should not be linked to HIV testing.
- HIV diagnostic testing or screening to detect HIV infection earlier should be considered distinct from HIV counseling and testing conducted primarily as a prevention intervention for uninfected persons at high risk.

Centers for Disease Control. (2006b). Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *Morbidity and Mortality Weekly Report, 55*(RR14), 1–17. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm on September 20, 2007.

the risks to these individuals. Participating in counseling, community education, and social and political activism are ways that C/PH nurses can play an important role in minimizing the risk of HIV infection among populations served and in minimizing the risk of negative effects on people who undergo HIV testing.

Exceptions to voluntary consent for HIV testing include situations in which there has been significant occupational exposure (e.g., to nurses, emergency medical technicians, firefighters, etc.) and the person whose HIV status is in question refuses testing. Other exceptions are prior to organ transplant donation, when a coroner needs to determine cause of death, and when testing is needed for emergency diagnostic purposes when the patient is unable to consent and a surrogate is not available (Dempski, 2006).

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Confidentiality

Confidentiality and the duty to warn were discussed in Chapter 9 and have similar applications in ethical relationships with persons infected with HIV. Persons who know or suspect that they have HIV often avoid testing or treatment because of fears about exposure of lifestyle, including sexual practices or drug use, discrimination and stigmatization, and loss of relationships (Beauchamp & Childress, 2001; Chenneville, 2003). As a general rule, a person's HIV status is confidential information (Dempski, 2006). HIV status may be disclosed when persons or their proxies provide written authorization to do so and when health care providers have a need to know, such as workers at a coroner's office or the health care staff of a correctional facility.

Statutory laws in each state must be consulted for directions regarding the duty to warn known sexual partners of individuals with HIV. Before a person's HIV status is disclosed to a known partner or partners, attempts should be made to encourage HIV-positive persons to self-disclose to other people who are at risk of infection due to their seropositive status. Newly diagnosed HIV-positive patients need to be informed that health department personnel may contact them to voluntarily discuss partner notification (CDC, 2006b). Professionals working at health departments should be available to help patients notify sexual partners and to provide HIV counseling and testing while keeping the patient's name confidential. "In the final analysis, the health professional is expected to weigh the likelihood of harm to other parties against his or her duty to keep confidentiality and act accordingly" (Fry & Veatch, 2006, p. 305).

Chenneville (2003) proposed a decision-making model that takes into consideration the premises contained within the *Tarasoff* legal case (see Duty to Warn in Chapter 9) as well as health care ethics that focuses on the best interest of the person who is seropositive. The first step in Chenneville's model is to determine whether disclosure is warranted. Assess the foreseeability of harm and the identifiability of the victim. Questions to consider when determining foreseeability are included in Box 11.7. Chenneville's second step is to refer to professional ethical guidelines, and the final step is to refer to state guidelines (pp. 199–200).

Ethical Reflections

- Identify and describe your state's laws regarding the duty to warn known sexual partners of individuals with HIV.
- Do you agree or disagree with the ethics of these laws? Explain.
- What are the ethical principles or approaches that are reflected in the laws?

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Box 11.7: Highlights From the Field: Questions to Assess Foreseeability of Harm

- Does the client use condoms?
- Is the client impulsive? Aggressive? Submissive?
- Does the client use substances (e.g., alcohol) that decrease inhibitions?
- Is the client afraid to disclose HIV status because of fear of rejection, discrimination, and so forth?
- Is the client intentionally trying to harm others?

Chenneville, T. (2003). HIV, confidentiality, and duty to protect: A decision-making model. In D. N. Bersoff (Ed.), *Ethical conflicts in psychology* (3rd ed., pp. 198–202). Washington, DC: American Psychological Association, p. 199.

The Duty to Provide Care

In accepting their professional nursing role, nurses make a contract or covenant with the public to provide certain services (ANA, 2003). There are only a few situations in which nurses ethically would be permitted to refuse care to individuals with HIV based on the patient being a danger to the nurse. Each health care institution should have policies that nurses can refer to for guidance in determining when concerns about the risks of care are justified in allowing nurses to refuse to provide care to these patients. One commonly accepted example or justification for refusal is when a nurse is pregnant. When patients with HIV are considered to pose a significant risk to nurses because of the patients' impaired judgment or altered mental status, security should be provided for all health care workers who are at risk.

Pandemic Influenza

Pandemics of influenza are considered to be rare but consistently recurring events (WHO, 2005). During the 1900s three influenza pandemics occurred—in 1918, 1957, and 1968. The 1918 pandemic was one of the deadliest disease events that has ever occurred, with approximately 40-50 million people dying worldwide during the pandemic. When new influenza viruses emerge and spread rapidly among the global population, the human immune system is not prepared to combat the new infection. The lack of immunity to a new influenza virus may result in many deaths as it did in 1918.

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When the next influenza pandemic occurs, health care professionals, including C/PH nurses, will be faced with many ethical issues and decisions. Among these issues will be decisions about how to fairly distribute vaccines and antiviral medications and how to fairly decide about restricting personal freedoms (CDC, 2007). The CDC has prepared a document outlining specific guidelines to address ethical considerations in the management of pandemic influenza (to view this document go to: http://www.cdc.gov/od/science/phec/panFlu_Ethic_Guidelines.pdf). The following guidelines are contained within this document:

- Identification of clear overall goals for pandemic influenza (p. 2)*:* Goals are different than in interpandemic years. During a pandemic, the goal is "preserving the functioning of society" (p. 3) rather than protecting people who are at the most serious risk from being harmed by influenza, such as elders and young children.
- A commitment to transparency throughout the pandemic influenza planning and response process (p. 3): Language used in explaining reasons for decisions must be clear, the basis for decisions must be open for review, and the process must reflect a respect for persons and involved communities.
- Public engagement and involvement are essential to build public will and trust and should be evidenced throughout the planning and response process (p. 3): The public is treated as a partner with the influenza experts. Vulnerable and marginalized people need to be included in related processes.
- Public health officials have a responsibility to maximize preparedness in order to minimize the need to make allocation decisions later (p. 3)*:* Examples "include shortening the time for virus recognition or vaccine production, increasing the capacity to produce vaccines or antivirals and increasing the supplies of antivirals" (pp. 3–4).
- Sound guidelines should be based on the best available scientific evidence (p. 4)*:* Processes and actions should be evidence based whenever possible. However, some processes and action may need to be based on evidence-informed data, which is a bit less rigorous.
- The pandemic planning process acknowledges the importance of working with and learning from preparedness efforts globally (p. 4)*:* This guideline is not based on merely benefitting U.S. citizens but rather on maximizing the common good of the global community.
- Balancing of individual liberty and community interests (p. 4): During a pandemic, usual individual liberties that are highly valued in our society may need to be suspended. If suspending liberties is necessary, care needs to be taken to use the least

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restrictive policies, to ensure "that restrictions are necessary and proportional to the need for protection" (p. 5), and to support people who are affected by the restrictions.

- Diversity in ethical decision making (p. 5): Historically, groups of people have been abused "in the name of the public good" (p. 5). During pandemic influenza, a variety of public voices must be included in planning and implementation processes.
- Fair process approach (procedural justice) (p. 5): Procedures must be well designed so that they lead to fair outcomes.

Ethical Reflections

- The people who developed the CDC document about ethical guidelines during an influenza pandemic have proposed that preserving the functioning of society needs to be prioritized above protecting people who are most at risk for developing the flu. How do you interpret this guideline? Do you believe that it is ethical? Why or why not?
- Discuss specific procedures that would be consistent with a "fair process approach" (procedural justice).
- Who (individuals or agencies) should decide about the priorities of distributing scarce resources during a flu pandemic?
- How might governments act in unethical ways during a flu pandemic?
- When are limitations on personal autonomy ethically justified during a flu pandemic?
- If you were a C/PH nurse during the peak of a major flu pandemic would you report to your job at the local health department or stay home with your family? Explain the ethical rationale for your decision. If you worked as an R.N. at a hospital, would you report to work during a flu pandemic? Explain.
- How could a C/PH nurse act as a community advocate during a flu pandemic?

Terrorism and Disasters

The great lesson of September 11 is that we are all connected. Either we are all safe or none of us is safe. Either we are all free of fear or none of us is.

—M. Pipher, 2002, *The Middle of Everywhere*, p. xiii

The terrorist attacks on September 11, 2001, and the anthrax-laced letters that followed this event highlighted the possible dangers of terrorist-related infectious diseases invading society (Farmer, 2001). Farmer proposed that "investing in robust public

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health infrastructures, and in global health equity in general, remains our best means of being prepared for—and perhaps even preventing—bioterrorism. Indeed, this was the refrain of several of our best public health leaders during the taxing investigations of these [anthrax] attacks" (p. xi).

Ethics-related guidance for C/PH nurses during any type of terrorism attack or before, during, or after natural or human-made disasters can be referred back to a variety of ethical approaches, such as social justice (fair distribution of resources), communitarian ethics (acting to facilitate the common good for communities), utilitarianism (considering actions that produce the greatest good for the greatest number of people), virtue ethics (having a good character and being concerned about the common good), deontology (acting according to one's duty), and ethical principlism (applying rule-based principles). During disasters, public health professionals must make critical decisions about how to triage scarce resources and everyday personal rights—health care, including first aid; food and water; medications and immunizations; warmth and housing; protection from harmful environmental elements; and the individual freedom to travel and mingle with other people. Because of the major impact that public health actions can have on human suffering and well-being, the decisions made by public health professionals during disasters are inherently ethical in nature.

However, there is another important element in ethics and public health care during disaster situations. This element is trust. Members of society expect health care professionals, especially public health professionals, to be trustworthy, as well as competent, while carrying out their roles during disasters. "Public health agencies [and public health professionals] cannot function well in the absence of public trust" (Public Health Leadership Society, 2004, p. 4). People should be able to trust public health professionals to act according to the public's best interest during a disaster. Actions to achieve the common good and good outcomes for the whole community must be balanced with actions directed at caring for the needs of individuals. Each community member has a personal story and each person's life narrative is important. Equanimity—evenness of temperament—is a good virtue for nurses to have during a disaster. Thich Nhat Hanh's story about Vietnamese boat people that was included in Chapter 10 also is very relevant to ethical nursing care during disasters (see Box 10.6 in Chapter 10).

Although standards of nursing practice may need to be altered during a disaster situation, a nurse's ethics should not be compromised during a disaster. At the point of a disaster is not the time for nurses to begin pondering and sorting out their ethical philosophies. The 5 R's Approach to Ethical Nursing Practice provides a pre-event guide for nurses to prepare to act ethically under any sudden and stressful situation, including situations such as those that occur before, during, and after disasters (see Box 11.8).

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Box 11.8: Highlights From the Field: The 5 R's Approach to Ethical Nursing Practice

1. Read
Read and learn about ethical philosophies, approaches, and the ANA's *Code of Ethics for Nurses*. Insight and practical wisdom are best developed through effort and concentration.

2. Reflect
Reflect mindfully on one's egocentric attachments—values, intentions, motivations, and attitudes. Members of moral communities are socially engaged and focus on the common good. This includes having good insight regarding life events, cultivating and using practical widsom, and being generous and socially just.

3. Recognize
Recognize ethical bifurcation points, whether they are obvious or indistinct. Because of indifference or avoidance, nurses may miss both small and substantial opportunities to help alleviate human suffering in its different forms.

4. Resolve
Resolve to develop and practice intellectual and moral virtues. Knowing ethical codes, rules, duties and principles means little without being combined with a nurse's good character.

5. Respond
Respond to persons and situations deliberately and habitually with intellectual and moral virtues. Nurses have a choice about their character development and actions.

Intellectual Virtues	**Moral Virtues**
Insight	Compassion
Practical Wisdom	Loving-Kindness
	Equanimity
	Sympathetic Joy

Insight: awareness and knowledge about universal truths that affect the moral nature of nurses' day-to-day life and work

(*continued*)

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Box 11.8: Highlights From the Field: The 5 R's Approach to Ethical Nursing Practice (continued)

Practical Wisdom: deliberating about and choosing the right things to do and the right ways to be that lead to good ends

Compassion: the desire to separate other beings from suffering

Loving-Kindness: the desire to bring happiness and well-being to oneself and other beings

Equanimity: an evenness and calmness in one's way of being; balance

Sympathetic Joy: rejoicing in other persons' happiness

Considerations for Practice

- Trying to apply generic algorithms or principles when navigating substantial ethical situations does not adequately allow for variations in life narratives and contexts.
- Living according to a philosophy of ethics already must be a *way of being* for nurses before they encounter disaster situations.

Ethical Reflections

- Nurses are likely to be presented with ethical dilemmas during disaster situations. Review the definition of an ethical dilemma in Chapter 2. Should nurses expect to receive or know clear and certain answers to questions arising from ethically-laden situations during a disaster? Why or why not?
- What can nurses do to best prepare themselves to navigate ethical dilemmas before, during, and after disaster situations? Explain.
- Consider a natural disaster situation such as the one that occurred after Hurricane Katrina. Identify specific opportunities that nurses may have to make ethical decisions in providing disaster care to a community. Include opportunities that are obvious as well as indistinct opportunities.
- Do you believe that public health nurses and acute care nurses face similar or different ethical dilemmas during a disaster? Explain and provide examples.

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Genomics

The Institute of Medicine (2003; as cited in ANA, 2007) outlined eight new domains of public health practice. In addition to the content area of ethics, another of the eight domains is genomics. The Human Genome Project (HGP) spanned 13 years and was a joint project overseen by the U.S. Department of Energy (DOE) and the National Institutes of Health (U.S. DOE Office of Science, 2006b). The project was completed in 2003 but a full analysis of the data obtained will require many years of work. The goals of the HGP were to:

- *Identify* all the approximately 20,000-25,000 genes in human DNA
- *Determine* the sequences of the 3 billion chemical base pairs that make up human DNA
- *Store* this information in databases
- *Improve* tools for data analysis
- *Transfer* related technologies to the private sector
- *Address* the ethical, legal, and social issues (ELSI) that may arise from the project (Para 2)

Three to five percent of the HGP budget was allocated to studying ethical, legal, and social issues (ELSI) (U.S. DOE Office of Science, 2006a). Some of the ELSI identified include the fair use of information obtained from genetic testing; the maintenance of informational privacy and confidentiality; stigmatization due to genetic differences among people; a number of reproductive issues, such as the impact of genetic information on reproductive decision making and reproductive rights; clinical issues, such as education and implementation of quality standards; uncertainty in regard to gene testing when multiple genes or gene-environment interactions are involved; considerations of whether behaviors occur according to free will or are determined according to genetic makeup; the safe use of genetically modified foods and microbes; and how property rights should be handled in regard to the commercialization of products. The HGP has opened up a wide array of issues about which all health professionals, including C/PH nurses, will continually need to become more familiar. However, many people in society still are not sure if the HGP has opened a Pandora's box. The following ethical reflections contain some of the questions directly cited from the ELSI study.

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Ethical Reflections

Gather reliable data and generate informed positions that answer the following questions. Engage in a debate with your colleagues about differing positions and provide examples.

- Who should have access to personal genetic information, and how will it be used?
- How does personal genetic information affect an individual and society's perceptions of that individual?
- How does genomic information affect members of minority communities?
- What are the larger societal issues raised by new reproductive technologies?
- Should testing be performed when no treatment is available?
- Should parents have the right to have their minor children tested for adult-onset diseases?
- Do people's genes make them behave in a certain way?
- Are genetically modified foods and other products safe for humans and the environment?

C/PH Nursing: Contributing to Building the World

Because C/PH nursing is population focused, C/PH nurses often have opportunities to improve the welfare of many people. C/PH nurses work with members of populations as equal partners and they collaborate with a variety of people to promote and protect the public's health (ANA, 2007). Participating in service learning experiences and adopting a philosophy of servant leadership are two ways to ground nursing practice in the principles of PHN.

Service Learning

Service learning is "academic experiences in which students engage both in social action and in reflection on their experiences in performing that action" (Piliavin, 2003, p. 235). Service learning is ideally suited for supporting the moral development of C/PH nursing students. Kaye (2004) defined service learning as "a teaching method where guided or classroom learning is deepened through service to others in a process that provides structured time for reflection on the service experience and demonstration of the skills and knowledge acquired" (p. 7). Service learning is a means for students and teachers to work with community leaders and agencies in collaboratively identifying and working toward a common good. All participants, including teachers, agency administrators, and staff, learn from the students during their interactions with them while the students benefit from

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developing an increase in community awareness. In service learning "community develops and builds through interaction, reciprocal relationships, and knowledge of people, places, organizations, governments, and systems" (Kaye, p. 8).

Service is usually focused on direct or indirect services, advocacy, or research (Kaye, 2004). In direct services, person-to-person interactions occur between students and the recipients of the students' work. Direct services may be aimed at students developing a broader awareness of the needs and issues of varying cultures, populations, or age groups while providing a needed service to a population. For example, providing a service to people with AIDS who are living at a specific AIDS hospice, to people who are staying at a particular homeless shelter, or to elderly persons who attend a specific day care center. A whole community or the environment is the focus of indirect service learning interventions, such as activities aimed at helping to organize and implement a community-wide health education program about safe sex or organizing an effort to decrease pollution of a local waterway. Advocacy—which is a key role of C/PH nursing—combined with service learning involves creating and supporting change in communities to benefit people in the community. Advocacy includes grassroots societal and political activism, such as working to educate a city council about the unmet needs of people with AIDS in the city. Service learning provides an excellent opportunity for students to become involved in community research. Students can participate in developing and conducting surveys and gathering, analyzing, and reporting data regarding issues of public health concern.

Students' reflections on service learning experiences are an integral and defining part of service learning. It is in this area that the students' moral imaginations and the development of intelligent habits are cultivated. Reflection helps service learners to consider the "big picture" in working for the good of communities. Reflective experiences can be guided through activities such as journal writing or teacher-led group discussions and processing of experiences. Service learners may benefit from thinking in terms of the intersecting human narratives that exist among themselves, their community collaborators, and the recipients of their services.

Ethical Reflections

- Conduct a literature review about service learning in nursing. Develop suggestions for service learning experiences that focus on each of the following: direct services, indirect services, advocacy, and research.
- Explain why service learning is related to ethics in C/PH nursing.

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Servant Leadership

In the late 1960s and early 1970s, Robert Greenleaf (2002) was one of several businesspeople who developed and articulated the concept of servant leadership in management. Greenleaf developed the idea of **servant leadership** after reading the book *The Journey to the East* written by Herman Hesse (1956). Hesse's book relates a story about a servant named Leo who is on a journey to the East with a group of men, members of a mysterious League, who are on a mission to find spiritual renewal. Leo brings the group together as a community with his spirit and songs. When Leo decides to leave the group, the small community becomes dysfunctional and disbands. Later, one of the journeymen discovers that, unknown to the journeymen, Leo was really the head of the League that had sponsored their original journey.

Leo was a noble leader who had chosen the role of a servant, a servant whose leadership was of the utmost importance to the sense of community of the journeying group. Greenleaf (2002) proposed that Hesse's story clearly exemplifies a servant leader through the portrayal of Leo. He suggested that "the great leader is seen as servant first, and that simple fact is the key to his [or her] greatness" (p. 21). In the story, even while Leo was directly in the role of the leader of his League, he viewed himself first and foremost as a servant (see Box 11.9).

Servant leaders who see themselves first as servants, at some later point in time make the choice to lead while serving. People who are more concerned with leading before serving often are motivated by a desire for power or to obtain material possessions, although a strong concurrent secondary motivation to serve is possible. Greenleaf (2002) explained how to distinguish between a servant-first leader and a leader who views service as a secondary or lower priority:

> **The difference manifests itself in the care taken by the servant-first [leader] to make sure that other people's highest priority needs are being served. The best test, and difficult to administer, is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society? Will they benefit or at least not be further deprived? (p. 27)**

When thinking about servant leadership, it is important to note that the role of the servant follower is as important as that of the servant leader. If there are no servant followers, or seekers, great leaders are not recognized because there is no one with the awareness to recognize them. "If one is servant, leader or follower, one is always

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Box 11.9: Highlights From the Field: The Nature of Service

During a Midwestern storm of rain, hail, lightning, and thunder, my mother stopped at the grocery store and asked me to run in for a loaf of bread. As I prepared to get out of the car, I noticed little Janie running down the street. She wore her usual tattered clothes, and her bald head, the result of some condition unknown to me, was unprotected from the hail. Many of our schoolmates teased her, judging her as inferior because of her poverty and appearance. I jumped out of the car and gave her my raincoat. She put it over her head and continued running. I remember thinking, "I am here to help others." I was ten years old.

Trout, S. S. (1997). *Born to serve: The evolution of the soul through service.* Alexandria, VA: Three Roses Press. (p. 13).

searching, listening, expecting that a better wheel for these times is in the making" (Greenleaf, 2002, p. 24).

Covey (2002) defined servant leadership as being consistent with moral authority and proposed that servant leaders and servant followers are, in reality, both followers. They are both followers because both are following the truth. Moral authority was described in terms of conscience and includes four dimensions:

1. Sacrifice is the heart of moral authority or conscience. Sacrifice involves an elevated recognition of one's small, peaceful inner voice while subduing the selfish voice of one's ego.
2. Being inspired to become involved with a cause that is worth one's commitment to it. A worthy cause inspires people to change their "question from asking what is it we want to what is being asked of us" (p. 7). One's conscience is expanded and becomes a factor of great influence in one's life.
3. The inseparableness of any ends and means. Moral leaders do not use unethical means to reach ends; and as the philosopher Kant advocated for moral behavior, servant leaders always must treat others as ends in themselves, never as a means to an end.
4. The importance of relationships is enlivened through the development of conscience. "Conscience transforms passion into compassion" (Covey, 2002, p. 9). Living according to one's conscience emphasizes the reality of the interdepen-

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Box 11.10 Highlights From the Field: "All Are Significant"

During my second year of nursing school, our professor gave us a quiz. I breezed through the questions until I read the last one. "What is the first name of the woman who cleans the school?" Surely this was a joke. I had seen the cleaning woman several times but how would I know her name? I handed in my paper, leaving the last question blank. Before the class ended, one student asked if the last question would count toward our grade. "Absolutely," the professor said. "In your careers, you will meet many people—all are significant. They deserve your attention and care. Even if all you do is smile and say hello." I have never forgotten that lesson. I also learned her name was Dorothy.

Covey, S. (2002). Foreword. In R. K. Greenleaf, *Servant leadership: A journey into the nature of legitimate power and greatness* (25th ed., pp. 1–13). New York: Paulist Press., p. 10.

dence of people and relationships. In relation to this fourth dimension of moral authority, Covey conveyed a story told by a nursing student, JoAnn C. Jones (see Box 11.10).

Ethical Reflections

- Reflect and write a narrative about why you want(ed) to become a nurse.
- Was (is) your primary motivation the desire to be a servant or a leader? Has your perception of the servant/leadership role changed over time? How?
- Consider several different work settings and jobs for C/PH nurses. Describe how you could be a servant leader in each of these settings and jobs.
- Highlights from the Field Box 11.11 contains examples from the ANA's (2001) *Code of Ethics for Nurses with Interpretive Statements*. How are these examples relevant to C/PH nursing?
- What other provisions and statements in the ANA's *Code of Ethics for Nurses* are particularly pertinent to C/PH nursing [see Appendix A]? Discuss these provisions and provide examples of how they apply to nursing practice.

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Box 11.1: Highlights from the Field: Code of Ethics for Nurses

- Individuals are interdependent members of the community (1.4, p. 9).
- The nurse recognizes that there are situations in which the right to individual self determination may be outweighed or limited by the rights, health and welfare of others, particularly in relation to public health considerations (1.4, p. 9).
- The nurse's primary commitment is to the recipient of nursing and health care services—the patient—whether the recipient is an individual, a family, a group, or a community (2.1, p. 9).
- Nurses, individually and collectively, have a responsibility to be knowledgeable about the health status of the community and existing threats to health and safety (8.2, p. 24).
- Nurses can work individually as citizens or collectively through political action to bring about social change (9.4, p. 25).

Web Ethics

Markkula Center for Applied Ethics: The Common Good
www.scu.edu/ethics/practicing/decision/commongood.html

Science and Environmental Health Network
http://www.sehn.org/about.html

An Inconvenient Truth
http://www.climatecrisis.net/takeaction/

The Luminary Project
http://www.theluminaryproject.org/article.php?list=type&type=3

Bill and Melinda Gates Foundation
www.gatesfoundation.org

HGP Information: Ethical, Legal, and Social Issues
http://www.ornl.gov/sci/techresources/Human_Genome/elsi/elsi.shtml

National Service Learning Clearinghouse
www.servicelearning.org

Greenleaf Center for Servant Leadership
www.greenleaf.org

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Summary

Over the centuries there have been amazing strides in public health measures that have improved the well-being of humans. However, members of the global community are still at risk from diseases that are thousands of years old, such as malaria and TB. Also, new environmental toxins, epidemics, and disasters are constantly threatening human health. Health disparities are not limited by geographic boundaries and abound in both rich and poor countries while people are told that health care resources are scarce. All of these issues present important ethical challenges for C/PH nurses, and C/PH nurses have exciting opportunities to be servant leaders at the forefront of working to improve the health of the global community. It is incumbent upon the nursing community to consider and act in response to the words of John Donne: "Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

Key Points

- Members of a community have a shared interest in a common good.
- Communities are moral in nature.
- The epicenter of communitarian ethics is the community rather than the individual perspective of any one person.
- There are a number of ethical theories and approaches that are useful in C/PH nursing. Nurses need to understand different ethical approaches and develop an ethical philosophy before a crisis or stressful situation arises.
- It is a moral choice when people decide how they choose to distribute societal benefits and burdens among the members of communities.
- Health care disparities are often associated with race, ethnicity, and economic status.
- Humans will not achieve true moral progress until people perceive the suffering of others who are not personally known to them as important in their daily lives.
- The human genome project has generated a plethora of ethical questions that will need to be answered by members of the global community
- Servant leaders view themselves as servants first and leaders second.

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Case Study: Community Building

Imagine that you will be the administrator for a new residential AIDS hospice that will be opened as an agency of Catholic Charities in the midsized conservative southern city where you live. The majority of the money for the hospice is coming from a federal grant, but you will need to raise additional funds in order to provide comprehensive care. The hospice will be located in a house in a mixed residential and business neighborhood, and the location of the hospice is to remain as confidential as possible. The citizens living in the neighborhood are very opposed to having the hospice in their neighborhood. Until now, the board of directors of the local Catholic Charities organization provided oversight of the grant and the plans for the hospice. The plans are to create a partnership with the local AIDS task force to provide community AIDS prevention education. It is now time to turn the hospice project over to you, the RN, hired as administrator.

Case Study Questions

1. You will need a governing body for the hospice. What types of people would you consider and how would you handle the selection process?
2. What types of services would you provide? What ethical issues might affect your decisions about the distribution of resources for the different services? What ethical theories would you use to guide your choices?
3. You may have more applicants for admission to the hospice than you have beds available. What criteria will you use to prioritize admissions to the hospice?
4. How would you recruit the staff and volunteers while trying to maintain confidentiality about the location of the hospice? What ethical issues would you include in your staff and volunteer orientation?
5. What would you do to try to build a sense of community that includes the hospice residents, the hospice staff, and the residents of the neighborhood where the hospice is located? That includes the city? Would building this sense of community be critical to the success of your program? Explain.
6. How might the philosophy of communitarian ethics provide you with guidance in developing the plans for the hospice? How might the use of moral imagination be involved (see Chapter 2)?

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CHAPTER 11 QUESTIONS

1. Most schoolchildren in a group from middle class families have access to health care while a smaller group of children from poor families in the same school have little access to health care. This can best be described as an example of

- **a.** the difference between a community and a population.
- **b.** a breach of ethical principlism.
- **c.** a health care disparity.
- **d.** the implications of utilitarian ethics.

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2. Just generosity is a virtue that can best be described as
   a. fairly distributing resources.
   b. giving and receiving based on need.
   c. donating to good causes.
   d. fairly punishing wrong doers.
3. Mandatory isolation of persons with TB who refuse to take their medications even with DOT is an example of
   a. utilitarian ethics.
   b. deontological ethics.
   c. ethical principlism.
   d. virtue ethics.
4. The key element underlying the precautionary principle is:
   a. Anticipatory action is taken based on scientific proof.
   b. Anticipatory action is taken when scientific certainty is absent.
   c. Anticipatory action is taken based on evidence-based practice.
   d. Anticipatory action is taken based on traditional science.
5. In public health, dilemmas may occur because of the need to consider the rights of individuals as well as the best interests of large groups. This is a conflict between which of the following ethical approaches, respectively?
   a. Utilitarianism and virtue ethics
   b. Principlism and virtue ethics
   c. Utilitarianism and deontology
   d. Deontology and utilitarianism
6. A key activity in protecting the health of the public from environmental harm is
   a. upholding personal rights.
   b. being virtuous.
   c. collaboration.
   d. upholding human dignity.
7. A key element that best describes communities in a moral sense as opposed to populations is
   a. interest in the common good.
   b. interest in community property.
   c. interest in common diseases.
   d. interest in a neighborhood.

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8. Voluntary testing for HIV is an ethical issue because
   a. it supports persons' rights.
   b. it is a utilitarian activity.
   c. it is the most virtuous policy.
   d. it involves risks as well as benefits.

9. All of the following are significant ethical issues surrounding the problem of malaria, except
   a. the high incidence of the disease compared with the low cost of prevention and treatment.
   b. the lack of education about the social and economic burdens of the disease.
   c. the high numbers of young children who develop the disease.
   d. the high risk of infection among poor U.S. citizens living in the South.

10. Mr. Samuels is an African American man. One of Mr. Samuel's parents has Huntington's disease. What ethics-related question needs to be considered?
   a. Is it ethical to test for a disease for which there is no curative treatment?
   b. Is Mr. Samuel at greater risk because of his minority status?
   c. Should Mr. Samuel's parents have been better counseled about birth control?
   d. Is Mr. Samuel's wife justified in divorcing him?

Chapter 11 Answers

Question 1: The correct answer is C.

Variations in health care access among groups separated by the characteristic of economic status can lead to poor health outcomes. This is called a health disparity.

Choices A, B, and D are incorrect because these choices are unrelated to the question.

Question 2: The correct answer is B.

As a virtue, just generosity means that people give help to other people based on the others' needs without seriously considering what other persons are due or deserve. People with the virtue of just generosity also are willing to receive help from other people.

Choices A, C, and D are incorrect because though fairly distributing resources may be included in just generosity, this answer is not the best description; Choices C and D also might be present in communities that display just generosity, but these choices do not directly define the virtue.

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Question 3: The correct answer is A.

The policy to restrict individual persons who refuse treatment for active TB in order to protect groups of people is consistent with utilitarian ethics. Individual liberties are sacrificed for the good of the larger group.

Choices B, C, and D are incorrect because these approaches to ethics do not describe the action proposed.

Question 4: The correct answer is B.

The precautionary principle means that people take action, especially in regard to environmentally related issues, before certain scientific evidence is available. People take action as a "precaution."

Choices A, C, and D are incorrect because the precautionary principle is not consistent with waiting to act until the traditional scientific method produces evidence.

Question 5: The correct answer is D.

Deontology has traditionally been used to support personal autonomy whereas utilitarianism is used to support the good of groups.

Choices A, B, and C are incorrect because these choices do not correctly represent the answer to the question.

Question 6: The correct answer is C.

People and communities must work together to protect the public from environmental harm. Individual efforts alone will not produce the best outcomes.

Choices A, B, and D are incorrect because though these issues may be related to environmental ethics, these choices do not directly address efforts to protect against environmental harm.

Question 7: The correct answer is A.

In communitarian ethics, an essential element of communities is that the members are interested in the whole community's common good.

Choices B, C, and D are incorrect because though these choices represent issues of possible interest to communities, these choices do not provide the best description of the differentiation between communities and populations.

Question 8: The correct answer is D.

Even voluntary testing for HIV has benefits and risks. For example, persons who test positive for HIV may endure emotional suffering, stigmatization, and discrimination.

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Choices A, B, and C are incorrect because voluntary testing does support autonomy but does not represent the best answer to this question; voluntary HIV testing is not directly associated with either utilitarian or virtue ethics.

Question 9: The correct answer is D.

People in the southern U.S. are not at high risk for malaria infection.

Choices A, B, and C are incorrect because these choices do represent significant ethical issues surrounding the problem of malaria.

Question 10: The correct answer is A.

One of the ethics-related issues generated by the expansion of the human genome project is that scientists will develop tests to identify diseases for which there is no cure. People may then be burdened with waiting for the inevitable suffering to occur with little hope of physical treatment or emotional relief. People diagnosed with a fatal but untreatable disease may experience problems with insurability, employability, family relationships, and stigmatization.

Choices B, C, and D are incorrect because the issue of minority status does not directly relate to ethics and Huntington's disease; often, persons do not know that they will develop Huntington's disease until after they have had children; the issue of divorce in this case possibly may prompt an ethics-laden debate, but this choice is not the best answer to the question.

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