

Virtue Ethics And Veracity in HIV/AIDS And Oncology Cases

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Introduction

The objective of this paper is poised at an analysis and application of virtue ethics approach to an HIV and oncological cases. The first part is an application of virtue ethics to a concrete case of HIV and the second part is an application of virtue ethics to an oncological case. What should be done when an autonomous patient simply confides in a physician that he/she does not want the third party to know about his/her HIV status? Or he/she does not want to know when tested positive? One important duty to note in clinical practices is the duty of confidentiality. To what extent should this be respected in situation like this? Should we respect the wish of the patient as indicated or keep confidential issues strictly confidential?

Questions such as this; show that the problem with truth-telling still remains a disturbing issue in clinical practices. It is not my intention to solve the problem, but to contribute to the on-going discussion on truth-telling and provide a suitable approach to addressing the dilemma of truth telling in clinical practice. It is clear from the literature that most of the approaches to truth telling are principle based and these approaches could not properly handle the complex moral problems embedded in truth telling.

This is my motivation for proposing virtue ethics as a better approach to addressing this problem. I am very much aware that virtue ethics approach cannot solve all the problems associated with truth-telling, but, it can give an important contribution to this moral difficulties posed by truth telling in clinical practices.

Case 1: A Case from HIV Clinical Context

Mrs. A., a twenty-eight-year-old lady, came from the Northern part of Nigeria. She is married, a housewife but does not have any child. She presented to the outpatient department with chronic cough and weight loss and was then diagnosed to have pulmonary tuberculosis. She was soon commenced with anti TB medications. She has also been offered a voluntary counselling and testing for HIV. She consented to have the HIV test under certain condition. She said: "I am not willing to have an HIV test but if you insist, I can only agree on the condition that I do not want to know about my status either positive or negative nor will I like anyone to know too". She was at the end tested and the result turned out to be reactive implying she is HIV infected. The counsellor was afterward faced with the problem of divulging this information to the patient since she has made her fear known prior to submitting herself for the test. She was quite aware of the perception of HIV in her environment and the stigmatisation associated with people living with HIV which may eventually result in isolation from the community. The risk associated with the failure to disclose the result to her and her husband was discussed over several counselling sessions in the coming weeks but she still declined disclosing her status to anyone. The physician and the counsellor were concerned about the consequence of the failure to notify her husband who is at risk but at the same time notifying the husband could mean breaching patient's autonomy and confidentiality.

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CASE 2: A CASE OF CANCER

Mr. Fuji a 69-year-old man was brought to the emergency room of a Medical Centre after coughing up blood. He presents with severe coughing, fatigue, chest pain, shortness of breath, and headaches. After stabilizing him, the emergency room team admits him to the hospital, where he was given (over the course of some few days) a thorough workup, including chest x-rays, CT scans, mediastinoscopy, and a PET scan. The diagnosis shown that he has an extensive small cell lung cancer. After almost three days in the hospital, the results of the various scans are in; and the attending physician, find it almost difficult to present the diagnosis and prognosis before the patient. Though, there are basically “two possible treatments” available for this cancer: chemotherapy and radiation, the physician strongly prefers beginning with the first (chemotherapy). Given the apparently advanced stage of the disease, even chemotherapy would be very unlikely to provide a complete cure, but it could provide some relief and lengthen the remainder of his life. The patient had earlier displayed attitude that suggested he would make a difficult patient. The attending physician is aware that this information need to be disclose to the patient but afraid that the patient may not cooperate since the available treatment would not bring about any cure and the family wants the physician to do everything possible to prolong the life of their father for additional years with the best option of treatment. The physician has in mind the need to treat the patient to the best of his knowledge at the same time acts non-maleficently.

Understanding HIV and Its Context from Case 1

The reality of HIV in our societies has raised a number of ethical dilemmas associated with disclosure especially when we consider the possibility of stigmatization associated with the infection. Stigma can therefore be seen as a feature of HIV and many people who are HIV positive report that their lives are affected by the fear of discrimination, depression, abandonment by spouse, loneliness and other consequences that may result from disclosure of such infection.

This is the reason why disclosure demands careful consideration because of the attendant potential adverse social consequences which may accompany such disclosure such as physical assault (1). HIV infections/AIDS is a disease with the dimension of public attention because it a disease affecting people in many developing countries especially in sub-Sahara Africa. Although, there is presently no permanent cure, drugs that suppress the multiplication/replication of the virus exist. There are researches going on in order to help address and interrupt with the continuous danger of HIV on life and health of the people. Its existence poses more threat to human life and this has devastating effects on the society as a whole because of the tendency to spread to other people through several media.

HIV is known to target the T-cells of the immune system. It also affects the brain system; nervous system as a whole and it can affect other parts of the human body. The danger with HIV is that it reproduces itself by manifesting itself in new T-cells and attacking other functioning of the human system. HIV renders the immune system redundant which naturally helps in fighting organisms in the body. Once the immune system has been weakened; several diseases penetrate the body. AIDS creeps in when the immune system has gone down. HIV is not equivalent to AIDS and it does not instantly lead to AIDS; this is the reason why an HIV tested positive person can live several healthy years without developing AIDS.

HIV is a disease that can be transmitted in so many ways; one major way of contracting HIV is through unprotected sex. Other ways includes using the injection used by an infected person, use of sharp object which has been used by carrier of HIV, infected blood transfusion, and receiving an organ from an infected donor. Physicians are overwhelmed by the social and ethical question generated by HIV/AIDS epidemics. This has great effects on the best methods or standard of communicating the disease to their patient. It is also worth noting at this point that the gravity of the disease should not be an excuse not to communicate

the test result to those who are affected. The most obvious ethical dilemma in dealing with HIV disclosure is the conflict between societal interest and individual rights, including rights to freedom of movement, privacy and access to goods and facilities (2).

Just as we can justify the reason for non-disclosure of HIV result: there are also good reasons to disclose. One of the most important reasons is that HIV infection is a chronic disease that calls for urgent attention and the need to know. This need to know could help in planning the follow up of the patient and how to handle the sexual dealing with a partner without causing more problems.

There is no doubt that the case presented above is a sympathetic one. The lady in question is unemployed and she depends so much on her husband for daily survival. Telling the truth by disclosing her status to her husband might result in potential disharmony and divorce. In addition she might experience stigmatization, discrimination and possibly isolation in the community she resides. If we look at the context in which she is coming from (Northern part of Nigeria) she stands to experience several difficulties in facing the reality of this problem. The questions associated with truth telling and disclosure then include:

- a. How do we balance the Hippocratic Oath and up-to-date professional codes of medical practice that physician should maintain the patient's confidentiality?
- b. How do we maintain the patient-physician relationship of trust that a patient has for the physician?
- c. What do we do and or how do we handle the consequences of disclosure for others who might want to be tested?
- d. Can we respect the patient's autonomy here at the expense of non-maleficence and the benefit of the other?
- e. Are physicians obliged to tell the truth?

There is no doubt that less number of individuals would turn out for HIV testing because of the fear of disclosure of their status without their consent. This will have an adverse effect on the public health goal of reducing transmission. The increasing number of people with HIV is a global problem which confirms the need for addressing the problem of truth telling and disclosure to infected persons. One of the things that could help decrease this spread of this infectious and terminal disease is disclosure/truth telling. As long as HIV status is strictly hidden especially from the partner then the problem continues to multiply.

In view of this, disclosure of serostatus remains an important tool for the prevention of further infection (3). Many people want to protect the patient from emotional trauma, pains and shock yet some are still in favour of disclosure in HIV case because they felt knowledge of HIV status would benefit the patient (4). Attitude towards HIV disclosure differ from cancer and other terminal illnesses because HIV is deadly and could continue to spread if not properly addressed.

Truth-Telling in HIV and Virtue Ethics

Truth-telling in the case of Mrs A is a very difficult issue. This young lady feels reluctant to have the HIV test because of her basic understanding of HIV and immediate perception of it in the community she belongs. The question then is do we tell her about her HIV status despite her wish not to know? On what basis should we withhold medical information? Should the result be kept to the physician? What happens to her husband? Are we also responsible for the consequences of our failure not to tell the husband? What are the duties of care-giver? What are the needs and importance of truth in this scenario? These and many more questions arise from the case at hand.

In addressing the above raised questions, there is a need for carefulness in order not to confuse and miss out some important facts related to this. The notion of autonomy is of significant concern and it is associated

with many ethical questions. We can simply say that this lady is autonomous and conclude that her wish be respected. This conclusion will definitely appear unwelcome. Decision making goes beyond autonomy especially when we recognise an individual as part of the immediate society and community.

Ordinarily, the use of practical wisdom reveals that confidentiality will be of less importance when it evidently constitutes a danger to the health of the generality of people. In medical practices, confidentiality is vital. However, the obligation of confidentiality is not an absolute one. It is mediated by greater interests for instance, where public interest in disclosure outweighs the desire to ensure confidentiality, health professionals are permitted though normally not obliged to breach confidentiality (5).

Close examination of the concept of truth-telling from a deontological perspective, presents it as a duty of the care-giver. Truth-telling from a deontological perspective is a duty of a care-giver to the patient. There is no doubt that duty related issues have great significance in health care giving. These duties are not without their problems because of the conflict they present. There is a duty to tell the truth by the care-giver and a right not to know on the part of the patient. The identification of the problems inherent in strict duty based approach will lead us to the main concern of this paper which is virtue based.

Truth-telling is not a mere concept that should be neglected. It is a concept that has to be taken with all sense of seriousness though executing it has several moral questions. It is worth noting also that moral problems are not problems we address using a no and yes responses. They are problems that need in-depth understanding of situation alongside thorough examination and needs to be carefully scrutinised. There is a serious need for virtue in analysing situations that goes with character. Since this study focuses on a virtue ethics approach; it will be of vital importance here to analyse this case using the three parameters highlighted in Chapter Four of this study which includes the focus on the attitude of the moral agent, internal goal of medical practice, and focus on community.

Proposed Solution to the HIV Case on the Basis of Virtue Ethics: Case 1

Virtue ethics from our first parameter is focused on the attitude of the moral agent. Here, the care-givers who have cultivated virtuous character identify the various virtues peculiar to practice and uphold this character to the maximum. They identify virtues such as honesty, truthfulness, patience, wisdom and etc. With the acts he has cultivated he is moved to act in a way that goes along with his practice no matter what the case may present. A virtuous physician who embraces virtuous acts is necessarily motivated with the need to execute virtuous acts necessary for his practice. He is moved by the act of honesty and truthfulness. He knows the right medium and means of communicating facts and truthful information to his patient in a manner that best suits the specific situations.

The major problem with truth-telling in the case in question is the conflict between autonomy and beneficence or non-maleficence. This is evidently the medical ethical problem generated by truth-telling. Medical ethical problems are characterised by conflict of principle (6). In this case, we could say that the virtue of benevolence should motivate the decision of the physician because of the good that telling may bring in this particular case. This is also necessary because of the medical oath of do no harm made by the physician. Doing good is not just for the individual alone but also for others.

If the physician wants to work along the line of benevolence; and by the virtuous character he possesses, he would recognise the fact that telling Mrs A of her situation would help her in decision making as regards her health. On the other hand, disclosure of such are uniquely associated with protecting others from possible exposure to HIV, suggesting that this disclosure can be focused more on others than on oneself (7). It is also good and necessary for the health of her husband.

Virtue ethics from the second parameter focuses on the internal goal of the practice. The internal goal of medical practice is the therapeutic convention of medical practice. No doubt, beneficence and non-maleficence are also important to the physician in discharging his/her duty to the patient. The decision that better promotes the internal goal of medical practice should be favoured over every other decision. Truth-telling obviously is a necessary condition of medical practices but could at times be withheld in order to avoid another vital interest that may help in promoting the healing process which the intervention hopes to achieve. Also important to this case is the woman's autonomy. However, respecting the autonomy here may be contrary to the internal good of medical practices of 'doing no harm'. Harm will be done to the husband of this young woman and the failure not to tell may also endanger the life and the future of others.

Virtue ethics from the third parameter focuses on the need to be concerned about community in decision making. It is always very easy to take a decision when the decision to be made does not have a negative effect on others. As pointed out earlier individuals are in relation to other beings in the society. According to P. Ricoeur, other beings are present in the world and this call for mutual respect for each other. Respecting autonomy also includes non-infringement on the autonomy of the others in the world. Despite the strong wish of this woman (Mrs A) not to know, the physician takes into consideration, the effects on the larger society which is at stake here (face the other) (8).

The relationship between a doctor and patient is a sensitive aspect of care-giving. Dealing with medical related problems is a difficult thing to do by mere emphasis on duties. From this perceptive, there are good reasons to say that the doctor-patient relationship goes beyond normal daily practice. It goes beyond duty based practice, moral obligations, respect for the others etc. Drane writes that, the doctor is bound to higher ideals and higher virtue because of the nature of the medical relationship (9). Care-givers often find themselves in situations where their knowledge of objectivity cannot address such controversial and sometimes confusing issues they encounter on daily practices.

Background Information of Lung Cell Cancer

Cancer is a form of tumour. Tumour simply refers to any kind of swelling. Swelling could be from various causes such as inflammation, infection and Neoplasia. However, neoplasm is the umbrella word for all forms of abnormal growth in the body. It can thus be defined as an abnormal mass of tissue, the growth of which is virtually independent and exceeds that of normal tissues (10). Unlike other form of swellings which are non-neoplastic, the growth of a neoplasm persists after cessation of the stimuli that initiated the change. Neoplasia is classified into two broad categories: benign and malignant. It is the malignant form of Neoplasia that is usually referred to as CANCER.

Cancer can be classified based on the cellular component from which they arise. Hence, we have: a. Carcinomas: those arising from epithelial cells (covering of cavities, tissue and organ). b. Sarcomas: which are those arising from mesenchymal tissues (musculo-skeletal components of cells/ tissue) (10). The nomenclatures of specific types of carcinomas/ sarcoma depend on their appearance and presumed cell of origin. Cancers exist for virtually every part of human body. Organs as small as ovary measuring only about 3.0 x 1.5 x 1.0 cm to big human components like the liver, all have their various forms of cancers. Some human cancers include Breast cancer, Lung cancer, Colorectal (large bowel) cancer, Prostate cancer, Non- Hodgkin lymphoma (white blood cancer), Gastric (stomach) cancer, Oesophageal cancer, Melanoma (cancer of the skin), Pancreatic cancer, Ovarian cancer, Renal cell (Kidney) cancer, Endometrial (uterine) cancer, Invasive Meningioma (Brain covering cancer), Cervical cancer, Hepatic (Liver) cancer and Seminoma (Testicular cancer) (11).

However, incidence of cancer in any population varies depending on factors such as Age, sex and geographical location. Some cancers are common among the elderly and almost never occur in the children. An example is

Prostate cancer in men, while some are almost exclusively seen in very young population. A good example of this is Wilms tumour which is usually diagnosed between the ages of 2 and 5 years. In the same vein, there are cancers that are only found in women. This kind of cancer is called cervical cancer and those found in men are called Prostate cancer. In Asia, more than any other part of the world, Nasopharyngeal and oesophageal cancers are common. In Africa, Cervical cancer remains a scourge partly due to underdevelopment, while the incidence of Lung cancer is highest in Europe and North America.

It is often said that cancers have no cause except risk factors but recent studies have gathered overwhelming evidence in the causative mechanisms of cancer. A good example of this is cigarette smoking, a cause of lung cancer (10). Though, cigarette smoking does not cause lung cancer in every smoker, it depends on the genetic predisposition of the smoker to induce the changes necessary for the emergence of cancer in the lung (11). Hence, like most other forms of illness, cancers come about by interaction between nature (gene) and nurture (environment and lifestyle). Other risk factors for cancer are Anticancer drugs, Infections like Schistosomiasis, Aniline dye, Asbestosis, Aflatoxin, Ultraviolet light and abnormal genes (such as BRCA1 and BRCA2) (11).

Clinical presentation of cancers depends on the primary organ / system involved as well as the secondary ones affected. Its effect could be due to sheer size leading to compression of the surrounding structures and distortion of normal anatomy. It could also be due to overproduction or underproduction of normal body chemicals with consequent change in body functions (10). Depending on the organ / system involved and stage of the cancer, patient's complain could range from simple cough, sweating, headache and weight loss to more disturbing one like noise in the ear, chest pain, dizziness, generalised body weakness, Bone pains, Drowsiness and possible loss of consciousness (coma).

Investigating what is wrong with a patient or which cancer he suffers from depends on the clinical presentation of the patient, available diagnostic technology especially in resource-poor environments like most parts of Africa and unfortunately affordability by the patient. Medical interventions also depend on the clinical presentation, cancer type, and level of expertise of the managing physician, established protocol for managing the illness and available technology in the centre where patient is being managed. Treatment could be purely medical, that is, involving the use of only drugs; mixed, which is combination of drugs and surgery with or without radiation (radiotherapy). The latter is usually preferred because combination of methods usually leads to increased response by the cancer.

Prognosis (outlook) of a cancer describes the likely outcome of a patient diagnosed with a cancer. It is often expressed in percentages of those likely to be alive after a period of time say 2 to 5 years with or without intervention. It depends majorly on the type of cancer, when the cancer was diagnosed whether early or late as well as management instituted. While most cancers are theoretically avoidable, the only way to avoid cancer is never to be born.

Small cell lung cancer

This is a variant of lung cancer. It is the most malignant of all lung cancers. Statistically, there is an equivocal link between the frequency of lung cancer and the number of cigarette smoking (pack-years). Like other types of lung cancers, small cell carcinoma of the lung is strongly associated with cigarette smoking. It is called small cell lung cancer because of the microscopic appearance of the tumour cells where it looks like small, oat-like cells (10).

Cough is the most common presentation of lung cancers in hospitals. It is often dry but may contain pus if there is associated (secondary) infection (11). Other common problems that patient with small cell lung cancer may present include weight loss, chest pain, difficulty in breathing (dyspnoea) and coughing up blood (haemoptysis). However, patient may present with uncommon symptoms because the cancer has either spread

beyond the lungs to parts of the body (metastasis) or because the cancer has grown so big as to disturb the normal function of contiguous structures. Some of these uncommon presentations include Epileptic seizures, Personality change, jaundice, bone pain, Anorexia, lassitude and skin nodules. Whichever way small cell lung cancer presents itself the attending physician who has obtained a history of cigarette smoking for a substantial period of time would be looking out carefully for it.

Whenever a presumptive diagnosis of lung cancer is made some investigations would have to be done to confirm the diagnosis, establish the cell type and define the extent of the disease. Some of these investigations include chest x-ray, Bronchoscopy (direct visualisation of the bronchial airway), Computerised tomography (CT) or Ultrasound guided biopsy, CT scan of the chest, Thoracotomy (opening of the chest), Bone scan and Liver Ultrasound. Though, various methods exist for the management of lung cancer but the fact that Small cell carcinoma has almost always spread to other parts of the body by the time of diagnosis makes it unfit for surgical intervention. The goal of treatment is to reduce tumour size, kill as many tumour cells as possible, prolong survival, enable good quality of life, prevent or minimise complications, and relieve symptoms of the disease as well as side-effects of the anticancer drugs.

To achieve these in small cell cancer, other forms of treatment apart from surgery are employed. These include Chemotherapy (use of anticancer drugs) and Radiotherapy (use of radiation materials to kill cancer cells). Small cell cancer is particularly responsive to chemotherapy but ultimately recurs (11). The overall prognosis in Bronchial carcinoma is about 6% with around 80% of patients dying within a year of diagnosis. The best outcomes are obtained when lung cancer is managed in specialist centre where it is possible to have multidisciplinary teams including Oncologists, Thoracic surgeons, respiratory physicians and specialist nurses. Lung cancer can cause depression and anxiety. Hence, family support is very crucial for these patients (11).

Analysis of a Case of Cancer from Case II

It is important to provide some basis relevant to the case of cancer as presented in case 2. Careful scrutiny of the case of the 69 year old man Mr Fuji suggests that truth telling is a difficult task for any physician confronted with this case. The first thing to note is the fact that the patient in question is a difficult patient. Secondly, the family wants him alive and thirdly, the physician is in a dilemma whether to present to him and the family the various options available to the patient. It must be quickly noted that presenting the various available options means he has to be informed that he has an extensive small cell cancer of the lungs. We have a case of veracity immediately evident in this case.

It is crystal clear that a 69 year old person is an autonomous adult and at the same time, an autonomous human being. Going by this case, there is no doubt in mind that he can be considered to be autonomous in the sense that he has the capacity to make a decision for himself since the case did not suggest to us that he was at any time unconscious.

For emphasis purpose, the case in question is a case in African context specifically from Nigerian context where family plays an important role in taking care of their sick relatives. This is a communalistic setting, therefore, decisions on the sick are not solely of the wife or husband of the patient. In fact, the wife or the husband gets the other family members involved in cases that seem impossible or terminal to avoid being blamed for anything negative that may happen to the patient. Often time, the wife or husband is being invited alongside any elder in the family to disclose prognosis and diagnosis of treatment.

The case of this man is difficult because the family (with the wife inclusive) wants the truth withheld from the patient in order to attain reasonable success in the course of treatment. The physician, also autonomous in his capacity, saw the need to disclose the truth to the patient in order to get him involved and also to discharge his duty as a veracious physician. This case presents to us some ethical dilemma and questions that

need to be addressed so that we can decide on how best to treat and care for the patient putting the context and other issues of autonomy, non-maleficence and physician's conviction into consideration.

The autonomy of the patient here is in conflict with the physician's intention of not wanting to cause further harm. Another ethical problem here is how best to deal with the issue of relatives who requested that the truth be kept away from patients so as to avoid harm. This case obviously cannot be addressed using principles that would give a Yes or No answer. It requires a theory that would put into consideration the relational and other aspects of the patient.

Proposed Solutions to the Case of Cancer On The Basis Of Virtue Ethics: Case II

Virtue ethics as noted many times in this study is not focused on rules or set of rules that help an individual in deciding the rightness and wrongness of an action but focuses on how to help the moral agent itself to develop a good character. The virtuous act cultivated by the physician over time helps the physician to make a decision in specific cases. A physician who has developed and cultivated the virtuous acts and character knows how best to address any given case. This is what virtue ethics focuses on (the shaping of character).

The physician addressing the case of Mr Fuji having internalised the internal goal of medical practice which is the therapeutic convention of medicine (do no harm) first think about how best to realise this goal in the course of discharging his duty as a virtuous physician. In Mr Fuji's case, withholding the truth from him would promote the therapeutic convention of whom he was called to discharge at duty.

The last step is to put into cognisance the role of the community as reflected in the works of Aristotle. In Aristotle's view, every state is a part of the community and every community is formed with a view to do well. Every man's daily activities are to achieve the good for oneself and the good for all. Aristotle spoke of the necessity of man and woman living together and in this condition can human life flourish.

He says that each individual is not self-sufficient when separated from the whole. The implication of this school of thought is that dealing with patient requires that you put people (family) around the patient into consideration. The family of Mr. Fuji going by the case at hand did not display in any way that they were already frustrated instead they demanded for more care which shows that they still want to participate in the care of their relative. Just like the physician, the family believes that he should not be told.

So the question that bothers us as bioethicists is whether non-maleficence should override the patient's autonomy. However, Virtue ethics would not immediately support this position. It would rather prefer to see if the character of the moral agent has been shaped, the internal good of medical practice has been internalised and the importance of the immediate community (family) has been taken care of. Only in this condition would virtue ethics suggest whether or not the truth should be told. Using Phronesis (practical wisdom) to analyse the case of Mr Fuji having taken care of other conditions, virtue ethics would suggest that the truth be withheld from Mr Fuji.

Conclusion

This paper has attempted to do a detailed analysis of truth telling in HIV and Cancer scenario using a virtue ethics based approach. It tries to explore some of the medical ethical problems posed by truth telling. It discussed the need for virtue in analysing and approaching ethical problems in medical practices viewing it from three parameters: moral agent, internal goals of health care practice and the role of the community. There is no doubt that virtue to a certain extent has been able to address the dilemmas posed by these issues without falling victim of conflict between principles. Amongst the strength of virtue is its' ability to take practical steps in the analysis of practical issues.

The use of practical wisdom in virtue approach shows that complex issues do not appeal to principle because if we stick to rigid principles we may not be able to approach issues in the right and ethical manner. Virtue is important for truth telling scenario and is a good way of approaching truth telling in clinical practices.

Having seen the importance of presenting issues related to the care-receiver's health situation in a way that reveals the reality i.e the truth of the patients' health; one should be careful in order to ensure it is done in a productive manner. However, it is important for practitioners to take note of how to approach practical and ethical dilemmas in long time care. Even when it is beyond reasonable doubt that truth is important for informed decision making; one should also note that truth has the tendency of bringing about confusion especially on how best it should be divulged.

Truth is to be sought after in everyday activities but it must be highly noted that it involves a lot of sacrifices and it is the greatest service. For care givers to serve humanity better; they need the act of truth telling and they must be passionate about the need to tell the truth. There are few and concrete things that make the communication of this such as in the case of Mrs A and Mr Fuji to be possible and easy to communicate.

One of which is the recognition of the need to prevent further harm on people. There is no doubt that there is a duty and need to ensure confidentiality and enhance patient's autonomy but when confidentiality and autonomy is extended to other people's autonomy and this is capable of having negative and devastating effects in their lives then such autonomy is meant not to be disrespected but to be given less recognition. But for Mr Fuji, autonomy and non-maleficence is the ethical problem identified. Autonomy may be undermined in this too since it is to prevent harm.

My analysis of virtue approach to truth telling in relation to the case of Mrs A. demonstrated very clearly that Mrs A should be informed of her HIV status. Telling her as I have earlier mentioned, will afford her the knowledge of her health status, give her the opportunity to make an informed decision, allow her to plan her future and face the reality of living with HIV. It takes virtuous physician whose moral character has been shaped by virtue (first parameter), who have internalised virtue related to its practice (second parameter) and who recognises the importance of the community (third parameter) to do this.

These three parameters if present in practice could help physicians to disclose the HIV result to the young lady in question. The virtuous physician therefore, presents the situation to her compassionately and tells her the need to get the husband informed. This could be done by getting her counselled and if she finds it difficult to tell it herself; the physician or counsellor could come to her aid by inviting the husband and present the diagnosis to him.

In the case of Mr Fuji, the truth may be withheld for the following reasons, Mr Fuji attitude suggests he would not cooperate with treatment and this will make the care for his health to be difficult. Secondly, the physician perceived telling him may cause harm and he is not in any way convinced that he should disclose the truth to him and lastly, going by the third parameter that points to the fact that we are not alone in the society, there is a need to equally consider the view of the people that surround Mr Fuji and the fear of losing him. Practical wisdom ("Phronesis") obviously suggests he should not be told.

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