Analysis of ethical dimensions of nosological diseases and financial physician-patient relationships

Fuzhan F. Parhizgar

Suzan S. Parhizgar

Rolando Pena Sanchez

Kamal Dean Parhizgar

EXECUTIVE SUMMARY

As modern scientific-based medicine is achieving much progress, arguments and disputes toward viewing "medicine is a science not as an art never ends." Scientific knowledge mining methods have been expected to explore some useful or hidden patterns of maladies and to explore philosophical foundations of life mysteries on the planet Earth. In biophilic sketching terms of what epistemic theories of maladies and nosological theories of diseases involve in tautological ethical theories of clinical interrelationships between physicians and patients, we have accounted their holistic assessments with the span boundaries of materialistic, socialistic, and spiritualistic conventional value systems of physicians' professional codes of ethics and natural and civic rights of patients. Our objectives in this article are; first, to define what we mean by tautological and epistemological interpretations concerning both patients and physicians value systems. Second, we have indicated that *diseases* are essentially viewed as extrinsic affective causes of abnormalities and *maladies* are intrinsic effective consequences that are related to patients' illnesses and sicknesses within biosophical and biophilic ethical boundaries of "vitalism" and "naturalism." Third, since nosological analyses are salient features of scientific deliberations, we have analyzed different philosophical foundations of alternative medicine in relationships among scientific, pragmatic, and spiritual value systems as foundation of modern commercial medicine. Fourth, we have analyzed the levels of tolerance of pain and suffering among different groups of patients.

Key words: Vitalism, Naturalism, Biosophy, Technosophy, Biophilia, Nosology, Normativism, Data-Mining, Statistical Normal Curve, Knowledge-Based Healthcare, Scientific-Based Commercial Medicine

INTRODUCTION

Biosophy (a biosystem of thought) and/or biophilia (a thoughtful tendency towards natural life) are the holistic bedrocks of medical ethics. They are global innate affinity of good faith for the sanctity of life and the beauty of the synergistic natural and artificial world in which we live in. Such incorporated visionary thoughts encompass global medical ethics to integrate human life and the environmental contradictory conditions of the realm of existence. Within such a thoughtful deliberation, two phenomena are viewed as the basic foundation for human existence: (1) tautological of ethical and epistemological of moral dimensions of life and (2) nosological conditions of scientific thoughts that deal with orderly rating or classifying maladies and diseases.

For effective development of ideas, theories, and paradigms of existence, a clear use of terms is necessary. So in terms of professional ethical and moral relationships between physicians and patients in pain and suffering management clinics customary professional relationships are to begin with definitions of these terms. Originally, to define something within a scientific framework meant to set limit on it. Tautological relationships between physicians and patients have broad intents of two kinds: (1) the view that the practice of medicine is an art and regards it based on the professional opinion-based deliberation of physicians and (2) the view that the practice of medicine is a scientific-based of a group of professionals and regards it as epistemic. Parhizgar and Parhizgar (2008: 223) indicated:

> The term *art* is the production or expression of what is creative, beautiful, appealing, and/or of what is more than ordinary significant. Arts are the establishment of human unity in variety, similarity, proximity, and connectivity in bounded perceptions. Arts are expository of an individual's emotional conceptions, sensational feelings, and critical thinking to explain or manifest something in specific causal forms… In a general term, we define *science* as simply the empirical rational process that can form the generalized inquiry by which viable understanding is obtained… Science is a rational convention related to the generalization of expected environmental norms, expectations, and values.

In the field of tautological medicine, both diagnoses and treatments of patients with maladies and diseases are subject to seven "Cs:" (1) Cure, (2) Care, (3) Control, (4) Communication, (5) Cooperation, (6) Coordination, and (7) Collaboration. Americans believe in both educational and practices of medicine as knowledge-based interdisciplinary scientific branches of knowing things. As each new

type of scientific research triangulation concerning diagnosis, treatment, and prognoses comes out, there would be clinical values either from a prognostic or diagnostic standpoint. One of the first deductive demands is the basis of assertion of a truthful statement to formulate it based on "the normal range." From another point of view, patients' affordability of medical costs and reasonability of medical charges are the most important issues in today's American life style.

ANALYSIS OF AFFORDABILITY AND REASONABLE FINANCIAL MEDICAL CARE COSTS IN THE U. S.

In regard of medical care, poor patients will not be able to afford the medical costs of visiting specialists in hospitals and clinics and/or buying comprehensive and expensive healthcare insurance packages. They refer to the retail clinics, in-store clinics, and mobile street clinics and will be hooked to the cheap generic type B medications and counter medicine or no medicine. Within this type of treatment, the major controversial question put medical providers to diagnose and treat those people that are energetic, productive, and wealthy. For example, in the early of the 20th century, in the United States of America, there were many humanitarian, religious, and county clinics and hospitals that used to provide free diagnoses and treatments for needy and poor people through donation of goodwill and good faith people. In the late 20th century most of these medical institutions were sold to the commercial (profit-making) medical groups and needy or poor people left without doctors and healthcare services. For example, the sale agreement between the former Mercy Sisters Hospital in Laredo, Texas as a non-profit medical institution and the Laredo Medical Group as a profit-making hospital. It left many families and classes of people without humanitarian medical attention. Residences in Laredo don't have any philanthropic and/or county hospital to treat poor people and non-documented alliances who work in the city and ranches. Also, Brown et al., (2012:118) indicated:

> In recent years, there has been unprecedented population growth in Texas's counties near the Rio Grandie because of the North America Free Trade Agreement (NAFTA) and immigration. Unfortunately, the population growth has outstripped the substantial economic growth, and the traditionally poor border region now has even more poor people. The counties in the Mexican border area between El Paso and Brownsville are among the most impoverished places in the country. Many of the poor live in colonias (depressed housing settlements often without running water or sewage systems). It is estimated that there are currently about 2,300 colonias in Texas. As many as 400,000 Texans live in substandard conditions in these settlements.

Such a status was extended nationwide to the point that forty five million citizens, residents, and no documented immigrants have been left without resources to be treated against diseases. In addition, professional medical authorities lost their expertise power and private healthcare insurance and/or organizations (e.g., HMOs, PPOs, and MCOs) gained privileges to run the national medical care services. Parhizgar and Parhizgar (2008: 246) stated: "We human beings, like other predator species; like the lion, the wolf, the wale, and the eagle, are the interlocutors between chaos and order, playing a vital creative role in keeping all natural species including human beings in balance. Human beings possess the ability and capability to be creators. Promethean utilitarian biosophical believers believe in creation of evolutionary forms of holarchy in which they perceive moral life should be based on amorality. They do not perceive themselves as creatures to be managed by other extra Gs' power (Gods and/or Governments). This means that they do not perceive life as an absolute phenomenon. They believe life is a balance between right and wrong, good and evil, just and unjust, beautifulness and ugliness, rich and poor, and worthiness and worthlessness. What is right for the wale is catching the fish or the death of the deer is not evil or wrong because the deer is a means to a wolf's end. This is the biosophy of balance of nature, which carries capacity the whole ecosystem to be maintained. From the utilitarian Promethean biosophical view, our human-oriented amorality should not regard all sufferings and pains including death as evil or immoral, because sentient life and death are either good or evil. They are integral parts of natural holarchical life experiences and processes. They believe death and suffering to be caused by human beings rather than by natural means. They view it as legitimate reasoning because they are creating a balance between life and death." *Lenders* are the economical first class people who will survive with prosperous medical care. Reich (2012) has indicated: "These financiers have so much power over the rest of the economy they get average taxpayers to bail them out when their bets in the casino called the stock market go bad. They have so much power they even shred regulations intended to limit their power." Life-time struggling debtors as the middle-class people will pay interest to lenders. Patients may survive without medical care services and die in misery and not only are they borrowing more money to pay their current medical debts, but as well as the interest on prior unpaid debts. Finally, this is the struggling process among three main groups: the *Wall Street* creditors and lenders, the *Main Street* debtors, and the featherbedding *Floor Street* healthcare insurance companies (Parhizgar and Parhizgar, 2012: 244)

CATEGORICAL, GRADUAL, AND DECISIONAL STATISTICAL TRENDS OF MALADIES, REMEDIES, AND HEALTH

Tautologically, we need to precisely define what statistical normal trends of maladies, remedies, and health are? In medical science and medical education, descriptive terms are used in three senses that may be termed: (1) categorical, (2) gradual, and (3) decisional (Murphy, 1997: 137).

What Are Categorical Descriptive Trends Concerning Maladies, Diseases, and Health?

What is the precision and accurate ground on which to decide how health, maladies, and remedies are to be grouped in regard of *categorical* descriptive terms of patients? This is an ontological problem of *taxonomy*. For example, the physician in a set of scientific case notes may choose to indicate that the patient is a female or male by judging through medical professional and scientific terminology that the patient has the karyotype XX, unlike the male, who has the karyotype XY. This is a useful and almost completely clean scientific categorization of genders to professionally introduce a patient to the scientific community. Ethically and morally, physicians' opinions should be based on scientific epistemological decision-making processes and/or to be based upon nosological maladies and diseases, not to be based upon sociopolitical ideological doctrines because the discipline of medicine is neutral. Therefore, physicians during the professional court witnessing hearing should relay on the scientific discoveries of medicine and avoid expressing their personal sociocultural, religious and political beliefs.

What Are Gradual Descriptive Trends of Maladies, Diseases, and Health?

In contrast to the categorical taxonomy, the *gradual* descriptive term of patients on the basis of gender maturity is based upon the natural time-line and psycho-physiological personality development between a child and a young adult by puberty. Then, regardless of gender categorization, physicians draw a line based on practical distinction other than arbitrary because males' puberty differs critically from females and person to person. There are two philosophical foundations concerning maturity of a patient concerning puberty: (1) vitalism and (2) naturalism.

The vitalists' stance is based upon religious philosophy that speaks the "sanctity of life." Some people in their deep heart believe that God is the creator of Earthy life and He does have the power to terminate it. This religious philosophy of the Earthly life is conditional for experiencing of a good life and envisions it as a bridge to the eternity. Therefore, life is viewed as experiencing of having good faith, good deed, and good ends as advancing towards salvation. In addition, through scientific deliberations Sommerhoff (1950: 6) indicated:

> [Except for borderline cases of life; lethargy] it would be hard to find any level of organic activity which does not invite us to think of vital activities as being somehow purposive, as being subject to tendencies which are directed towards the fulfillment of specific and mutually interrelated ends. On the phenomenal level from which all science must proceed, life is nothing if not just this manifestation of apparent purposiveness and organic order in material systems.

The naturalists' stance is based upon religious philosophy that speaks the untouchable sanctity of human genes that are immortal. They believe that human genes have the right number of chromosomes as well as the right DNA to be human and have those biological attributes as life. Naturalists believe in quantitative assessments of the normal life regardless of the quality of life span of patients. That is one of the major critical ethical issues in the field of clinical intervention that sometimes physicians make decisions on the basis of their own quantitative valuable life for patients and they determine for patients how to live and how to die by providing or depriving them required food and medications.

There are differences between pure science and clinical medicine and between ethical and legal. Philosophically, naturalism is the opposite of normativism. Naturalists view that health judgments are valuable judgments through application of ethical and moral convictions. However, normativism emphasizes upon analyses that rest on the concepts of biological function and statistical standardization and normalization of knowledge-based, opinion-based, and merit-based equation among strengths and weaknesses, and opportunities and threats (SWOT analysis). Since nowadays the American medicine is based upon "scientific-based medicine," which is expressed by the theses: "Health is the absence of diseases," it, scientifically, requires applying statistically oriented data within the scientific domain of the normal curve distribution. From the normative view, the philosophy of being healthy is related to the clinical judgments concerning young and old, male and female, Hispanic and Anglo ethnicities, and classes of diseases. Therefore, instead using natural medicine versus normative medicine, it would be better to emphasize more on pragmatism to use normal versus pathological values. Within the domain of such arguments, the scientific objective of medicine, then, is to analyze the normal and pathological distinctions between *values* and *trends.* Nevertheless, scientific naturalism of health is conformity to the specificity of characteristics of a species design. Accordingly, pathology of clinical health concerning species' design is the differentiated functional operation of species population (as regards somatic medicine) forms the subject matter of physiology. It is the interlocking hierarchies of functional

processes, at every level from organelle to cells to tissues to organs to gross functioning anatomy, by organisms of a given species to maintain and survive their lives.

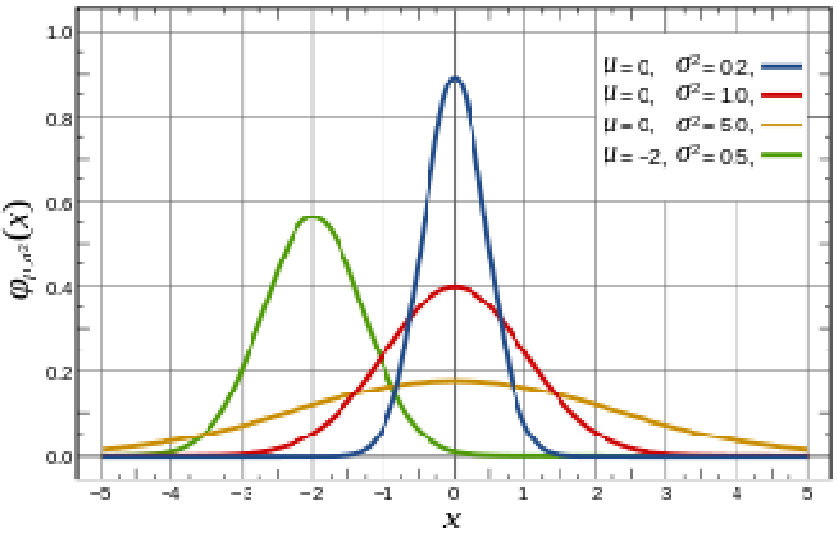
What Are Decisional Descriptive Trends of Maladies, Diseases, and Health?

The ontological *decisional* descriptive terms can be best judged by scientific deliberations based on nosology of maladies in general and illnesses and sicknesses in their specific terms of commercial medicine. There is a basic difference between scientific normativism or vitalism and naturalism. Normativism or vitalism is defined as a standardized formulation of health within the boundaries of ontological biological concepts. For the sake of scientific clarity of normatism or vitalism, we would like briefly to describe what is the scientific normal curve distribution?

What Is the Scientific Normal Curve Distribution? The normal distribution is the most important and most extensively used distribution in Statistics and allied sciences; due to its graphical representation it is sometimes called the "*bell curve",* which is also called the "*Gaussian curve*" in honor to the mathematician-statistician Karl-Friedrich Gauss; although Gauss played an important role in its history, Abraham de Movire first discovered the normal distribution.

Actually "the normal distribution" is a family of normal distributions, where each member can differ from each other in their means (μ) and in their standard deviations (σ); in other words, by varying the parameters μ and σ, we obtain different normal distributions. A normal distribution with a mean of 0 and a standard deviation of 1 is called a standard normal distribution. Figure 1 shows four normal distributions.

Figure 1. Normal distributions differing in mean and standard deviation.



Graphic Source: *http://en.wikipedia.org/wiki/Normal_distribution*

The density f(x) of the normal distribution (the height for a given value on the x axis) of the normal distribution is shown below. The parameters μ and σ are the mean and standard deviation respectively and define the normal distribution. The symbol e is the base of natural logarithm and **π** is the constant pi.

$$f(x) = \frac{1}{\sqrt{2\pi\sigma^2}} e^{\frac{-(x-\mu)^2}{2\sigma^2}}$$

Some of the main properties of the normal distribution are:

(a). The normal distribution is symmetric around its mean.

(b). The mean, median, and mode of a normal distribution are equal.

(c). The area under the normal curve is equal to 1.

(d). Normal distributions are defined by two parameters, the mean and the standard deviation.

(e). Approximately 68% of the area of a normal distribution is within one standard deviation of the mean.

(f). Approximately 95% of the area of a normal distribution is within two standard deviations of the mean.

(g). Approximately 99.74% of the area of a normal distribution is within three standard deviations of the mean.

The normal distribution is important because of the Central Limit Theorem, which states that the population of all possible samples of size n from a population with mean μ and standard deviation σ

approaches a normal distribution with mean μ and standard deviation $\sigma/\sqrt{n}$ when n approaches to a sufficient large value.

An example of a typical application (Pena-Sanchez, 2009)): A group of college students at a school takes a Management test. The distribution is normal with a mean of 75, and a standard deviation of 4. Everyone who scores in the top 30% of the distribution gets a certificate. What is the lowest score (L) someone can get and still earn a certificate?

Solution: $X \sim N(\mu,\sigma) = N(75,4)$ and $Z = (X - \mu) / \sigma \sim N(0,1)$

$P(X>L)=0.3$, or $P(X \leq L)=0.7$, Thus, from the standard normal table: $(L-75) / 4 = 0.525$ Therefore, $L = 77.1$

In order to understand how scientific inferential medical statistics works, we must look at the special properties of a population distribution called the *normal curve.* Assume for a moment that the normal range of values is a set of properties that characterizes the normal population density. How do we find the normal population distribution? A physician through recording all his/her patients' historical characteristics who has visited in his/her office and/or in hospitals, he/she can compile statistical data as the normal population range. Then, on the basis of nosological maladies he/she can specify patients' valuable similar characteristics of their maladies in classified categories. He/she may apply the normal curve distribution formula to characterize classes of d patients' maladies due to genetic influences, animal and plant parasites, intoxication, trauma, circulatory disturbances, psychic control, metabolism, and mechanical abnormality. Notice that all classes of patients' curve should be symmetrical (the left is a mirror image of the right) and bell-shaped – high in the middle, where most scores are equivalent to 68%, and 16% higher than 68% and 16% lower the farther you get from the 68%. This type of curve is called a normal curve distribution. It should be noted that a skewed distribution is one in which scores cluster toward one end instead of around the middle. In addition, in a normal curve distribution, the median, mode, and mean values are the same.

Obviously, in clinical interventions, physicians need both empirical (experiential) and tautological (experimental) ethical and moral convictions. Empirically, physicians need to diagnose and treat patients in terms of inherent characteristics of each individual patient. Tautologically or experimentally physicians need to diagnose and treat patients in terms of triadic concrete class-based medical scientific deliberations. This means that they need to look at patients through pathological signs of normality. However, through tautological diagnostic and treatment prescriptions, physicians look through literature of nosological maladies and diseases that are bounded with multiple causes and effects such as sarcoidosis, that do not confine

their manifestations to one tautological normal scientific diagnostic and treatment system such as the coronary or the lungs diseases, or almost any bodily system. A cardiologist may analyze the records of 500 patients personally visited per year and deduct the frequencies with which the various symptoms such as blood pressure ranges, nervous system, artery system, pulmonary system, and digestive system are affected. But if the physician compares the frequencies with which the various manifestations occur in the different series there are sometimes startling discrepancies among observers. Nevertheless, manifestation of ubiquitous characteristics among all groups should be the same. When we are talking about ubiquitous characteristics, we mean that trends or norms of values should be characterized by ubiquity; being everywhere at the same time, or to be omnipresent. In another series, they are rare, but pulmonary diseases are present in the majority of cases. Therefore, diagnoses will be dependent upon specialization of physicians. Cardiologists are interested in coronary diseases with patients with congestive heart failures, and oncologists are interested in pulmonary diseases and the part of scientific lung abnormality that should treat the patients that have tumors.

In conclusion, in expressing the professional opinion based on decisional descriptive trends or norms, physicians need to consider two major phenomena: (1) control class and (2) normal structural functionalized pathological symptoms. Nevertheless, in clinical interventions, the common features of conditions of life calls for pathological normality ordering in medicine by other two characteristics: (1) maladies and (2) remedies.

Nevertheless, it is a fact that we as human beings are living within three major environments: (1) materialistic, (2), socialistic, and (3) spiritualistic. Within each cluster, we search for prosperous promises that are not provided by other alternatives. As much as the nature of pain and suffering exponentially increases, patients tend to choose complementary and alternative medicine and very often they do not inform their physicians and clinicians these types of information. Such a discrepancy is based on multicultural orientations.

Human bodies are depositories of maladies and diseases among all other natural substances. Through intellectual abilities, human beings possess the ability to resist diseases, eradicate pain and suffering, and convert unpleasant conditions into happiness. In a general term, patients express their pain and suffering concerning psychosomatic conditions in terms of diseases, illnesses, sicknesses, lesions, disorders, handicap, deficiency, and retardation interchangeably. Some medical experts believe that the concept of malady is generally meant

to include all of the above symptoms (Clouser, Culver, and Gert, 1997: 176).

Also, as we use the term *malady,* it refers to an expanded sense of abnormal conditions of psychosomatic and societal or cultural conditions of an individual's life. The main reason that we include societal or cultural conditions of abnormalities is related to some other symptoms of social disorders such as addiction, alcoholism, and sadistic sexual behavior. Pain and suffering are indeed manifestations of a combination of ritual, psychological, cultural, social factors, and physiological deviations from the natural expected normal trends of life. Also, pain and suffering from maladies are viewed as means of probing the relationship between mind and body, and of examining the dualism that somehow underlies our various conceptions and perceptions of thinking, sensing, and feeling. In addition, the magnitude of pain and suffering is limited to the degree of endurance that patients can feel about abnormalities. The different meanings that attributed to pain and suffering as the result of maladies necessarily are related to unpleasantness of punishment conditions of life to be resisted on the endurance capacity threshold of the reality of the existence of life. Also, it is not so much the altered meaning of pain and suffering conferred by a society that is interested in this article, but rather the consequences of such a reinterpretation on the patients' own experiences of pain and suffering from maladies.

From the standpoint of moral and ethical views, endurance of maladies are related to a combination of establishing a state in which an individual's power and spiritual inspiration play an important role in his/her psychosomatic and sociocultural capacity to resist maladies. It is spontaneously evident in the opposition between pains, which physiological, and suffering, which is considered mental. If we may accept the pertinence of this distinction, then the acceptance of the real philosophy of life would be imaginable and possible. Rey (1993: 3) elaborated on circumstances between pain and suffering from maladies by the following explanation:

> But if we take a closer look at the linguistic meaning of the terms pain and suffering, a second distinction can be superimposed on the first: the word suffering seems more to refer to the subject which pain seems more the objectification of this suffering, which legal parlance translates perfectly when it evaluates the "*pretium doloris.*" When a doctor questions a patient, he (she) is more likely to ask, "Where does it hurt?" or "Are you suffering?" or even "What seems to be the trouble?" rather than to ask him(her) directly what type of pains he (she) feels; however, he (she) transcribes in his (her) patient's file "abnormal pain" or "lower back pain." The etymology of the

> verbs from which the nouns pain and suffering are derived provides another perspectives on their specialized meanings: to suffer, for instance, from the Latin *sufferer*, means to bear, to endure, to allow, or so many verbs which necessitate an active subject or even more, a person; …

Nonetheless, when pain is intense and persistent or simply chronic, it always involves the entire magnitude of dimensional severity of suffering. It does not only limit itself to the painful region, but also is affecting all parts of body and mind and cultural, social, and spiritual status of an individual. The patient's entire personality and emotionality become doleful, and even his/her rational thinking becomes dull. In addition, our account of malady not only includes physical as well as mental maladies. Maladies not only include all segmented harms to be rendered to the holistic body and mind of an individual, but also they are related collectively to physiological, psychological, and social features of people in society.

Maladies always have specific languages, whether they are manifested through crying, sobbing, tensing, of the features, or twisting body in a circular fashion by lying down on the floor, and they are communicating within mind and body in themselves as well. As such, maladies are defined by communication channels of permissiveness or their notions of transgression, between what can be shown or what must be kept hidden. These norms or behavioral manifestations depend upon the sociocultural foundations of psychological, sociological, and religious orientations in which they arise. Conditions of maladies may be perceived at three major levels: (1) acute or chronic, (2) critical or emergent, and (3) reversible or irreversible.

The nature of a disease is more than merely as of diagnostic clinical observation by anatomical and/or physiological facts concerning a given state of affairs to be acknowledged by physicians and/or clinicians. It is an anatomic and patho-physiological underpinning abnormality within a particular defined professional context. Moreover, one must make a difference between an "illness" and a "disease." One can have a disease without being ill (one may feel very well in the first stages of AIDS) or can be ill without having disease (one can feel very ill for a variety of non-pathological reasons). Therefore, the questions arise: What counts as a disease? And what does not count as an illness or sickness? For example, Leprosy and Epilepsy to name but a few can be a differentiate social contract.

Happiness is first and foremost a state of intrinsic genetic or somatic harmonious functional structuring of an individual's life. Nevertheless, human nature is an intimate union of intellectual, sensitive, emotional, and somatic life. It seems logical to conclude that

an individual can be really happy as long as he/she continues to live safely without illness or sickness. Nevertheless, the American Medical Association's Standard Nomenclature of Diseases and Operations has broken down the range of medical conditions into the following categories:

- Disease due to genetic and parental influence, (e.g., a gamma glubolinemia, down syndrome, etc.)
- Diseases due to intoxication, (e.g., Arsenic, Cyanide, etc.)
- Disease or infection due to a lower plant or animal parasite, (e.g. Cholera, malaria, etc.)
- Disease or infections due to a higher plant or animal parasite, (e.g., Athlete's foot, fleas or lice, etc.)
- Diseases due to trauma or physical agent, (e.g., scars, stab wounds, etc.)
- Diseases secondary to circulatory disturbance, (e.g., coronary occlusion, gangrene)
- Diseases secondary to disturbance of the integration of psychic control, (e.g., macular paralysis or spasm, seasickness, etc.)
- Diseases due to or consisting of a static mechanical abnormality, (e.g., dental malocclusion, gallstones, etc.)
- Diseases due to disorder of metabolism, growth, or nutrition (e.g., malnutrition and obesity, vitamin deficiency, etc.)
- Diseases due to unknown or uncertain cause with the structural reaction manifest, (e.g., atherosclerosis, liver cirrhosis, etc.)
- Diseases due to unknown or uncertain cause with the functional reaction alone manifest, (e.g. epilepsy, migraine, etc.).

CONCLUSION

It is a fact that all people are facing difficult circumstances as a result of illnesses, sicknesses, and injuries. It is not possible to find a perfect human being on this planet. Pleasure, pain, satisfaction, and suffering (PPSS) are known as general characteristics of all human being in all generations. Pain management is a type of specialization in

the field of medical practice. There are ethical, moral, and legal principles that physicians and clinicians should observe them in personal and professional behavior. Pain management is a professional pragmatic process that requires physicians to create a joint venturing partnership between a physician and a patient in order to first locate the exact symptoms and its side effects. Second, physicians through their training experiences should diagnose patient and plan for finding alternative treatments. Sometimes physicians may eradicate pain and return back the patient into healthy condition and other times, the severity of pain and suffering will be extended to the time of death. In all different scenarios, physicians should provide patients some medications that may relieve patients from very chronic or acute pain. Assessment of treatment for continuity of medications or changing them would need scientific methodologies. Nevertheless, physicians should respect patients' dignity, privacy, and autonomy and their professional integrity.

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