

ETHICS



Why study Ethics of Healthcare?

- Create awareness of other perspectives
- Sensitise ourselves to the reason for our beliefs
- Enable conclusions which embrace both of the above
- Develop skills in constructing reasoned arguments
- Introduce a variety of ethically sensitive issues in medicine
- Try to find the best solutions based on human rights

3 important approaches to help that guide difficult decisions are:

- 1.Laws**
- 2.Professional codes and guidelines**
- 3.The principles and theories of ethics**

Our own natural decision-making abilities are often included:

- Our own beliefs
- Science
- Common sense

What we use for our decisions:

1.Laws

2.Professional codes and guidelines

3.The principles and theories of ethics

- Our own beliefs

- Science

- Common sense

- Laws can be arbitrary (even if not obviously so).
- Laws can be unjust (at least in some situations).
- Laws may not expressly address the issue at hand.

- Common sense and our personal beliefs may be different.

- Science might help to clarify an issue , but eventually not help to protect human rights.

How can Philosophy help?

Ethical theories and value judgements can help with:

- **Clarity**: reasoned understanding of the own position
- **Plurality**: consideration of other positions
- **Awareness**: understanding criticism of the own position and preparation of counterarguments against them
- **Flexibility**: ability to adjust the position in accordance to new events and information
- **Justification**: stated clear arguments in support of the own position and decision



FOUR GLOBAL VIEWS

DIGITAL IMAGES OF EARTH



PERSPECTIVE

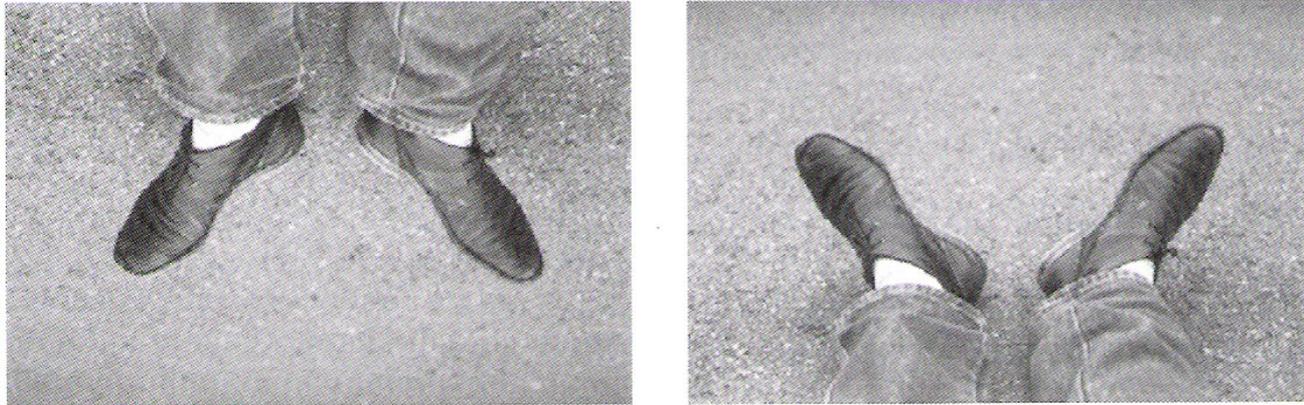


Figure 1.1

The problem with perspective is that you need to know where you stand. ('Ottawa shoes' Patrick Brennan 1989. Reproduced with kind permission of the artist.)

...Doctors are more frequently accused of malpractice or negligence for reasons of poor communication with patients than any other reason.

So communication skills have to be trained!

MEDICAL ERROR

Physicians not only work under uncertainty; they also may make mistakes. A 1999 Institute of Medicine (IOM) report on medical error estimated that between 44.000 and 98.000 Americans die each year as a result of medical errors, as many as those who die of vehicular accidents, breast cancer, or acquired immunodeficiency syndrome (AIDS).

July 21, 2006

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HEALTH

Report Finds a Heavy Toll From Medication Errors

By Gardiner Harris

Medication errors harm 1.5 million people and kill several thousand in the U.S. annually, a report said.

WASHINGTON, July 20 - Medication errors harm 1.5 million people and kill several thousand each year in the United States, costing the nation at least \$3.5 billion annually, the Institute of Medicine concluded in a report released on Thursday.

Drug errors are so widespread that hospital patients should expect to suffer one every day they remain hospitalized, although error rates vary by hospital and most do not lead to injury, the report concluded.

The report, "Preventing Medication Errors," cited the death of Betsy Lehman, a 39-year-old mother of two and a health reporter for The Boston Globe, as a classic fatal drug mix-up. Ms. Lehman died in 1993 after a doctor mistakenly gave her four times the appropriate dose of a toxic drug to treat her breast cancer.

Recommendations to correct these problems include systemic changes like electronic prescribing and tips for consumers like advising patients to carry complete listings of their prescriptions to every doctor's visit, the report said.

"The incidence of medication errors was surprising even to us," said J. Lyle Bootman, dean of the University of Arizona College of Pharmacy. "The solutions are complex and far-reaching and will present challenges."

The report is the fourth in a series done by the institute, the nation's most prestigious medical advisory organization, that has called attention to the enormous health and financial burdens brought about by medical errors.

The first report, "To Err Is Human," was released in 1999 and caused a sensation when it estimated that medical errors of all sorts led to as many as 98,000 deaths each year - more than was caused by highway accidents and breast cancer combined.

After the first report, health officials and hospital groups pledged reforms, but many of the most important efforts have been slow to take hold.

Drug computer-entry systems, which are supposed to ensure that hospital patients get the right drugs at the right dose, are used in just 6 percent of the nation's hospitals, said Charles B. Inlander, president of the People's Medical Society, a consumer advocacy group, and an author of the report released Thursday.

Electronic medical records can help ensure that patients do not receive toxic drug combinations. The 1999 report urged widespread adoption of these systems. Thursday's report called for all prescriptions to be written electronically by 2010.

Just 3 percent of hospitals have electronic patient records, said Henri Manasse, chief executive of the American Society of Health-System Pharmacists. Few doctors prescribe drugs electronically.

Even simple medication safety recommendations - block printing on hand-written prescription forms - are widely ignored.

Arthur Levin, director of the Center for Medical Consumers and an author of the 1999 report, said that just about everyone in the health system was to blame. "This country has not taken seriously the alarms we sounded in 1999," Mr. Levin said. "Why?"

lth: Report Finds a Heavy Toll From Medication Errors

Health organizations defended their efforts.

Alicia Mitchell, a spokeswoman for the American Hospital Association, said that since 1999 hospitals had "actively engaged in looking at using information technology to improve patient safety."

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A recent poll by the association of its members found that 92 percent intended to adopt electronic patient records, Ms. Mitchell said. But such systems are complicated and need to be built gradually, she said.

Thursday's report urged the Food and Drug Administration to improve and standardize the drug information leaflets given consumers. It noted that confusing information on drug labels was an important cause of medication errors.

On Tuesday, the drug agency finished a years-long process by issuing voluntary guidelines

to reform consumer drug information leaflets, said Dr. Scott Gottlieb, the agency's deputy commissioner. Many of these leaflets are not regulated by the F.D.A.

And on June 30, the agency completed a lengthy effort to clarify and standardize information on drug labels. The new labels could prevent nearly 300,000 medication errors each year and will make electronic prescribing efforts far easier to carry out, Dr. Gottlieb said.

Thursday's report said that the common practice whereby drug companies provided free drug samples to doctors should be discouraged because such samples were poorly controlled. It urged drug makers to package more pills in individual packages. And it criticized drug makers as failing to disclose the results of all clinical trials involving their drugs.

Alan Goldhammer, a spokesman for the Pharmaceutical Research and Manufacturers of America, a drug industry trade group, said he differed with some of the report's conclusions but concurred with the broad goals of increasing the use of information technology to reduce medication errors.

"Everybody is working on that right now," he said.

Thursday's report said that in any given week, four out of five adults in the United States took at least one medication. A third take at least five different medications. As the use of medications has soared, so, too have medication errors, Dr. Manasse said.

Effective strategies to prevent such errors have, however, been known for years, Mr. Inlander said.

"This is not rocket science," Mr. Inlander said. "It's simple. The key is having the will to make these changes in an organized and uniform way. And it's not that expensive."

Accountability and team work:

Easier or more difficult to achieve?

Advantages /Disadvantages for

- Patients
- Doctors ?

Table 2.1

Qualities contributing to successful teamwork⁵

- Dedicated time and place to meet
- Tolerance of self-examination
- Understanding of group dynamics
- Stability and consistency in group members

Table 2.2

Characteristics resulting in unsuccessful teamwork⁵

- Hierarchy
- Insistence on priority of own discipline
- Reluctance to participate in team meetings
- Stereotyped attitude
- Confusion of opinions with facts

Ethical theories:

Immanuel Kant and the *deontology* (duty-based)

1. Act in such a way that your actions can and ought to be universalizable
2. Treat people as ends in themselves and never solely as means to an end
3. Act in such a way as you would have others act towards you

Ethical theories cont.:

Consequentialism

- Casuistry
- Contextualism
- Virtue ethics
- Intuitionism
- Relativism
- Pragmatism
- Liberalism
- Ethics of Care
- Rights
- Principlism (Autonomy, Beneficence/ non-maleficence, Justice, Utility, Truth)

The Goals of Medicine

- 1. Promotion of health and prevention of disease*
- 2. Maintenance or improvement quality of life through relief of symptoms, pain, and suffering*
- 3. Cure of disease*
- 4. Prevention of untimely death*
- 5. Improvement of functional status or maintenance of compromised status*
- 6. Education and counseling of patients regarding their condition and prognosis*
- 7. Avoidance of harm to the patient in the course of care*
- 8. Assisting in a peaceful death*

A Practical Approach to Clinical Ethics

■ MEDICAL INDICATIONS

The Principles of Beneficence and Nonmaleficence

1. What is the patient's medical problem? history? diagnosis? prognosis?
2. Is the problem acute? chronic? critical? emergent? reversible?
3. What are the goals of treatment?
4. What are the probabilities of success?
5. What are the plans in case of therapeutic failure?
6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?

■ QUALITY OF LIFE

The Principles of Beneficence and Nonmaleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life?
2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?
5. Is there any plan and rationale to forgo treatment?
6. Are there plans for comfort and palliative care?

■ PATIENT PREFERENCES

The Principle of Respect for Autonomy

1. Is the patient mentally capable and legally competent? Is there evidence of incapacity?
2. If competent, what is the patient stating about preferences for treatment?
3. Has the patient been informed of benefits and risks, understood this information, and given consent?
4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
5. Has the patient expressed prior preferences, e.g., Advance Directives?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

■ CONTEXTUAL FEATURES

The Principles of Loyalty and Fairness

1. Are there family issues that might influence treatment decisions?
2. Are there provider (physicians and nurses) issues that might influence treatment decisions?
3. Are there financial and economic factors?
4. Are there religious or cultural factors?
5. Are there limits on confidentiality?
6. Are there problems of allocation of resources?
7. How does the law affect treatment decisions?
8. Is clinical research or teaching involved?
9. Is there any conflict of interest on the part of the providers or the institution?

MEDICAL INDICATIONS

- 1. The Principles of Beneficence and Nonmaleficence**

PATIENT PREFERENCES

- 2. The Principle of Respect for Autonomy**

QUALITY OF LIFE

- 3. 1 + 2**

CONTEXTUAL FEATURES

- 4. The Principle of Loyalty and Fairness**

In medical history decision making was paternalistic.

Replaced by patient autonomy [?] this shift is exemplified in the legal requirement of

informed consent to treatment.

Shared decision making is now the ideal.

But:

The patient is the ultimate and authoritative decision maker, because he or she alone determines what will be done to his or her body and how this action will affect his or her life.

Special cases in the clinical relationship:

- *Children (minors)*
- *Persons with mental disorders or disabilities*

Rights, that have to be discussed are concerning

1. Patients

2. Practitioners

3. Society

The universal declaration of HUMAN RIGHTS (1948)

Article 1

Because all human beings are born free and equal in dignity and rights, they should act as brothers towards each other.

Article 2

No distinction should be made determined by color, nationality, politics, possessions, race, religion, sex, or status.

Article 3:

Everyone has the right to life,
liberty and security of person.

Article 4:

No one shall be held in servitude or slavery.

Article 5:

No one shall be subjected to torture, degrading treat or punishment.

Articles 6, 7, 8, 9, 10 and 11:

No one shall be
disenfranchised of law...

Article 12:

Everyone has the right to privacy of correspondence, family and home. Honour nor reputation shall be attacked.

Article 13:

Everyone has the right of freedom and movement.

Articles 14 and 15 concern
asylum and nationality.

These articles have little medical
relevance.

Article 16:

Everyone has the right
to marry and procreate.

Article 17:

No one shall be
arbitrarily deprived of
the right to own property.

Article 18:

Everyone has the right to freedom to observe and practice religion.

Article 19:

Everyone has the right to hold opinions and impart ideas without interference.

Articles 20 and 21:

These concern participation
in political activities.

Article 22:

Everyone has the right
to social security.

Articles 23 to 30:

These deal with rights to work, remuneration, leisure, education and culture.

The New Hippocratic Oath – 1998

• *Patients Rights*

I promise that my medical knowledge will be used to benefit people's health. Patients are my first concern. I will listen to them, and provide the best care I can. I will be honest, respectful and compassionate towards patients.

I will do my best to help anyone in medical need in emergencies. I will make every effort to ensure that the rights of all patients are respected, *including vulnerable groups who lack means of making their needs known.*

I will exercise my professional judgement as independently as possible, uninfluenced by political pressure or by the social standing of my patient. I will not put personal profit or advancement above my duty to my patient.

I recognize the special value of human life, but I also know that prolongation of human life is not the only aim of Healthcare.

If I agree to perform abortion I agree that it should take place only within an ethical and legal framework.

I will not provide treatments which are pointless or harmful or which an informed and competent patient refuses.

I will help patients find the information and support they want, to make decisions on their care.

I will answer as truthfully as I can, and respect patients' decisions unless that puts others at risk of substantial harm. If I cannot agree with their requests, I will explain why.

If my patients have limited mental awareness, I will still encourage them to participate in decisions as much as they feel able.

I will do my best to maintain confidentiality about all patients.

If there are overriding reasons which prevent my keeping a patient's confidentiality I will explain them. I will recognize the limits of my knowledge and seek advice from colleagues when needed.

I will acknowledge my mistakes.

I will do my best to keep myself and my colleagues informed of new developments and ensure that poor standards or bad practices are exposed to those who can improve them.

I will show respect for all those with whom I work and be ready to share my knowledge by teaching others what I know. I will use my training and professional standing to improve the community in which I work.

I will treat patients equitably and support a fair and humane distribution of health resources. I will try to influence positively authorities whose policies harm public health.

I will oppose policies which breach internationally accepted standards of human rights. I will strive to change laws which are contrary to patients' interests or to my *professional Ethics*.

*While I continue to keep
this Oath unviolated, may it
be granted to me to enjoy
life and the practice of the
Art respected by all, in all
times.*

Rights of

- *Practitioners*

They have a right not to be exploited commercially either by their employers or by their patients.

Rights of

- *Society*

In many societies, the costs and opportunities for doctors to acquire their professional training comes from the society itself, that society has the right to expect the doctors it has trained to serve the society by way of appreciation and repayment.

How do we (for ourselves) place value on life?

There are essentially 3 elements to consider when determining the value of life:

- **Quality**
- **Quantity**
- **Sanctity**

The quality of life criterion asserts that there is a difference between the *type* of life and the *fact* of life.

This is the primary difference to the sanctity criterion!
The sanctity criterion asserts:

- **All life is worth living under any condition because of**
- **the inherent value of life.**

Quantity might not be identical with quality but, often, increased quantity in medicine can be equal to cure or control of disease and hence does enhance quality of life.

The Compression of Morbidity principle cited by Downie and Calman is useful for guiding these decisions:

Compression of morbidity principle: the objective of increasing life-span should be associated at the same time with an increasing quality of life or reduction of disability.

In distribution of resources this model for decision making is sometimes applied: **(Consequentialism)**

- the greatest amount of good for (least amount of harm)
- the greatest amount of time for
- the greatest number of people

Which problems arise with this theory?

World Medical Association Declaration of Helsinki:

Ethical principles for medical research involving human subjects

(adopted by the 18th WMA General Assembly Helsinki, Finland, June 1964...Edinburgh, Scotland, October 2000)

Introduction:

The World Medical Association has developed the Declaration of Helsinki as a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects.

CLINICAL RESEARCH

Clinical research is essential to modern medicine: new therapeutic and diagnostic interventions must be tested and evaluated by applying them to humans, and often those humans must be patients, persons suffering from the disease for which the intervention is designed. In the past, patients often were unwilling and unknowing subjects of clinical research. Today, this is ethically and legally unacceptable, and research is clearly distinguished from treatment. Physicians must know how that distinction is made and be aware of their responsibilities when they undertake clinical research. Ethics training for investigators is required by the National Institutes of Health.

Definition of Clinical Research

Clinical research is defined as any clinical intervention involving human subjects, patients, or normal volunteers, performed in accordance with a protocol designed to yield generalizable scientific knowledge. The protocol sets out the research techniques, such as randomization and double blinding, and the statistical techniques necessary to establish validity of the data. The benefits of research accrue to persons other than the subject of research, namely, to future patients, to the professional doing the research, and to society in general. Even when the subject personally benefits—for example, a cancer goes into remission as the possible result of treatment with an experimental drug—future patients benefit from the knowledge produced by the research. The research protocol usually is designed as a clinical trial in which *patients are randomized*

to the investigative intervention or to an alternative, such as a placebo or to current best treatment. This randomization is ethically justified by “clinical equipoise,” that is, a hypothesis based on the opinion of the relevant community of experts that, on the basis of available evidence, there is no difference between the trial intervention and alternatives. The purpose of the research is to demonstrate that this assumption is correct or is wrong in favor of one or the other treatment. In addition, patients and usually investigators are not aware of which intervention the research subject is receiving.

Innovative treatment

Most clinical activity involves familiar procedures and medications, many of which have never undergone the close scrutiny of a formally designed clinical trial.

Their efficacy is attested only by cumulative experience. New treatments are constantly being devised by commercial firms and by individual physicians.

Recommendations

Policy, regulation, and the requirements of most research institutes insist that investigators take the following actions:

- 1. Disclose their financial interests to the institution and even to the research subject**
- 2. Identify their financial affiliations in any published papers**
- 3. Divest themselves of substantial interests**
- 4. Participate in mechanisms to ensure the validity of data, such as outside peer review**
- 5. Physicians who have deep involvement with drug sponsors should recuse themselves as investigators for the products of these companies.**

Extract from Patient's Charter used by Dundee Teaching Hospitals Trust.

We believe you have a right –

- to be treated as an individual, with courtesy, and respect for your dignity, privacy, beliefs and culture
- to equal access, as promptly as possible, to proper and efficient attention from appropriately trained staff
- to be introduced to those providing you with care and to be provided with clear and understandable information about available services
- to be informed about, and involved in, all aspects of your condition and proposed care, with access to your health records with safeguards
- to be offered choices wherever possible in relation to your treatment
- to decide whether or not to participate in medical teaching and research
- to be guaranteed confidentiality of information relating to your care
- to be accommodated in safe, clean and comfortable surroundings
- to be provided with continuity of care as required within and between different health services, including those in the community
- to receive practical help, information and advice about healthier living for you and your family, in relation to nutrition, exercise, smoking and alcohol.

Lit.: Medical Ethics, Schwartz, Preece, Hendry
Saunders, 2002



The most important human endeavor is the striving for morality in our actions. Our inner balance and even our very existence depend on it. Only morality in our actions can give beauty and dignity to life.

-- Albert Einstein

The American lives even more for his goals, for the future, than the European. Life for him is always becoming, never being.

-- Albert Einstein

Conclusion???

- Being

and

- Becoming

**Responsibility for present and
future generations!**

The ideals which have always shone before me and filled me with the joy of living are **goodness, beauty, and truth**. To make a goal of comfort or happiness has never appealed to me; *a system of ethics* built on this basis would be sufficient only for a herd of cattle.

-- Albert Einstein

*What spirit is so empty and blind,
that it cannot recognize the fact
that the foot is more noble than
the shoe, and skin more beautiful
than the garment with which it is
clothed?*

-- Michelangelo

All religions, arts and sciences are branches of the same tree. All these aspirations are directed toward ennobling man's life, lifting it from the sphere of mere physical existence and leading the individual towards freedom.

-- Albert Einstein

Only a life lived for others is a life worth while.

-- Albert Einstein

The real problem is in the hearts and minds of men. It is not a problem of physics but of ethics. It is easier to denature plutonium than to denature the evil from the spirit of man.

-- Albert Einstein

**When we show our
respect for other living
things, they respond
with respect for us.**

Native Indian Proverb

**Love, by its very nature, is
unworldly, and it is for this reason
rather than its rarity that it is not
only apolitical but anti-political,
perhaps the most powerful of all
anti-political human forces.**

-- Hannah Arendt

The New Hippocratic Oath – 1998

Remember:

...to Help or at Least

Not to do Harm !