多元社會之醫學倫理與諮詢
Bioethics & Ethics Consultation in a Diversified World

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International Society for Clinical Bioethics, Croatia 國際臨床醫學倫理學會

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5th International Conference on Clinical Ethics and Consultation - Bioethics & Ethics Consultation in a Diversified World

5th
International Conference on Clinical Ethics and Consultation
第五屆國際醫學倫理諮詢研討會

多元社會之醫學倫理與諮詢
Bioethics & Ethics Consultation in a Diversified World

中山醫學大學 •
2009 Mar 09-11 Chungshan Medical University, Taichung, Taiwan

中央研究院 •
2009 Mar 12-13 Academia Sinica, Taipei, Taiwan

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Content 目 錄

Opening Remark

Chairman Chou, Dr. Agich, Prof. Kun-Yen Huang, Distinguished guests, Ladies and Gentlemen:
Good morning!

On behalf of Chung Shan Medical University, I cordially welcome your participation in the conference of the fifth International Conference on Clinical Ethics and Consultation (ICCEC), which is co-sponsored by many other institutions--Taiwan Bioethics Association, the Ministry of Health, Ministry of Education and National Science Council, etc.

Under the theme of “Bioethics and Ethics Consultation in a Diversified World”, this conference will focus its discussion on the theoretical part of bioethics namely “Bioethics in a diversified world”. It is truly an honor and a privilege to invite many prominent speakers to share their knowledge and expertise on bioethics and related topics. Many of them are the world's most eminent scholars in this field; some are also our old friends. Thank you all very much for your participation and presentations! We are looking forward with great anticipation to hearing the lectures and will greatly benefit by the sharing of expertise in bioethics.

At last, I want to extend my sincere thanks to all the attendees and moderators here. I wish the fifth International Conference on Clinical Ethics and Consultation (ICCEC) a great success, and all of you gain a worthwhile and substantial experience here. Thank you very much!

Jia-Yuh Chen, M.D., Ph.D.
President
Chung Shan Medical University

Greetings from the International Society of Clinical Bioethics and the Local Steering Committee

The International Society of Clinical Bioethics is pleased to hold its 6th annual meeting along with the 5th International Conference for Clinical Ethics and Consultation at Chungshan Medical University in Taichung. Taiwan. ISCB was inaugurated and registered in Croatia eight years ago through the effort of Dr. Van Potter and Dr.Ivan Segota…etc. Dr.Van Potter did not live to see the realization of his suggestion of this society but his disciple, Dr.Segota carried on to bring scholars and interested friends together to form this society aiming at in-depth discussion and research of various bioethical issues. The members of this society came most of the European countries including France, Russia, Spain, Portugal, Slovenia, Bulgaria, …. and Canada, Brazil, Japan, Malaysia, Taiwan, Korea, USA …etc. Though a small society, ISCB has held annual meetings in Croatia(twice) , Japan, France, Taiwan (twice) respectively every year since its inauguration. ISCB members enjoy a close friendly relationship among one another besides its fervent discussion of various bioethical issues at the conferences. Ethics consultation is one of the main interests of the Society and the society is pleased to share a common theme – Ethical Consultation in a Diversified World with the 5 ICCEC at its annual meeting in Taiwan in 2009.

Taiwan, as its old name Formosa reflects, is a beautiful country. To personally experience the beauty of this island , the steering committee has decided to include a small tour in the program in Taichung, free of charge, to the conference participants to Sun Moon Lake, Taiwan's most popular resort park. A visit to the world famous Taiwan National Palace Museum and the world tallest building, Taipei 101, while in Taipei. Much thank must be extended to Chungshan Medical University, Academia Sinica and National Health Research Institute for sponsoring this conference. We are also grateful to the generous supports from National Scientific Council, Ministry of Health, Ministry of Education, Taiwan United Medical Association, Medical Research Ethics Foundation, Bureau of Foreign Trade, Taiwan Bioethics Association…etc .Without their help, this conference would not be able to take place.

Many scholars around the world had sent in their abstracts and wish to come but due to various reasons, some can not make it. Dr. Ivan Segota, the founding president of ISCB had wish that he could come but due to health reason, he sent his regards and we wish him a speedy recovery.

The conference's banquet will be held at the beautiful Grand Hotel in Taipei in the evening of March 13. We are happy to announce that Dr. H.C.Wang, the vice president of Academia Sinica, Dr.Chi-wan Lai, the Executive Secretary of the Medical Education Committee will bring greetings to you and Dr.Ken-N Kuo, director of NHI and Dr. C.J.Chen, the former Minister of Health will share with us their important works. Thank you for your participation. We are looking forward to your next visit to Taiwan.

Sincerely yours,

Michael Cheng-tek Tai. Ph.D.
Convener, Steering Committee, 5 ICCEC
President, International Society for Clinical Bioethics

International Conference on Clinical Ethics and Consultation (ICCEC) Series

Background

This series of conferences was founded by George J. Agich and Stella Reiter-Theil to fill a significant gap that they perceived in the field: the gap between the explosion of clinical ethics, ethics committees, and ethics consultation services around the world on the one hand and the relative lack of critical and academic discussion of the many practical, institutional, and ethical issues associated with this work on the other. Each conference is organized by a local host, in close collaboration with the founders. An international program committee supports the development of the program, including the formulation of the program theme and managing reviews of abstracts.

The Series

1. ICCEC

The inaugural conference in the series, Clinical Ethics Consultation: First International Assessment Summit was organized in Cleveland, Ohio, USA on April 4-6, 2003 with sponsorship by a large group of international societies including the American Society for Bioethics and Humanities, Australian-Asian Bioethics Society, Canadian Bioethics Society, European Society for Philosophy of Medicine and Healthcare, European Association of Centers of Medical Ethics, International Association of Bioethics Education Network, and the Swiss Academy of Medical Sciences. These organizations recognized that although ethics committees and formal ethics consultation services have grown rapidly in North America and spread to Europe and other parts of the world during the last two decades, opportunities for open discussion of challenges involved in ethics consultation and clinical ethics in general have lagged. This conference was an effort to fill this gap. It was held in Cleveland and attracted more than 150 participants, mostly from North America and Europe.

Buerkli, P.: 2003, _Clinical ethics consultation–first international assessment summit_, Ethik in der Medizin 15,250–252.

2. ICCEC

The second International Conference: Clinical Ethics Consultation was held in Basel, Switzerland on March 17-20, 2005. The meeting was hosted by the Institute for Applied Ethics and Medical Ethics – now named "Department for Medical and Health Ethics" - Medical Faculty / University Hospital Basel, the Swiss Academy of Medical Sciences, and the Department of Bioethics, Cleveland Clinic Foundation with the support of renowned Swiss foundations. Participation in this meeting doubled from the Cleveland conference to over 300, with considerable international participation. As the first event in the field of clinical ethics consultation taking pace on an international scale, the Basel conference received much attention. The Basel conference further developed the focus on reflection and research on clinical ethics consultation. The publication of two thematic journal issues resulted from this conference and two conference reports.

Reiter-Theil S, Agich GJ (eds) (2008) Thematic Section "Research on Clinical Ethics and Consultation". Medicine, Health Care and Philosophy. A European Journal. 11, 1

Agich GJ, Reiter-Theil S (eds) (in progress/2009) Special Issue "Clinical Ethics Consultation". Cambridge Quarterly of Health Care Ethics

Slowther A.M.: _Conference Report. 2nd International Conference: Clinical Ethics Consultation, March 17–20, 2005, Basel, Switzerland_. EACME Newsletter 13, April:http://www.eacmeweb.com/file.asp?lang=en&page=newsletter/n13.htm.

3. ICCEC

The third International Conference on Clinical Ethics and Consultation was held as a joint meeting with the Canadian Bioethics Society in Toronto, Canada on May 30 – June 3, 2007. Participation was extremely positive and the collaborative arrangement between the Canadian Bioethics Society and the ICCEC enjoyed a remarkable success with over 600 participants in the joint meeting. At this meeting, plans were made to have schedule annual, rather than biannual, meetings beginning in 2008. As a result of the enlarged scope of the conference program, a rich variety of thematic sessions was offered and brought together the often separate communities of bioethics and clinical ethics.

4. ICCEC

The Fourth International Conference on Clinical Ethics and Consultation will be held in Rijeka, Croatia on September 5, 2008 as a satellite of the 9th World Congress of Bioethics of the International Association of Bioethics. Responsibility for the program organization rests with Stella Reiter-Theil, George Agich in collaboration with Iva Sorta as the local host. The goal of this year's conference is to focus again on CEC as a practice to be reflected and discussed on the background of experiences and cases. Another, more special interest, is to invite colleagues from countries in transition to the dialogue. A poster session on quality and educational issues of CEC will round out the one day plenary program. This satellite conference will be complemented with sessions on clinical ethics consultation and clinical ethics scheduled during the World Congress of Bioethics, September 5-8, 2008.

http://www.bioethics2008rijeka.info/en/fourth_international_conference_on_clinical_ethics

5. ICCEC

The 5th International Conference on Clinical Ethics and Consultation with the theme “ Bioethics and Ethics Consultation in a Diversified World “ will be held in Taiwan from March 9 to 14, 2009. The first two days (March 9 and 10) will be held jointly with the International Society for Clinical Bioethics as a pre-conference to the 5th ICCEC at Chungshan Medical University, Taichung, Taiwan (Taichung is the third largest city of Taiwan with population of one million and 2.5 hours away by car from Taipei, the capital). Those who attend this pre-conference will be issued a Certificate of Attendance by the university. This pre-conference will focus its discussion on bioethics in a diversified world. A banquet will be held to welcome the attendees in the evening of March 9 at the Hotel National. A tour bus will take everyone on March 11 to Taipei for the official conference of 5th ICCEC from March 12 to 14 to be held at the Academia Sinica, Taiwan’s premier research center whose former president is a Noble Prize laureate. The theme of discussion in Taipei will be on Clinical Ethics and Consultation in a Diversified World.

This 5th ICCEC is organized by Dr. Michael Cheng-tek Tai, a dean at the Chungshan Medical University and the president of ISCB with help from Dr.Agich and Dr. Reiter Theil. Sponsoring bodies include Chungshan Medical University, Taiwan Bioethics Association, Academia Sinica, Taiwan's Ministry of Health, Taiwan's National Research Council…etc.

6. ICCEC

The Sixth International Conference on Clinical Ethics and Consultation will have the theme: "The Art of Clinical Ethics," and will be held in the Portland Museum of Art (Portland, OR) on May 11-14, 2010.

Program for 5 ICCEC and the Pre-conference

March

10 - 11 at Chungshan Medical University, Taichung
Program of pre- Conference of the 5th ICCEC
12 - 13 at Academia Sinica, Taipei (end at noon)
5th ICCEC

(A workshop on Basics of Consultation at Taiwan University Medical College in the 13th afternoon for the local participants)

March 9 (Monday) **Location: Room 210 CSMU 2 Floor**

Annual Meeting and Conference of International Society for Clinical Bioethics

09:00-09:20（20’）	開幕式 Welcome and Greetings: Dr. Jia-Yuh Chen 陳家玉, President of CSMU（5’） Dr. Ivan Segota, Founding President, ISCB（5’） Dr. Michael Tai 戴正德, President, ISCB（5’） Dr. Ju-Chuang Chou 周汝川（5’）Chairman, Board of Directors, CSMU
09:15-9:35（20’） --------------------- 09:35- 10:15（40’）	An Agreement to enhance mutual relationship between University of Rijeka School Medical Faculty and Chungshan Medical University Dr. Jia-Yuh Chen 陳家玉 and Dr. Miljenko Kapovic -- Moderator: Dr. Michael Tai 戴正德（5’） Speeches: Dr. Hans-Martin Sass － Interactive Health Care Principles and The Clinical Setting.（35’）
10:15- 10:30 (15’)	Coffee Break
10:30-11:00（30’）	ISCB Annual Meeting Agenda: 1. Report from General Secretary（15’） 2. Election of Next President (2009-2011)（15’）
11:00-11:40	Tour of The Chungshan Medical University and Hospital
11:40-12:40	Bus Leaves for Zen Temple and Sun Moon Lake (Lunch in Bus)
12:40-13:40	Tour to Zen’s Temple
13:40-17:00	Tour to Sun Moon Lake
17:00-18:30	Go to Chiau-Yuan Restaurant
18:30-20:30	Dinner at Chau-Yuan Restaurant
20:30	Return to Hotel

March 10 (Tuesday)

08:30-09:00（30’）	Registration **Location: CSMU Hospital 12 Floor**
09:00-09:25（25’）	Welcome Remark Moderator: Dr. Michael Tai 戴正德（5） Dr. Ju-Chuang Chou 周汝川（5’）Chairman, Board of Directors, CSMU Dr. Jia-Yuh Chen 陳家玉（5’）President, CSMU Dr. George Agich（5’）Initiator, ICCEC

	Dr. Kun-Yen Huang 黃崑嚴（5’）/ Dr. Jen-Hung Yang 楊仁宏 Chairman, Medical Education Committee, Ministry of Education, Taiwan
09:25-10:45（80’）	Plenary Session & Discussion
09:25-09:30 09:30-10:00 10:00-10:30 10:30-10:45	Moderator: Dr. Kun-Yen Huang 黃崑嚴（5’）/ Dr. Jen-Hung Yang 楊仁宏 **1. Dr. William Deal**（30’） The Development of Education in Bioethics, Humanities, Professionalism, and Diversity in U.S. Medical Schools **2. Dr. George Agich**（30’） International Advance Directives: A Skeptical View Discussion (15’)
10:45-11:05（20’）	Coffee Break
11:05-12:40（95’）	Concurrent Sessions & Discussion **Location: CSMU Hospital 12 Floor & 10 Floor**
Taichung Ia. Bioethics and Culture (I) Location: CSMU Hospital 12 Floor Moderator: Dr. John Tuohey（5’） **1. Helene Anderson**（15’） The Adaptation of Belief and Culture in a Paradigm of Ethical Consideration **2. Holm Soren**（15’） The Role of Religion and Culture in Clinical Ethics Consultation **3. Mark J. Bliton and Stuart G. Finder**（15’） Experience of Responsibility in Ethics Consultation **4. Chau-Hui Shu 釋昭慧**（15’） Dependent Origination Protecting Life and Middle Path **5. Tian-Zhang Wu 伍天章**（15’） Analysis and Formation of Medical Spirit Discussion (15’)	**Taichung Ib. Ethics and Education** Location: CSMU Hospital 10 Floor Moderator: Dr. Te-Jen Lai 賴德仁（5’） **1. Godkin Dianna**（15’） Clinical Ethics Summer Institute—Educational Innovation for Meeting the Needs of Diverse Healthcare Organizations **2. Goran Pelcic**（15’） Multi-disciplinary as a Way in Protecting the Sources of Life--Water **3. Jen-Hung Yang 楊仁宏 (15”)** The Role of Faculty Development in Medical education **4. Hsin-Chen Hsin 辛幸珍**（15’） Three-level Courses in Ethical Education **5. Hsiu-Ming Tsao曹秀明** (15’) How Can Thomas Aquinas’ Ethical Theories Solve the Dilemma of Medical Ethics? Discussion (15’)
12:40-14:00	Lunch
14:00-15:35（95’）	Plenary Session & Discussion **Location: CSMU Hospital 12 Floor**
14:00-15:20 15:20-15:35	Moderator: Dr. D.J. Tsai 蔡篤堅（5’） **1. Dr. Harper Gordon**（35’） Medical Ethics, Professional Development, and Quality Improvement **2. Dr. Henry Perkins**（35’） Ethics Group, Gender and Patient’s Beliefs about the Soul after Death Discussion（15’）
15:30-15:50（20’）	Coffee break

15:50-17:25（95’）	Concurrent session & Discussion **Location: CSMU Hospital 12 Floor & 10 Floor**
Taichung II.a. Bioethics and Culture (II) **Location: CSMU Hospital 12 Floor** Moderator: Dr. Rick Singleton（5’） **1. Philip Crowell**（15’） The Ethnic Cultural and Spiritual Impact on Ethical Consultation for End of Life Decision-making **2. Kotalik Jaro**（15’） Health Care among Canadian Aboriginal Population—Clinical Bioethics Perspective **3. Paul Norbert**（15’） De Singularibus Non Est Scientia...There is no Science of Singularities!? On Theoretical Challenges and a Methodological Framework for Clinical Ethics. **4. Tuohey John**（15’） Use of Placebo Discussion (15’)	**Taichung IIb. Ethics and Education** **CSMU Hospital 10 Floor** Moderator: Dr. Meng-Chih Lee 李孟智(5’) **1. Gordana Pelcic**（15’） Under Age Patients’ Autonomy Regarding to the Health Care Laws in Croatia **2. Kyle Anstey**（15’） Informed Consent and Professional Interpretation Services **3. Iva Sorta-Bilajac**（15’） Back to the Basics: Is There a Place for Virtue Ethics Approach in Genetic Counseling? **4. Xiao-Mei Zhai 翟曉梅**（15’） On Physician-patient Trust Relationship and Medical Professionalism **5. Hsang-Yiong Yen 顏上詠**（15’） Public Consultation and Ethical Governance in Taiwan Biobank Discussion (15’)
17:30	Bus Leaves for Hotel
18:00-20:30	Banquet
20:30	Free Time
March 11 (Wednesday)	
8:30	Bus Leaves Hotel (Check Out)
8:30-9:00	Registration **Location: CSMU Hospital 12 Floor**
9:00-10:45（110’）	Plenary Session & Discussion
9:00-9:40	Moderator: Dr. Harper Gordon （5’） 1. **Dr. Stuart G. Finder and Dr. Mark J. Bliton**（40’） Choosing to Enroll : Potential Subjects’ Responses to an Ethics Questionnaire for a Phase 1 Study of Deep-brain Stimulation in Early Parkinson’s Diseases
9:40-10:30	2. **Dr. Sasa Ostojic**（50’） Current View on Bioethics and Genetics : Genetic Counseling
10:30-10:45	Discussion (15’)
10:45-11:05（20’）	Coffee break
11:05-12:25（80’）	Concurrent session & Discussion **Location: CSMU Hospital 12 Floor & 10 Floor**

Taichung IIIa. **The issue of death and bioethics (I)** **Location: CSMU Hospital 12 Floor** Moderator: Dr. Gordona Pelcic（5’） **1. Kathleen Deloach**（15’） Ethics and Palliative Care: an Umbrella Effect **2. Ida Mahmutefendic**（15’） Dysthanasia – Dying with Dignity ? **3. Henry Perkins**（15’） Beyond Medical Science—Patients’ Beliefs about the Moment of Death. **4. Helene Anderson**（15’）**.** End of Life Models in Practice –Why Consistency Matters for Patient Care **5. Ivan Kaltchev**（15’） The Dignity of An Unborn Child – A Bioethical Position Against Abortion Discussion (15’)	**Taichung III.b.** **The Issues of Death and Bioethics (II)** **Location: CSMU Hospital 10 Floor** Moderator: Dr. K.M. Liu 劉克明（5’） 1. **Vina Vaswani**（15’） End of Life Situations: Indian Religious and Utilitarian Perspectives **2. Ayodele Samuel Jegede**（15’） Ethnomethodological Understanding of End of Life Decision Making in Africa **3. Ming-Liang Lai 賴明亮**（15’） End of Life Issue: Viewpoints from Physicians in Taiwan **4. Anisah Bte Che Ngah**（15’） Assisted Reproduction Technology (ART): The Malaysian Experience**.** **5. Sato, Tsutomu**（15’） Disease and Discrimination : a Case of Hansen Disease Discussion (15’)

12:40-14:00	Bus Leaves for Shihmen Reservoir (Lunch in Bus)
14:00-15:00	Shihmen Reservoir
16:00	Check in at Activity Center, Academia Sinica
17:00	Dinner
	A Free Night in Taipei
March 12 (Thursday)	
08:30-09:00（30’）	Registration **Location: Academia Sinica Conference room 1**
09:00-09:30（30’）	**Welcome and 5ICCEC Opening** Moderator: Dr. Michael Tai 戴正德（10’） Greetings From: Dr. Chi-Wan Lai 賴其萬, Ministry of Education（5’） Dr. Ken N Kuo 郭耿南 National Health Research Institute（5’） Dr. Y.T. Ho 何橈通, Medical Ethics Research Foundation（5’） Dr. George Agich. ICCEC（5’）
09:30-10:50（80’）	Plenary Session & Discussion
09:30-10:35	Moderator: Dr. Stuart Finder（5’）
09:35-10:05	**1. Dr.George Agich**（30’） What Does Method Contribute to Ethics Consultation?
10:05-10:35	**2.Dr. Shun-Seng Chen 陳順勝**（30’） An Overview of Bioethical Consultation in Taiwan
10:35-10:50	Discussion (15’)

10:50-11:00（20’）	Coffee Break
11:00-12:20（80’）	Concurrent Session & Discussion **Location: Academia Sinica Conference room 1 & room 2**

Taipei I.a. Ethics Consultation (I) **Location: Academia Sinica Conference room 1**	**Taipei I. b. Consultation and Research Ethics** **Location: Academia Sinica Conference room 2**
Moderator: Dr. Chi-Wan Lai 賴其萬（5’）	Moderator: Dr. Chien-Min Chu 朱建民（5’）
1. John Tuohey（15’） Full, Partial or Non-Disclosure of Medical Information to Patients Autonomy of the Decisionally Incapacitated	**1. Vitezic, Dinko**（15’） The Advantages of Centralized Ethical Review Process of Clinical Trials: Croatian Experience
2. Helene Anderson（15’） Utilizing a Multidisciplinary Approach to Create an Effective Ethics Consultation Team	**2. Ahn Ducksun**（15’） Physisican’s Perspectives on Patient Autonomy in University Hospital of Confucian Culture
3. Michael Tai 戴正德 (15’) The Function of Medical Ethics Committee and the issues of consultation	**3. Shui-Chuen Lee 李瑞全**（15’） A Theory of Family-Centered Bedside Consultation
4, Louis Aldrich 艾立勤（15’） Post-Modern Bio-Ethics and the Death of Taiwan's Society	**4. Eubong Lee**（15’） The Problematic Conflict Between Dual Committees and Animal Experiments in Korea
Discussion (15’)	Discussion (15’)

12:20-14:00	Lunch (poster session in the hall: **Yoko Itojima**—Necessity of Death Education for Medical and Nursing Students)
14:00-15:30（90’）	Plenary Session **Location: Academia Sinica Conference room 1**
14:00-14:05	Moderator: Dr. Shun-Seng Chen 陳順勝（5’）
14:05-14:40	**1. Dr. Reidun Forde**（35’） Why Do Clinicians Contact Clinical Ethics Committee ? A Survey
14:40-15:15	**2. Dr. Ann-Marie Slowther**（35’） Cultural Differences and Ethical Decision-making among Clinicians: The Experience of International Working in the UK
15:15-15:30	Discussion (15’)
15:30-15:50（20’）	Coffee Break
15:50-17:05（95’）	Concurrent Session & Discussion **Location: Academia Sinica Conference room 1 & room 2**

Taipei II.a.Ethics Consultation (II) **Location: Academia Sinica Conference room 1**	**Taipei II.b .Consultation and Research ethics** **Location: Academia Sinica Conference room 2**
Moderator: Dr. Yu-Mei Yu 余玉眉（5’）	Moderator: Helene Anderson（5’）
1. Jochen Vollmann（15’） Evaluating the Impact of Clinical Ethics Consultation: a Systematic Review and Critical	**1. Daryl Pullman**（15’） An Ethics Framework to Resolve Challenges in Providing Appropriate Care

Appraisal of Methods and Outcome Criteria **2. Rick Singleton**（15’） Consultation on Organizational Core Values **5. Shuh-Jen Sheu 許樹珍**（15’） Capturing the Role as An Ethics Consultant: An Authoritarian or A Facilitator **4. Boris Yudin (15’)** Ethical Advice for Immunization: Case Study **5. Tsang-Tang Hsieh謝燦堂**（15’） Research Ethics in Perinatal Medicine Discussion (15’)	**2. Katsunori Kai**（15’） Model of Regulation on Medical Innovation/Medical Research from the View Point of Comparative Law **3. Salvador Ribas**（15’） Healthcare Ethics Committees: A Systematic Review **4 Shimoda Motomu**（15’） Rationality of Refusing Treatment: Clinical Ethics Conference at the Department of Emergency Medicine **5. Glen Ellis**（15’） Race, Ethics and Clinical Trial Discussion (15’)
17:05-17:30（25’）	Relax
17:30	Bus leave for Taipei Grand Hotel
18:00	Banquet
March 13 (Friday)	
08:30-09:00（30’）	Registration **Location: Academia Sinica Conference room 1**
09:00-10:30（90’）	Plenary session & Discussion
09:00-09:05	Moderator: Dr. George Agich（5’）
09:05-09:40	**1. Dr. Stella Reiter-Theil**（35’） Challenges for Clinical Ethics as it Develops Internationally
09:40-10:15	**2. Dr. Reidun Forde**（35’） Evaluation of Clinical Ethics Consultation – An Alternative Approach
10:15-10:30	Discussion（15’）
10:30-10:50　（20’）	Coffee Break
10:50-11:05	**Dr. John Tuohey**（15’） The 6th ICCEC in Oregon, USA
11:05-12:30（56’）	**The West meets the East --** Round Table Dialogue Between International Guests and Taiwan’s Participants:
11:05-11:10	Moderator: Dr. D.J. Tsai 蔡篤堅(5 ’)
11:10-11:25	**1. Chien-Te Fan 范建得**　(15 ’)
11:25-11:40	**2. Chien-Min Chu 朱建民** (15’) Respondents:（21’）
11:40-11:47	**1. Dr. George Agich**　（7’）
11:47-11:54	**2. Dr. Stella Reiter-Theil**（7’）
11:54-12:01	**3. Dr. John Tuohey**（7’）
12:01- 12:16	Discussion
12:16	**閉幕式 End of 5 ICCEC**

12:30-	Two Programs:
	1. A Tour to Palace Museum and free evening
	2. Workshop on Ethics Consultation for the Local Health Professionals at Taiwan University Hospital Sponsor : Taiwan University Hospital Co-sponsor: 5 ICCEC / CSMU / ISCB…

Principles and Practice of Clinical Ethics Consultation

主辦單位：台灣醫學會、台大醫院、台灣大學生醫暨科技倫理法律社會中心、衛生署醫學倫理委員會、中山醫學大學、中央研究院、第五屆國際醫學倫理諮詢研討會

時　間：2009年03月13日（星期五）下午1:30至5:30

地　點：台大醫院國際會議中心 301會議室（台北市徐州路2號）

Organizers：Taiwan Medical Association, Taiwan University Hospital, Taiwan University Bioethics Center, Ministry of Health Bioethics Committee, Chungshan Medical University, Academia Sinica, 5th International Conference on Clinical Ethics Consultation(ICCEC)
Time: 2009 March 13 Friday
Location: Taiwan University Hospital, International Conference Center, Room 301
Address: No. 2, Sec. 2, Shi Zao Road, Taipei, Taiwan

Time	Topics and Speakers
13:20~13:30	♦ Welcome and opening address ♦ Workshop introduction Daniel Fu Chang Tsai, MD., PhD,
13:30~13:50	**Special Lecture: Introduction to clinical ethics consultation** ♦ George Agich, Ph.D., Director of BGeXperience Program (University Values Program) and Professor of Philosophy
13:50~15:20	**Panel I: Approaches to clinical ethics consultation** ♦ speech — Stuart Finder, Ph.D., Director of the Cedars-Sinai Medical Center Ethics Program, USA: **“The Importance of Clinical Disposition in the Practice of Ethics Consultation”** — Richard Singleton, Ph.D., Professor, Pastoral Studies in Queen’s College, Memorial University of Newfoundland, Canada: **“From Core Values to Policies to Practices: Ethics Implementation in a Complex Health Care Setting”** — Reidun Forde, M.D., Professor and Director of Medical Ethics at the University of Oslo, Norway: **“Challenges and success criteria from a Norwegian Perspective”** — Anne Slowther, M.D., Associate Professor in Clinical Ethics at Warwick Medical School and Director of the Clinical Ethics Support Program at the Ethox Center in the University of Oxford, UK: **“Instructing or advising: conflicting views of a clinical ethics committee”** ♦ discussion
15:20~15:50	Coffee Break
15:50~17:30	**Panel II Cases for clinical ethics consultation** ♦ presentation — Case presentation: Daniel Fu Chang Tsai, MD., Ph.D, Associate professor, Department of Social Medicine, National Taiwan University College of Medicine, Taiwan — Soren Holm, MD, PhD, Professor, Cardiff University, UK — George Agich, Ph.D., Director of BGeXperience Program (University Values Program), and Professor of Philosophy, USA — Daryl Pullman, Ph.D., Professor of Medical Ethics, Memorial University of Newfoundland, Canada — Stella Reiter-Theil, Ph.D., Professor and Director, Department of Medical and Health Ethics, University of Basel, Switzerland. ♦ discussion
17:30~17:40	♦ Conclusion Daniel Fu Chang Tsai

Greeters

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中山醫學大學醫學董事長

Jia-Yuh Chen 陳家玉
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Speakers and Paper Presenters

March 9

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March 10

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March 13

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Oral Present Abstract

March 9

INTERACTIVE HEALTH CARE PRINCIPLES AND THE CLINICAL SETTING

Hans-Martin Sass
Senior Research Scholar and Director of the European Professional Ethics Program, Kennedy Institute of Ethics, Georgetown University, Washington DC, USA.

Health is not just a status, rather a balanced result of health-literate and risk-competent care of one's own physical, emotional, and social well-being and well-feeling with the support of health care professional. To care for my health primarily is my own responsibility and benefit. Principles in health care ethics are the four C's - COMPETENCE, COMPASSION, COMMUNICATION, COOPERATION - for all partners involved. Principles of respect for autonomy and justice are civil rights; the no-harm and do-good principles always had been essential in expert ethics, in medicine and elsewhere; these are common sense principles already integrated in the four C's. The interactive model of the four C's will be exemplified by presenting interactive principles and virtues, eight each for the expert and for the lay person, based on traditional rules by 15th century Confucian doctor Gong Tingxian.

March 10 Plenary Session

The Development of Education in Bioethics, Humanities, Professionalism, and Diversity in U.S. Medical Schools

William Deal

Senior Vice President and Dean Emeritus, University of Alabama School of Medicine

Medical education in the United States and the rest of the world has changed significantly over the past twenty years, for example, the introduction of problem-based learning and the Objective Structured Clinical Examination (OSCE). It will continue to do so. Schools have always been excellent at teaching the basic and clinical sciences but with astounding speed, scientific advances have created dilemmas for physicians. The need for education in bioethics became apparent during this time. In order to analyze bioethical issues, a firm base in the humanities is required; hence, an increasing emphasis on the humanities has occurred. Professionalism is a relatively new term but has taken its place in the curricula of U.S. medical schools along side bioethics and the humanities. Diversity as a medical school subject may be unique to North America. It is important in understanding cultural, religious and gender issues as they relate to patient care and patient expectations. Bioethics, the humanities, professionalism and diversity education are now required topics in U.S. medical schools. Problems exist: there is no standard curriculum for each subject, evaluation methods vary, fiscal support is weak and curriculum time is scant. In summary, subjectively, bioethics plus humanities plus professionalism plus diversity education equals higher quality patient care.

International Advance Directives: a Skeptical View

George J. Agich Ph.D.
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Advance directives have their longest history in the United States; a reflection on this experience might be helpful in framing the cross-cultural consideration of advanced directives. First, advance directives are made possible by state laws. There is no federal law on advance directives except for a federal regulation that requires healthcare institutions to inform patients about the existence of advanced directives within the particular state.

Despite consistency on many points, advance directive laws in the United States were shaped in different legislative contexts with somewhat different approaches to implementation. Many of these differences are immaterial in practice, because advance directives and the underlying ethical principles of patient self-determination, including the right to refuse life-sustaining treatment, are so widely accepted and are reflected in the guidelines articulated by national professional medical organizations. Although some variations are superficial, others are substantive. For example, the Ohio law does not permit the withholding or withdrawal of artificial nutrition and hydration unless certain statutory provisions and language are met. Fortunately, this does not mean that all dying patients are mercilessly supplied with artificial nutrition and hydration unless they have completed the advanced direct of documents correctly. Rather, with the involvement of ethics consultants and committees, physicians regularly rely on ethical recommendations that often reflect the professional guidelines that justify the withholding and withdrawal of artificial nutrition and hydration for some patients. The important point to note is that advanced directives laws are structured to *force* physicians and healthcare institutions to withhold or withdraw life-sustaining treatment or at least to give them legal permission to do so. In situations where physicians and healthcare institutions are confident that they are ethically justified to withhold or withdraw this treatment, it typically is done. When this occurs, the legal basis is not the advance directive law as such, but the ethical and practice standards of the medical profession.

I, for one, worry that although the demand for a common global approach to advance directives can be grounded theoretically, a common approach might encounter practically troublesome circumstances. That is not to say that an advance directive document that includes language to the effect that ? intend my wishes to be carried out in whatever location or local health care institution that I might receive care?色?are objectionable. Rather, one must not expect such declaration to have a universally identical response. Thus, I distinguish the question of *need* or *utility* for a global uniform approach to advance directives from that of the *feasibility* of a universal approach. I argue that widespread advocacy for and education about advance directives, however, is more likely to be effective in assuring that patient wishes are honored than attempting to achieve some international accord(s) on advance directives. Such a system will accept diversity as a necessary complication that cultural variation brings.

The deeper question is to what extent should cultural differences be tolerated if local customs and practices conflict with sound ethical considerations. Patient wishes and expectations will necessarily be constrained, for example, by local resources as well as customs. I will argue that these variations are best addressed by education rather than coercion. For this reason, I support the efforts of international bodies such as the World Medical Association to undertake educating physicians about the ethical foundations of advance directives; national professional organizations, both health professional and academic, should also educate legislative bodies and the public about framing their advance directive laws or regulations in such as way that they allow health care providers to incorporate whatever form of advance directives a patient may have into medical decision making.

March 10 Concurrent Sessions Taichung Ia. Bioethics and Culture (I)

The Adaptation of Belief and Culture in a Paradigm of Ethical Consideration

Helene Anderson RN, BSN, CCRN, Ann Bryant MSW, LCSW,
Bronwyn Evenson RN, BSN, CCRN, Marsha Rice RN, BA and John Tuohey PhD.

In the dynamic of globalization of the planet it behooves us all to be more sensitive/ aware of cultural differences. The Healthcare provider who becomes more engaged in cultural diversity can learn to appreciate each individual's particular values and beliefs, This can make the atmosphere around end of life decision making on of safety and inclusion.

This presentation will draw on the experiences of the multi-disciplinary ethics committee in a tertiary care hospital. It will address the ethical issuers related to the beliefs and cultural differences of North American Indian surrounding end of life decision making. The hierarchy of familial authority / decision making differs greatly and impacts the traditional decision making process. These cultural differences provided the opportunity for the ethics consult team to educate, teach and facilitate dialogue about the importance of acknowledging and accepting cultural differences.

We will provide a model for the framework of thought and process the decision-making used by the consult team. This framework allows the team to carefully individualize the ethical issues and our approach. The importance of acceptance / understanding of differences in belief and background of the elder Native American patient are highlighted. When culture and belief create misunderstanding, the ethics consult team is able to examine the differences and create understanding. This clears the way for appropriate care planning and allowing for the total support of the patient and family.

Keywords: Cultural Differences

The Role of Religion and Culture in Clinical Ethics Consultation

Søren Holm, BA, MA, MD, PhD, Dr MedSci

Cardiff Law School, UK & Section for Medical Ethics, University of Oslo, Norway

This paper will discuss the role a patient's religion and culture should play in analysing and discussing ethical issues in clinical ethics consultation in a multi-cultural environment.

The first part of the paper will present a case of a family requesting a specific, normally very minor non-clinical procedure to be performed on an elderly patient with severe dementia as part of the preparation for a very significant religious festival. This had been done the two preceding years but staff was now unwilling to perform the procedure because the patient had become agitated when it was performed a year ago. The case was therefore brought to the clinical ethics committee (CEC) which had to consider two issues:

Should the procedure be performed by the staff?

If not, should staff allow relatives to perform the procedure?

Based on this case the paper will then discuss:

Does it matter whether the procedure is required by religion or culture?

Can a clear distinction be drawn between religion and culture?

Does it matter what view the majority culture has on this procedure?

Does the patient's own previously held views matter and why?

I will argue that the distinction between religion and culture or between what is required by religion and what is "merely" cultural is in most cases spurious and drawn primarily to either valorise or devalue a certain practice.

What matters is whether a given value is deeply held and whether giving it up will require major transformations in a persons system of beliefs (in the non-religious sense of beliefs).

I will further argue that an attempt to determine the patient's objective "best interest" is also futile and unlikely to further the resolution of the problem since that concept is culturally determined.

The Experience of Responsibility in Ethics Consultation

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In the global spectrum of positions regarding the conduct and content of clinical ethics consultations, there is a persistent and serious practical concern which has received little direct and explicit attention within the field of clinical ethics. This concern arises from the fact that quite often an ethics consultation must identify and examine dominant and "ready-made" meanings prevalent in clinical work as well as identify and talk about what is morally at stake in, and possibly neglected by, those dominant beliefs, all in order to discover what may be ethically relevant for just those individuals involved in the specific clinical circumstance. The persistent issue for ethics consultants is thus this: how can we discern if we are of help, and who is it we are "helping," since to continue acting in a particular situation is to preserve the presumption that we are of help; can we, in other words, discern whether we are of help while in the middle of a situation? How this concern is addressed, moreover, reflects deep-seated commitments regarding the meaning of responsibility in clinical ethics practice.

Clearly these matters are keenly complicated, multi-faceted, and resistant to simple solutions. For example, simply complying with a person's wish—for instance, his explicit desire to have a ventilator removed, no matter how earnestly expressed—does not guarantee that in performing that action for which he wishes we will then be "helping," since we must acknowledge that this person may not know "what's good for himself." Additional matters at play, therefore, include the fact that an ethicist also encounters tensions related to ethical concerns about respect and harm as part of the discernment regarding "help."

Our presentation is a dialogue composed by different voices to illustrate this concern regarding the question of "help." After sketching the bases for appreciating why this concern is ingredient to clinical ethics practice, we explore the question of whether it is more harmful or beneficial to identify and articulate crucial factors inherent to the core meanings and values voiced by a particular individual, crucial factors that the ethics consultant may see as having remained unspoken, and possibly unacknowledged, and perhaps unimagined. We suggest that if ethics consultants do not hold up for inspection and test influential pre-suppositions, crucial factors, core meanings, values and beliefs, and so on, then further questions arise regarding the meaning of "ethics" in clinical ethics consultation. (Word count 394)

Dependent Origination, Protecting Life & Middle Path

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This paper introduce three cores of Buddhist Ethics: Dependent Origination, Protecting Life and the Middle Path.

‘Dependent Origination’ is generally known as ‘causes and conditions’, is the core and most fundamental principle. It is also the unique Buddhist ideology that distinct Buddhism from other religions in the world. All phenomena in the universe, be it human, events, matters or scenes (these are collectively called Dharma in Buddhism), are not free from the law of ‘combination of causes and conditions’.

‘Protecting Life’ is a moral principle that develops naturally from the Law of Dependent Origination. It based on three major principles: ‘putting oneself in others’ shoes’, ‘interdependency’, and ‘equality of all dharma nature’ of the dependent originated phenomena. ‘putting oneself in others’ shoes’ is the morale ground for protecting life. This is named as the Golden Rule Theorem in ethical study. The ability of ‘putting oneself in others’ shoes’ is the moral entity that develops in accordance to the principle of ‘interdependency’ and ‘equality of all dharma nature’ of the dependent originated phenomena.

‘the Middle Path’ is: ‘to make a relatively best choice without selfish thought among the causes and conditions that we see, hear, sense and know.’ When we say causes and conditions that we ‘see, hear, sense and know’, we have hinted that there are limitations in our sense organs and understandings. The doer must understand that these causes and conditions that we ‘see, hear, sense and know’ do not encompass all causes and conditions. Thus, when we make a decision, we do not dare to boast that all our selections are the ‘absolute truth’. We can only humbly acknowledge that this is the ‘relatively best choice’ that we can make at the moment.

In addition, the practice of ‘putting oneself in others’ shoes’ and the ability of seeing the insight of dependent origination and selflessness – which develops under the study of the Law of Dependent Origination – can assist us to put self-benefit aside but to think for the benefit of the sentient beings and make a ‘non-selfish’ selection/choice.

The three major principles of ‘protecting life’, such as ‘putting oneself in others’ shoes’, not only help us to relate better to others’ feelings when meeting/communicating with others, but they can also develop according to the Law of Dependent Origination and become ethical judgments and practical conducts that are in accordance to the Middle Path.

Key Words

Sattva (being, creature), pratītya-samutpāda (dependent origination), protecting life, madhyamā-pratipad (the middle path), putting oneself in others’ shoes , interdependency, equality of all dharma nature.

醫學職業精神的探析與建構

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【摘要】从理论与实践的结合上对医学职业精神的辨析与构建进行探讨。对于加强医学职业精神建设，促进医学科学发展，更好地为公众健康服务，具有重要意义。

【关键词】医学职业精神；辨析；构建

Connotation of Medical Professionalism and Its Construction

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This article discusses the connotation of medical professionalism and its construction on the basis of the combination of concerned theory and practice. Therefore, it is of primary importance for strengthening further construction of medical professionalism , serving the public health, and improving development of medical science.

Key words: medical professionalism; connotation; construction

March 10 Concurrent Sessions Taichung Ib. Ethics and Education

Clinical Ethics Summer Institute: Educational Innovation for Meeting the Needs of Diverse Healthcare Organizations

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The demand for clinical ethics services within healthcare organizations is increasing. No program exists in Canada (outside of formal graduate programs or fellowships) to provide hands-on education and leadership development to enhance clinical ethics capacity within healthcare organizations.

In 2006, in an effort to fill this gap, the first Clinical Ethics Summer Institute (CESI) was held in Toronto, Canada. Building on its success, the second CESI was held in Hamilton, Canada in 2008. The mission of CESI is to build clinical ethics capacity and competencies through innovative educational programs and provision of practical resources. The vision of CESI is to be a leader in improving the quality of health care by strengthening clinical ethics resources in health care organizations.

The strategic goals for CESI include:

CESI meets or exceeds participants' expectations.

CESI is nationally and internationally recognized for delivering excellent and relevant educational programs that showcase best practices and innovations in clinical ethics from across Canada and around the world.

CESI is responsive to the needs of diverse health care organizations and participants.

CESI promotes and supports the creation of communities of practice to build and sustain capacity and competency in clinical ethics.

Attendance at both of these four-day Institutes was over 100 and participants represented a broad spectrum of professional backgrounds and healthcare organizations (from community agencies to acute care hospitals). Persons in administrative roles comprised between 25 and 35% of the audience. Participant feedback was used to evaluate the level of attainment of the strategic goals as outlined above. Participant evaluations of both Institutes were overwhelming positive.

In this presentation, members of the CESI Organizing Board will discuss their approach to developing the framework, content, and structure of CESI 2006 and CESI 2008 and the lessons learned over the course of delivering the two Institutes. Given that there is currently no professional credentialing process for clinical ethicists, one of the important considerations was to ensure that reasonable expectations about practice standards, required skills, and education were articulated and discussed.

Lastly, ongoing educational challenges for CESI which are shared by the larger clinical ethics community will also be briefly explored. These include: a) providing content that is applicable and relevant to those with less and more ethics expertise who are practicing in different healthcare environments; b) assessment of an individual's competency to engage in clinical ethics activities including consultation; and c) professionalization of the field of clinical ethics.

Further information about CESI is available at the website (www.clinicalethics.ca).

Multi-Disciplinary As A Way In Protection The Source Of Life- Water

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Water is integral part of every living body. Microorganisms, plants, animals, humans can't exist without water. Water is 80% of body mass in newborn and 60% in adults. Water is sours of life and need of every human being from the birth to the death. Preventive medicine should insure the men's health by insuring him right and healthy feeding among other things. The role of epidemiologist-ecologist in the field of public health is becoming more and more important. The control of water quality and food in general, and informing the public about it, so that the public could adjust their behaving a nd tray to make it closer to the ecological point of view. On the other side public could influence on the politician and the government to save our «last silver» that our ancestors left us. The sours of drinkable water in the future decades will be «the last silver» for the humanity in general. The protection of the water as the sours of life is demanding emergent organization of multydiscplinar tim (ecologist epidemiologist, politicians, journalist…..)in which union bioethics could and have to take important role.

Three-Level Courses in Ethical Education

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For more than a decade, medical ethics has been included in the core medical curricula in our medical school as a single course with formal lectures. Here we propose a revised curriculum with three-level courses in ethics and identify a general consensus on the objective of each level. The diverse aims in each level imply the need for diversity of methods in teaching ethics. In general, there has been a move from formal lectures to more small groups, student-oriented and case-based discussions.

For the first level, which deals with the issues in "life and ethics", an elective course was designed for first and second year students, with an aim to cultivate an attitude to be respectful to life, considerable of risk vs. benefit, and understanding better in diversity. Beside formal lectures, a variety of teaching methods were used to initiate discussions on life issues, e.g. Problem-base Learning (PBL), narratives education and other classroom-based activities. At the second level, "biomedical ethics" is a core curriculum for the fourth years' medical students, which was designed to cultivate the ability of moral reasoning and values in medical profession. The combination of large group presentation and small group discussion allowing the materials of presentation (ethical principles and theories) triggers small group discussion. Two PBL cases were selected to offer real-life scenarios with ethical issues. The aim is to stimulate moral sensitivity in medical aspects and to practice moral reasoning in decision making. "Clinical ethics", the third level course is accompanied by students' clinical learning during the fifth year. This is designed with a major task to enquire students to bring ethical consideration in their clinical learning. A total of 12 groups were led by 12 clinicians selected from various clinical disciplines. These clinicians have been trained to be PBL tutors for students groups, and serve as discussion leaders in their departments. The strategy of having clinicians involve in ethics teaching improves vertical integration of clinical and preclinical training in ethics.

The three level courses in ethics represent only part of ethical education. Medical ethics teaching ought to take place at regular interval throughout students' medical career, and time should be set aside within existing teaching waiting for ethical reflection relevant to each stage of students' experiences. Both formal and hidden curriculums are important to achieve the ultimate goal of medical ethics. As such developing, a model of well-integrated ethics program is a major task we must undertake.

Key Words：Curriculum reform、Medical ethics education、

Problem-base Learning、Clinical ethics

How can Thomas Aquinas' Ethical Theories Solve the Dilemma of Medical Ethics?

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This article intends to find a solution for a historical dilemma in medical ethics, i.e., pro-life vs. pro-choice. In theory, neither camp of supporters can persuade each other. For example, people whose standpoint is pro-life will opposite to abortion and euthanasia. On the other hand, people whose standpoint is pro-choice will agree with abortion and euthanasia. They both have some insights of human rationality. In other words, they both are meaningful. However, in practice, people still have to make a better interpretation and decision of the dilemma to go beyond the impasse.

I argue that the ethical theories formulated by Thomas Aquinas can be used as a reference to solve the above dilemma in medical ethics. Aquinas created two tiers of virtues, i.e., cardinal and theological. The four cardinal virtues are prudence, temperance, justice, and fortitude. The cardinal virtues are natural and revealed in nature, and they are binding on everyone. It is on the level of personal ethics which can also be extended to a societal level. The three theological virtues are faith, hope, and charity. These are supernatural and are distinct from other virtues in their object, namely, God. It is on the level of meta-ethics. I would agree with Aquinas that the cardinal virtues are not enough for human beings escaping from the temptation of earthly desires. Only are the cardinal virtues combined with the theological virtues people can make a pertinent decision to solve a dilemma, especially in medical ethics. I call the combination of cardinal and theological virtues "Aquinas' life virtues". This is a holistic view to think over the dilemma between pro-life and pro-choice in medical ethics. I believe that this attitude can let us not only make decision but also make decision with virtues. The virtues can be seen as reliable resources for making a better decision in a medical dilemma.

試論多瑪斯的生命倫理思想對醫療倫理兩難的回應

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多瑪斯將人的德行分本性之德和超性之德，本性之德是指明智、正義、勇敢、節制，超性之德是指信、望、愛。我將此關係歸納為：本性之德是個人倫理，個人倫理的延伸是社會倫理，超性之德是形上倫理；綜合起來我稱之為多瑪斯的生命倫理。個人倫理指出人和自己有倫理關係，如：理智應駕馭欲望；社會倫理是個人倫理的延長，人能駕馭自己的欲望則天下太平；形上倫理是指人和形上來源的關係，是具有倫理性的。

醫療倫理兩難以生命神聖性和生命自主性之爭為代表，持生命神聖性（pro-life）觀念者，反對墮胎，不贊同安樂死。持生命自主性(pro-choice）觀念者認為每個人都有選擇生或死的權利。本人以為前者是具有超性之德的一種主張，但是「反對墮胎，不贊同安樂死」則否定了人本具有的本性之德是有可能夠做出明智的決定。因此，這種主張不符合正義原則，因為它剝奪了人為自己作決定的「權利」。後者認為每個人都有選擇生或死的權利，本人以為，持此主張者是站在每一個人有理性，所以有權自己作決定。但是多瑪斯認為，未受聖神薰陶的人衹能修本性之德，很難向上超昇。事實上人在做決定時，容易受慾望的干擾而不「明智」，反而做出錯誤的判斷。因此，我們若僅主張每個人都有權利做選擇，而不強調應充實自己明智、正義、勇敢、節制的本性之德，提昇信、望、愛的超性之德，則這將是一個極大的錯誤，也容易使人做出不明智的選擇。

所以，我們在面對生命神聖性或生命自主性等醫療兩難的困境時，從多瑪斯生命倫理的整體思維來思考，當能有所領悟，並能找到作決定的依據。

March 10 Plenary Session

Medical Ethics, Professional Development and Quality Improvement

Harper Gordon
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Training and support for clinical ethics is usually discussed in terms of the relevant knowledge domains – the philosophy of values, clinical decision-making, the theory and practice of consultation. But such knowledge-based approaches omit two other perspectives. The practice of clinical ethics also requires consideration of the professional development of the stakeholders and of the systemic support for quality of care provided. Appreciation of these domains has suffered in the late 20th century, during the ascendancy of biomedicine, at times extending to a view of medical practice as limited to biomedicine. In this presentation, the development of clinical binocularity in healthcare trainees will be reviewed, including the contribution of medical humanities. To expect competence in clinical ethics to emerge from training programs devoted exclusively, even predominantly, to biomedicine is unrealistic. In addition, the role of systems theory (including error science) in supporting quality and safety will be discussed, as applied to clinical ethics consultation.

ETHNIC GROUP, GENDER, AND PATIENTS' BELIEFS ABOUT THE SOUL AFTER DEATH

Henry.S. Perkins
JD Cortez, HP Hazuda. The University of Texas Health Science Center, San Antonio, Texas, U.S.A.

BACKGROUND: Quality terminal care should address patients' spiritual concerns. Culture undoubtedly influences such concerns, but little research exists. We sought to characterize, by two possible cultural influences—ethnic group and gender—patients' beliefs about one spiritual concern, what happens to the soul after bodily death.

METHODS: We conducted intensive, open-ended interviews with 26 Mexican Americans (MAs: 14 men, 12 women), 18 Euroamericans (EAs: 7 men, 11 women), and 14 African Americans (AAs: 7 men, 7 women). Content analysis identified subject beliefs about several topics: Does the soul live on continuously after bodily death? Does it leave the body? If so, when? and What is the afterlife like? Because subjects might not address a topic or might mention multiple beliefs about it, percentages may add to under or over 100%.

RESULTS: Majorities or near-majorities of all ethnic groups and ethnic-gender subgroups said the soul lives on continuously after bodily death, resides a while in the body, and eventually goes to heaven. (See table.) Yet differences arose over other beliefs. Majorities of MAs and EAs—but not AAs—said the soul leaves the body at the moment of bodily death. Still, noteworthy minorities of MA and AA men said the soul leaves before bodily death, and a noteworthy minority of EA women said the soul leaves afterwards. Estimates for its departure ranged from 15 minutes to a month after bodily death. In every ethnic group, majorities or near majorities of women—but not men—said the soul lives for some time as a spirit in this world. Furthermore, of all ethnic-gender subgroups only EA men had neither a majority or near majority saying the soul in the afterlife gains relief from physical suffering, nor a noteworthy minority saying the dead interact with the living. Few subjects except MA men mentioned God's interaction with the soul.

CONCLUSIONS: Some cultural beliefs about the soul after death are similar across ethnic groups and genders; other beliefs differ. Our findings give American health professionals a place to begin, but not to end, discussions about such beliefs with dying patients.

Table

	MA Men (%)	MA Women (%)	EA Men (%)	EA Women (%)	AA Men (%)	AA Women (%)
SOUL LIVES ON CONTINUOUSLY	71	100	100	91	86	100
SOUL LEAVES BODY. . .						
● Before Bodily Death	29	8	14	9	29	14
● At Bodily Death	71	75	71	55	29	43
● After Bodily Death	14	17	0	27	0	0
WHERE SOUL IS . . .						
● Inside Body	79	42	57	64	71	43
● In This World as Spirit	29	42	14	45	43	71
● In Heaven	71	75	100	91	71	86
AFTERLIFE EXISTENCE						
Relief from Physical Suffering	57	42	29	55	57	43
The Dead and the Living Interact	29	33	14	36	43	43
God Interacts with Soul	50	25	14	27	29	14

(FINAL, 19 Sept. 2008, words = 499, limit = 500)

March 10 Taichung II.a. Bioethics and Culture (II)

The Ethno-Cultural and Spiritual Impact on Ethical Consultations for End-of-Life Decision Making"

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Co-chair of British Columbia Women's Hospital Ethics Committee

Director Department of Spiritual Care

Children's and Women's Health Centre of BCM, Canada

How do cultural/religious concepts, values and beliefs correlate with the language of bioethics discussions of autonomy, beneficence, and 'do no harm'? What do we mean by the term culture? And how is the diversity of religious cultures appreciated and acknowledged in the ethics consultation process? This presentation demonstrates how the "thick" concepts of religious cultures are a primary lens for patients who adhere to a particular religious tradition, and how the concepts and clinical language of medicine becomes incorporated into the interpretive process of determining what is happening and what the illness and the end-of-life (EOL)decisions should mean.

In this presentation we ask how are Muslims, Aboriginal/First Nations, Christians, Jews, Hindus, Buddhists, to respond personally and/or collectively to E.O.L. decisions, based upon their own respective commitments to: Qur'an, harmony with nature, Gospel, Torah, Ahimsa, compassion, or Dharma. There is a natural desire for healthcare professionals to create a 'shopping list' or 'cookbook' in order to better anticipate patient needs, and to 'tidy up' culture, as the same as other epidemiologic variables, such as smoking, age, gender or fertility rates. On one hand, this is a positive move in trying to respond to cultural and religious diversity in ethical consultations, however, on the other hand, this presentation identifies some of the significant hazards in this approach and suggests a 'middle way'.

It is crucial that our understanding is broadened as our communities become more diverse and we become aware that the risk to minorities on poor end-of-life care is occurring due to cultural misunderstandings. We underscore that connected to this issue are the rights of families. We will argue that the rights of families to medical knowledge and their roles in decision making are just as valid, inalienable and crucial to the cultural/religious belief systems of many ethnic minority communities as are Western patient autonomy models.

In this presentation, we will briefly survey the attitudes, convictions, practices and customs of a variety of ethnic and cultural backgrounds, looking particularly at end-of-life philosophies, with special reference to the philosophies of major religions, their customs pertaining to death and dying, as well as their attitudes toward such things as advanced directives, organ donation, and withholding/withdrawing life-prolonging treatments. This examination will engage the debate on the advantages and disadvantages of coupling a patient's "personal values history" with his medical history in considering her/his anticipated end-of-life event. We will attempt to reconcile some of the principles of ethics with the language of cultural attitudes and religious reflection, and then argue that we must move beyond mere cultural sensitivity to cultural/ethical competency in our consultation process.

Health Care among Canadian Aboriginal Population- Clinical Bioethics Perspective.

Kotalik Jaro

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Health status of aboriginal people in Canada, about 4% of the total population, is in most aspect much worse than the rest of Canadians and many difficulties are encountered in the provision of health services to aboriginal individuals and communities. Examination of the situation from perspective of clinical bioethics could provide significant assistance in addressing this issue. Firstly, the condition of these First Nations is such that thy need to be recognized as vulnerable group, and hence the effort to overcome the discrepancy in health status is a moral obligation of Canadians and these people deserve a special consideration when in contact with health care system. Because of very small numbers of aboriginal health care professionals, this population receives care mostly from non-aboriginal providers. In such situation, the power imbalance and other moral aspects of patient-professional relationship need careful attention. An aboriginal patient is disadvantaged by differences in language, social status, education, knowledge, social support and geography. Just as importantly, the aboriginal patient raised and living in a traditional community has a set of values which may differ significantly from the values which the professional is used to consider and accommodate. The traditional aboriginal understanding of personal autonomy, role of family and community, disease and health, caring and healing, death and dying is significantly different from the no-aboriginal population. A professional providing an advise to aboriginal patients need to be aware of these difference when balancing benefits and risk, seeking consent to medical intervention according to principle of autonomy, or rationing health care resources in keeping with principle of justice. The attention to ethical aspect of care for and among aboriginal population has a potential not only to improve the experience of care and the quality of care for these vulnerable individuals and communities but also to improve the ethical quality of health care in general.

De singularibus non est scientia...there is no science of singularities!?

On theoretical challenges and a methodological framework for clinical ethics

Paul Norbert

Director of the Institute for the History, Philosophy, and Ethics of Medicine

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The still rising significance of clinical ethics consultations is deeply rooted in three strands of the development of modern medicine. First, clinical practice underwent a profound shift from the 1950ies on. Novel options to medically control even critical situations - especially at the beginning and at the end of life - expanded the therapeutic reach of medicine on one hand and forced us more and more to critically deliberate on the medical usefulness, the ethical justifiability and the social desirability of - sometimes highly invasive - medical interventions. Second, patient autonomy became one of the hinges on which medical decision-making in a patient-centered mode began to swing. Third, the economization of medicine started to set limits to our deliberate decision making processes by confronting applicability and desirability of interventions with the criterion of affordability. In this context, clinical ethics consultations became a tool for either analyzing decision making processes in institutions or organizations and providing guidelines for safeguarding ethical principles or supporting bedside decision-making by integration normative evaluations and implementing differentiated processes of ethical deliberation into medical problem solving.

This presentation examines some of the theoretical challenges of bedside clinical ethics. The main focus will be on the problem of applying normative theories (as the main source of ethical expertise) to individual cases in an arena of diverging interest (as the main source of ethical conflict). Beyond principles of biomedical ethics (BEAUCHAMP and CHILDRESS) a more procedural approach with a focus on the operationalization of normative deliberation will be discussed. A model of guided deliberation in clinical ethics will be presented in order to allow for both, the actual application of theoretical normative concepts and the appreciation of individual values in contingent settings. The four steps of deliberation including 1) a reconstruction of the medical and the personal situation of the patient (including a reconstruction of the assumed will if necessary), 2) an analytical approach towards applicability, desirability and affordability (ten HAVE) of diagnostic and therapeutic options, 3) a critical normative evaluation of the identified viable options in the light of situated knowledge (KNORR-CETINA), preferences and values and finally 4) the facilitation of consensus and the application of consensual options for treatments will be discussed using clinical cases from our daily practice. In doing so, the applicability of our reconstructive approach (BIRNBACHER) to clinical ethics in intercultural settings will also be critically evaluated.

Use of Placebo

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The use of placebos in research is well established, but what about in the management of patient care? A 1999 study suggested that 59% of interns surveyed were familiar with the use of placebos in patient care, with 50% of those having become familiar with placebo use from another physician not the ethics literature. As recently as 2008 a survey of internists in Chicago, USA, showed that 45% have used a placebo to manage patient care, with only 12% saying they had no ethical place in care management. This study is in contrast to evidence shown in a 2001 European study that placebos have no clinical effect. Even so, or maybe for that reason, might there be a place in the care of a patient to use a placebo? This oral presentation will explore this question. It is of particular interest to us as we have seen several consults in which the use of a placebo has been considered. For example, suppose there is a patient who insists they have 10 out of 10 pain, yet other objective clinical observations suggest otherwise: would an ethics consultant ever think it appropriate to use placebos to 'test' the patient's true pain experience? What of the patient who is given the wrong, and less potent, analgesic as a result of pharmaceutical error: might it be permissible to substitute what the patient thinks she is receiving with this 'placebo?' Suppose there is a patient who is extremely demanding of a care team's time: can a placebo be used to help manage that patient's demands on staff time? If a family insists on some last ditch effort to save the life of a loved one and there is no clinical basis to believe their plan will work, would an ethics consultation agree to use a placebo to satisfy the family and avoid harming the patient?

KEY WORDS: Placebo, clinical consultation

March 10 Taichung IIb. Ethics and Education

Under age patients' autonomy regarding to the health care laws in Croatia

Gordana Pelcic

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Anamarija Gjuran Coha
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A child has the full right of protection of his or her life by provision of optional medical care. Within provision informed consent has great value as a moral basis fundamental to human relationships, the recognition of individual autonomy, dignity and the capacity for self determination. Adult patient benefit psychologically from their involvement in decision and contribution to the efficacy of treatment through their observations, perceptions and active participation. The same right should have minor's patients, the healthcare professionals have duty to respect evolving capacity and autonomy of the child and they have to consider the views of the child in many matters including the medical decisions.

The minors, according to the Croatian's laws, do not have capacity to decide in every legal meter, as in the medical decisions until eighteen years old.

The health care law use to have general form for informed consent in which the parent or guardian has to sign in behalf of minor.

According to the last supplement of the same law, there is the new informed consent form – procedure specific form. Procedure specific form does not mention under age patient, only his/her parent or guardian. The new form is created with the goal to protect the patients, to improve ethical view. But it did not take in consider the assent of the child and his autonomy. The pretty much same situation is within the Protection patient's right law.

We will analyze theses laws and tray to give our perceptions and views.

Informed Consent and Professional Interpretation Services

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Global migration has placed an unprecedented burden on social services for receiving countries throughout the world. Immigration policy, often driven by the country's need for unskilled labour, tends not to require language proficiency for entry. For example, each year Canada receives approximately a quarter of a million immigrants, almost half of whom are not proficient in either of the Country's official languages.

There is not only a potentially enormous demand for interpretation services, but also a clear need for these services. While immigrants and refugees with legal status may be entitled to services including health care, the country's ability to bridge the language barrier is one of the most important determinants of health for the this population.

Despite the overwhelming potential demand for interpretation services, and the positive impact of these services on health outcomes, the provision of professional interpretation services in Canada is neither mandated nor supported with dedicated Federal or Provincial funding. Instead, these services are merely available to varying degrees depending on the policies of individual healthcare organizations. Many of these organizations encourage, but do not require the use of professional interpretation services, while discouraging but not prohibiting informal interpretation through untrained, bilingual staff or the patient's family members.

Focusing on the use of family members instead of professional interpreters, we discuss how the failure to mandate use of professional interpretation services leads to serious ethical issues in patient care: most notably, failings in obtaining informed consent to treatment and personal care. These stem from family members' frequent lack of proficiency in both languages; their lack of knowledge and training to competently interpret medical procedures and concepts; and their tendency to significantly filter the information provided to the patient. This filtering may also lead to a failure to disclose serious diagnoses to patients due to a family desire to "protect" them from negative information.

Family preferences against disclosure also present as an ethical issue when professional interpreters are appropriately utilized: In Canadian hospitals, it is not uncommon for family members to dismiss the hospital interpreter from visits where diagnosis or consent to treatment is the subject of discussion with a care provider. We outline strategies for health care professionals in responding to this dismissal, discussing it with family members and managing disclosure to patients.

Back to Basics: Is there a Place for Virtue-Ethics-Approach in Genetic Counseling?

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Most common approach to analyzing and solving ethical dilemmas in contemporary medicine is the four-principles-approach. However, as the critique of principalism has showed us back in the 1970’s, this framework has its limitations. These limitations especially emerge when facing the challenges of new technologies and the consequences of their usage, such as the case of clinical genetics.

Our time is one of genomics, HUGO, and similar accomplishments which bring us to the gene-sequence-approach vs. the good old fashioned “holistic” approach of treating illness. We are not helping a person overcoming pain and suffering any more, we are now helping a genome to be as healthy as possible in order to allow our (good, healthy, adequate) genes to be transferred in the next generation. This is, of course, a very simplified deliberation on what has become of modern medicine in the context of clinical genetics, more precisely in the context of genetic counseling.

Going back to basics, we are definitely facing the limitations of the principalistic approach. Principles do allow us to act with clarity, simplicity and universality (Campbell AV, 2003), on the other hand, they do not take account of the importance of the emotional element of human experience (Gardiner P, 2003), thus they suffer the neglect of emotional and personal factors, oversimplification of the issues, and excessive claims to universality (Campbell AV, 2003).

Exactly this “virtues and vices” of the four principles (Campbell AV, 2003) come in the focus of moral deliberation when we as health care providers have to offer advice which will create consequences not only for the patient coming for the advice and having to make a decision upon it, but the extend of these consequences goes beyond our patient (a person, a couple, the family) and intervenes with the future of the offspring. The patient of a genetic council is, thus, not only the person seeking it, but the entire family and future generations.

In this context it is very difficult to determine the rightness of the decision-making-action, neither from the deontological point of view (underlying the duties and rules all moral agents involved in the case have to obey in order to make the best possible decision), nor from the one of consequentialism, that is the “destiny” of (the consequences for) the offspring - the most often object of moral deliberation in genetic counseling.

Virtue ethics could help facing moral challenges geneticists and their patients encounter in the everyday enterprise of practicing a “harm reduction interventions” (Christie T, Groarke L, Sweet W, 2008), in the context where moral agents act as “time/space travelers” and council/decide for both themselves and others, both now and for the future. Virtue ethics provides insights into moral characters, offering a blend of reason and emotion, and paying attention to the context of decisions (Campbell AV, 2003). In considering the relationships, emotional sensitivities, and motivations that are unique to human society, it is also relevant for understanding our (multi)cultural concerns (Gardiner P, 2003; Islam G, 2007). Generally, it provides a fuller ethical analysis and encourages more flexible and creative solutions than principlism or deontology/consequentialism alone (Gardiner P, 2003).

The key concept for virtue-ethics-approach in genetic counseling is a strong sense for professionalism of the genetic counselor, which (summed up to the four fundamental virtues originating from John Gregory’s concept of professionalism) consists of integrity, compassion, self-effacement and self-sacrifice (Coverdale JH, 2007). If we try to broaden up the virtue-ethics-approach to all moral agents (patients also) engaged in the process of genetic counseling, we could follow the “seven basic virtues in medicine” approach, that is: prudence (practical wisdom), justice, temperance, courage, faith, hope, and love (Bryan CS, 2005; Bryan CS, 2006; Bryan CS, 2007).

In conclusion, it should be stated that neither virtue-ethics-approach, nor the four-principles-approach should claim to be superior to the other. Only together they provide a morally adequate context for helping patients, families, surrogates, healthcare providers, or other involved parties address uncertainty or conflict regarding value-laden issues emerging in genetic counseling.

Key Words: ethics, clinical; genetic counseling; principle-based ethics; virtues

論醫患信託關係與醫學的專業精神

On Physician-Patient trust relationship and medical professionalism

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在5.12四川汶川抗震救災過程中, 醫務人員所表現出來的大勇無畏，大愛無私，讓人們看到了醫生專業精神最光輝燦爛的一面。在廢墟中，在生命的召喚下，醫務人員的人道精神與科學精神完美結合，他們高超的醫術與超越了醫學專業的信念、情操、勇氣和愛心高度契合，實踐了“健康所系、生命相托”的神聖醫學誓言，對世界範圍內呼喚“醫學專業精神”回歸做出了最好的詮釋。在危難中，透過醫生在生死抉擇中義無反顧與患者生死相依，不惜犧牲自己的生命來實現救死扶傷的專業使命的情景，最為和諧的醫患關係畫面呈現在世人面前。大災過後，人們不約而同會更多思考這樣一個問題： 如何將這樣的醫患關係持續下去？

醫患關係的本質

醫學存在最根本的理由是一個人在沮喪和危機中呼籲幫助，另一個人懷著關切的心情想來幫助他。這種求助的願望和提供幫助的願望促成了最初的醫患關係。直至今日，醫學的實踐遠不止把醫學科學的知識運用于患者的異常情況。醫學實踐注意中心是病人，為病人謀福利是它不變的宗旨。治療病人並不是只把病人的痛苦當做我們對抗的敵人而已，更重要的是在舒解他們的痛苦時，也能幫病人感受到有人關懷他們，使他們更能承擔這個痛苦。正如北京協和醫院著名內科專家方圻教授所說，對病人的同情心和責任感是每一個醫生的靈魂。對患者的同情心源自醫生對人類遭受疾病痛苦的敏感性，對患者的責任感源自醫學的專業精神。從本質上看，醫患關係強調醫患雙方都是主體，都是戰勝疾病和痛苦的主體。在國外醫學院校的課堂上，學生們常常會聽到老師們這樣的告誡：對醫患間親密關係重要性的強調永遠不會過分”。

醫患關係模型

醫患關係模型是一種概念模型, 醫務人員在這個模型下指導和組織自己的醫療實踐。不同的模型反映不同的衛生保健原則和什麼好醫生和好患者的不同評價標準，凝聚著對醫學的看法，對醫務人員的作用以及對醫學倫理學原則的看法。

在已經提出帶來醫患關係模型中，醫學家長主義模型在醫療中有很長的歷史。醫學中的家長主義視醫患關係為家長與子女式的關係。為了子女的利益可不考慮子女的決定或者代子女作決定，由醫生決定患者的醫療問題。家長主義模型的基礎是“有益”的倫理原則。醫患關係的重點在於醫務人員的知識和權威。患者的生命和健康靠醫務人員的醫學知識、技能和良知來保證。家長主義模型的決策過程集中于醫務人員的權力和控制。醫務人員的經驗和價值不受質疑，醫患之間的討論非常有限。決策最終是醫務人員的責任，病人是被動從屬的。

二十世紀中期，我們的社會和醫學都已經改變，醫學家長主義在應用於這個瞬息萬變的時代時不斷受到挑戰。人們認識到，我們生活在多元的價值觀時代，不同的文化、民族、種族、信仰與精神、社會經濟地位以及個人和集體認同的其他方面形成了病人以及醫生在個人層面上的不同的價值觀。價值和優先權的多樣性使得自我決定權幾乎成為社會的一項普遍信念，因此對醫學家長主義的批評也越來越多。認為家長主義破壞了對患者自主權的尊重和對患者的價值觀的考慮，忽視了患者“境遇”在倫理決策中的作用，要麼把患者所有的價值特別是生活價值取向全都包含在醫療價值之內，要麼就是以醫生的價值觀取代了患者的價值觀。結果可能是：治癒了患者，但患者最珍視的價值、生活計畫/生活種類以及與別人的關係等可能都會遭到破壞。（不過需要指出的是，在搶救危重病人的生命時（life－saving），醫學家長主義仍然是有效的，有時甚至是唯一有效的模式）

針對家長主義的弊端，人們提出了契約模型。契約模型認為：醫患是平等的合夥人，患者是自主的，能夠對自己的想法和行動做出獨立判斷，並將其付諸實施。契約模型是用契約形式把交易雙方的要求明確起來。醫務人員是具有權威力量的人，這種力量培植了醫療中的家長主義作風。為克服它，要把病人看作一個自主的實體，即，以契約模型來縮小擁有力量的醫務人員與脆弱的病人之間的差距。契約模型強調醫患關係以病人為中心和病人的自主性。患者的優先考慮和目標是醫療決策時首先要考慮的；患者的經驗和價值是主要的。契約模型承認病人的獨立和控制權，因此有時又被稱為 “患者獨立選擇模型”。

不過，契約模型有兩個重大缺陷。第一個缺陷是它忽視了一個事實：需要幫助的、處於擔憂焦慮的病人實際上不可能與擁有知識和技能的醫生處於平等地位，醫患之間確實存在知識擁有上的不平等。這種不平等使得一個病人實際上不可能完全通過協商談判與醫生達成一個契約。患病，疼痛，痛苦，藥物治療和患者的情緒狀態更增加了病人的脆弱性和醫患之間事實上的不平等。這種模型的第二個缺陷是它忽視了“信任”在醫患關係中的作用，縮小了醫患雙方的倫理學要求，只陷於用法律來規定雙方義務，甚至陷入了法律的“條文主義”。單純強調法律的程式，甚至使得程式正義超越了實體正義，而忽視了程式正義恰恰是為了維護實體正義。結果就有可能出現這樣的悖論：為了實現保護患者最佳利益（實質正義）而堅持某種程式（程式正義），其結果恰恰是極大損害了患者的利益。

根據醫患關係的特點：患者處於脆弱和依賴的特殊的地位，醫患關係是一種比較親密或親近的關係，患者的求醫行為不言而喻地隱含著對醫生的信任。因此，醫患關係被視為一種

“信託關係”—— 信任和託付。信託關係有兩個基本性質：一個是醫患關係的“行仁性”，行仁性是強調“醫本仁術”；另一個是醫患關係的“契約性”，契約實行強調醫患雙方平等。這裏的契約性是指醫患關係帶有契約的性質，只是類似一種契約關係，醫患關係與一般的契約關係有所不同。醫患關係一般不是從明確地協商定立某種契約開始，也不是一種在契約生效期間的“短期行為”，而是一種應該努力培養的長期穩定的對患者全面負責的關係。契約是一個法律概念，不是倫理概念，而醫患關係中的契約概念包含深刻的倫理學含義，雙方具有獨立人格，但醫療決策能力有差別；雙方具有不同的價值、信念、利益和目標；雙方關係是自願建立，可隨雙方意願中斷。如果只認識到或只強調其行仁性，而沒有認識到其契約性，可能導致醫療中的家長主義（行仁 — 醫高於患），如果只認識到或只強調其契約性而沒有認識到行仁性，把會將醫學降低到法律條文主義和其最低綱領。

在信託模型中，醫療決策過程涉及到患者與醫務人員的相互信任。患者出於對醫生的信任而把自己的健康和生命託付給醫生。患者一旦進入醫患關係，便賦予醫生診治他的獨特權力。醫患關係的不對稱性，病人的脆弱、無權地位決定了醫生對病人的特殊責任和信託義務，照管他的健康、生命。信託模型也強調病人（非醫務人員的）的目標、價值和願望，但醫生是利用自己的知識、經驗和智慧，作為病人的指導者而積極參與並積極主動地指導醫療決策的。信託模型既承認患者的決策能力也承認患者的脆弱性，因此要提高病人的理解力，方法包括醫務人員與患者公開的交換資訊和富有價值的對話，醫務人員個人對病人安康的承諾。這種模型中，病人與醫務人員將共同承擔結局的責任。

倫理學上勝任的醫務人員能夠值得患者信任來採取行動，以促進受託進行醫療的患者的最佳利益，為了維護患者的利益而工作。醫務人員對病人的“他性”（與自己不同的地方）持開放態度，對他所遇到的種種“境遇”具有敏感性，而不僅僅是擁有醫學專業知識。一個智慧的行醫者能夠認識並採用最好的方法來達到某個目的。醫生應該使用他們的權力負責任地關懷他們的患者，對醫療工作中可能面臨著的種種道德的不確定性給予合理的關注。這就是醫生的誠信。美國醫學專家委員會這樣描述醫生的能力： “醫生應該擁有醫學知識、判斷力、專業精神和臨床與交流的技能，為病人提供優質的醫療。對病人的醫療包括促進健康，預防疾病，診斷、治療和處理病情，對病人及其家屬的同情尊重。醫生應該通過畢生的學習和不斷提高的實踐來維持這種能力”。

醫學的專業精神

專業（Profession）與職業（Occupation）不同。職業是指作為人們常規謀生手段的一項活動，某種行當。專業（Profession），在詞源學上，來自於拉丁語“professio”，意思是對公眾承諾的聲明。“Profession” 是指一群對公眾所期待的社會責任有公開承諾的執業團體。他們與委託人之間的利益關係被界定為信託關係。傳統意義上，西方社會接納四種職業為專業：醫師、律師、教師、神職人員。通常是要求嚴格訓練和專門學習的職業，如法律、醫學和工程專業。社會學家認為，專業是這樣一種能自我調控的職業，它要求通過系統的、有既定目標或學院式的訓練，使執業者擁有專業技能知識，從而提供有倫理準則約束的、規範的服務，而這種服務遠比利益需求的定位要高。專業具有對內和對外兩種

社會學功能：對內，是一種自存自衛的本能——專業共同體通過嚴格的自省自律，採取集體行動來維護專業的壟斷權（執照行醫）以及在在公眾心目中不可替代的地位（公眾的社會期待），諸如設定和強制實施高水準的行業標準、嚴格的專業准入制度等，從而保持專業的誠信；對外，體現服務社會的責任。它要求個體和專業共同體的行為能增加社會福利，推動社會進步，從而強化這種不可替代的社會地位。為什麼專業精神要強調本身對於社會的責任呢？根據社會契約論的觀點，權力和義務是一種類似契約的平衡關係。而專業所以要強調對於社會的責任，是因為在行業領域中，專業擁有排他性的壟斷特權以及由此獲得的社會尊重與信任。專業對社會貢獻的高品質服務也是建立在社會給予的尊重信任和壟斷特權基礎之上的。支撑和引導專業來實現它內在的高品質社會服務功能的是倫理法則。正是基於信託關係的倫理法則內在規定了專業對於社會所肩負的責任。在傳統上，醫學一直高度強調並踐行專業精神：李杲（1180-1251）：“汝來學覓錢醫人乎？學傳道醫人乎？”；趙學敏：“醫本期以濟世” ；徐大椿： “救人心，做不得謀生計”。 “醫學界是一個道德共同體，醫學實踐是一項道德事業，而專業精神則是一種道德承諾。從希波克拉底誓言以來，醫師專業精神一直是醫學專業的核心內涵。” （Frederic W. Hafferty）

今天，世界各國醫療衛生都出現不同程度的危機，在解決醫療衛生福利制度中的問題時，都嘗試運用市場機制。但市場機制運用不適當，過度的商業化，使醫生越來越淡化對病人在道德上的同情心和對社會的責任，出現不同程度的醫學專業精神的缺失。

“商業”本身是一個中性術語。個人經濟獲益並不一定與服務于病人的宗旨不相容，但經濟上的野心決不能壓倒醫學專業的倫理。在美國文化中，醫學一直是商業活動（除了僧侶行醫時），因此永遠產生道德問題。今天的醫學一頭紮入商業之中，醫學的本身的道德高度一落千丈。美國的麻煩是雙重的：“其一，醫療衛生制度是有缺陷的，被投資者擁有的企業和市場競爭所統治，創造了一個新的商業化環境。這種制度與社會和個人醫療需要，與醫學專業精神不相容。其二，新一代的醫生很容易接受市場價值，以代替專業的價值，他們太願意相信醫療只不過是另一種經濟商品，他們只不過是商品“供應者”。這種醫療是令人無法承受地昂貴，不公平，對社會的需要無動於衷”。美國學者Jerome Kassirer在他的“重商主義與醫學綜述” (377-386)中指出，“金錢的吸引力是一個腐敗者，它將我們從對病人福利的關注引開。當醫療商業製造或惡化醫生的利益衝突時，醫療商業化就成為一個問題。歷史表明，醫生的企業家主義（entreoreneurialism）是醫生利益衝突的主要來源。商業化的醫療消除了醫療中的關鍵成分：有益（beneficence），這就失去了醫患信任的基礎。商業化保留了醫學的客觀要素，但這像是感恩節的火雞，失去了心臟。” 雖然在理論上商業化和競爭可能會節省一些費用，但是它對醫療衛生不起作用。而且不可能因此使醫療衛生就更加負擔得起的，不可能使基本醫療衛生更加普遍可及，品質更好。

中國大陸的醫學也面臨著專業精神嚴重流失的挑戰。前衛生部副部長張之強在《我的一生》（2006年版）這樣描述醫院承包制：“此口一開，如大河決堤，‘承包’‘創收’之風大興。醫院承包，科室承包，為了賺錢，花樣翻新。救死扶傷，發揚革命人道主義精神，全心全意為傷病員服務等準則被逐漸置諸腦後，而代之以‘想方設法賺錢’。藥商趁機打入醫院，影響著藥房和醫生；醫生治病，做手術，收取紅包；給病人開大處方、多項檢查；急病一時交不夠押金不收住院，以致延誤治療。凡此種種，名目繁多，最終都是一

個字：錢。”（302頁）

在權力和商業資本達成妥協後，對醫學專業施壓，迫使傳統的醫學專業精神和價值觀受到了市場化壓力的重大影響。政府財政投入不足大大加重了導致醫學實踐過程的過度商業化傾向，腐蝕了醫學的專業精神。醫患之間本質存在的信託關係被扭曲變形，嚴重的甚至淪為赤裸裸的商業關係。醫學只能在專業知識與技能領域保持著權威。醫患之間的互相不信任，醫療糾紛猛增。醫生本應該對合理分配資源負有專業責任，醫生在滿足病人診治疾病需要時，應該是基於明智的、成本效益的考慮來提供治療，避免過多的、不必要的檢查、藥物治療和手術。因為提供不必要的服務不僅使病人遭受本可避免的傷害，加重他們的負擔，而且浪費了本可以提供給其他病人的資源。但是，或出於醫學防禦目的，或由於商業化的驅動，醫生開出過多的不必要的醫療檢查，不僅加重醫療費用，而且造成醫療資源的浪費，藥品和醫療設備製造商對期望投資有合理回報的股東負有最終的信託責任，但如果通過與醫生或醫院建立不正當親密關係增加費用和加重病人負擔，不僅影響了醫學專業判斷和醫療行為的獨立性與無偏倚性，使利益衝突成為一個問題，破壞了醫學科學的誠信，惡化了醫患關係，導致醫患關係緊張到劍拔弩張的程度，也破壞了企業的誠信。醫學作為商業還是專業的界線越是模糊，追求利潤最大化傾向越是影響醫療決策，越有可能的就是：費用的考慮將不正當地影響醫療決策。

自2000年以來，美國以專業精神來對抗腐敗力量。按照醫學的專業精神，醫生的責任是將病人的最佳利益置於首位：（1）經濟考慮永遠不應該影響醫生的決策，不管是在臨床實踐還是在研究之中；（2）醫療資訊必須擺脫經濟糾纏引起的偏見；（3）專業必須負責避免高額醫療費用：（4）如果經濟紐帶繼續存在，那麼一切醫療方案都應該透明，必須努力保護有傷害風險的病人。

2002年歐洲內科聯合會、美國內科協會、美國內科醫師協會、美國內科理事會等共同發起和倡議的“醫師憲章：新千年的醫師專業精神”首次發表於《美國內科學年刊》和《柳葉刀》雜誌。目前為止，包括中國在內的37個國家和地區的120個國際醫學組織簽署了該憲章。醫學雖然植根于不同的文化和民族傳統之中，但醫生治病救人的任務是共同的，這就是憲章的共同基礎。

醫學專業精神要求將病人利益置於醫生個人利益之上，為此需要求制訂培養能力和維護誠信的標準。2002年醫師專業宣言中提出三項基本原則和十項專業責任。三項基本原則包括：病人利益放在首位；病人自主性；社會公正。十項承諾包括提高業務能力的承諾；對病人誠實的承諾；為病人保密的承諾；與病人保持適當關係的承諾；提高醫療品質的承諾；改善醫療可及的承諾；有限資源公正分配的承諾；對科學知識的承諾；在處理利益衝突時要維護信任的承諾；專業責任的承諾。

將病人利益放在首位的原則：是建立在為患者利益服務的基礎上。信任是醫患關係的核心,而利他主義是這種信任的基礎。市場力量、社會壓力以及管理的迫切需要都絕不能影響這一原則。

病人自主性原則要求醫師必須尊重病人的自主權。醫師必須誠實地對待病人並使病人在瞭解病情的基礎上有權對將要接受的治療做出決定。只要這些決定和倫理規範相符合, 並且性

質樣的要求不會導致不恰當的治療, 那麼患者的這種決定就極為重要。在病人同意治療和在治療後醫生必須確保病人完全和真正地知情。這並不是要病人在細節上參與醫療決策，共同做出決定，而是對醫生的治療建議做出決定。

全國乃至在全世界，人們對四川汶川抗震救災中醫務人員所表現出來的那種醫學專業中最深刻的理性的光輝, 最深刻的對人類痛苦的敏感性（同情心）深深地震撼和感動。在災難中，醫生無需在利益衝突和市場力量的困境中做出艱難的抉擇，道德考慮而不是財政考慮成為醫療優先選擇的主要基礎。在這樣的醫療環境中，患者信任醫生，把生命全部託付了醫生；醫生無愧地踐行了醫學專業精神和價值。人們在驚歎醫學專業精神和價值觀迅速回歸的同時，也不斷思考和期待著：紅旗到底能打多久？

重建醫患之間被破壞的信託關係不僅僅在於醫師、醫學專業內部的努力，也需要和患者與整個社會各個力量一起的努力；政府的財政支持與律法的權力支持對於專業壟斷地位也是必須的；必須在體制、資源分配上有所改變。在商業環境中堅持醫學的專業精神是不容易的，過度追求商業化，醫學不僅會出軌，而且會犯方向性錯誤。放鬆金錢霸權，堅持醫生的專業精神和角色，重建醫患信託關係，要求進行深刻的改革，包括重新確定醫療工作和醫療機構的目的和方向。

Public Consultation and Ethical Governance in Taiwan Biobank

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Large scale population base genetic database bank (also called biobank) project has been considered to be one of major governmental medical and healthcare policies in Taiwan recently. The undergoing Taiwan Biobank project that aims to collect at least 200,000 biological samples from the general public, aged 40-70, who are from Taiwan's three main national races has attracted medium attention and caused public concerns. Without sufficient public consultation provided in its preliminary study, the Taiwan Biobank has faced a few waves of criticism from different interest groups such as indigenous communities, human rights association and scholars' challenges. Because biobank issues are complicated and controversial, this paper focuses on the analysis of public consultation and ethical governance issues in Taiwan Biobank.

March 11 Plenary session

Choosing to Enroll: Potential Subjects' Responses to an Ethics Questionnaire for a Phase 1 Study of Deep-Brain Stimulation in Early Parkinson's Diseases

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As part of an innovative Phase 1 study of deep brain stimulation in early stage Parkinson's Disease, we meet with all potential subjects as part of a robust informed consent process. Before our final meeting with these potential subjects, we provide them with two handouts: a three page study-specific information sheet which outlines a series of ethical issues associated with the study, and a three-part Ethics Questionnaire consisting of 13 question meant to help potential subjects assess their understanding of the study and their potential participation in it. In providing these materials, we are explicit that the aim is to help potential subjects reflect on their own decision-making process regarding whether or not to enter into this study in order to better ensure that they make what is for them the best decision. We also invite these potential subjects, if they are willing to do so, to provided us with written answers to the questionnaire in order to help us learn about the decision-making process of individuals facing the prospect of entering into this kind of innovative study. We are explicit that they need not send us this information, and that if they chose to do so, their answers are to be submitted anonymously.

This presentation will report on the initial findings from 12 of the initial 13 subjects(1 chose not to complete the Questionnaire) enrolled in the study (out of a possible 45 potential subjects expressing interest in the study).

After a brief overview of the study, the role ethics consultants play in the informed consent process, and the three page study-specific, ethics-oriented information sheet and a three-part Ethics Questionnaire provided to potential subjects, attention will turn toward the data gathered from the Ethics Questionnaires completed by the 12 research subjects. The data is presented in terms of three broad considerations:(1)subjects' understanding of the purpose, study design, and potential risks and benefits of the study,(2) subjects' motivations for enrolling in the study, and (3) subjects' hopes and expectations when deciding to become a research subject.

Against these data, it will be suggested that especially in early stage research projects, e.g., Phase 1 and Phase 2, greater attention needs to be paid to how potential subjects actually decide whether or not to serve as research subjects.

Current View on Bioethics and Genetics: Genetic Counseling

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Currently, there are over 4000 known genetic disorders and diagnostic tests are available for over 1400 of them. The rapid and constant advances in human genetics, as well as the possibility of prenatal and postnatal genetic analysis for predisposition to diseases, and genetic modification of humans, opens numerous bioethical questions because medical genetics is developing faster than law regulations and public opinion. The specificity of genetic disorders comes from the fact that they, for now, cannot be cured but with the proper medical and psychological support the quality of life can be improved. Genetic predisposition to diseases represents a life-long risk factor which often affects familiy relations and quality of life, including development of depression, tension and anxiety. The availability of more information and more possibilites, including the selection of embryos with favourable „gene maps“ and with decreased risk of hereditary diseases, should facilitate important decisions, from personal to social level. This also leads to the problem of basic human rights of the „less perfect“ concepts in relation to the collective „evolutionary imperative“ for constant improvement of human species. Around us there is an unavoidable pressure on both doctors and parents to make sure that children are born healthy. The development of prenatal tests has promoted the idea that it is a part of responsible parenthood to avoid the birth of a disabled child. It is obvious that through the sofisticated alleviation of human „imperfection“ – that is, through selection of values of human life according to hereditary features – we are returning to the old eugenics through a new approach, through individual eugenics.

The increasing number of hereditary disorders, as well as the increasing interest of medical profession on the role of new genetics in health and disease, emphasizes the importance of genetic counselling, a lifelong process of providing professional and scientific genetic informations, with significant legal and social implications. Due to its distinctive social and psychological importance for an individual or a family, and with it for the society, it is appropriate to say that genetic counselling is also bioethical. This is why bioethics, in its interdisciplinarity, represents a „bridge“ between ethical principles and genetic practice in extremely technologized clinical circumstances. At the same time, the initiation of premature ethical discussions raises the question on the ethics of the discussions themselves due to the fact that they are not based on the competent and detailed knowledge of the problems in medical genetics. This is why the critical area for the 21st century is to increase health professional and public education about genetics/genomics. Therefore genetic counseling might be considered more as patient-education than as actual advice and should include ethical information in addition to medical and social facts. Although in the managment of genetic disorders the prevention is dominant (meaning the prevention of giving birth to a „different“ child), the main goal of genetic counselling is to help individuals and families understand or cope with genetic diseases as well as to provide lifelong medical and psychological support, and not only to decrease the incidence of genetic disease.

Key words: bioethics, genetic counselling, medical genetics, genetic information, new eugenics

March 11 Taichung IIIa. The issue of death and bioethics (I)

Ethics and Palliative Care: An Umbrella Effect
Consultant Ethical Decision Making

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Many of the most common ethics consults are rendered at the end of life. A family cannot consent to withdrawal. A patient cannot give up hope and pushes for futile, in appropriate and burdensome treatment. A patient is suffering unnecessarily because a family does not want their loved one sedated. The question presents itself: are these dilemmas purely ethical, or is there another discipline that may seem more appropriate?

Many systems draw a clear, differentiating line between palliative care and ethics. I propose an ethics program that joins the two. This program creates a standard of assessment that allows for ethics to asses and recommend palliative, in lieu of the prior and similarly, for the palliative care tem to assess and recommend ethics if needed. Inappropriate and burdensome treatment is an ethics issue. Futile treatment does call for an ethics team. An uninformed patient/family seeking aggressive treatment with a non-existent clinical understanding should be evaluated ethically speaking. But the common denominator, the crossover element in these dilemmas is the quality of life factor. And though this phrase can purely be defined as subjective, subjectivity depends on understanding.

In the United States, palliative care is not embraced with the open arms that it offers a hospital and its' patients. Some administrators view it as a money pit, unnecessary, as it is a trend that will pass. But the reality is that as a Neurologist treats the brain and a Nephrologist treats the kidneys, a Palliative physician treats the symptoms. That is their organ. And it is our responsibility as ethicists and advocates to open the healthcare umbrella up to this realm of medicine. Our consults may benefit and our patients will benefit.

DYSTHANASIA – DYING WITH DIGNITY?

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The term «dysthanasia» is a Portuguese expression; it's a neologism of Greek source, in which the prefix «dys» means «an act with mistake», and «thanatos» means «death».

As the opposite of euthanasia (the shortening of life), the term dysthanasia means exessive prolongation of patient's life, and it can often include in itself the prolongation of patient's agony, suffering and finally death. The circumstances of dysthanasia include in themselves no hope for (permanent) cure, therapy by different drugs and application of sophisticated technology. This way of resistance from death regularly happen in hospitals. But there are amny ethical dilemmas: are all available therapeutic means to be used to prolonge a bit a life of terminally ill patient? Is a physician's duty to endlessly maintain the life of a person with irretrievable damaged brain? How to treat the patients with chronic «vegetative» consditions? How fare with insulin with diabetics? When to begin and when to end with dialysis? When to stop with reanimation? These very practical and often questions are tightly connected with dysthanasia.

Is a dysthanasia «good death» or maybe more accurately said «good dying»? Does it mean «a death in dignity»? World Health Organization in its notifications emphasises the need to abate a pain, to decrease a suffer, to end the life in dignity when there are no more chances for permanent cure.

Someone would say the physicians have discovered the old ethical obligation of end of providing useless treatments, after the change of charging the hospital costs. Anyway, the debates on this issue have become more and more intensive. A physician has a right to refuse to provide a useless treatment, even it is requested by the patient. It is obvious a fair distribution of means given to the health system by a community has been becoming more and more important.

Making desicions is a medical treatment useful and can it provide patient's life and health, or it belongs to the domain of dysthanasia, is not rarely difficult. We can hope the discussions of the scientists in bioethics will help the physicians in their final decisions.

BEYOND MEDICAL SCIENCE: PATIENTS' BELIEFS ABOUT THE MOMENT OF DEATH. (970925)

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PURPOSE: Not all beliefs about the moment of death are grounded in medical science. Yet such beliefs surely affect when people think a person has died and how people think the body should be handled. Because no pertinent research exists, we explored those beliefs according to two possible cultural influences—ethnic group and gender.

METHODS: We conducted intensive, open-ended interviews with 26 Mexican Americans (MAs: 14 men, 12 women), 18 Euroamericans (EAs: 7 men, 11 women), and 14 African Americans (AAs: 7 men, 7 women). Content analysis identified themes in subjects' responses. Because not every subject mentioned every theme, percentages sometimes added to under 100%.

RESULTS: Subjects showed limited explicitness and little consistency by ethnic group or gender about which bodily changes they believe signal the moment of death. The heart stops beating, the lungs stop breathing, and the body cools were mentioned most often. Although MA men and EA women divided their opinions among the three changes, AA women mentioned only the lungs stop breathing. Just one subject each among the other ethnic-gender groups expressed an opinion. Two subjects alone mentioned brain criteria.

In contrast to beliefs about changes signaling the moment of death, beliefs about the death state showed some consistency across ethnic groups and genders. A near majority of MA women and majorities of the other five ethnic-gender groups said the soul "goes" or "leaves" the body at death. Significant minorities of all groups except MA women also explicitly described the soul's afterlife in terms of "death-like" experiences they or others had had during comas or cardiac arrests. These experiences were mostly visual but sometimes auditory. In every ethnic group more men than women mentioned such experiences. Furthermore, significant minorities in all six ethnic-gender groups believed the body retains some sentience after death—especially hearing and feeling.

CONCLUSIONS: Our data suggest that beliefs about the moment of death vary widely and cannot be readily classified by ethnic group or gender. No single paradigm, including medical science, appears to explain them all. In fact, our data may not reflect the full diversity of such beliefs. Some subjects here expressed their beliefs; many did not (perhaps because they had not thought about their beliefs or felt uncomfortable talking about them). Thus, health professionals should try to elicit each patient's beliefs and to honor those beliefs in declaring death and handling the dead body.

Table. Subject Beliefs

	MA Men (%)	MA Women (%)	EA Men (%)	EA Women (%)	AA Men (%)	AA Women (%)
Bodily changes signaling the moment of death:						
Heart stops pumping	14	0	14	27	14	0
Lungs stop breathing	7	8	0	27	0	43
Body cools	21	0	0	27	0	0
Soul “goes” or “leaves” at death	64	42	57	55	57	57
“Death-like” experiences	21	0	29	18	29	14
Sentience of the dead body	29	17	14	36	29	14

End of Life Models in Practice：Why Consistency Matters for Patient Care

Helene Anderson RN, BSN, CCRN, Ann Bryant MSW, LCSW,

Bronwyn Evenson RN, BSN, CCRN, Marsha Rice RN, BA and John Tuohey PhD.

Providence St. Vincent Medical Center (PSVMC) is an academic teaching hospital in Portland, Oregon. It is part of Providence Health and Services the largest health care system on the West coast. End of life protocols used as a guideline for the inpatient health care team ensure consistency with practice and patient care delivery. The protocols are designed to reduce risk, ensure the delivery of quality care, support the ethical decision making process and to create an atmosphere of ethical direction. Sample protocols include the Physician Orders for Life Sustaining Treatment (POLST), advanced directives, withdrawal of mechanical ventilation, brain death and organ donation.

The outcomes are measured by an analysis of information collected from The End of Life Family Survey. This survey is mailed to all families of patients who die in PSVMC. It helps measure family satisfaction with this important inpatient experience. The satisfaction data can then be linked to practice standards reinforced by the protocols for end of life care. Providence St. Vincent was awarded the national 2003 Circle of Life Award for exemplary delivery of end of life care.

When end of life protocols for practice are followed by trained staff, care plans can be more easily developed for a variety of unique situations which can be laden with difficult ethical issues. Patients and families are more likely to develop confidence in the care team because of the consistency that is enhanced by the utilization of these protocols.

Keywords： End-of-Life

THE DIGNITY OF AN UNBORN CHILD -A Bioethical Position against Abortion

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The paper consists of two sections. In the first section the author validates the definition of abortion as homicide. Following the Christian tradition, the author embraces the brilliant analyses of Pope John Paul II. According to the fundamental moral obligation of humanity, abortion is a highly condemnable act by a human being. In the second section the author examines the underlying biological, thanatological and ethical arguments in favour of the dignity of an unborn child. The author concludes the following: humanity is obligated to put an end to the incredibly dangerous justification of abortion because, according to the author, abortion is one of the most fundamental problems of contemporary civilizations

March 11 Concurrent Session Taichung III.b. The Issues of Death and Bioethics (II)

End of Life Situations: Indian Religious and Utilitarian Perspectives

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Hindu philosophy tells, of a long-held belief that every person is born with a fixed deposit of breaths and dies as soon as that number of breaths has been taken. In today's spinning-out-of-control modern medicine, this concept is fast losing relevance.   Life and death are no more looked upon as mystic events.   Traditionally Indians have been fatalistic in their outlook. In India people looked at death as the final act to be lived through at home surrounded by near and dear ones, bidding final good byes. Then progress ushered in an era of machines and tubes, which made it possible to prolong life processes. Often in modern medicine, we come across situations where life can be sustained indefinitely, but without a meaningful existence. Who should make such a decision, regarding postponing the inevitable - doctor or patient? In the Indian context, patient looks upon a doctor as Vaidyo Narayano Hari, meaning that the doctor is embodiment of God, who should guide them in their time of need, through his wisdom. This adds burden on doctors to understand and construe not just the wish of the patient but of the family of the patient as well.

India is a land of different religions.   Most religions, still believe in doing one's best to save the life of the patient. The Karma theory comes in the way of the Hindu and the Buddhist way of thinking which does not allow life to be cut short in any way.   If life is cut short, then the soul has to take rebirth again to complete the cycle of birth and death, and can be redeemed only when all the karmic debts have been repaid. The cost of keeping a person on life support systems can be unaffordable to many families, yet some face huge hardships to continue on life support for a few days more, expecting some supernatural force to intervene. Although autonomy of the patient is venerated in the developed countries, in India the ground reality is different. The physician is torn between his duty to inform the patient on one side and the family's wish that physician should make the decision on behalf of the family, without directly involving the patient. At the level of decision making for the family, what are his parameters - quality of life, the wish of the patient, or of the relatives, the financial burden to the family?

In a resource limited settings of a religio-cultural pot-pourri, should there be a different hierarchy of bioethical principles? Despite, patient wanting to be on the ventilator for as long as he or his family wishes, in the event of his not affording, can we say the principle of utility takes precedence over autonomy? Especially if these decisions are to expected to be made by the doctor since patient/family are not in a position to decide, won't the burden on doctor be too cumbersome? Our existing bioethical guidelines do not adequately address the utilitarian dilemmas. These issues need to be discussed in public fora, for more awareness.

Ethnomethodological Understanding of End-of-Life Decision Making in Africa

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Background: Increased capacity of health care professionals, armed with improved medical technologies, to sustain life even when there is no hope of recovery has created the need for decision making. With the advancement in medical technology the question of when to let patients die is a subject of debate among physicians, philosophers and theologians. What man value is closely connected with how he views the universe. Value, as perceived in the field, enters mightily into decision-making and influences how make decisions are made. End-of-life decision making is value laden. It arises from the norms and values of society. Hence, it is difficult to understand what role ethics committees should play. This paper explores the context of end-of-life decision making in a rapidly expanding bioethical global age

Methodology: The study utilized an anthropological approach to explore end-of-life decision making in Yoruba culture of Nigeria. Specifically, it aimed at examining the concept of death, cultural beliefs about end-of-life, decision making in end-of-life, factors influencing end-of-life decision making and the role of ethics committees in end-of-life decision making. Thirty In-depth Interviews In Africa, little is known about end-of-life decision making within the context of bioethics. were conducted among young and male and female adult of Yoruba descent in two selected communities. Content analytical approach was used for data analysis.

Result: In Yoruba culture, death is socially constructed being interpreted as “Iku” (meaning: end of existence). It has both physical and social significance. Hierarchy of authority is the basis of implementing traditional advance directive. Socialization, gender, form of marriage, property, patriarchy, religious belief and tradition are the major considerations in end-of-life decision making. Education, public engagement, resource allocation and advocacy are important roles for ethics committees.

Conclusion: Further research into end-of-life decision making strategies will illuminate the diversity of cultural practices about end-of-life decision making and strengthen clinical practice.

End of Life Issue: Viewpoints from Physicians at Taiwan

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A law for palliative care and do-not-resuscitation (DNR) was passed by Legislature Yen in 2000 and revised again in 2002. This study was designed to evaluate the physicians' viewpoints about DNR and tracheotomy related issues among the students and staffs in a medical center at Taiwan.

Methods

Two cases seen at Neurological Ward and ICU, National Cheng Kung University Hospital were presented in a special lectures about ethics and patient-physician communication. The answers to four questions related to DNR, tracheotomy, persistent vegetative state (PVS) were collected and analyses.

Results

There were 82 persons joined the study, including students, residents and visiting physicians. The appropriate response to the families' request during the end-stage of disease, especially after DNR was signed, was found only in 56% of attendants. The understanding of the difference between the DNR signed by the patients and by the families was even less satisfactory (43%). They were relative better in differentiating the clinical meaning of tracheotomy and PVS announcement timing (65% and 74% respectively).

Conclusion

A short course containing issue of end-of- life care like hospice, brain death, PVS, and DNR; using case demonstration may be helpful for clinical application of terminal management among the physicians.

ASSISTED REPRODUCTION TECHNOLOGY (ART): THE MALAYSIAN EXPERIENCE

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It is interesting to note that in Malaysia, the concept of assisted reproduction technology has been gaining popularity since its inception in early 1990's. This could be attributed to the mushrooming of ART centers in the country in both government and private hospitals. Till date, there are more than 30 such centers in the country. Although there are some initial cultural resistances amongst the Muslims, however with the issuance of the fatwa (religious doctrine) from the National Fatwa Council in 1982, which states that test-tube babies are deemed legitimate as long as certain requirements are followed, the demand for ART has been increasing from year to year. As for Non-Muslims, consisting of Buddhist, Hindus and Christians, the overall opinion is that it can be done to treat infertility.

There are no laws specifically dealing with assisted reproduction technology in Malaysia. As such, ART centers have from time to time sought assistance from the Ministry of Health for guidelines and directives. Fortunately, in November 2006, The Malaysian Medical Council has issued a Guideline on assisted reproduction. The Malaysian Medical Council is a statutory body set up under the Medical Act 1971. Thus, the Guideline has the force of law to be read in conjunction with, the Medical Act and Regulations and Code of Professional Conduct 1987 issued by the said statutory body. This article will summarize the gist of the guideline with reference to the practice of ART in Malaysia.

Disease and discrimination --- a case of Hansen disease in Japan and Taiwan

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Hansen disease is a disease that has been discriminated severely all over the world. Leprosy prevention law in Japan constituted in 1907. Then five public leprosaria were built. And the law in 1931 was revised to pick up the patients to leprosaria compulsorily. This is named Mu-raiken movement. Citizen and officials had deprived the human rights from the patients. The law had been kept on for about 100 years after the world war II till 1996.

In Taiwan a public leprosarium Rakuseien was built in 1930 under the rule of Japan. And patients had been isolated compulsorily according to the Japanese prevention law. Discrimination had been severe. But after the war the compulsive isolation was abolished and the patients have been treated at the hospital as outpatients. I will consider that Japan and Taiwan have something in common and in difference.

March 12   Plenary Session

What Does Method Contribute to Ethics Consultation?

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Abstract

This paper distinguishes the theoretical and practical approaches to the question: “What does method contribute to ethics consultation?” I argue that theoretical approaches do not address the central features of ethics consultation as a practical activity; rather, they accept and idealize certain features of cases, which removes them from their location in the actual social settings and life-world within which they are situated. In contrast, the practical approach views ethics consultation as an activity that involves complex communications between stakeholders and complex processes of interpretation. I conclude with a discussion of the positive contributions that serious attention to method brings to ethics consultation as a practice.

March 12 Concurrent Session Taipei I.a. Ethics Consultation (I)

Full, Partial or Non-Disclosure of medical information to patients

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It often happens in our clinical settings that families of patients request the clinical staff to not fully disclose information to a patient, or to do so using veiled language so as to avoid specificity about a disease or prognosis. The most common explanation given by a family for this is that such information would not, in their own country, be shared with the patient, that symbolic language would be used, or that the information would be less than specific or explicit. In the United States, the norm is for patients to receive full and detailed information about their clinical status. A tension results when the two cultures of care come together at the bedside.

A common way of resolving this issue is to obtain what is called ‘informed refusal’ from the patient for receiving such information. In this way, it is said, the culture is respected and our ethical norms are followed. In fact, I will suggest that this refusal is not ‘informed,’ and in fact this practice does not respect the patient’s culture, but merely tolerates its approach when that can be justified by western values.

This presentation will explore, analyze and critique the way we here in the United States navigate the cultural divide between a perceived absolute value on the one hand and a relative value open to cultural adaptation on the other. Themes of deception, information management, and conspiracy to hide information, communication and clinical integrity will be explored.

Utilizing A Multidisciplinary Approach To Create An Effective Ethics Consultation Team

Helene Anderson RN, BSN, CCRN, Ann Bryant MSW, LCSW,
Bronwyn Evenson RN, BSN, CCRN, Marsha Rice RN, BA and John Tuohey PhD.

The benefits of a multidisciplinary Ethics Team include a reduced ethical risk by reducing error and enhancing patient safety, improved quality of care, building of morale / ethics confidence, increased efficiencies, and an environment of ethical leadership. By positioning bedside nurses within the consult team and within the context of a broader ethics education program, the team is more effective. Incorporating case managers and pastoral care team members with those directly caring for the patient assures that ethical issues are directly integrated into the plan of care.

This presentation describes the development, education, and implementation of an ethics team that depends heavily the multidisciplinary team. It meets the standards set by the Society for Health and Human Values, The Society for Bioethics Consultation Task Force and other accrediting agencies.

First, the design of the Ethics Team will be described followed by an in depth review of the required educational modules. Members of the consult team attend weekly meetings and are mentored by the director of the ethics center. During these sessions, members of the team learn to lead a consult in order to: organize the case around explicitly ethical criteria, bring clarity to articulate key questions, define terms/ concepts, identify and balance various interest / concerns present in the case, and assist in developing and evaluating a care plan that reflects the ethical considerations raised.

Implementation and maintenance of the program will then be described. The conclusion of the program will include a facilitated discussion with participants. This session is relevant for any bedside nurse who addresses ethical dilemmas in their clinical practice.

Keywords: Ethics Consultation Team

Mechanism of Ethical Consultation

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Implementing the functions Medical Ethics Committee has been a focused emphasis of the UNESCO in recent years. Almost all the medical centers in the developed and developing world, this committee has been established to provide service and to promote medical care quality. Among the functions of medical ethics committee, namely, education, policy and guidance recommendation, case study and consultation, this later one seems to be most practical in a personal sense to help each individual solve clinical doubt and dilemmas. This presentation will share the findings of my interviews with five individual physicians in Canada of how they respond to the mechanism of consultation and comment on it.

Post-Modern Bio-Ethics and the Death of Taiwan's Society

Fr. Louis Aldrich 艾立勤
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This paper will have three major parts. First, we will present an overview of the statistics that show Taiwan is trapped in what demographers call the "second demographic transition": prolonged below replacement level reproductive rates. Taiwan's present reproductive rate is about 1.1, only half of the 2.2 necessary to maintain its current population. At this rate, Taiwan's population will halve each generation. Adding to this problem will be the radical aging of the population: an increasingly greater number of the elderly must be supported by an increasingly smaller percentage of working people. An additional problem for Taiwan is the unbalanced ratio of men to women; women between 18 and 45, because of selective abortion, will no longer constitute their normal 50% of that population cohort. If this population implosion is not corrected, the present Taiwan society (democratic and economically developed) will simply die, or the present "Taiwanese" will be replaced by non-Taiwanese (mainland Chinese or Philippinos).

Second, we will argue that Taiwan's becoming trapped in the "second demographic transition" is directly related to the government and media promoting a post-modern bio-ethical agenda. Demographers tell us that certain conditions are necessary for the "second demographic transition" to come about: widely available, effective contraception; freely available abortion as a back-up to failed contraception; a sexual liberation ethos that accepts pre-marital sex and co-habitation in place of marriage. The results of effective conrtraception, freely available abortion and sexual liberation are fewer people marrying, those who do marry marrying later, and those who do marry having fewer children or no children. It is this combination of results that has lead to the 1.1 reproductive rate with which Taiwan now suffers. Demographers tell us that till now no society that has entered the "second demographic transition" has emerged from it. In fact, Japan, the nations of the European Union, Singapore, Russia, etc., are also trapped in a population implosion that each recognizes as a serious problem, but till now have been powerless to reverse.

Third, we will examine various, till now, failed attempts to reverse the population implosion characteristic of the second demographic transition-- child allowances, child care for working mothers, bonuses for each birth-- and ask if it is possible for these policies to ever work as long as the government and media continue to promote a post-modern bio-ethics: promoting contraception, abortion and sexual liberation as positive rights for each citizen. We will offer some examples of groups within developed nations with healthy reproductive rates: these groups tend to be those whose religious or moral values strongly support the natural family. Because the starting point of post-modern bio-ethics is not the natural family as the foundational unit of society, but rather individual self-determination, we will ask if such a bio-ethics can ever save Taiwan from its present slow march toward societal death.

March 12 Concurrent Session Taipei I. b. Consultation and Research Ethics

The Advantages Of Centralized Ethical Review Process Of Clinical Trials: Croatian Experiences

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With the adoption of EU Clinical Trials Directive in 2001, the implementation of Good Clinical Practice in the conduct of clinical trials was set on the European level, including the description and enforcement of the responsibilities of ethics committees. Although the ICH E6 Guideline on Good Clinical Practice and the EU Clinical Trial Directive pose standardised requirements on independent ethics committees concerning their roles and responsibilities, the organisation of their work differs from country to country. Until 2004, opinions on clinical trials in Croatia were issued on local level, by the ethics committees of the institutions in which the clinical trial was conducted. And although the legal requirements on what is required for a favourable opinion were set, diversities in their interpretation were seen. This than caused variations, both in the information that the committees wanted and their time to respond. Since 2004, all clinical trials in Croatia, both unicentre and multicentre, have to be reviewed by the Central Ethics Committee and a favourable opinion must be issued before a clinical trial commences. Croatian Central Ethics Committee is an independent committee of 19 members, including medical doctors from various field of expertise, a representative of patients, a theologian and a lawyer. During the procedure, Central Ethics Committee assesses both the scientific and the ethical considerations of the trial, including qualifications of the investigators, institutions and monitors, the insurance, and the methods and amounts of payments. Opinions on clinical trials are issued in 30 days from the date of a valid application. Since December 2007, Central Ethics Committee is also responsible for issuing opinions on non-interventional trials. Based on previous arguments, the advantages of the Central ethics committee are obvious: single application form, standardised requirements, standardised assessment, no variations in time-to-respond, single point of contact and a single database of clinical trials. This brings us to the conclusion that the model of centralised ethical review process is suitable for smaller country such as Croatia and that it allows an efficient and standardised assessment.

Physician’s Perspectives on Patient Autonomy in University Hospital of Confucian Culture

AHN, Ducksun M.D.,FRCSC, M.A.(Lit), M.A.(Bioethics), Pg.Dip.(Med.Ed)

Confucianism is still accepted as a social norm in South Korean society. As a political theory, Confucianism proposes a system of benevolent paternalism, which extends to all relationships- including the one between physicians and patients. Patient autonomy, however, is not usually advocated in Confucian culture; therefore, the current institutional value of the Western model of ‘respect for person’ is in question.

To explain the current controversial value of autonomy in a Confucian context, it is necessary not only to understand the underlying socio-cultural and socio-historical aspects of South Korea, but also to explore relevant empirical data. A brief history of Korea is presented here, arbitrarily divided into pre-colonial, colonial, and post-colonial periods. Some distinct features of Confucianism, society, and medicine in South Korea are described in relation to the concept of autonomy.

For the purpose of empirical data collection, the semi-structured focused group interview was chosen. Doctors’ perception and practice on “patient autonomy” and its moral value in Confucian culture were explored in two university hospitals. By doing so, doctors’ concepts of “patient autonomy” were put into perspective. Several themes from the interview data which are central to the Western concept of patient’s autonomy in a Confucian context were categorized and discussed.

The Western principle of autonomy is still in its infancy in South Korean society. Current doctors’ perception on patients’ autonomy is culturally very relative and contradictory. Respecting patient autonomy is not quite yet real in practice, but is pervasive in principle. However, compelling evidence suggests that young doctors value autonomy even though there is no clear cut demarcation between patient autonomy and family autonomy in the current South Korean society. Finally, as South Korea become more democratized, it is acknowledged among doctors that current negative cultural tendencies collide significantly with the new culture of globalization, of increasing individualism, of the Internet era, and with a growing degree of awareness of patient rights by South Korean citizens.

A Theory of Family-Centered Bedside Consultation

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In contrast to the west, physicians in Taiwan usually have to deal with not only the patient but the patient's family as a whole. It may lead to some improper intervention of the treatment and jeopardize the rights of the patient. However, it has the benefit that proves to help both the patient and the physician in their decision making if properly handled. This paper tries to show how it is reasonable and effective in bedside consultation. It will present a moral reason why the Chinese and in particular the Confucian regards the treatment of the patient is not sheerly the personal business of the patient, but the family business as a holistic group. Intimate family relationship has its bearing upon our moral deliberations. The conflict of interest between family members is properly dealt with a Confucian solution is proposed and argued. The contribution of such a model to the benefit of the patient as well as to the lessening of the burden of the medical profession at critical decisions is presented in comparison with the patient centered model.

The Problematic Conflict between Dual Commitees on Animal Experiments in Korea

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According to the article 7 of Korean Experiment Animal Law, which was enacted in March 2008, animal experiment facilities shall institute and manage an operating committee so as to ensure ethics, safety and reliance of animal experiments.

However, prior this new animal experiment law, Animal Protection Law, which was amended in January 2007, in article 14 prescribed that animal experiment facilities shall have an Ethical Committee for Animal Experiments for contriving protection of experimental animals and ethical treatment on animals. Both law delegate decisions on what animal experiment facilities are to each presidential decree.

In general level, people agree that if one animal experiment facility has two committees, it would make situations complicated and work of both committee overlapped.

Nevertheless, in practical level, two ministries, one of which is the Ministry for Food, Agriculture, Forestry and Fisheries(FAFF), and the other of which is the Drug and Food Safety Administration(DFSA), insist that an unified committee shall be charged to themselves, so under their controls.

When it comes to interpreting relation between Experiment Animal Law and Animal Protection Law, DFSA explains it as general law and special law. Conversely, FAFF considers that two laws are redundancies.

Examining this systematically conflicting situation on animal experiments, this research has a purpose to analyze a phenomenon of conflicts between laws.

Key words : Animal experiment, Animal welfare, Conflict of law

March 12 Plenary Session

WHY DO CLINICIANS CONTACT CLINICAL ETHICS COMMITTEES?

A SURVEY

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Background All Norwegian hospital trusts have a clinical ethics committee (CEC). Section for medical ethics (SME) at the University of Oslo is given the responsibility to secure the quality of the work of these committees. In 2004 an evaluation study was done. Part of this evaluation was done by interviewing clinicians who had brought cases to be discussed in different committees. The clinicians appreciated that the cases were discussed systematically, but they wanted to be present during the discussions. In 2008 we (SME) have done a new evaluation study, but now with more clinicians and more committees.

Method A questionnaire which includes questions used in the 2004 study was sent to all Norwegian CECs. The committees were asked to contact the clinicians who had submitted cases involving particular patients during the last 18 months. The questionnaires were anonymous and were to be returned directly to SME by the clinicians. The clinicians were asked why CEC was contacted, what kind of ethical problem they had, how their expectations were met, and what kind of procedures the CECs had used during the deliberation. Critical comments and suggestions for improvement were welcomed.

Results Most clinicians found this service of the CEC useful, but some were also rather critical. This presentation will present more results from the study in order to learn which factors clinicians may find meaningful and useful and what they disfavour when their ethical problems are discussed in a CEC.

Cultural difference and ethical decision-making among clinicians: the experience of international doctors working in the UK

Anne Slowther

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Abstract

Clinical ethics consultants and clinical ethics committees need to possess a range of competencies to provide effective advice and support to patients, families and clinicians. One important competency is an awareness of, and sensitivity to, diverse cultural perspectives that may influence ethical decision-making, particularly in a multi-cultural society such as the UK. The need to consider a different cultural perspective will usually arise when an ethics consultation involves a patient or family from a minority ethnic background. However it may also arise when the clinician involved is from a different culture or indeed a different society.

The UK has a long history of international doctors coming to work in its health care system. The General Medical Council, which licenses all doctors who work in the UK, records registrations of doctors from many different international jurisdictions. In addition there are an increasing number of international doctors who have refugee status in the UK. There is some evidence that ethical decision-making in medical practice varies across different jurisdictions and cultures, particularly in the area of end of life decision-making and consent/information sharing, Doctors coming to work in the UK may be faced with a different societal culture and an unfamiliar health care system, both of which will shape their experience of ethical practice. Information provided prior to working in the system may not be sufficient to prepare them for what this actually means for them in practice. In order to develop improved methods of supporting doctors in their transition to working within the UK ethical regulatory framework it is necessary to understand more fully both the difficulties they perceive in this process and any potential mismatch between their knowledge and attitudes and those expected of doctors practising in the UK.

We are conducting a study funded by the UK General Medical Council, to explore the experience of doctors who have qualified outside the UK in working within the ethical regulatory framework and ethical culture of UK heath care practice. The study uses a combination of qualitative interviews with a sample of non UK qualified doctors from ten jurisdictions and a questionnaire survey of both UK qualified and non UK qualified doctors. This paper will present the findings of this study and reflect on the implications of cultural diversity among clinicians as well as among patients for the health care system as a whole and for clinical ethics support services in particular

March 12 Concurrent Session Taipei II.a. Ethics Consultation (II)

Evaluating the impact of clinical ethics consultation: a systematic review and critical appraisal of methods and outcome criteria

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Background: During the last three decades ethics consultation has been implemented in numerous hospitals and other health care institutions in North America and Europe. The clarification of ethical issues, facilitation of the decision making process and the improvement of patient care have been defined as goals of clinical ethics consultation. The impact of clinical ethics consultation has been object of a number of evaluation studies. This paper presents and discusses the results of a systematic review on methods and outcome criteria which have been used in evaluation studies of clinical ethics consultation.

Method: Systematic literature review on evaluation studies investigating the outcome of ethics consultation using the PUBMED database. In addition a search of bibliographies of relevant articles identified via the PUBMED research had been performed. As a final step of literature research the bibliographies of all first authors of relevant articles identified up to this point were reviewed for further relevant publications. A content analysis of full text of all relevant articles was performed.

Results: 14 relevant articles could be identified, 13 of them had been published by researchers from the USA. One study conducted by a Norwegian research team as well as one study conducted in the USA used a qualitative research approach whereas all other studies predominantly used empirical-quantitative methods. In the majority of studies satisfaction of patients, families or members of the health care team with the ethics consultation service had been used as outcome criteria. Mortality, intensity of treatment, days in hospital/intensive care unit had been used as objective criteria to determine the impact of ethics consultation.

Conclusion: The use of satisfaction of consultees as well as objective criteria such as days spent on the intensive care unit as outcome criteria beg questions with respect to their relevance for normative conclusions regarding the value of clinical ethics consultations. With respect to the methodological approach used there is scarcity of qualitative research. The use of such methods may provide valuable insight with respect to factors which contribute to a clinically relevant as well as ethically appropriate impact of ethics consultation

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Consultation on Organizational Core Values

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The ethics service of Eastern health carried out an extensive consultation to articulate the core values of the organization. This consultation was stimulated discussion, allowed for education and provided a substantial foundation for the ongoing ethics education, policy review and development and case consultations.

This session will describe the structure, process and outcomes of the organizational core values consultation.

Capturing The Role As An Ethics Consultant: An Authoritarian Or A Facilitator

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Following the modernity and advanced technology development, ethics consultation has become increasingly important and complex in clinical setting. The purpose of this presentation tries to introduce the potential role characteristics and core knowledge and skills for being a health care ethics consultant from introducing the western references and identifying some current indigenous knowledge development in this field. This presentation is divided into five main sections which include: 1) define the nature and goals of ethics consultation, 2) discuss the qualification and conceptual model for being an ethic consultant, 3) identify the types of knowledge necessary for being an ethics consultant, 4) provide the types of skills for conducting ethics consultation, 5) introduce the character traits and educational training for the ethic consultants, 6) discuss the potential difficulties of being an ethics consultant in Taiwan. It is hoped not to totally adopt the western model but aims to build up a more comprehensive perspective including a solid scientific and humanistic based knowledge for becoming an ethics consultant in this country. The further indigenous study and real practice evaluation are needed in order to promote the quality of health care in Taiwan.

Key words: ethics consultant, knowledge, skills, role characteristics

ETHICAL ADVICE FOR IMMUNIZATION: CASE STUDY

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In 1994 report “Vaccinoprophylaxis and Human Rights” had been published by the Russian National Committee on Bioethics of the Russian Academy of Sciences. The report dealt with rather controversial issue – state policy in the field of immunization. Authors of the report analyzed current practices of immunization in Russia. More specifically, they talked about mass, almost universal and obligatory inoculations of children, which were carried out even without assaying kids’ immune status. There was a lot of information about cases of adverse effects, postvaccinal complications resulting from such practices. At the same time, however, there was no effective system of registration of such cases and, respectively, of more or less reliable statistics of the complications.

The main role in preparation of the report was played by virologist Galina Chervonskaya. After the report was published she became very actively involved in protection of human rights, first of all – of parents’ right to make free and informed choice in matters of vaccination of their children. New grounds for such activities were generated by the Federal law “On Immunoprophylaxis of Infectious Diseases”, which was adopted in 1998. Chervonskaya was actively involved in drafting of the law, which includes many essential norms, aimed at protection of rights of children and parents.

Despite the law was adopted more then ten years ago, it is still rather difficult to ensure its fulfillment in everyday life. One of the problem consists in the fact is that in many cases not only parents but health professionals and personnel of preschool institutions as well do not know about its existence and, consequently, its content. Yet there a lot of problems in current Chervonskaya holds a lot of consultations not only for parents, but for medical professionals as well. She gets invitations and visits many Russian cities. During her consultations she tries to explain medical issues, such as possible risks associated with inoculations and consequences of refusal from inoculation; legal issues, such as parents’ right to request information about goals of inoculations and associated risks, their right to refuse from an inoculation, means to ensure the right, and possible social consequences of their choice; ethical issues, arising in the context of interrelations between parents and health professionals.

RESEARCH ETHICS IN PERINATAL MEDICINE

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The fundamental dilemma of medical research is that because progress results from experimentation on human subjects, the few are put at risk in order to benefit the many. How can we minimize the disadvantages while maximizing the advantages?

We will discuss three vulnerable groups which require additional regulations: pregnant women, the fetus, and the newborn. First, pregnant women are vulnerable for obvious reasons. Second, regardless of whether the subject of the study is the mother or the fetus, the fetus is vulnerable—and unable to give consent. The inability to give consent also holds true for our third group--newborns.

This does not mean, however, that women of reproductive age should be excluded from clinical trials. Although, perhaps as an over-protective measure in response to the Nazi horrors, women of reproductive age were excluded from clinical trials, this stand has proven to be discriminatory, and so was later abandoned. Studies on pregnant women and fetuses have been the source of several medical breakthroughs. Thus, the point is that the risk to women of reproductive age should be minimized; and, further, that in event of pregnancy, the decision whether or not to terminate may not be made by the investigator.

With respect to the fetus, the parents must be fully informed on the risk vs. benefit of the proposed study. However, studies whose purpose is to benefit the pregnant woman at minimal risk to the fetus, require only the pregnant woman’s consent. On the other hand, where the purpose is study of the fetus and the risk is greater, consent is obligatory from both parents.

On this issue, one more point ought to be kept in mind: when we speak of risk to the fetus, apart from immediate effects, the researcher must consider long-term ones as well—particularly malformations which might appear only after a considerable lapse of time.

As for our final group, newborns, three conditions apply. First, in cases where viability is uncertain, the newborn may be used as a subject if the study carries no additional risk and the aim of the study is to increase the viability of such subjects. Second, cases in which the newborn is *not* viable *may* be used for study if and only if the expected data can not be obtained from other groups, the patient’s life is not prolonged artificially, and both parents give their consent. Third, newborns who can survive are classified as children, for whom a separate set of rules apply. Furthermore, the use of the placenta and aborted fetuses also require the woman’s consent.

In conclusion, investigators must respect the person, whether it is the mother, the father, the fetus, or the newborn. Researchers must further minimize the risk and maximize the benefits for all parties concerned. And finally, those engaged in research must abide, not only by the Helsinki Declaration, international regulations, but by local laws as well.

March 12 Concurrent Session Taipei II.b .Consultation and Research Ethics

An Ethics Framework to Resolve Challenges in Providing Appropriate Care

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The ethics service within Eastern Health had a series of case consultations on medically discharged patients, transfer of clients within the regional authority, placement of difficult clients, people living at risk in the community, and uncooperative clients and substitute decision-makers. An ethics working group prepared ethics guidelines on providing appropriate care across the continuum. The ethical principles and concepts articulated have contributed to resolution of many patient flow issues and provided a framework to balance autonomy, best interest, risk, and fairness. The ethics consultation service and clinical efficiency staff collaborated to forecast problems, find solutions, collect data, and inform the organization about appropriate care.

This session will highlight the guidelines and ethics framework developed and used within Eastern Health. This initiative was recognized as a leading practice by the Canadian Council on Health Care Accreditation in the fall of 2007.

Model of Regulation on Medical Innovation/Medical Research from the Viewpoints of Comparative Law

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The area of life science is very dynamic and flexible. Symbolic Event is a invention of iPS Cell by Prof. Yomanaka in Kyoto University (2007). In the Post Genome Era, it may be disadvantages for mankind that the law regulates too strongly the activities in this field, because it obstructs the progress of life science or medicine. And it concerns the problem, if it is against freedom of study and research (Art.23 of Japanese Constitution). On the other hand, freedom of study and research is not unlimited.

Prof. Koichi Bai , who is the most famous scholar of medical law and founder of medical law in Japan , has already pointed out 3 points on this problem in 1974. 1)Awareness of the margin of legal intervention into natural facts and progresses of natural science. 2)Role of law in adjusting conflict between one interest and the other interest. 3) Awareness of positive meaning of legal approach, or guarantee and establishment of fundamental rights. This perspective is very useful also now.

In this presentation, I discuss with objects of regulation by classifying (a) objects to regulate clearly (e.g. Crime, abuse of eugenics, genetic discrimination etc.), (b) objects to promote (e. g. genome research etc.), (c) objects to permit with conditions (e.g. therapeutic cloning, ES-cell, stem cell, iPS-cell etc.) from the viewpoints of comparative law in connection with bioethics..

Healthcare Ethics Committees: A Systematic Review

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In 2005 the Universal Declaration on Bioethics and Human Rights stated that “ethics committees should be established (…) to (…) provide advice on ethical problems in clinical settings”. The historical precedents of ethics committees in hospitals and health care centers date back to the 60's and 70's in the United States. During these last 40 years, many have debated the function, duties, qualifications, and composition of such committees. Healthcare ethics committee are the practical point of view of bioethics himself, and have been established in many countries around the world. However, we have not been able to identify any systematic reviews concerning the prevalence of HEC internationally.

Based on a systematic review of the literature, and in an evidence based analysis, this study reviews the prevalence and implementation of healthcare ethics committees internationally, their composition, functions, and outcomes, and the identify other types of ethics support (individual ethicists, etc). The analysis is descriptive and comparative.

The large majority of the identified prevalence studies are from North-America and Western Europe. Findings indicate that healthcare ethics committees have been developed first and foremost within hospitals in North America, Europe and Australia. In some countries, committees function as Institutional Review Boards in addition to performing healthcare ethics committees tasks. The HEC prevalence reported and the scarcity of published information in many countries, indicate that universal access to HEC is far from accomplished

Key words: ethics committee, ethicists, ethical review, ethics consultation.

Rationality of Refusing Treatment: Clinical Ethics Conference at the Department of Emergency Medicine

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In some large hospitals in Japan a clinical ethics conference is regularly held as well as medical case conferences in each department. Although the topics dealt with are mostly associated with patients at the terminal stage, other clinical settings like fertility treatment, obstetrics, pediatrics or neurology are faced with hard ethical decision making. As a member of the clinical ethics conference at the department of emergency medicine I will focus on the case of a patient with mental disorder brought into the hospital due to serious burns from failure to commit suicide. My presentation is based on the discussion at the conference and the related consideration in line with such points at issue as the rationality of refusing treatment, validity of compulsory treatment and care plan for the patient after leaving hospital.

Race, Ethics and Clinical Trials

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Minority groups, particularly blacks in the United States, are assumed to be genetically predisposed to virtually all common chronic diseases. Genes are regularly proposed as the cause when no genetic data have been obtained, and the social and biologic factors remain hopelessly confounded. .Ethnicity is a catch-all term that describes a set of lifestyle/behavioral/cultural experiences. In racially stratified societies, culture, genes, and environment are strongly confounded. In practice, the term "ethnicity" often functions as a stand-in for race and refers to both potential genetic factors and acquired effects of environmental exposures. Although the term may remain indifferent about whether genetic and environmental effects are causal, its lack of clarity about which of the explanations is primary often leads to confusion. Because ethnic-specific trials assume that some inherent factor in the patient influences the response, interpretation would be easier if that factor was defined, and the results could be more easily generalized to other subgroups that shared that factor. When possible, therefore, the rationale for an ethnic-specific trial should be supported by arguments that distinguish between genetic or environmental effects. Otherwise, restriction of enrollment using such a "fuzzy" category could be an unreliable tool in clinical trials.

This presentation will look at the ethical dilemmas posed by this issue through a case study of the approval process of the first clinical trial of a race-specific drug in the U.S.

March 13 Plenary Session

Challenges for Clinical Ethics as It Develops Internationally

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This panel will focus on some of the challenges that clinical ethics faces as it develops internationally. Among these challenges to be discussed is, first, ***a*** tendency for ethics committees to be established as “alibi committees” rather than robust change-effecting bodies. Second, the degree to which defining what kind of preparation is necessary for individuals to perform ethics consultation is an issue. Is there an emerging consensus or disagreement about the responsibilities of clinical ethics consultants? Third, to what degree, if any, should ethics consultation be clinical, that is, engaged in the daily care of patients and conversation with relatives rather than functioning at a distance such as an ethics committee review of cases?

EVALUATION OF CLINICAL ETHICS CONSULTATION – AN ALTERNATIVE APPROACH

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Section for Medical Ethics University of Oslo

Background In 2000 the Norwegian parliament decided that all hospital trusts should have a clinical ethics committee (CEC). Section for Medical Ethics at the University of Oslo is given the responsibility to strengthen the quality of the CECs' work. Evaluation is part of this. In 2004 a survey indicated that the CECs work very differently. In the years thereafter we made a manual for the work of the committees and in particular recommendation as to how individual patient cases should be dealt with. As a follow up we in 2007 conducted a new study to compare the work of the committees.

Method All (34) CEC received an anonymous case dealing with life prolonging treatment to a severely ill youth. This case had previously been referred to and discussed in one CEC. The committees were asked to discuss the case the way they do in ordinary prospective cases and to write a report on their discussion.

In addition the CECs were asked to fill in a short questionnaire about where the deliberation would have taken place if this had been a real case and who would have participated in the deliberation.

Results 17 committees returned the written reports and the questionnaire. The reports followed the same procedure. However, we found that the CECs seemed to assess the medical facts, the diagnosis and prognosis rather differently and accordingly also came to somewhat different conclusions. The committees varied regarding emphasis on patient discomfort or pain, whether life prolonging treatment should be withdrawn or how long one should await the parents' acceptance of the situation. How law was interpreted or whether costs of treatment were emphasized also varied somewhat.

Interpretation This study indicates that Norwegian CECs may have improved their systematic case discussions. That there are still differences among the committee's regarding important aspects of this work, underscores the need for continuous quality improvement work and critical scrutiny of the committees' conclusions.

The 6th ICCEC in Oregon, USA

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Other Accepted Abstract

Ethical Considerations in Bariatric Population and the Impact on Healthcare

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An unfortunate consequence of twentieth century living is the increase of the bariatric population. The cascading medical problems and costs resulting from the obesity are drawing comment and concern from the medical community, schools, governments and population at large. This presentation will examine the information gather at an acute care hospital in the US, which focused on increased numbers of bariatric patients, the questions of prolonged hospitalization and the discussions about restrictions of care. The increase risk of morbidity and mortality in this population raises concern about treatment options, care planning, cost effectiveness and staff safety. We will also examine this population through the lens of the ethical paradigm utilizing justice, autonomy, beneficence and clinical integrity. Those institutional concerns pale in comparison to the overall consequences to the bariatric patient in terms or emotional well-being, acceptance, self worth and overall health.

Keywords: Bariatric

Ethical Imperatives & Considerations: What To Do When Hospital Capacity Exceeds Its Limits

Helene Anderson RN, BSN, CCRN, Ann Bryant MSW, LCSW, Bronwtn Evenson RN, BSN, CCRN, Marsha Rice RN, BA and John Tuohey PhD.

The practice of temporarily closing hospital emergency departments due to lack of capacity, a practice known as going on diversion, has gained national attention in recent years as a symptom of the shortcomings in the US health care system. In the past, crowding led emergency rooms to divert incoming ambulances to other hospitals. Surrounding hospitals often got filled to capacity as will. The delays in our community are the result if the region's booming population growth, the slow pace of hospital expansions, and policy changes limiting how often ambulances are sent from hospital to hospital in search of an available emergency-room or hospital beds. Emergency rooms often are the entry point for patients who need to be moved somewhere else in the hospital. If no beds are available in the intensive-care unit or on a medical ward, the patient must wait in an emergency-room bed.

Diversion systems have been developed to address the limited resources such as the shortage of beds, and qualified staff. These diversion programs carry an ethical obligation to the community regarding access and limitations to available services. There is also an ethical imperative to cooperate within our community to address scarcity of resources with other hospitals that face similar challenges. This presentation will discuss the fiscal impact, emotional distress, using the ethical paradigms as a problem solving method.

Keywords: Ethical Considerations, Divert

Design and Implementation of a national Biobank IT infrastructure in Taiwan

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Biobanks collect biological materials, track clinical outcomes over time and obtain longitudinal information for population genetic analyses and disease progression studies. Taiwan has a relatively homogeneous population in terms of genetic background, a high quality medical service and a nation-wide health insurance system, which are ideally suited for biobank studies. Taiwan Biobank Project was launched and initiated with a pilot study in 2005. The pilot study will start with 15,000 participants, increasing to 200,000 participants for subsequent phases of the project.

As the project progresses, increased emphasis and attention on the ELSI aspect is being placed by the public. Information concerning an individual's genetic makeup is of a highly personal and sensitive nature. Thus, access to the information in a biobank requires a careful balancing of the rights of individuals and the needs of the public health research community. To support the biobank project activities, an Information Technology (IT) platform aiming to reduce errors in subject recruitment, to support public health professionals, to improve the quality of sample management in the laboratories, to develop standards for data exchange, to increase the security level of data management and to address the privacy concerns of the participants involved is under implementation. As the project involves multiple sites, the IT platform is designed to equip the capabilities of exchanging information between applications of electronic health records, subject coding systems, demographic information, genetic profiles and laboratory processes. A service oriented architecture (SOA) will be built to maximize the interoperability of data integration/management across several distributed point-of-service systems.

In the paper, we present the benefits of the project, the imperatives for the IT infrastructure needed and discuss technologies to be used to address these requirements.

Research ethics in the context of health care system

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Introduction
Within the health care system doctors are commonly engaged in potential conflicting roles as health care providers and investigators. Ethical issues and biases related to doctors/patient relationship, selection and inducement, differentiate attention to patients and research participants and issues of confidentiality are some of the main aspects to mention. In addition, the influence of external funding, professional competition, and work load may compromise the quality and ethics of medical research.

Objective
To present a bioethics tutorial programme to support the training of students, investigators and ethics committee members on the issues associated with research activities within health care system.

Methods
The tutorial material uses participatory methodologies to improve understanding and practice. For each ethical issue addressed the participants are provided with reference texts, discussion questions, case stories from movies and news articles. The package covers common issues on biomedical research organized in five defined topics: history of research ethics; clinical research; social science research in health, research in genetics and behavioural research.

Results: The material has been validated and it is used for the last four years. As part of the development of this methodology three books on research ethics and a tutorial CD were published. A retrospective analysis of research project design, conduct and analysis is under the way to document the effectiveness of the training.

Conclusion: The use of participatory methodologies have shown an increased positive impact among future doctors and clinicians in identifying and addressing bioethics issues and conflicts derived from the overlapping role and responsibility that doctors play as health care providers and investigators within the health system.

Acknowledgement: This work received support from the University of Brasília, the Special Programme for Research and Training in Tropical Diseases – TDR/WHO, the Ministry of Health – Brazil, and the Latin American Forum of Research Ethics Committees Members – FLACEIS.

Truth Telling vs Beneficent Protection from Distressing Information – a Recurring Dilemma in Pediatric Ethics Consultation

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A recurring ethical dilemma in pediatric ethics consultation is the conflict between health care professionals' duty to disclose potentially distressing information to patients (in this case children), and the duty of parents to protect their children from harm. Three aspects of this dilemma will be discussed in this presentation.

1. The duty of health care professionals to disclose information to patients is not absolute. In pediatrics there is also a duty to respect parents' role in shaping the context of care and information provision. Relevant contextual factors will be suggested to assist health care providers with decision making.

2. One's cultural background affects the value one places on truth telling in the health care context. Both the importance and limitations of this statement will be considered.

3. Parents' desire to withhold information about their child's impending death from that child is especially challenging for the child's health care providers. Arguments supporting sensitive disclosure will be presented. In most cases parents' wishes should be respected, creating the need for careful and creative planning for providing the child's care and assisting the team with their moral distress.

Reasonable cultural differences in case of obesity in small children?

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Obesity is a growing problem in western countries. Despite the increasing knowledge about the risks of unhealthy food and little exercise more and more people suffer from overweight, including small children. Interestingly, cultural differences play a role with respect to obesity as well. Several studies show that within specific ethnic minorities the prevalence of overweight and obesity is higher. Apart from social-economic causes, different cultural views about nutrition, health and body weight also affect people's lifestyles and food patterns. It is known, for example, that overweight and fatness are sometimes viewed as signs of good health and wealth (fat is beautiful, heavy is healthy). In this view, overweight may be valued differently. With regard to the growing problem of overweight amongst small children, different views and ideals about child raising play a role as well: it may be considered good to over nourish and indulge one's children. Effective health information programmes may need to take these judgments and beliefs into account, and they may even aim to persuade target groups to change their beliefs and evaluations about weight. However, for such interventions to be morally justified, it matters whether the beliefs that are targeted are basic moral views that are embedded in a specific cultural perspective, or 'just' factual beliefs about weight and health. The objective to persuade people to reject incorrect factual beliefs is not as morally problematic as the objective to persuade people to reject normative views that may be central in common views of life in their own culture.

In this presentation I will explore what different views on food, overweight and child-raising exist among cultural minorities and what weight we must give to these views. In short, I will explore whether different views on overweight could be reasonable when taking these cultural differences into account.

Bioethical Concerns with Community Engagement for Taiwan Biobank in Indigenous Tribal Areas

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In light of Taiwan's unique population structure and the well accumulated heath and domicile records, the convergence of Taiwan Biobank aiming to the implementation of prospective cohort study of local epidemic diseases was thought to be beneficial both in better understanding the causes of diseases and their curing solutions and in advancing the policy of prevention and treatment formations. Therefore, in 2003, the Academia Sinica in Taiwan was sponsored to initiate the feasibility study of Taiwan Biobank project, wherein the significance of developing Taiwan Biobank was highlighted in the research report released in 2004.

After the prevalence of population based genetic research brought by the improvement of genetic engineering, the traditional doctrine of informed consent, which is essential to the observance of human dignity and autonomy, is under stringent challenge. Since the gene, it would give impetus to some hidden troubles such as privacy infringement, humiliating or racially discriminating the indigenous people, migrants and other minorities due to the ethnic group related characteristic of genetic information. And the rationality laid behind the Principle of Informed Consent, traditionally based on an individual moral subject and supposed to guarantee human integrity and autonomy, shall be challenged accordingly.

In April, 2007, an unprecedented event happened in the bio-research history of Taiwan. After the tissue collection procedure was denounced as violation of required informed consent principle, it was for the first time that some participants asked the researchers to destroy biological samples by observing a ceremony. After the sacrificial rites for memorizing the ancestors presided by the sorcerer of Kavalan people, the participant destroyed the saliva sample collected by the researcher who was recognized as "The Mother of Taiwan Blood." The case sufficiently revealed the trend that indigenous peoples' awareness of human rights has been strengthened, and the researchers should be aware of the ethical issues of biomedicine research, and with more cautiousness and carefulness as well.

In this paper, we would like to argue that the balance between the freedom of speech and expression through the research and the protection of participant/subjects' fundamental rights might be achieved progressively subject to the Constitution Law and Indigenous

People Basic Law of Taiwan, and by taking into consideration “The Universal Declaration on the Human Genome and Human Rights” adopted by the UNESCO, the U.S and Australian policies concerning indigenous people, and Taiwan’s domestic experiences in tribal health management and promoting self governance rules in Taroko tribes. Bearing in mind these experiences, Taiwan is now developing its own special mode of group consent in researches related to indigenous tribes, which can be taken further as the mode for future biomedicine research purposes.

從手術簽字審視醫療活動中道德與法律之衝突

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手術簽字不應成為實施手術的必要條件，手術治療及其他醫療活動中道德與法律之衝突有其產生的理論和現實根源，其實質是利益衝突。合情不合法與合法不合情是道德與法律衝突的兩種具體情形。單純的道德譴責或責任追究無助於衝突的解決，完善法律、提升道德、調適利益是避免及減少衝突的有效途徑。

關鍵字：道德 / 法律 / 衝突

From Operation signature Surveying Impact between Morality and Law during Medical activity

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Operation signature shouldn’t be necessary condition. There are theory and realism springs of that morality is in conflict with law during operation treatment and other medical activity, its essential is benefit impact. What fair and reasonable but wrongful and legality but unreasonable are two incorporates that morality conflict with law. Simplex morality condemn or obligation run is disadvantageous to solve impact, It is availability approach to avoid and reduce impact that perfecting law, advancing moral and adjusting benefit.

Key words: moral / law / impact

End of life care: neither end of life, nor care
Some paradoxes of modern intercultural (bio)ethics of death and dying

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The present paper departs from the provokative hypothesis that modern (bio)ethics advocates the saving, curing, and prolonguing of human life, without knowing the elementary qualities of death. According to that opinion, the entire bioethics might seem more like buying time and practicing tolerance until we will be able to judge.

In order to present the reflections of that problem upon some other disciplines, the present paper attempts to summarize the current scarse knowledge and views shared by neurosciences regarding the process of dying. Most of the data presented origin from the so-called «near-death experiences» (NDE), only recently shifted as a topic from the realm of «para-science» to science. By confronting bioethical arguments of euthanasia, dysthanasia, and misthanasia, with anthropological, linguistic, psychological, sociological, and other aspects of death and dying, a discussion is offered on how (bio)ethics and and end of life care might overcome the existing paradoxes.

The Research Ethics and IRB Practices in Biobank Proceeding

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The project to establish a biobank in Taiwan has been debated among scientists, law professors, human right activists and bioethicists. Among many questions being raised, one that concerns me the most is whether or not biobanking a human subject experiment ? Or perhaps it is not simply because of its purpose thus should be treated differently from other research projects ? Biobanking project certainly requires volunteers' informed consent before any tissue can be extracted. But biobank will not destroy the tissues taken after the initial genetic study is completed and may also re-examine them to find other needed information years later. Should a re-consent be needed or should there be any mechanism established to govern the procedures ? This presentation will argue that a certain system must be established such a Ethics Governance Committee to ensure that biobank observes the requirements of IRB. There has to be some mechanism established when the collected and stored tissues are to be studied again for other reasons.

Some scientists may include a clause in the original informed consent form that they agree to authorize thee researchers to do a further study on their tissues. This paper will argue that this practice is questionable and thus recommend a guideline to all IRB when researchers desire to use the pre-collected tissues for other research including biobank.

Does inducement invalidate informed consent?

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In order to get sufficient subjects, researchers or donor organizations may offer money or some sort of benefit for them which is generally known as inducement. Ethical Guidelines such as CIOMS, FDA, and so on state that inducement is unethical as it may invalidate informed consent requirement. Some ethicists quote this guideline and argue that inducement undermines voluntariness. They present three arguments for invalidates informed consent. First, people will not consider risk to get the benefit. Secondly, inducement undermines better judgment. Finally, vulnerable people especially the poor people may compromise with risky circumstances for money. While other ethicists reject this orthodox argument and claim that inducement is ethically acceptable. Since inducement is not harmful for either subject or researcher rather beneficial. They argue that inducement protects autonomy not freedom. I analyze both of these arguments and claim that inducement does not violate the basic elements of informed consent. In addition, I propose that subject has *a prima facie* right to be benefited from the research.

Keywords: inducement, informed consent, Guidelines, benefit, better judgment, vulnerable people, prima facie right.

BIOETHICAL HERMENEUTICS OF MAHATMA GANDHI'S STAYAGRAHA

Jose Ma. Ernesto Jacinto Ybanez Tomacruz

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Mahatma Gandhi's Satyagraha is more forthrightly known in the social and political language. Yet, Gandhi himself said that his politics is but an expression of his religion, of his ethics. Ergo, Satyagraha, though more known to be used in the socio-political arena, is essentially ethical. As such, Satyagraha can therefore be also woven into the Bioethical fabric. For both the western and eastern frontiers of Bioethics to have a real, enriching, and empowering melding, they should learn to understand
and discourse with each other. Ergo, this paper is a means of integrating Mahatma Gandhi's Satyagraha into contemporary Bioethics. More specifically, this study on Gandhi's Satyagraha is a deliberate attempt of Eastern philosophy to weave into the fabric of the extant Western bioethical literature.

There is no question that Bioethics in the western world, specifically, in Europe and North America, has already achieved a certain robustness. So we can even say that it has in a sense already developed into a culture of its own, at least since its formal inception during the later part of the past century.

Yet, though Bioethics was born in the western world, its ethical and epistemological foundations weren't something unique to the western world. Eastern/oriental cultures already had, definitely even before the ancient Greeks (as earliest representatives of western thinking), coherent and systematic notions about sickness, diseases, healing, handicaps, aging, mores, ethics and other related ideas used
by Bioethics. However, because the contemporary medicine and science where Bioethics emerged are largely products of western civilization, so eastern thinking hasn't yet significantly informed Bioethics as western thinking does. Nonetheless,specially with the impetus given by factors like the eastern/oriental countries: a)gaining global geopolitical and economic clout; b) having their citizens continually migrating to the west; c)attaining higher levels of education; d)getting access into western science and technology (including the medical field); e)making breakthrough into the information highway of the internet, and the like, it was but inevitable that the proverbial east-meets-west phenomenon happened, and is still bound to grow more rapidly once it reaches the state of proper momentum. But before this state of proper momentum is reached, a lot of groundwork has to be done, maybe, more specially from the eastern/oriental side, or maybe, ideally from both sides.

Satyagraha has several tenets. However, we shall only deal with the two most important ones, namely *Satya* and *Ahimsa*. *Satya*: Truth, according to Mahatma Gandhi, posits spirituality and centrality in one's life. It is multi-faceted and one has but a glimpse of it, thus it should be born of consistent self-examen. Satya is also social, thus should be something communicable to people. Ahimsa is non-violence and the co-principle of Satya. It also means goodwill, and patience. Ahimsa makes Safyagraha not passive but an active creative power. Ahimsa implies courage and moral strength. It is non-discriminating and though non-violent, it is conflict-born and can thus be conflict-spawning.

Key Terms: Mahatma Gandhi, *Satyagraha*, *Satya*, *Ahimsa*, *Satyagrahi*.

A Search for a Universal Bioethical Philosophy to Transcend Pluralistic Non-Scientific Religious and Philosophical Roots of Ethics

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Classical examinations of both Western & Eastern ethical philosophies, whether based as a universal absolute set of prescriptive rules or as a secular utilitarian-consequential set of quidelines for behavior , derived as a consequence of rational and logical derivations from a few basic assumptions or as pragmatic rationalizations of unconscious feelings, have never had the advantage of integrating the modern scientific view of human beings as producer of the ethical philosophy with the actual ethical principles.

Few contemporary ethical philosophies , even Rawls' A Theory of Justice,, have made use of modern sciences' view of the human in an evolving physical universe, inextricably tied to ever changing physical, chemical and biological ecosystem, whose individual genes must interact with the physical, chemical, biological, social and cultural world. The one exception is the ethical view propped by Dr. Van R. Potter, in which he recognized, in his "Bioethics" and later in "Global Bioethics", that, during the biological and cultural evolution of the human species, each human tribe or culture survived in their unique environments . Their survival was because of the adaptive responses of their genes and the unique physical and the cultural environment in which they found themselves,. Therefore, the Aboriginals of Australia, the Eskimos of Alaska, The Nomads of North Africa, the Samoans of the South Pacific, the causasians of Western Europe, The Eastern Indians , the Native Americans of North & South America, the Mainland Chinese and the sub-Sahara black Africans, to name but a few, all evolved biologically, socially and culturally in close stewardship with their physical environments,. Each developed a unique ethical philosophy, based on their view of human nature in their particular environment, whether it was in a resource-rich or poor land, in cold or warm or changing weather environments or whether it was in on an island or on large expanses of land.
The old ideas that (a) the human being was a special biological creature; (b) the ethical principles were absolute and universal[(c) human ethical principles were independent of the physical l and other scientific laws of nature; d) ethical principles had to be handed down to flawed human beings by either divine intervention or by "pure" logical thought has brought us to our present state… which is ethical chaos. In Global Bioethics, the clear insight is that, regardless of our religion, society and culture that all of us are a part; the education or lack of; and the particular ethnic class we belong to, we have (a) the same human nature, (b) are subject to the same laws of the physical nature, (c) have the same biological make-up , and (d) have the same biological and psychological needs based on our genetic and environment interactions.

In spite of those who argue that (a) human beings are not subject to forces of evolution,

(b) human beings' phenotypes and behaviors are not the result of genetic and environmental interactions, and (c) there are forces affecting human behavior that are beyond scientific comprehension, the science of evolution, astronomy, physics, chemistry, genetics , and cultural anthropology make it very clear that all human beings were derived from a common stock and that all human beings have the same requirements for being human(food, temperature, social interactions, water).

Given that we are all inextricably dependent on clear water, adequate and safe food, clear air, social codes for individual sense of self- dignity and self- worth. In addition, today, we all share the same limited resources on a finite planet, there must be a new ethical philosophy that transcends ethnicities, races, religions, political ideologies that ignore scientific views of human nature. While science cannot determine our ethical values, our ethical philosophies and values cannot ignore scientific facts. The old "naturalistic fallacy" and the old dichotomy between values and facts will have to be challenged.

New cultural , religious and philosophical frameworks for ethical guidelines will have to incorporate into their icons for the well-springs of ethical values, the new scientific views of human nature. These include humans as the result of "nature and nurture", not nature versus nurture; the cybernetic view of human nature; the hierarchical view of human nature; the biological/social/cultural evolutionary view of human nature; and the bio-symbolic or bio-psychological view of human nature.

Lastly, rather than trying to deal with the specific issues of any new ethical problem, such as stem cell research, widespread use of nano-technolopgy; gay marriage or limiting the number of children, each individual problem should be viewed in the larger context of human survival with dignity for all in a fragile planet, where all of us require, not only basic needs to be met ,but also a stewardship for the planet for our children and grandchildren. Only by understanding our biological/cultural human nature, can a new bioethics be born.

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Bioethics - Knowledge
How to Use the Knowledge for the Human Survival and the Quality of Life

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The importance of Bioethics in teaching physicions could be substantiate by the seeing of the «father of bioethics»- professor Van Renselaer Potter II, who has always observed bioethics as new discipline wich will be link between knowledge end reflection, dinamic admission in human neverending pursuit of the wisdome; knowledge how to use the knowledge for the human survival and the quality of life.
With the main aim to find out the ethics value connecting bioethics and palliative medicine the attention is focused on 4 basic principes of modern medical ethics – bioethics: beneficence, nonmaleficence, autonomy and justice.
Palliative medicine is the medical discipline focused on the relief of suffering and the promotion of quality of life.
The term "palliative care" may be used generally to refer to any care that alleviates symptoms even if there is hope of a cure by other means; thus a recent WHO statement calls palliative care "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness." Palliative care relief from suffering, focused on the treatment of pain and other distressing symptoms, psychological and spiritual care and on the ethical aspects in end-of life care and support system to help the individual live as actively as possible, and a support system to sustain and rehabilitate the individual's family.
Beside the relife from suffering, psyhosocial aspects the patients and caregivers very important part of palliative care/medicine are the bioethical aspects of care.
Due to the emphasis it places on clinical activity, clinical bioethics greatly depends on the interaction of clinicians and patients in everyday repression of diseases. In palliative medicine that is conditio sine qua non for quality and human care for patient.

Key words: bioethics, palliative medicine, clinical bioethics

Bringing Culture to the Core: A Plan for Expanding the Core Competencies of Clinical Ethicists

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The clinical ethics consultation approach employed by a particular clinical ethicist is to varying degrees a function of the skills he brings to the consultation. Until the publication in 1998 of the ASBH's *Core Competencies for Health Care Ethics Consultation* there was no generally recognized skill set or knowledge base identified to which clinical ethicists could refer. This presentation will expand these core competencies to include, alongside ethical analysis, consensus building and facilitation, *cultural competence* as an essential skill needed to conduct ethics consultation in the increasingly culturally diverse institutions in which many Western clinical bioethicists find themselves practicing today.

The ASBH recognizes in the *Core Competencies* document that, "the multicultural nature of health care institutions and the patients they serve make knowledge of different cultures and faith communities critical for consultation".[1] This "knowledge of different cultures and faith communities" has since come to be recognized not only as body of knowledge but as a discrete and measurable set of skills known collectively as "cultural competence".[2] While the ASBH recognizes that "advanced skills" in this area are useful in some ethics consultation, they see this as residing in other hospital professions (e.g., social workers and chaplains) who they recommend be brought into consultations because of this expertise. Cultural competence in this context can be defined as, "having the ability to interact effectively with people of different cultures [… and comprising] four components: (a) Awareness of one's own cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and worldviews, and (d) cross-cultural Skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures".[3] However, we will argue that cultural competence is not a specialized body of knowledge and process skill independent of the consultation process but a corpus so critical to effective cross-cultural clinical ethics consultation that it must also be a core competency for the Clinical Ethicist and not resident in an adjunct participant. Accordingly, it is no longer adequate to simply have knowledge of multicultural issues; the Clinical Ethicist must be skilled in cultural competence.

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[1] American Society for Bioethics and Humanities, "Core Competencies for Health Care Ethics Consultation" 1998. p.19.

[2] http://www.cmwf.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

[3] Mercedes Martin & Billy Vaught (2007). "Strategic Diversity & Inclusion Management" magazine, pp. 31-36. DTUI Publications Division: San Francisco, CA.

Training in cultural competence is now commonplace, particularly in healthcare[4] and is designed to address the specific pedagogical needs of its learners. We will outline a training module in cultural competence tailored to the unique needs of clinical ethicists for their work in consultation. This module will include components addressing formal knowledge acquisition, reflective practice, and strategies for life-long learning.

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[4] http://www.calendow.org/Collection_Publications.aspx?coll_id=26&ItemID=316, http://www.hrsa.gov/culturalcompetence/, http://www.aamc.org/meded/tacct/culturalcomped.pdf.

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