EACME Newsletter

European Association of Centres of Medical Ethics

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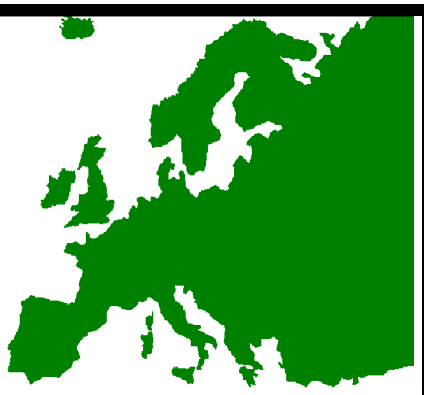

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CONTENTS

EDITORIAL

Revealing values in our global world

Lately, there has been a lot happening in our global world. The media kept us updated about each event. Politically triggered revolutions in Northern African countries, a vast nuclear tragedy in Japan - all of these events are reported live to our living rooms as soon as we turn on the TV. In addition, they are broadcasted in the Internet, via Facebook and so on. We learn much about the events and actions, but often misunderstand much about the hidden values of the protagonists or persons affected.

Luckily, there was some 'good' news too, and some actions and values, which seem easy to understand: love and marriage. So, we could spot an everlasting belief in romance when we looked to London at the end of April 2011 and watched Prince William getting married to Kate Middleton.

Or, let us take a look at Rome, Italy, but watch out, we are not going to talk about Berlusconi's values here. May 1st, former Pope John Paul II was beatified. After beatification, the blessed one can be publicly adored. Beatification is a strong value in the Catholic Church. So within – or even despite – our modern world of fast communication tracks, iphones, Internet and Facebook, some somewhat older traditions, values and actions are still at work too.

And what has all this got to do with biomedical ethics? A lot. Natural sciences, and especially the discipline of medicine itself, reflects the fast pace of our global times in unique ways. Cutting edge research, international collaborations, high quality therapies, but also a mix of somewhat older traditions and beliefs, combined with high demands, visions and expectations both from the researchers and doctors' perspective, but also from the side of the patients and families. This

is when ethics comes in, to explicitly express the implicit, to give words and concepts to the unspoken, and to clarify values, which are at stake or in danger. And this is also what we are going to do when we will meet in Turkey this year. EACME's yearly conference takes place in Istanbul 15 to 17th of September 2011. The topic of our conference is: "Bioethics from a cross-cultural perspective" – so some global issues will probably accompany us throughout this year.

So let us now reveal some of the contributions of our current newsletter. Among others, Steve Edwards helps us to understand some of the controversial debate surrounding organ donation and brain death. Jan Schildmann et al. present some intriguing (and in Germany controversially discussed!) research in the field of palliative medicine, and you will read about 'Health and Happiness' and much more. Please enjoy our Newsletter, and don't hesitate to contact us with ideas, reports, contributions etc.

Yours,

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END-OF-LIFE PRACTICES OF PALLIATIVE CARE PHYSICIANS IN GERMANY: REFLECTIONS ON AN EMPIRICAL-ETHICAL STUDY

Jan Schildmann, Julia Hötzel, Christof Mueller-Busch, Jochen Vollmann

In Germany as in many other countries, there is an ongoing debate about the appropriate ethical and practical approach towards end-of-life decision making. At the Institute of Medical Ethics and History of Medicine, Ruhr University Bochum (www.rub.de/malakow.de) normative and empirical aspects of end of life decision is a focus of research which is taking place within an interdisciplinary and international setting. Recently our study group published results from an empirical-ethical study on end-of-life practices of physician members of the German Association for Palliative Medicine (Schildmann et al. 2010, Schildmann et al. 2011) which sparked off considerable scientific and public debate in Germany. In this contribution, we provide a summary of key results of the study. This will be followed by reflections on the methodical challenges of empirical-ethical research at the end of life and on the possible contribution of such research regarding the discussion on normative aspects of end-of-life care.

In 2009 we conducted a cross-sectional postal survey among physician members of the German Association for Palliative Medicine using the EURELD (European end-of-life decisions)-survey instrument. Physicians were asked to answer all questions on end-of-life practices and decision making with respect to the last patient who had died under their care within the last 12 months. We received 901 completed questionnaires (response rate: 55.8%) and the key findings were as follows:

- In the majority of cases limitation of medical treatment (78.1%) and/or symptom alleviation (69.1%) with possible life shortening had been performed by the respondents.
- In 10 cases medication had been administered by the physician (N=9) or the patient (N=1) with the intention to hasten death.
- In 213 cases (27.3%) end-of-life practices had been performed with the intention to shorten life. This includes limitation of treatment with the intention to shorten of life as well as administration of substances with partial or explicit intent to shorten life reported by physicians.
- In 22 cases physicians indicated that they had not involved competent patients in the decision-making process. The most frequently given reasons for this practice were „best interest" of the patient (N=11) and avoidance of "possible harm" for the patient (N=11).

In light of the existing data from international surveys such as the EURELD (European end-of-life decisions) study which had been conducted in six European countries (van der Heide et al. 2003), the aforementioned results could have been expected. However, the publication of the results was followed both by considerable debates which focused on methodical aspects of the study, and by discussions about the relevance of empirical data for the normative debate on end-of-life decision making.

Regarding the method used in this survey, it was frequently questioned whether this study adequately reflected clinical practice at the end of life. This criticism was based on the wording of questions which asked physicians about their practices at the end of life. End-of-life practices as defined in the EURELD questionnaire refer to practices (e.g. withholding or withdrawal of treatment) *and* the physician's expectation that such practices may have shortened the life of the patients. The following table provides an example with respect to the withholding of treatment:

4 Did you or a colleague perform one or more of the following actions – or ensure that this action/these actions would be performed – **taking into account the probability or certainty that this action would hasten the end of the patient's life?**

4a Withholding of treatment

☐ yes
☐ no

On the one hand, the combination of an action *and* the expectation regarding possible consequences of this action may be justified on the ground that the focus of empirical-ethical research is on ethical controversial practices. On the other hand, such a formulation of questions carries the risk of misinterpretation because of the combination of two different aspects within one question. Indeed there is evidence that results on the prevalence of different end-of-life practices differ if the respective parts of the question (i.e. action and expectation) are separated into two questions (Seale 2009). We acknowledge the aforementioned aspect as a factor which might have led to a misunderstanding of the question on the side of the respondents. Nevertheless, we argue that the appropriate framing of different end-of-life practices (e.g. "withdrawal of treatment" instead of "passive euthanasia"), the inclusion of many normatively relevant aspects (e.g. physicians' intention, patients' involvement in decision making) and last but not least the extensive testing of the survey instrument justify the use of the EURELD-questionnaire to gather data on ethically relevant aspects of end-of-life practice. Furthermore, there is to our knowledge no evidence that a different way of framing the questions would have changed the results substantially.

The second issue of controversies was that of the relevance of the empirical data gathered by the study for the normative debate. Clearly the data can not tell us anything about what ought to be done at the end of life. However, we were interested in the outcomes of this study for a variety of reasons. First of all, information about the spectrum of end-of-life practices and their respective frequencies may direct the focus of attention to end-of-life decision making in clinical practice which deserves further ethico-legal analysis. In this respect, it is notable that a significant proportion of the debate focuses on the comparatively few cases of assisted suicide and ending patient's life on request. However, from the perspective of a clinical ethicist who is responsible for ethics consultation or the training at a clinical institution, the high numbers of cases in which treatment was limited with foreseen or even intended shortening of life may be of interest in terms of an information how best to prioritize his or her time and attention.
The empirical data gathered in this study may be also discussed on the background of normative positions incorporated in the law or also in professional codes. Taking into account that the target population of our study was restricted to physician members of the German Association for Palliative Medicine, it is a remarkable finding that a relevant proportion of respondents also intends shortening of life as part of their practice. In contrast to normative statements on the side of the representatives of palliative medicine, the study indicates that there is support for intended shortening of life among a proportion of members of the German Association for Palliative Medicine. The obvious discrepancy between empirical data on end-of-life practice of palliative care physicians on the one hand and the normative statements forwarded by palliative care associations on the other hand may serve as starting point for further discourse regarding an appropriate normative and practical framework on end-of-life practice. In this respect, the controversies sparked off following the publication of our results may also be framed as a possible contribution of empirical-ethical research to the debate on normatively acceptable end-of-life practices. Colleagues are invited to participate in the ongoing empirical- ethical studies as well as other research activities of the Institute within the newly established Visiting Fellow Program Bochum (http://www.ruhr-uni-bochum.de/malakow/forschung/fellowships.html).

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OBJECTION DE CONSCIENCE – UN DÉBAT AMÉRICAIN

Toujours bien intéressant Hastings Center Report, revue de l'institution de bioéthique connue de la région de New York. On trouve dans le dernier numéro un article (1) consacré à un livre sur les conflits de conscience dans les soins (2). Ce qui m'a interpellé c'est que, alors que la faculté d'objection de conscience par un professionnel de santé n'est pas contestée en France, en Suisse et dans les pays proches, sous réserve de limites en rapport avec l'urgence ou des intérêts majeurs du patient (3), il apparaît qu'aux Etats-Unis beaucoup jugent que « the professional standard is no conscientious objection » (la règle est que l'objection de conscience n'est pas admissible). Un éthicien aussi connu et respecté que Dan Brock pense ainsi qu'il ne saurait y avoir objection à des actes ressortissant à « what is legal and professionally accepted » (ce qui est légal et généralement accepté par la profession). Extrait du propos de C. McLeod : « Une des questions qui intrigue le plus en éthique médicale est de savoir si des médecins individuels peuvent, pour raisons de conscience, refuser des soins (…) le problème est de savoir la mesure dans laquelle les médecins doivent subordonner leur intérêts à ceux de leurs patients ». Je le note parce que, pour la plupart d'entre nous ici, ces questions sont en principe résolues (on a le droit d'objecter).

Dans le livre analysé par McLeod, l'auteur - dans un sens « européen » - s'oppose à la prohibition complète de l'objection, concluant qu'il est nécessaire d'admettre un peu d'objection de conscience (some conscientious objection…)! A cet égard, Fernandez Lynch estime que la profession, par ses organes, a la responsabilité de s'assurer que les patients obtiennent les services (licites) qu'ils demandent ; ceci par des arrangements entre confrères, l'objecteur de conscience s'assurant que le patient va pouvoir obtenir le service requis d'un autre médecin (c'est souvent le mode de faire mis en oeuvre dans notre pays, la Suisse, de manière informelle). La profession - ou l'autorité -, dit-elle, ne saurait renoncer à sa responsabilité de fournir un service qui est devenu un soin standard.
Elle propose une solution institutionnelle, passablement formelle à vrai dire : « Les médecins devraient faire enregistrer leurs objections de conscience auprès de l'autorité qui les autorise à pratiquer [l'Ordre en France], autorité qui doit vérifier la sincérité desdites objections et rejeter celles qui sont discriminatoires. Les patients ont accès à ces registres, ce qui facilite le morals matching [à savoir permettre aux patients et médecins qui partagent les mêmes valeurs de se retrouver]. S'ils ne peuvent trouver un médecin qui satisfasse leur demande, les patients peuvent se plaindre à l'autorité compétente ». Pour un pays, les Etats-Unis, en principe très libéral, on peut dire que cette proposition apparaît lourde. Pas sûr qu'elle serait aisément admise dans nos pays européens !

A noter encore que dans son analyse McLeod confirme les principes qui doivent être observés : « Indépendamment de leur objection de conscience, les médecins sont obligés d'informer les patients de toutes les options thérapeutiques [y compris celles auxquelles ils seraient opposés en conscience], de traiter en cas d'urgence et, si possible, d'orienter les patients concernés vers des confrères/structures susceptibles de fournir les soins requis ». Elle relève enfin que, à son avis, le médecin qui dénie un soin à un(e) patient(e), non seulement crée pour lui/elle un inconvénient mais lui fait du tort.

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BRAIN DEATH AND ORGAN DONATION

Brain death and organ donation

Introduction
This discussion paper is in three parts. The first summarises the current state of play with regard to the definition of human death. As will be shown, the current definitions employed in the UK and USA (brain stem and whole brain respectively) have been subjected to compelling criticism. If accepted, these criticisms imply that vital organs are currently removed from living patients for the purposes of transplantation, and thus

that the 'Dead Donor Rule' (DDR) is frequently violated. The second part of the paper summarises two ways of responding to this situation. The first response recommends simply retaining the status quo. The second way of responding is to revise the current definition of death (brain stem or whole brain death). But this also faces several problems. The final part of the paper outlines a controversial way forward. It is one which seeks to endorse explicit violations of the DDR in certain specified circumstances.

Brain death

Since the emergence of the concept of brain death (Ad hoc committee Harvard medical School, 1968) it has been subjected to criticism. But in recent years, such criticisms have become more common and indeed more compelling in the eyes of many (President's Council, 2008, p.40). Confusingly, 'brain death' is not a uniform phenomenon. Countries which share the same medical and scientific traditions endorse differing definitions of brain death. In the USA a 'whole brain' definition (WBD) prevails whereas in the UK a 'brain stem' definition (BSD) has been adopted (BMA 1978). Further lay people fail to understand the differences between terms such as 'PVS' (persistent vegetative state), 'coma', 'brain death', 'brain stem death', and 'whole brain death' (Smirnoff et al, 2004, p.2330). Confusion is not restricted to those outside medicine. Many healthcare professionals (HCPs) struggle to explain the differences between the terms just mentioned. A recent editorial in Nature writes of a person diagnosed as brain dead as being "to all intents and purposes dead" (Editorial, 2009, p.570) and that any residual brain activity which occurs after brain death "...has nothing to do with a person being alive in any meaningful sense" (ibid.).

Criticism of brain-centred definitions of death (BSD/WBD)

The most salient criticisms levelled at definitions of brain death (I use this term to encompass both BSD and WBD) share the same scientific presuppositions as are invoked in defence of it. Thus, it is agreed that the human being is most appropriately conceived of as a biological organism when it comes to the determination of death. Hence the human being dies when the organism which constitutes them dies. Death occurs when the organism irreversibly loses the capacity for integrated, holistic function. This is indeed the rationale for both WB and BS definitions of death (President's Commission, 1981; Lamb, 1985). One way to capture this difference is to distinguish between a mere 'bag of organs' and a functioning organism. So even if after the point at which brain death occurs some residual function is found in the dead organism – e.g. nails growing, hair growing, even heart beat – this does not show, it is claimed, the organism is in fact alive. Rather, it is a mere 'bag of organs': such function is not that of an organism, just random events in a 'bag of organs'.

Thus, critics of definitions of brain death need find only one example of a function which satisfies the definition of being 'holistic'/'integrative' and which is correctly attributable to the organism as a whole and which occurs after WB/BS death occurs, to show that WB/BS death does not mark the death of the organism as a whole. Many such functions have been identified. It is not the case that a ventilated patient, after diagnosis of brain stem death, necessarily putrifies. This is because, it is claimed, in some patients the body retains the capacity for holistic-organismic function and so the cells do not necrose. Striking examples are provided by dead patients who gestate foetuses (President's Council, 2008, p.42). It is claimed, reasonably enough, that the organism as a whole must continue to function in order to provide a place for the foetus to continue to develop.

To be clear, it is not being claimed that such patients are healthy in any sense, or are capable of recovering consciousness or physical health. Nonetheless, it is claimed, they are not yet dead – even though they may be moribund.

Organ donation

If accepted, the claim that current definitions of death are mistaken has alarming implications, not least in the context of organ donation – the main method for which involves patients diagnosed as brain dead. (The other main method 'donation after cardiac death', is even more controversial than donation following brain death. Patients whose hearts are eligible for transplant and who satisfy criteria for 'cardiac' death would be unlikely to meet criteria for brain death (ACCCM, 2001, p.1827).)

It should be acknowledged at the outset it is reasonable to think that organ donation is a good thing, and that if one is to act in ways which might impede the achievement of that goal – of reducing even the numbers of organs available for transplant – then one needs sound justification for one's acts. But having said that, given the importance attached to the informed consent of patients in most medical contexts, it is striking that organ donors often donate without knowledge of basic information regarding the process of organ removal. Thus for example the survey referred to above (Smirnoff et al 2004) reported that more than half of respondents believed that ventilation is withdrawn prior to organ removal, but in donation on grounds of brain death this is not the case. And of course in the UK one can register as a donor with no understanding of what is involved in the process.

Also although patient autonomy is considered of great importance in medical practice generally it is strangely neglected in the context of organ donation. In the UK, a person's desire to donate organs might be overruled by their next of kin, and a wish not to donate might be similarly overruled.

So there are many existing problems regarding the ethics of organ donation. But these are intensified in light of the problems with the definition of death as it currently stands. For if those criticisms are true, it implies that the 'dead donor rule' is systematically violated. This is the rule that it is wrong to remove vital organs from living patients, certainly without their consent and perhaps even with their consent. Therefore, one wonders what is the best way to proceed?

Response 1. Retain the status quo
One can argue for this in at least two ways. First, it could be argued that there is a working consensus at present to the effect that the problems which beset current definitions of death are best ignored. It is difficult enough to obtain much-needed organ donors, so any course of action which is likely to impede this should be avoided. Second, as mentioned above, those patients who meet the criteria for what we currently term 'brain death' are never going to recover, and will never regain consciousness. So, it is perfectly permissible to remove their organs. After all, they can produce great benefit to their recipients, and since the patients themselves can't benefit from them, surely the right thing to do is to remove them.

In response to the first argument, given the extent of current misunderstanding – even amongst HCPs – it would be difficult to claim there is any kind of consensus about the current definition. Most HCPs are unaware of the challenges to it so in no sense do they consciously agree to take part in a 'conspiracy' to maintain the status quo. In response to the second argument, put plainly this strategy advocates transgressing the DDR; it claims that it is justifiable to remove vital organs of a living patient. But this clearly amounts to a killing of that patient – an intentional ending of their life. Thus it seems to run against a moral norm which seems fundamental to medical practice namely 'do not kill'. So such a change would involve a very radical departure from current norms (and laws) which (officially) oppose the intentional killing of patients.

Further, the organs are being removed in order to benefit another person in need of them. Exactly the same kind of claim could be advanced about patients in PVS. Therefore, acceptance of the force of this response would seem to mark a substantial change in the moral norms of medicine as these are currently practiced. Moreover, it may be that the problems with the definition of death are reported in very alarmist terms in the popular media. The preservation of the status quo is not solely in control of the medical profession. Such a development might prove a serious setback to the organ transplantation programme, and to the trust which the public has in the medical profession.

So, in response to the 'retain the status quo' option: it can't plausibly be called a conspiracy; it violates DDR; it violates obligations of autonomy; and it risks undermining trust in medical profession and in the practice of organ transplantation. Thus there are strong arguments against this first strategy.

Response 2: Revise the definition of death
If retaining the status quo is not a credible option, it would seem there is no option other than to accept criticism of brain–centred definitions and revise the definition of death accordingly. If the criticisms offered above are accepted, then one should adopt the kind of definition offered by Shewmon (2001) according to which ventilated patients with independently beating hearts are alive and certainly not dead - a "circulatory-respiratory" definition (Shewmon, 2001, p.469).

This may cohere with the general norms of respecting autonomy just mentioned. But brings with it serious problems. First, the idea of explaining to the public that there has been a change in the definition of human death presents a major challenge. It is likely to result in a decrease in the numbers of organ donors in at least the short term. It would fuel scepticism about the medical profession and about the whole process of organ donation. It would fuel the suspicion held by some that the well being of the recipient is a factor in the treatment of the dying patient, so that their care would be adversely affected. So in so far as these are adverse consequences, they give reasons to avoid option 2.

Also, second, it may turn out to be a very costly option. This is because, of course, a new group of patients will emerge who are moribund but not yet dead. Pressure to care for such patients will make additional demands upon healthcare budgets as well as presenting further problem-cases for practitioners in the form of tough decisions about when to withdraw treatment, and management of the organ donation process. And longer term, if the DDR is to be retained, the prospects for organ donation are likely to be impugned by adoption of the new definition of death (the cardio-respiratory definition). This is because the organs that are obtained will not be in as good a condition 'as fresh' as those that can be obtained under the present systems – of either donation after brain death or donation after cardiac death.

Thus this second option brings with it serious problems too – not least the likely reduction in the numbers of organs available for transplant.

3. A way forward? Radical option
Given the difficulties with either of the two options discussed so far, what should be done? One thing seems clear, although increasing the numbers of organs

available for transplant is a good thing, this cannot be done at any moral price. Hence we do not compel people to have their healthy organs removed for the benefit of others in need of organ transplants. The autonomy of the potential donors is an important constraint on the benefits that their organs could bring to others in need of them. In other words, respecting the autonomy of the potential donor is considered more morally weighty than the well being which removal of the organs of the potential donor could produce. This weighting of values is apparently reflected (if in a confused manner) in current UK policy regarding organ transplantation. Even though organs from dead people (diagnosed as dead by current standards) could benefit potential recipients, the autonomous authorisation of the dead person or their close kin is required. So prima facie, it looks as though an ethically justifiable solution to our problem must attach due weight to the autonomy of potential donors, and this weight is greater than the weight of the potential benefit which can be obtained by potential recipients.

What, then of the DDR? At present, it seems, the hope is that this can continue to be breached in the hope that nobody will notice. But the definition of brain death is creaking under the weight of criticism and surely cannot be maintained, sincerely, for much longer. If the definition of death is revised in accord with the criticisms, and if the DDR is upheld, then there are likely to be many fewer organs available for transplant, and they will be in worse condition. This is so since current practices of diagnosing death by neurological or cardio-pulmonary standards will need revision and organs obtained at a much later stage in the dying are likely to be in a less healthy condition for transplantation.

A way forward is to respect donor-autonomy and to sanction overt, informed violations of the DDR. This would be a way of addressing some problems with the current situation vis-a-vis information-giving and consent. And, it would help reduce the impact of the likely drop in numbers of organs available for donation. Thus, the proposal is that once patients are in a condition in which they are moribund but not yet dead – a state close to, or equivalent to, that which we now call brain stem death – organs could be removed from patients who have made it clear that this is what they want in these circumstances (Miller, Truog, Brock, 2010). Some form of living will/advanced directive could be drafted to do the work of registering the informed consent of the donor to the procedure.

Conclusion

So, to recap, present practice in the context of organ donation involving brain dead donors relies upon a false definition of death. How can death be redefined without jeopardising the transplantation programme? It can be done by adoption of a more credible definition of death, in conjunction with sanctioning breaches of the DDR.

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REPORT ON THE CONFERENCE "HUMAN MEDICAL RESEARCH : ETHICAL, ECONOMICAL AND SOCIO-CULTURAL ASPECTS"

February 7-11, 2011, Bochum, Germany

The international conference "Human Medical Research: ethical, economical and socio-cultural aspects", organized by Jan Schildmann, Oliver Rauprich, Verena Sandow, and Jochen Vollmann, took place at the Institute for Medical Ethics and History of

Medicine, Ruhr University Bochum between February 7 and 11, 2011. The conference was sponsored by the German Federal Ministry for Education and Research. A main goal of the conference was to provide a forum for young scholars (PhD students and post-docs) from different countries in Europe to discuss normative and empirical aspects of human medical research from the perspective of different disciplines. To this aim, fourteen young scholars coming from nine European countries met in the historical building of "Malakowturm" (a former mining shaft tower) and worked around three predefined topics: 1. normative and empirical aspects of evidence-based medicine, 2. conflicts of interest in medical research and 3. challenges of global medical research.

The five days of the conference included presentations by the conference participants who came from different disciplines and fields including medical ethics, medicine, philosophy, theology, and others. The presentations were followed by discussion for which plenty of time was given in order to facilitate the exchange between different disciplines. The introductory presentations by Nunziata Comoretto (Rome, Italy), Rieke van der Graaf (Utrecht, Netherlands) and Kristi Lõuk (Tartu, Estonia) provided a framework to analyse medical research with humans from an ethical perspective. They outlined substantial distinctions, such as interventional and non-interventional or therapeutic and non-therapeutic biomedical research on humans, each of which requires a different ethical framework. There was a focus on more recent developments in human medical research such as adaptive designs in clinical research or implications of the building of large biobanks. In the following presentations, Flavio D'Abramo (Rome, Italy) discussed ethical and epistemological issues at the base of translation of cancer molecular biomarkers, while Annelien Bredenoord (Utrecht, Netherlands) offered an overview of the increasing ethical debate around the disclosure of individual genetic data to research participants, due to the rapid developments in sequencing technology. The concept of conflicts of interest was delineated according to a historical perspective by Fiona McClenaghan (London, United Kingdom), specified in special areas as higher risk studies in pediatrics by Anna Westra (Leiden, Netherlands) and analysed with reference to the ethical foundation of the regulation of conflicts of interest in patient care and medical research by Verena Sandow (Bochum, Germany). A large number of presentations focused on the challenges of global medical research. In this respect, Ilja Pavone (Rome, Italy) explored the double standard approach in biomedical research in developing countries according to an ethical and legal perspective, while Thomas Zimny (Warsaw, Poland) focused on research involving human subjects and human biological material from a European Patent Law perspective. Rael Strous (Beer Yaakov, Israel) focused on the challenge of ethical decision-making in a global medical context, where issues of concern to medical ethics may be influenced by ethnic, cultural and time factors. Such a cultural perspective was exemplified by Susy Olave Quispe (Madrid, Spain), who presented a validation of a guide for reviewing clinical trials, which is to be used for the Peruvian research ethics committees, and by Mansooreh Saniei (London, United Kingdom), who analyzed the interrelation between human embryonic stem cell research and cultural peculiarities in Iran. A further starting point of reflection on the relevance of intercultural context was represented by Axel Siegemund (Dresden, Germany), who critically analyzed pharming (the production of pharmaceutical products using genetically modified plants and animals) as an ethically challenging application of biotechnology, bringing together the perspectives of environmental ethics, animal welfare and medical ethics.

In addition to the aforementioned presentations, the conference also included three workshops allowing work in small groups and to elaborate on specific topics such as "value judgments in the analysis and synthesis of evidence" – supported by Prof. Daniel Strech (Hannover, Germany), "conflicts of interest in medical research" – supported by Prof. Wolf-Dieter Ludwig (Berlin, Germany), and "medical research ethics in a global context" – supported by Prof. Michael Parker (Oxford, United Kingdom). In his public lecture "When is medical research in developing countries ethical?", Professor Parker focused on the challenges of high profile research which is sensitive to the ethical and cultural aspects of such collaboration. The presentation, which also draws on the practical experience of the speaker as a research ethicist, can be accessed via the website of the Institute.
http://www.ruhr-uni-bochum.de/malakow/institut/aktuelles.html#d110209

Last but not least, it should be pointed out that there was also sufficient time during the conference for informal discussion and networking, which not only contributed to a good working atmosphere, but also served as a basis for future co-operation. In summary, the five days of presentation, discussion and reflection provided an excellent opportunity to further the understanding of challenges regarding human research on the scientific empirical level, as well as the normative and socio-cultural level. The work begun will continue, since all participants have agreed to work on a publication which will summarise the results of the joint work.

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NEW RESEARCH ETHICS ACTIVITIES

Welcome to Ioana Elisabeta Hirişcău at the Department of Medical and Health Ethics in Basel.

The arrival of a new researcher from Romania, Ioana E. Hirişcău, MA, PhD, at the Department of Medical and Health Ethics in Basel is an opportunity to share information about recent work being carried out on research ethics.

At the Department of Medical and Health Ethics (MGE), Medical Faculty Basel, we have been engaged in developing a research and teaching knowledge base in the area of ethics of science and research ethics under the leadership of Prof. Dr. Stella Reiter-Theil. Since 2003, courses on research ethics have been offered to students at bachelor, master, doctorate and post doctorate levels, particularly in collaboration with the Swiss Nanoscience Institute / National Competence Center of Research in Nanoscale, and also the Faculty of Psychology. Based on this work, invitations have been accepted from inter alia the Paul Scherrer Institute, Switzerland, and EMPA (a Swiss Research Institute of the ETH Domain) to give talks on the subject.
The MGE has also become increasingly active in European research in this area; e.g., Stella Reiter-Theil has been appointed independent ethical advisor to the SEYLE project: "Saving and empowering young lives in Europe: promote health through prevention of risk-taking and self-destructive behaviors" (EU FP 7, grant no. 223091), noting that with the FP 7, the EU is said to "Get Tough on Ethics."[1] The objectives of the SEYLE project include the collection of information on the health and well-being of adolescents in eleven EU member states; performing interventions in adolescents leading to better health through decreased risk-taking and suicidal behaviours, and evaluating the outcomes of these interventions from a multidisciplinary perspective including social, psychological and economical aspects. The aim is to recommend an effective intercultural model for promoting health for adolescents in Europe; provide information for evidence-based prevention programs for adolescents in culturally diverse populations, and increase awareness and knowledge among policy makers, professionals and the public.

As a member of the MGE team, the author has furthermore been appointed under the aegis of Prof. Dr. Reiter-Theil and Prof. Dr. Andreas Papassotiro-poulos to be responsible for the Work Package Ethics for a further EU project: the ADAMS Alzheimer's disease-alcoholism-memory-schizophrenia research consortium. [2] This project is investigating genomic variations that underlie common neuropsychiatric diseases and disease-related cognitive traits in different human populations. ADAMS is also funded by FP 7 (grant no. 242257) and involves twelve partners, six coming from the EU and 6 from the Russian Federation. The completion of the human genome sequencing project and the development of high-through put genomic technologies have resulted in increasingly large and complex genomic data sets being generated, and in an increasing number of genome-wide association studies being conducted, combined then with deep sequencing work being undertaken.[3] These activities bring ethics of science challenges at the individual, community and population levels, particularly when noting the ethos that has developed in the scientific community of the rapid sharing and public release of genomic data.[4, 5] An issue at the centre of these reflections is the 'inclusion question'; what is the moral status of human genomic material; what is the status of data derived there from? Which standards should apply to research that deals not with the whole human being, but with human biological sample and the data derived from the samples, and furthermore what is the significance of whether the samples and data are a) personally identified; b) identifiable qua a group or a community, and if c) the samples and data are irreversibly anonymised (so that no link can be made to an individual)? Just as in the SEYLE project, the cross-border nature of ADAMS places these reflections into a challenging context, particularly when considering in ADAMS the multi-faceted historical developments underway in the Russian Federation.

In continuation of this growing area of speciality, the MGE colleagues are now pleased to announce that Ioana Elisabeta Hirişcău from Romania is joining the team in Basel. After her University studies of philosophy and clinical psychology, Ioana has just completed her PhD at the "Iuliu Hatieganu" Medical University, Cluj-Napoca. The title of the PhD dissertation is "Risk and Protection Factors of the

[1] Mary Fitzgerald, "The EU Gets Tough on Ethics," *Technology Ireland*, 03 2007. URL: ftp://ftp.cordis.europa.eu/pub/fp7/docs/technology-ireland.pdf. Accessed 8th April 2011.

[2] See the ADAMS website http://genseq.molgen.mpg.de/cms/index.php?page=the-group

[3] Jeantine E. Lunshof, Ruth Chadwick, Daniel B. Vorhaus & George M. Church, "From Genetic Privacy to Open Consent," *Nature Reviews Genetics* 9, 406-411, May 2008. Doi:10.1038/nrg2360.

[4] William W. Lowrance "Privacy, Confidentiality, and Identifiability in Genomic Research." URL: http://www.genome.gov/Pages/About/OD/ReportsPublications/IdentifiabilityWorkshopWhitePaper.pdf. Accessed 8th April 2011.

[5] See in particular the Bermuda principles and Fort Lauderdale agreement, available on URL http://www.genome.gov; also of interest is the Berlin declaration on Open Access to Scientific Knowledge , see URL http://oa.mpg.de/lang/en-uk/berlin-prozess/berliner-erklarung/, Accessed 12th April, 2011.

Sexual Dysfunctions after Radical Prostatectomy." It focuses on the impact of the consequences of the radical prostatectomy on the quality of couple`s life. Ioana has also been involved in supporting the local SEYLE project activities in Cluj. She is now engaged in preparing her project on SEYLE and ADAMS research ethical issues. Ioana's position has been made possible due to the generous grant made by the Basel Botnar Foundation to the MGE.
Ioana will be undertaking 'comparative ethics' research, i.e. the comparative analysis and evaluation of normative ethics in different countries of Europe as expressed in codes, guidelines, legal instruments etc., with the geographical focus being the EU, central and eastern European countries, and EU candidate and potential candidate countries.

The primary aim of the research will be to locate and compare bioethical and public health ethics guidelines, codes, and national laws, particularly referring to vulnerable populations such as young people who are at risk of mental health difficulties, or who already suffer from mental health problems. The situation regarding psychology research will be the focus of this work, taking an as example the SEYLE project, with one objective being to compare and contrast the findings with the Swiss situation.
It is hoped that the trans-border nature of the SEYLE, ADAMS and now this new 'BOTNAR' project will lead to fruitful synergies that can be used to support the design and implementation of prevention and public health programs and interventions, and make thereby a contribution not only to medical and health research, but also to the practice of clinical medicine and public health.

Acknowledgements:
We thank the Botnar Foundation, Basel, for making this project possible so generously.
Many thanks go to the Dean of the Medical Faculty Basel, Prof. Dr. A. Urwyler, and for his support for our idea.
We are also grateful for the trust of the Principal investigators of FP 7 SEYLE, Prof. Dr. Danuta Wasserman, Karolinska University, Stockholm, and Prof. Dr. Andreas Papassotiropoulos, Basel, FP 7 ADAMS, in allowing us to contribute to their important and challenging work.

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CÉSARIENNES – INTERPELLANTES QUESTIONS ÉTHIQUES

En Suisse, une grossesse sur trois se termine aujourd'hui par une césarienne. Au moment de mes études (années 1960), on était au-dessous de 10%. Les temps changent, la médecine progresse et veut mettre toutes les chances du côté des patient(e)s, en vue de la meilleure qualité de vie possible et d'un inconfort minimal. Toutefois, le fait est qu'on se demande jusqu'où ira à l'avenir l'impact des « variantes technicisées de la manière de faire des enfants dont nous avons l'habitude » (1).

Les organisations de sages-femmes s'émeuvent de cette désaffection de l'accouchement par voie basse - je me souviens avoir vu en Angleterre des affiches de cliniques promouvant la césarienne sous le slogan « Saving the love channel ». Récemment j'ai été frappé d'apprendre que, dans un service universitaire de Suisse alémanique, on accepte de routine de faire une césarienne sur le souhait de la femme quand, après avoir reçu les explications adéquates sur la non-nécessité de l'opération, la femme persiste dans sa demande. Certains considéreraient l'accouchement vaginal comme un « bizutage » (ce genre d'épreuves initiatiques entre étudiants ou membres d'une corporation) ! Well… j'avoue me sentir vraiment ici d'une ancienne génération. Pourtant, je me suis beaucoup engagé pour la reconnaissance et l'inclusion dans la loi des droits des patients ; mais la question semble de plus en plus actuelle de savoir si les patients sont en droit d'exiger des prestations de leur médecin (2).

La même interrogation, césarienne ou pas, peut se poser en sens inverse ; elle est discutée dans le dernier numéro de la revue de bioéthique Hastings Center Report (3). C'est de savoir s'il peut être admissible, et quand, qu'un tribunal ordonne la césarienne d'une femme contre sa volonté. Je m'y suis intéressé comme médecin officiel (cantonal), en rapport avec le fait que, dans certains Etats des USA, une césarienne d'autorité avait pu être décrétée chez des femmes toxicomanes proches du terme dont on juge qu'elles mettent gravement en danger le bien-être de l'enfant (4). Néanmoins, de notre côté de l'Atlantique, aucun pays n'admet que, si la personne concernée le refuse, une aussi sérieuse atteinte à l'intégrité physique puisse se justifier, même au nom du bien de l'enfant qu'elle porte.

Ici une remarque : Kolder et al. montrent que les femmes qu'on a contraintes à une césarienne contre leur gré tendaient à être pauvres, issues d'une minorité et souvent ne parlaient pas anglais. Un exemple de plus de cette constante de santé publique que les soins prodigués aux gens dépendent de leur statut et que les disparités socio-économiques se traduisent en injustices (NB : cela peut s'appliquer à la césarienne de convenance, très vraisemblablement plus aisément accordée à la femme de classe moyenne ou aisée).

Minkoff et Dryerly décrivent des mouvements de balancier aux Etats-Unis en ce qui concerne les césariennes « forcées », citant aussi plusieurs recours acceptés par les tribunaux supérieurs qui ont jugé qu'il n'était pas justifié de les pratiquer. Préoccupation : « Bien que les obstétriciens acceptent le droit des femmes de refuser des gestes médicaux, les vingt dernières années ont vu une érosion de ces droits. Cet affaiblissement est pour une part lié à deux choses : les guerres sans fin à propos de l'avortement et la vision que la relation entre femme et fœtus a fondamentalement un caractère de conflit ». Avec ce commentaire : « Aujourd'hui les contraintes sur les droits des femmes enceintes sont souvent plus prononcées que les limites posées aux droits des parents sur leurs enfants déjà nés ».

Pour conclure, d'un autre auteur américain ce conseil aux femmes : « Posez à votre gynécologue la question suivante : peut-il y avoir une circonstance dans laquelle vous refuserez de me laisser décider moi-même de ce qui concerne mon traitement ? » (5). Intéressant… : avec sans doute tous ceux qui se préoccupent d'éthique, j'estime que le droit de la femme de refuser est entier et déterminant, au cas où une instance quelconque s'avisait de lui imposer une césarienne ; je ne suis pas à l'aise s'agissant de son droit, par convenance, de requérir une césarienne. Convient-il que je sois plus attentif à mes propres tendances paternalistes ou machistes ?

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DISSERTATION

From Setting Limits to Shaping Practices
Trust and accountability in health care for older people

When I first started this thesis, I was a lawyer with specific ideas on decision-making, medical practice and informed consent. Based on the knowledge I had gathered during my studies, I had a clear-cut idea on how I would be fighting for the rights of older people in health care and how I would be improving their social position. On my travel a map, called informed consent, would direct me, providing a solid framework for advocating the rights of older people.

Now, a few years later, at the end of my travel, my perspective has changed profoundly. I still believe in informed consent as a valuable starting point and beacon for shaping medical practice and the communication between physician and patient. But there is so much more. So many parties influencing everyday medical practice in several ways and on various levels, so many varieties in the utilization of the rules of informed consent, numerous dilemma's in selecting and communicating treatment options, so many ways of respecting the older patient and countless manners of providing good care. In my teaching work, I encountered many cases of routine high tech medical interventions, including extensive surgery, on patients deep into their eighties and sometimes nineties. One of the most important lessons for me as a freshly graduated lawyer was that not all people have to be rescued and not all doctors treat older patients badly. Medical practice concerning older people is not either black or white, but instead can best be described as consisting of many shades of grey. It is difficult to judge a practice as right or wrong.

This obviously does not mean that there is nothing left to say about this practice. We need to remain aware of the still existing risk of evolving into a practice in which the older patient is not respected and his

rights are being violated or in which an older patient is treated at the will of the individual doctor. The framework we developed, concerning accountability and trust, is a valuable tool in this context. An important role in this framework is reserved for the professionals involved in the care for older people. This thesis is written with several groups of professionals in mind, working with older people or involved in their care. For instance, physicians and other health care workers, but also patients, managers, medical professional organizations, representative organizations for older people, insurers, and policy makers. All these people are the stakeholders that are needed for building a medical practice based on trust and the framework of accountability as presented here in this thesis. Now, it is their move.

So, what does this mean, this changed perspective on informed consent? In this context the distinction between analogous reality and digital abstraction, as made by the Dutch sociologist of law, Schuyt (Schuyt, 1982), is relevant. By talking about informed consent as the patient's right and the physician's duty, by focusing on the rules and boundaries as provided by law, and by only concentrating on informed consent as the outcome of a process, to be judged as right or wrong in specific cases on the level of the physician-patient relationship, informed consent is transformed into a digital abstraction, and thus the subtle nuances of reality of, in our case the decision-making process concerning older people, are lost. To be sure, at a certain level this digital abstraction is required and should be maintained, for example when conflicts arise concerning the information and decision-making process between physician and patient.

But, the decision-making process is so much more than mere informed consent. To make use of the roads that have been mapped in this thesis, to employ the opportunities provided by these roads, a change in the perspective on informed consent is needed, from a digital abstraction to an analogous reality. Thus, new medical decision-making practices can be built and shaped, based on trust and accountability of physicians. Accountability for the medical and non-medical arguments used in the decision process, for the way these arguments are communicated, and for the outcome, the decision that has been made. Thus, the building blocks for shaping this practice are the discussions on what it means to provide good care to older people (what arguments play a role here and how are they communicated) and on being transparent about the various value judgments from the diverse stakeholders influencing the decision process. Subsequently, trust in doctors is shaped based on the way physicians use the building blocks needed for building and shaping an accountable practice.

The prime focus of this study is the role and impact of value laden judgments on the decisions being made in medical practice concerning older people. These judgments influence the decision-making process from the onset. This position of value judgments is generally not recognized as such by medical professionals. According to doctors, the decision-making process concerning older people is primarily based on objective evidence gathered based on medical research. After the objective evidence has been individualized according to the subjective needs of the patients, values and value laden arguments come into play by way of the wishes and desires of the patient concerning treatment, non-treatment, fears and anxieties, and quality of life. This is, however, a too simplistic perspective on how the decision-making process really takes place, and too one-dimensional regarding which arguments are influencing this process at what time.

In this context, informed consent is also one of the building blocks for shaping this practice. What needs to be accomplished is that physicians have the knowledge, motivation and competencies required for reaching a decision based on the rules of informed consent, and in addition reflect on why informed consent is important and valuable. It is not enough if physicians follow the rules of informed consent because everybody knows that is what should be done. It is not satisfactory if physicians inform patients because that is considered to be good practice, turning informed consent into a mere constraint for medical decisions: as long as they comply with informed consent, they are all right.

What is aspired in this thesis is that physicians realize that they cannot only focus on the outcome of the decision-making process in terms of informed consent. Before this final step is reached, a practice is shaped in which informed consent is one of the building blocks. Physicians need to take an active role in shaping a decision-making practice in which they are held accountable for the way they communicate the value-laden arguments in the decision-making process with their patients. In this practice, the process, the prerequisites regarding the process on both the institutional and relational level, and the outcome form important building blocks, in addition to informed consent.

Thus, a practice is shaped concerning the care for older people in which the analogous reality, that is the uncertainties and complexities indentifying this care, is not lost to a digital abstraction of rules and regulations. What is aspired is that physicians consider the arguments for judging informed consent as valuable. By holding medical professionals accountable for the way they communicate the value laden arguments in the decision-making process with their patients, informed consent becomes more than a simple outcome.

What has been showed in this thesis is that for the medical profession to demonstrate itself as trustworthy, consisting of trustworthy professionals, it needs to take

action. First, it has to acknowledge that value judgments influence the decision-making process from the start. Second, these value-laden arguments have many sources. That is, it is not just the patient bringing these arguments to the fore, but physicians themselves also are guided, knowingly and unknowingly, by these judgments from various stakeholders on both the relational and institutional level such as managers, insurance companies, and supervising authority bodies and second opinion arrangements. Third, physicians have to reflect on these personal judgments and whether they can be judged as 'good' arguments. Subsequently, physicians are held accountable for communicating these judgments. By being transparent about the various arguments influencing the decision-making process, patients and other stakeholders are given the opportunity to judge whether the arguments used are acceptable.

Finally, the Erman logics model provides a three-step procedure for strengthening the position of older people in policymaking and health care practice. The first step involves providing safeguards for respecting the rights of older people (Erman, 2006). This implies setting laws, rules and regulations, which give the elderly their due. The second step involves building a structure on this rules-based foundation in which institutional mechanisms, such as organizations representing the elderly, supervising bodies and guideline developers, are embodied. The interests of the older patient need to be built into these institutional arrangements, thus protecting these interests in the negotiation and bargaining process. Based on these first two steps, we have now given shape to the legal en institutional preconditions for strengthening the position of older people. However, one final step has to be taken, as the preconditions we have identified have to be filled in with what actually happens in medical practice concerning older people, on the relational level. In this context, the third step implies that the stakeholders, physicians, insurers, patient organizations, policy makers, etc, take responsibility and be accountable for addressing value issues regarding the care for older patients. On this level, the stakeholders involved have to be aware of the role and impact of the value judgments influencing their discretionary freedom and their and other stakeholder's actions in each of the three steps, thus influencing the care provided to older people. For, every direct relationship between each of the stakeholders on both levels is imbued with value laden arguments.

So, what are the consequences of these three steps for the relationship and communication process between physician and older patient? In this relationship, the patient's and the physician's values play their part, but also the value laden arguments of the stakeholders involved, underlying their guidelines, protocols, instructions, or policies. But also, these arguments have their impact on each of the previous steps, as they influence the stakeholders' interest and may change the policies and regulations on a national, regional or local level. In other words, although we distinguish three separate steps, each step is linked to the other in two directions, influencing each other back and forth. Thus, the significance of preserving the deliberation process becomes clear: it cannot be set in advance which arguments can be considered appropriate and justified, but has to be judged every time a decision is made.

If we assume that in the care for older people, these three steps are identified and respected, then we will be able to trust individual physicians and the medical profession as a whole, dependent on the way they use the arguments from multiple stakeholders trying to influence medical practice and on the appropriateness of these arguments. Physicians are held accountable for the procedural and substantive quality of their decisions. Accordingly, accountability in health care practices is regulated by the norms and rules, which are the outcome of giving good arguments to protect the rights and entitlements of older patients, in other words, by giving the elderly a virtual voice: physicians are held accountable for the kind of arguments they use to serve the older patient's situation. In this respect, we propose that the deliberation-based framework on accountability and trust implies a radical and paradigmatic shift: not controlling but shaping practices in health care, which may deserve trustworthiness. Thus, we will move from a practice of setting limits to shaping practices in the care for older people.

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INTERNATIONAL ASSOCIATION FOR EDUCATION IN ETHICS (IAEE)

In April 2011 the International Association for Education in Ethics was officially established. At the initiative of UNESCO, a group of international scholars in ethics education created this global platform for exchange of experiences in the teaching of ethics. The Secretariat is established at the Center for Healthcare Ethics, Duquesne University, Pittsburgh, USA (www.duq.edu/chce).

Teaching ethics has a special significance at the global level and addresses a variety of different perspectives providing new insights into ethics from various cultural experiences from around the world. However, exchange of these experiences with education at the global level has been virtually non-existent. Thus, establishing a platform to promote education in ethics at a global scale is an exciting new initiative.

The goals of IAEE are to exchange and analyze experiences with the teaching of ethics in various educational settings, to promote the development of knowledge and methods of ethics education, to function as a global centre of contact for experts in this field, to promote contacts between members from countries around the world and to enhance and expand the teaching of ethics at national, regional and international levels.

The IAEE will be organizing international conferences and other scholarly meetings. The first international conference will take place at Duquesne University in Pittsburgh, USA, in May 2012. This conference will feature keynote lectures from experts and parallel sessions regarding a wide variety of fields. These fields of study include: bioethics, medical ethics, nursing ethics, pharmacy ethics, dental ethics, science ethics, engineering ethics, philosophical ethics, religious ethics and business ethics.

Those who are interested in becoming members of the International Association for Education in Ethics or would like to attend the first conference should visit the Center for Healthcare Ethics website at www.duq.edu/chce/iaee. For more information: contact Professor dr. Henk ten Have (tenhaveh@duq.edu). Registration for membership: www.duq.edu/chce/iaee/register.cfm

BOOK ANNOUNCEMENT

Brigitte Feuillet, Professor at the Faculty of Law, Rennes and Member of the Institut Universitaire de France would like to draw your attention to the release of the book “Who is my Genetic Parent ? Donor Anonymity and Assisted Reproduction: a Cross-Cultural Perspective”.

Brigitte Feuillet-Liger, Kristina Orfali, Thérèse Callus

Editeur: Bruylant

ISBN: 978-2-8027-2999-0

316 pages - Parution: 03/2011

For more information:
http://www.bruylant.be/st/fr/fiche.php?id=13097

VACANCIES

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RUHR UNIVERSITÄT BOCHUM

RUB

Research Associate in Medical Ethics, Bochum, Germany

The Institute for Medical Ethics and History of Medicine (Director: Prof. Dr. med. Dr. phil. Jochen Vollmann), Ruhr-Universität Bochum, Germany, is offering a position as a Research Associate (Salary scale E 13 TV-L, 50%) beginning in October 2011 (or later).

The post forms part of the NWR-Junior Research Group "Medical Ethics at the End of Life: Norm and Empiricism" (Head: Dr. med. Jan Schildmann, M.A.) at the above named institute which is supported by a major fund of the Ministry for Innovation, Science and Research of the state of North Rhine-Westphalia (2010-2014). The post is presently limited to two years; an extension is possible.

The profile of the research post comprises development, conduct and analysis of empirical research projects on ethical aspects at the end of life in modern medicine. The work requires competences regarding qualitative and quantitative socioempirical research. We offer a dynamic research environment with the possibility for the preparation of a Ph.D. in the field of Medical Ethics or further post-doctoral qualification. The projects of the junior research group have an interdisciplinary and international orientation. We cooperate with the Centre for Medical Ethics Bochum, other faculties of the Ruhr-Universität Bochum and national as well as international research partners.

We are looking for a talented and dedicated young scholar with strong intellectual abilities, an interest in interdisciplinary research, flexibility, team-working skills. Candidates should have successfully completed a degree in social sciences, psychology, medicine, philosophy, or another relevant discipline. Experience in the field of biomedical ethics is advantageous. The working languages in our Institute are German and English.

In accordance with the Ruhr-Universität's internationalisation strategy, we also expressly invite applications from abroad. The Ruhr-Universität Bochum is committed to promoting the careers of women in areas in which they are under-represented and, therefore, actively welcomes applications from female candidates. As an equal opportunities employer, we explicitly encourage applications from suitably qualified disabled candidates and other groups.
Further information on the Institute for Medical Ethics and History of Medicine can be found on our homepage (www.ruhr-uni-bochum.de/malakow/). The Welcome Centre of the Ruhr-Universität provides additional information (http://international.rub.de/welcomecentre/index.html.en).
For further questions, in advance of your application, please contact Dr. Jan Schildmann (e-mail: jan.schildmann@rub.de).

Please send in your application to the address below by **June 15, 2011**. International application may be sent via e-mail.

Prof. Dr. Dr. Jochen Vollmann
Abteilung für Medizinische Ethik und Geschichte der Medizin
Ruhr-Universität Bochum
Markstraße 258a
D-44799 Bochum, Germany
PHILOSOPHY OF MEDICINE / MEDICAL ETHICS

Employment as Ph.D-candidate (four-year position) at the Division for Heath and Society, Department of Medical and Health Science, Linköping University, Sweden.

This is a Ph.D-candidate position in philosophy of medicine and medical ethics. This is one of the major fields of research at the Division for Health and Society, in which for example ethical projects in the area of reproduction technology as well as children and health are about to start. Requirements: A successfully completed degree in Philosophy or Religious Science. The position requires a sufficient command of English for international collaboration and publication.

The successful candidate will be part of a dynamic and international research environment.

For more information contact: Docent Kristin Zeiler (kristin.zeiler@liu.se), head of the division Marie Jansson
(marie.jansson@liu.se) or administative personell Anna Schenell (anna.schenell@liu.se).

The application should include curriculum vitae, application form (see
www.liu.se/jobba) and all other merits that she or he wishes to refer to. The application need to be sent to: Dnr LiU-2011-00822, Registrator, 581 83 LINKÖPING, Sweden (registrator@liu.se) **no later than 29 May 2011**.

ANNOUNCEMENTS

In 2011 the annual EACME conference will take place in Istanbul (Turkey) 15-17 September 2011.

The Turkish Bioethics Association and the European Association of Centres of Medical Ethics (EACME) will organise the EACME Annual Conference.

The Turkish Bioethics Association will be the host and co-ordinator of the event.

Conference chair: Yesim Isil Ulman.

The main topic of 2011 is: Bioethics from a Cross-Cultural Perspective.

The four central topics are:

1) Bioethics and Humanities
2) The European Biomedicine Convention: a Platform of Dialogue
3) Human Rights in Bioethics: Universalism and Particularism
4) Bioethics in Conflicting Issues

More information: http://www.eacme2011.org/

Globalising European Bioethics Education
Summer School
Istanbul, Turkey
September 11-14, 2011
In Conjunction with the European Association of Centres of Medical Ethics Annual Conference, September 15-17, 2011

Venue: The Peak Hotel, Istanbul
Meals and housing: The Peak Hotel, Istanbul

Price per participant per day: 110 EURO (room and breakfast and lunch included)
Contact and registration: Heather Ames (h.m.r.ames@studmed.uio.no)

Application deadline is June 10, 2011

For more information: http://www.gleube.eu

Master in Ethics: for me, why not?

The Master Ethics: Life, Norms and Society is an interdisciplinary program examining the ethical challenges of our time. The increasing technological, biological, economic, religious and legal complexities of today's society is raising more and more ethical challenges. From a European and global perspective, this MA programme brings together academics from different disciplines in order to produce new insights and progress. The course also relies on an interdisciplinary approach to contemporary issues.

Five Interdisciplinary possible Courses of Study (French or bilingual degree courses Fr/En): Medical Ethics and Bioethics**;** Human Rights: Principles, Norms and Interpretation; Ethics and Society; Ethics and Religions; Ethics and Management.

Next Public Information Meeting
Tuesday 24th may, 2011
(CEERE*- Strasbourg)
For more information: http://ethique-alsace.unistra.fr

International Visiting Fellowships in Medical Ethics, Bochum, Germany

The Institute for Medical Ethics and History of Medicine (Director: Prof. Dr. med. Dr. phil. Jochen Vollmann), Ruhr-Universität Bochum, Germany, invites applications for Visiting Fellowships in Medical Ethics beginning in 2011 or later.

The fellowships are awarded to doctoral or post-doctoral researchers under the Institute's newly established International Visiting Fellowship Programme in Medical Ethics. In accordance with the Ruhr-Universität's internationalisation strategy, the programme is intended to promote international presence and collaboration in the Institute.

The fellows will be given intensive research support and office facilities in the Institute. The University's International Office (http://www.international.ruhr-uni-bochum.de/intoff/index.html.en) and Welcome Centre (http://international.rub.de/welcomecentre/index.html.en) provide support and advice prior to and during the stay in Bochum. The duration of the fellowships is negotiable up to a maximum of 2 years. Fellows receive a monthly stipend between 1.000 € and 1.500 € to cover their living expenses in Germany, depending on their qualification and age. A supplementary allowance is available for fellows with children under 12 years of age. Fellowships do not provide medical insurance or other social benefits. Social security or tax-payments are not deducted from the stipend.

The application should include (1) a curriculum vitae, (2) a short outline (ca. 1-2 pages) of the purpose of your visit, including the topic of your intended study, the planned output, and possible relationships to existing research focuses of our Institute, (3) a tentative work schedule, (4) two letters of recommendation, and (5) a copy of one of your writings, preferably an international publication.

Please send in your application by June 1, 2011

IBC 37: Intensive Bioethics Course

The Intensive Bioethics Course is a week-long academic program in bioethics designed for health care practitioners, policy makers, and clinical researchers.
The course addresses the day's most challenging topics in health care ethics in a setting that allows for sustained dialogue through lectures and small discussion groups with a distinguished faculty.

Kennedy Institute of Ethics, Georgetown University, Washington, D.C.
June 6-10, 2011

For more information:
http://kennedyinstitute.georgetown.edu/programs/ibc.cfm

Ethics Teacher Training Course
June 20 – 24, 2011-02-11
Duquesne University, Pitssburgh PA, U.S.A.

For more information: http://www.duq.edu/chce

International Conference: What makes us moral?
Amsterdam, June 23-24, 2011
VU University Amsterdam

For more information:
http://www.ph.vu.nl/nl/onderzoek/secties/praktische-filosofie/conference-what-makes-us-moral/index.asp

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The **Australian Association of Bioethics and Health Law's 2011 is organizing a conference - on the Gold Coast, Queensland, 7-10 July, 2011**.

PLUS an additional day on Medical Futility on July 11th at UQ Herston SOM in ES Meyers.
See www.cdesign.com.au/aabhl2011

The main conference canvases the following themes: Expectations, Hope and Futility: Law and Bioethics in Contemporary Healthcare.

The first Symposium on Ethics of Environmental Health will take place in Prague, Czech Republic, August 24-27. It will be a satellite meeting of the 14th International Congress of Radiation Research in Warsaw, August 28 - September 1.
http://www.seeh2011.org

Special Issue of Nursing Ethics
'Nursing Ethics at the End-of-Life'
Guest Editor: Chris Gastmans

Submission deadline: 30th August 2011

This special issue of Nursing Ethics invites scholars, both theoreticians and practitioners, to contribute to a fruitful debate on nursing ethics perspectives on end-of-life care. The assumption behind this thematic issue is that nurses play an important role in end-of-life care. These experiences are reinforced by their patient-centered practice, their provision of continuous 24-hour care, and their experience and expertise in caring for dying patients and their families. During these care processes, nurses are frequently confronted with ethical issues regarding the end of life. By means of empirical and theoretical clarification this special issue aims to contribute to the development of nursing ethics views on end-of-life care in order to voice the nursing ethics perspectives in the debate.

For more information:
http://www.uk.sagepub.com/journals/Journal201821/manuscriptSubmission

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Human Embryo Research: Law, Policy and practice
An **international conference** hosted by the Anscombe Bioethics Centre.
8 September 2011 Oxford UK

For more information:
http://www.anscombebioethics.bigcartel.com

"Publish or Perish. Intensive Course on research and publishing in the field of bioethics."
Leuven, Belgium, 3-6 October 2011

The Centre for Biomedical Ethics and Law (Leuven University) is organising an intensive course on research and publishing in bioethics and medical humanities. Many (young) researchers are struggling to get their work published.
This course aims to provide practical tools to get well planned research work published.
For more information: http://www.masterbioethics.org under Intensive Courses.

Third European Conference on Health Law- Open for registration
Leuven (Belgium) 6-7 October 2011
An ageing Europe - Health Law Revisited

www.eahl2011.eu
info@eahl2011.eu

CFP: Moral Responsibility: Analytic Approaches, Substantive Accounts and Case Studies.
International Conference, Center for Ethics & Value Inquiry (Ghent University, Belgium) Monday and Tuesday 18-19 October 2010
For more information visit the conference website at:
http://www.cevi-globalethics.ugent.be/MR2010

Cultivating Morality: Human Beings, Nature and the World. International Conference on Moral Education, Nanjing International Conference Hotel, **24-28 October 2011**.
More information: http://nanjing2011.org

Intensive Course "Ethics of Reproductive Technologies"
(Leuven, Belgium, 16-18 November 2011)
The Centre for Biomedical Ethics and Law (of Leuven University) is organising an intensive course on Ethics of Reproductive Technologies. The objective of this course is to focus at some of the most challenging ethical issues in reproductive medicine, as well on the level of fundamental notions as applied clinical questions.
During the course experts will give presentations on various topics in the domain of reproductive medicine. There will be time for intensive discussions. The language of instruction will be English.
For more information: http://www.masterbioethics.org under Intensive Courses.

Intensive Course "Nursing Ethics"
Leuven, Belgium, 7-9 December 2011

The Centre for Biomedical Ethics and Law (of Leuven University) is organising an intensive course on Nursing Ethics. The objective of the course is to foster exchanges on foundational and methodological approaches as well as on contemporary and educational issues in nursing ethics. This course works from an interdisciplinary (philosophical, theological, nursing, clinical-ethical) perspective.

For more information: http://www.masterbioethics.org under Intensive Courses.

DEADLINE NEXT NEWSLETTER

Deadline for the second edition of 2011:

AUGUST 15, 2011

If you wish to promote an event, or to inform your EACME-colleagues about the results of your work, descriptions of projects, book reviews etc. Any good ideas?

Don't hesitate to contact editor Rouven Porz: rouven.porz@insel.ch or Angelique Heijnen : a.heijnen@maastrichtuniversity.nl

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