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Addressing requests by patients for nonbeneficial interventions.
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Volk, Michael L; Lieber, Sarah R; Kim, Scott Y; Ubel, Peter A; Schneider, Carl E
Contracts with patients in clinical practice.
Lancet 2012 Jan 7; 379(9810): 7-9
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Mangat, Mona V; Burke-Galloway, Linda
First amendment rights of patients and physicians.
JAMA: the journal of the American Medical Association 2011 Dec 14; 306(22): 2455; author reply 2455-6
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Document 4
Lieber, S R; Kim, S Y; Volk, M L
Power and control: contracts and the patient-physician relationship.
International journal of clinical practice 2011 Dec; 65(12): 1214-7
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Document 5
Dyer, Clare
Ombudsman reports GP to the GMC for refusing to apologise to a patient.
BMJ (Clinical research ed.) 2011 November 10; 343: d7322
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Conway, Brian V
Should doctors feel able to practise according to their personal views and beliefs?--Yes.
The Medical journal of Australia 2011 Nov 7; 195(9): 496
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Jerrold, Laurance
Litigation and legislation. Don't bug me.
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McGough, Robert
Any qualified provider. The choice is theirs.
The Health service journal 2011 Oct 20; 121(6279): 28-9
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Document 9
Gopichandran, Vijay; Gaitonde, Rakhal
When the patient's family refuses care: a practical ethical dilemma.
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Devadasan, Roopa
Response: caught between two world views.
Indian journal of medical ethics 2011 Oct-Dec; 8(4): 249-51
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Demehri, Natasha
2011 Humanism in Medicine Essay Contest: third place: The heart in my white coat.
Academic medicine : journal of the Association of American Medical Colleges 2011 Oct; 86(10): 1280-1
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Document 12
**Document 13**
DeMaria, Anthony N

The confessions of an inefficient provider.

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**Document 14**
Murtagh, Lindsey; Miller, Matthew


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**Document 15**
Becker, Frank

[Ethical aspects of physician-patient relations in the new media]. = Etiske aspekter ved lege-pasient-relasjoner i nye medier.
Tidsskrift for den Norske lægeforening : tidsskrift for praktisk medicin, ny række 2011 Sep 6; 131(17): 1677-9

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**Document 16**
Lloyd, Barbara Teresa; Stirling, Christine

Ambiguous gain: uncertain benefits of service use for dementia carers.
Sociology of health & illness 2011 Sep; 33(6): 899-913

**Abstract:** Community services for carers of people with dementia can assist in relieving caregiver burden and delay the institutionalisation of the person with dementia. Under some conditions, however, engagement with dementia services may produce unintended negative consequences, resulting in increased confusion and a reduction of agency for carers. Drawing on an analysis of three salient aspects of caregiver identities, this paper examines specific instances and consequences of 'ambiguous gain', defined as 'a putative or demonstrated benefit that, as an unintended outcome, results in increased uncertainty and a consequent reduction of agency or wellbeing at the level of individual or collective identity'. The paper concludes with a discussion of implications for policy and practice.

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**Document 17**
Gupta, Vidya Bhushan; Brosco, Jeffrey P; Patel, Nidhip; Braddock, Adam; Stein, Martin T

An ethical conflict between parents and clinician in a child with a language delay.
Journal of developmental and behavioral pediatrics : JDBP 2011 Sep; 32(7): 559-60

**Abstract:** CASE: A developmental-behavioral pediatrician evaluated a 2-year-old child for developmental delays. He
determined that the child had mild expressive language delays; the child had an intelligible vocabulary of 20 words and at least 20 other words that he said unclearly. He said a few contracted 2-word phrases, such as "gimme" and "its ok." He was shy and generally clung to his parents who spoke softly and very little. His development in all other domains was normal. Hearing evaluation and the neurological examination were normal. The pediatrician provided suggestions to the parents in order to stimulate language and scheduled a follow-up appointment in 3 months. The parents asked him to refer the child for early intervention and write a letter to the US Immigration and Naturalization Service. They asked that the letter state that the child had a disabling condition and returning the child and his family to their country of origin would cause permanent harm to the child. The parents then gave the pediatrician a draft of a letter that had been prepared by an immigration lawyer. The physician explained to the parents that the child had a mild expressive language delay and that he would like to see the child again in 3 months before deciding on early intervention. He advised them to obtain a copy of his medical note from the medical records department. The parents insisted that he write the letter and got upset and called him "heartless" when the physician refused to write the letter.
Document 23
Groll, Daniel
What health care providers know: a taxonomy of clinical disagreements.
Abstract: Some assume that respecting patient autonomy means clinicians should refrain from expressing opinions about what's in a patient's best interests. But depending on the kind of medical decision the patient is making, a clinician may have expertise vital to the patient's best interests—and even if she doesn't, she may still know what is best.

Document 24
Kipnis, Kenneth
Impairing loyalty: corporate responsibility for clinical misadventure.
The American journal of bioethics : AJOB 2011 Sep; 11(9): 3-9
Abstract: A medical device manufacturer pays a surgeon to demonstrate a novel medical instrument in a live broadcast to an audience of specialists in another city. The surgical patient is unaware of the broadcast and unaware of the doctor's relationship with the manufacturer. It turns out that the patient required a different surgical approach to her condition—one that would not have allowed a demonstration of the instrument—and she later dies. The paper is an exploration of whether the manufacturer shares, along with the doctor, responsibility for the death of the patient. Three arguments for corporate responsibility are considered; two are criticized and the third is offered as sound.

Document 25
Hall, Alicia
Foxes guarding the henhouse: systemic responsibility for corporate harms.
The American journal of bioethics : AJOB 2011 Sep; 11(9): 10-1

Document 26
Harter, Thomas D
Corporate moral culpability in health care: when the implications don't fit the crime.
The American journal of bioethics : AJOB 2011 Sep; 11(9): 12-3

Document 27
Spillman, Monique A; Sade, Robert
Does fortune foul fidelity?
The American journal of bioethics : AJOB 2011 Sep; 11(9): 14-5
Document 28
Trachtman, Howard
**Blind spots.**
The American journal of bioethics : AJOB 2011 Sep; 11(9): 16-8
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Document 29
Degeling, Chris; Townley, Cynthia; Rogers, Wendy
**Understanding corporate responsibility: culture and complicity.**
The American journal of bioethics : AJOB 2011 Sep; 11(9): 18-20
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Document 30
Chiapperino, Luca; Oishi, Janaina Oliva
**Challenging the idea of corporate responsibility: physician's obligation to disclose information.**
The American journal of bioethics : AJOB 2011 Sep; 11(9): 20-1
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Document 31
Johnson, Lee J
**Be careful if ending treatment agreement.**
Medical economics 2011 Aug 10; 88(15): 56, 58
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Document 32
Berger, J T
**Redefining the domains of decision making by physician and patient.**
Georgetown users check [Georgetown Journal Finder](#) for access to full text

Document 33
Thorgaard, Keld; Jensen, Uffe Juul
**Evidence and the end of medicine.**
Medicine, health care, and philosophy 2011 Aug; 14(3): 273-80
**Abstract:** Fifty years ago, in 1961, Feinstein published his first path-breaking articles leading to his seminal work Clinical Judgement and to the establishment of clinical epidemiology. Feinstein had an Aristotelian approach to scientific method: methods must be adapted to the material examined. Feinstein died 10 years ago and few years before his death he concluded that efforts to promote a person-oriented medicine had failed. He criticised medicine for not having recognized that only persons can suitably observe, evaluate and rate their own health status. Feinstein's position was—as in Clinical Judgement—methodological. He didn't espouse ethical principles. He pointed to methodological deficiencies in clinical epidemiology and evidence-based medicine. In this article we'll provide a
framework for understanding and justifying Feinstein's call for a person-oriented medicine which recognizes patients as co-actors in clinical reasoning. It's argued that craftsmanship and practical wisdom are integrated in clinical judgement and reasoning and that clinical reasoning is not only about means to achieve the end, health. We do also reason and deliberate about ends. The 'defining end' of medicine (health) has continuously been negotiated and so been the object of deliberation. For centuries among professionals, in recent years among professionals and patients. These negotiations and deliberations lead to ongoing specifications of health as a 'guiding end', i.e. an end guiding clinical reasoning about what to do in particular situations. Feinstein's self-critical account to clinical epidemiology at the end of his professional career reflects the fact that patients during the last 30-40 years (i.e. in the period after the publication of Clinical Judgement) widely have been recognized as persons with rights to autonomy. Feinstein's lesson is, however, that espousing and recognizing ethical ideals is not enough. A change of clinical practice and its methods is necessary. His critique also implies that clinical epidemiology and evidence-based medicine as practiced haven't provided such a turn.

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Document 34
McGee, Summer Johnson
To friend or not to friend: is that the question for healthcare?

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Document 35
Brudney, Daniel; Lantos, John
Agency and authenticity: which value grounds patient choice?
Abstract: In current American medical practice, autonomy is assumed to be more valuable than human life: if a patient autonomously refuses lifesaving treatment, the doctors are supposed to let him die. In this paper we discuss two values that might be at stake in such clinical contexts. Usually, we hear only of autonomy and best interests. However, here, autonomy is ambiguous between two concepts-concepts that are tied to different values and to different philosophical traditions. In some cases, the two values (that of agency and that of authenticity) entail different outcomes. We argue that the comparative value of these values needs to be assessed.

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Document 36
MacGillivray, Brian H; Pidgeon, Nick F
Humility needed in decision-making.
Nature 2011 July 27; 475(7357): 455

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Document 37
Hytten, Karsten
[Prayer during physician consultation?]. = Bønn under legekonsultasjon?
Tidsskrift for den Norske lægeforening : tidsskrift for praktisk medicin, ny række 2011 Jul 1; 131(13-14): 1319

Georgetown users check Georgetown Journal Finder for access to full text
Conscientious refusals to refer: findings from a national physician survey.
Journal of medical ethics 2011 Jul; 37(7): 397-401

Abstract: Regarding controversial medical services, many have argued that if physicians cannot in good conscience provide a legal medical intervention for which a patient is a candidate, they should refer the requesting patient to an accommodating provider. This study examines what US physicians think a doctor is obligated to do when the doctor thinks it would be immoral to provide a referral.

Approaching patients and family members who hope for a miracle.

Abstract: A clinical problem may arise when caring for patients or their surrogates who prefer continued aggressive care based on the belief that a miracle will occur, despite a clinician's belief that further medical treatment is unlikely to have any meaningful benefit. An evidence-based approach is provided for the clinician by breaking this complex clinical problem into a series of more focused clinical questions and subsequently answering them through a critical appraisal of the existing medical literature. Belief in miracles is found to be common in the United States and is an important determinant of how decisions are made for those with advanced illness. There is a growing amount of evidence that suggests end-of-life outcomes improve with the provision of spiritual support from medical teams, as well as with a proactive approach to medical decision making that values statements given by patients and family members.

"Dios bendiga usted!" "God bless you!".
Journal of palliative medicine 2011 Jul; 14(7): 879-80

Involuntary discharge of a patient receiving hemodialysis.

Professionals online: sharing too much?
Community practitioner : the journal of the Community Practitioners’ & Health Visitors' Association 2011 Jul; 84(7): 14-6
Tensions between medical professionals and patients in mainland China.

Abstract: In China, state investment into public hospitals has radically decreased since the early 1980s and has brought on the dismantling of the healthcare system in most parts of the country, especially in rural areas. As a result of this overhaul, the majority of public hospitals have needed to compete in the so-called socialist market economy. The market economy stimulated public hospitals to modernize, take on highly qualified medical professionals, and dispense new therapies and drugs. At the same time, liberalization has clearly affected the attitude and behavior of both medical professionals and the general public. The public has many concerns about the healthcare system for various reasons: there are long hospital waiting lists, patients experience difficulties in obtaining an appointment to see a qualified doctor, and, over the past decades, there has been an increase in out-of-pocket healthcare expenditure. These and other changes in post-reform China have radically reshaped the doctor-patient interaction, which is increasingly eroded by tension and violence.

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Document 48

Hytten, Karsten

[Private relationship between physician and patient], = Privat forhold mellom lege og pasient.

Tidsskrift for den Norske lægeforening : tidsskrift for praktisk medicin, ny række 2011 Jun 3; 131(11): 1100

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Document 49

Gadgeel, Shirish M

Hope and realism: the perfect balance?


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Document 50

Witt, Catherine

Professional boundaries in an electronic age.

Advances in neonatal care : official journal of the National Association of Neonatal Nurses 2011 Jun; 11(3): 141-2

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Document 51

Graber, Mark A; Graber, Abraham D

Black, white or green: 'race', gender and avatars within the therapeutic space.

Medical humanities 2011 Jun; 37(1): 9-12

Abstract: Personal identity is critical to provider–patient interactions. Patients and doctors tend to self-select, ideally forming therapeutic units that maximise the patients' benefit. Recently, however, 'reality' has changed. The internet and virtual worlds such as Second Life (http://www.secondlife.com/) allow models of identity and provider–patient interactions that go beyond the limits of mainstream personal identity. In this paper some of the ethical implications of virtual patient–provider interactions, especially those that have to do with personal identity, are explored.

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Document 52

Hardonk, Stefan; Daniels, Sarah; Desnerck, Greetje; Loots, Gerrit; Van Hove, Geert; Van Kerschaver, Erwin; Sigurjónsdóttir, Hanna Björg; Vanroelen, Christophe; Louckx, Fred

Deaf parents and pediatric cochlear implantation: an exploration of the decision-making process.

American annals of the deaf 2011 Summer; 156(3): 290-304

Abstract: The study examined factors in deaf parents' decision between cochlear implantation (CI) and traditional hearing aids for their child. The subjects were 6 Flemish children ages 5-9 years with severe/profound congenital hearing loss, with at least 1 deaf parent. The researchers, who conducted thematic content analysis of qualitative data collected through parent interviews, found that with the exception of a family with 1 hearing parent, parents gave priority to Deaf identity, sign language, and ethical issues in deciding between CI and hearing aids. Medical risks were also mentioned. The researchers conclude that the decision-making processes of the parents involved factors that have also been found among hearing parents, as well as aspects that have not been reported to play a role in hearing parents' decision making. A further conclusion is that deaf parents' perspective merits attention in professional practice and empirical research.

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Document 53
Boone, Brandy A

The "casual" patient is still your patient.
Delaware medical journal 2011 Jun; 83(6): 179-80

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Document 54
Payne, Kate

Summer to do list: living up to trust.
Tennessee nurse / Tennessee Nurses Association 2011 Summer; 74(2): 8

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Document 55
Will, Jonathan F

A brief historical and theoretical perspective on patient autonomy and medical decision making: Part II: The autonomy model.
Chest 2011 Jun; 139(6): 1491-7

Abstract: As part of a larger series addressing the intersection of law and medicine, this essay is the second of two introductory pieces. Beginning with the Hippocratic tradition and lasting for the next 2,400 years, the physician-patient relationship remained relatively unchanged under the beneficence model, a paternalistic framework characterized by the authoritative physician being afforded maximum discretion by the trusting, obedient patient. Over the last 100 years or so, in response to certain changes taking place in both research and clinical practice, the bioethics movement ushered in the autonomy model, and with it, a profoundly different way of approaching decision making in medicine. The shift from the beneficence model to the autonomy model is governed legally by the informed consent doctrine, which emphasizes disclosure to patients of information sufficient to permit them to make intelligent choices regarding treatment alternatives. As this legal doctrine became established, philosophers identified an inherent value in respecting patients as autonomous agents, even where patient choice seems to conflict with the physician's duty to act in the patient's best interests. Whereas the beneficence model presumed that the physician knew what was in the patient's best interests, the autonomy model starts from the premise that the patient knows what treatment decision is in line with his or her true sense of well-being, even where that decision is the refusal of treatment and the result is the patient's death.

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Document 56
Eliott, Jaklin A; Olver, Ian

Dying cancer patients talk about physician and patient roles in DNR decision making.

Abstract: Within medical and bioethical discourse, there are many models depicting the relationships between, and roles of, physician and patient in medical decision making. Contestation similarly exists over the roles of physician and patient with regard to the decision not to provide cardiopulmonary resuscitation (CPR) following cardiac arrest [the do-not-resuscitate or do-not-resuscitate (DNR) decision], but there is little analysis of patient perspectives.

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Final responsibility for treatment choice: the proper role of medical doctors?
Holm, Søren

Abstract: To analyse whether the traditional allocation of decision-making responsibility is still justifiable. And, if not to analyse the strength of claims made by other health care professions and by patients.

Shared decision making: trade-offs between narrower and broader conceptions.
Cribb, Alan; Entwistle, Vikki A

Abstract: Shared decision-making approaches, by recognizing the autonomy and responsibility of both health professionals and patients, aim for an ethical 'middle way' between 'paternalistic' and 'consumerist' models of clinical decision making. Shared decision making has been understood in various ways. In this paper, we distinguish narrow and broader conceptions of shared decision making and explore their relative strengths and weaknesses. In the first part of the paper, we construct a summary characterization of an archetypal narrow conception of shared decision making (a conception that does not coincide with any specific published model but which reflects features of a variety of models). We show the shortcomings of such a conception and highlight the need to broaden out our thinking about shared decision making if the ethical (and instrumental) goals of shared decision making are to be realized. In the second part of the paper, we acknowledge and explore the advantages and disadvantages of operating with broader conceptions of shared decision making by considering the analogies between health professional-patient relationships and familiar examples of 'open-ended' relationships (e.g. friendships). We conclude by arguing that the illustrated 'trade-offs' between narrow conceptions (which may protect patients from inappropriately paternalistic professionals but preclude important forms of professional support) and broad conceptions (which render more forms of professional support legitimate but may require skills or virtues that not all health professionals possess) suggest the need to find ways, in principle and in practice, of taking seriously both patient autonomy and autonomy-supportive professional intervention.

Is evidence able to persuade physicians to discuss spirituality with patients?
Saguil, Aaron; Fitzpatrick, Annette L; Clark, Gary

Abstract: Patients believe that spirituality informs health; frequently, they wish to share their beliefs with physicians. Although a large number of physicians believe it their responsibility to be aware of patient beliefs, many do not address spirituality because they do not believe it their role to do so. These physicians would perhaps feel differently if presented with evidence that associated spirituality with positive health outcomes. This national sample of family medicine residents were asked if, presented with evidence that spirituality was associated with improved outcomes, they would be more likely to initiate discussions of spirituality with patients. To varying degrees, most residents agreed that they would be more willing to initiate spirituality discussions if presented with good evidence. Geographic region of training, religious preference, and Spiritual Well-Being Scale quartile predicted both strength of agreement and whether a resident would be as responsive to spirituality oriented research as to investigations of traditional therapeutic modalities. Although residents indicated that they would be more responsive to publications on traditional medical therapies, familiarity with the spirituality literature as part of a residency educational curriculum may help break down barriers to addressing this issue with patients.
Howe, Edmund G

**Helping patients by involving their families.**
The Journal of clinical ethics 2011 Summer; 22(2): 99-106

**Abstract:** Patients and their family members may become highly interdependent as patients near the end of life. To best help these patients, healthcare providers can try to become a member of the patient/family team. By becoming a member, careproviders can improve patients’ and family members’ access to medical information, more effectively offer advice, and assure patients and family members that they can still choose to do what they think is best.

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Meeker, Mary Ann

**Responsive care management: family decision makers in advanced cancer.**

**Abstract:** The purpose of this prospective study was to develop a grounded theory explaining the process that family decision makers use to make care decisions with or for a family member with advanced cancer. Adult surrogate decision makers were recruited for multiple interviews over the patient's care trajectory: 40 surrogates provided 80 semi-structured interviews. Analysis of these narratives revealed a process of responsive care management that is inclusive of, but not limited to, decision-making roles. Monitoring, buffering, and taking over comprise the three phases of the process. Decision making was embedded within the family member's broader relational and care responsibilities.

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Nelson, James Lindemann

**Trusting families: Responding to Mary Ann Meeker, "Responsive care management: family decision makers in advanced cancer".**
The Journal of clinical ethics 2011 Summer; 22(2): 123-7

**Abstract:** Mary Ann Meeker's article admirably reminds readers that family members are involved in—or "responsively manage"—the care of relatives with severe illness in ways that run considerably beyond the stereotypes at play in many bioethical discussions of advance directives. Her observations thus make thinking about the role of families in healthcare provision more adequate to the facts, and this is an important contribution. There's reason to be worried, however, that one explicit aim of the article—to ease the standing anxieties that many clinicians and ethicists have about the reliability of family members as proxy decision makers—will be frustrated by its very success. Those already inclined to suspicion may tend to think that the more intricate and pervasive the ways in which families influence the healthcare decision making of their sick, the more chances they have for altering the connection between patients' interests and the actions of professional providers. To determine whether and when such alterations are something to be concerned about, we'll need to supplement a better grasp of the pertinent facts with a deeper sense of how human agency works and why we value it. We may also need some reminders about the defensibility of diverse moral understandings. Although both professionals and family members may profess an ethic that sets patients' interests above those of non-patients—as Meeker's own results suggest—any strict allegiance to such a framework may be more notional than normative—as her findings also hint. The actual working norms (among professionals, as well as within families) will likely be more complex, but not necessarily any the less defensible for that.

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Needlestick injuries: strategies for patient testing are feasible.

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Document 64
Dyer, Clare

GP accused of "pushing religion" on patient opts for full GMC hearing.
BMJ (Clinical research ed.) 2011 May 24; 342: d3275

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Document 65
White, Douglas B; Brody, Baruch

Would accommodating some conscientious objections by physicians promote quality in medical care?
JAMA : the journal of the American Medical Association 2011 May 4; 305(17): 1804-5

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Document 66
Haywood, Carlton Jr.; Lanzkron, Sophie; Hughes, Mark T; Brown, Rochelle; Massa, Michele; Ratanawongsa, Neda; Beach, Mary Catherine

A video-intervention to improve clinician attitudes toward patients with sickle cell disease: the results of a randomized experiment.
Journal of general internal medicine 2011 May; 26(5): 518-23

Abstract: Clinician attitudes toward patients are associated with variability in the quality of health care. Attitudes are typically considered difficult to change, and few interventions have attempted to do so. Negative attitudes toward adults with sickle cell disease have been identified as an important barrier to the receipt of appropriate pain management for this patient population.

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Document 67
Gracia, D

[Conscientious objection: debatable choices]. = Objeción de conciencia: las lecciones de un debate.

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Document 68
Couceiro, A; Secane, J A; Hernando, P

[Conscientious objection in the clinical setting. A proposal for its appropriate use]. = La objeción de conciencia en el ámbito clínico. Propuesta para un uso apropiado. I.
Revista de calidad asistencial : órgano de la Sociedad Española de Calidad Asistencial 2011 May-Jun; 26(3): 188-93

Abstract: Social changes and new technologies have brought new problems in doctor-patient relationships. In many clinical contexts conscientious objection is misused, with negative effects for patients, healthcare professionals and institutions. The paper aims to clarify what conscientious objection means in a plural society based on a deliberative democracy and to show the different ways of understanding this society in order to respect both the ethical reasons
of individuals and the compulsory normative framework of the Rule of Law. Furthermore, the paper identifies some clinical settings where conscientious objection is often invoked by healthcare professionals, and points out and analyses the arguments that explain why this appeal for conscientious objection is neither legitimate nor correct. Finally, it provides examples of the legal basis and Spanish jurisprudence, as well as the relevant clinical and ethical literature on this topic.

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**Document 69**

Frank, Jennifer E

**Conscientious refusal in family medicine residency training.**

Family medicine 2011 May; 43(5): 330-3

**Abstract:** Conscientious refusal among physicians to provide medical care is known to exist. The prevalence of conscientious refusal in residents and behaviors surrounding moral objections is largely unknown. The purpose of this study was to identify the prevalence of moral objections among family medicine residents and faculty members and to identify beliefs and actions surrounding conscientious refusal.

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**Document 70**

White, Douglas B

**Rethinking interventions to improve surrogate decision making in intensive care units.**

American journal of critical care : an official publication, American Association of Critical-Care Nurses 2011 May; 20(3): 252-7

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**Document 71**

Marcum, James A

**Care and competence in medical practice: Francis Peabody confronts Jason Posner.**

Medicine, health care, and philosophy 2011 May; 14(2): 143-53

**Abstract:** In this paper, I discuss the role of care and competence, as well as their relationship to one another, in contemporary medical practice. I distinguish between two types of care. The first type, care(1), represents a natural concern that motivates physicians to help or to act on the behalf of patients, i.e. to care about them. However, this care cannot guarantee the correct technical or right ethical action of physicians to meet the bodily and existential needs of patients, i.e. to take care of them-care(2). To that end, physicians must be competent in the practice of medicine both as evidence-based science (technical competence) and as patient-centered art (ethical competence). Only then, I argue, can physicians take care of (care(2)) patients' bodily and existential needs in a compassionate and comprehensive manner. Importantly, although care(1) precedes competence, competence—both technical and ethical—is required for genuine care(2), which in turn reinforces an authentic care(1). I utilize the play Wit, especially the character Jason Posner, and Francis Peabody's exposition on caring for patients, to illustrate the role of care and competence in contemporary medical practice.

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**Document 72**

Köpke, Sascha; Meyer, Gabriele

["Oath of confidentiality" in nursing. "I can not tell you, ask the doctor"!]. = Vom "Schweigegelübde" in der Pflege. "Das darf ich Ihnen nicht sagen, fragen Sie den Arzt"!

Pflege Zeitschrift 2011 May; 64(5): 307
Document 73

Terrell, Lekeisha

Case study. To tell or not to tell. Commentary.
The Hastings Center report 2011 May-Jun; 41(3): 15-6

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Document 74

Devi, Sharmila

Facebook friend request from a patient?
Lancet 2011 Apr 2; 377(9772): 1141-2

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Document 75

Kurpad, Sunita Simon; Machado, Tanya; Galgali, R B

"When a yes should mean no": doctors and boundaries.
Indian journal of medical ethics 2011 Apr-Jun; 8(2): 126-7

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Document 76

Sangram, Rajesh

Are doctors justified in refusing to give emergency treatment?
Indian journal of medical ethics 2011 Apr-Jun; 8(2): 129-30

Georgetown users check Georgetown Journal Finder for access to full text

Document 77

Kirschner, Kristi L; Brashler, Rebecca; Crigger, Bette-Jane; Wynia, Matthew K; Halvorsen, Anita

Should health care professionals Google patients or family members?
PM & R : the journal of injury, function, and rehabilitation 2011 Apr; 3(4): 372-6

Georgetown users check Georgetown Journal Finder for access to full text

Document 78

Suchorzewska, Janina; Basi?ska, Krystyna

[Significance of measuring family satisfaction in the intensive therapy unit]. = Rola i znaczenie badania satysfakcji rodzin chorych leczonych w oddzialach intensywnej terapii.
Anestezjologia intensywna terapia 2011 Apr-Jun; 43(2): 119-22

Abstract: Recently, numerous studies have been devoted to the issues of satisfaction of ITU patients and their families. Good relationships between the medical personnel and family members are essential for interpersonal communication built by both parties. The knowledge of rules ensuring proper relations with patients and their families
is an important element of the medical staff education. To date, neither the medical curriculum nor additional training have focused on this issue. Good communication between the patients’ families and physicians, thus the feeling of safety and satisfaction with the intensive care provided, should be based on controlled paternalism, provision of reliable information, confidence moulded, by mutual understanding and respect, elimination of impulsive reactions.

Georgetown users check Georgetown Journal Finder for access to full text

Document 79
Pinsky, Ellen
The olympian delusion.
Journal of the American Psychoanalytic Association 2011 Apr; 59(2): 351-76

Georgetown users check Georgetown Journal Finder for access to full text

Document 80
Brothers, Kyle B
Dependent rational providers.
The Journal of medicine and philosophy 2011 Apr; 36(2): 133-47

Abstract: Provider claims to conscientious objection have generated a great deal of heated debate in recent years. However, the conflicts that arise when providers make claims to the "conscience" are only a subset of the more fundamental challenges that arise in health care practice when patients and providers come into conflict. In this piece, the author provides an account of patient-provider conflict from within the moral tradition of St. Thomas Aquinas. He argues that the practice of health care providers should be understood as a form of practical reasoning and that this practical reasoning must necessarily incorporate both "moral" and "professional" commitments. In order to understand how the practical reasoning of provider should account for the needs and commitments of the patient and vice versa, he explores the account of dependence provided by Alasdair MacIntyre in his book Dependent Rational Animals. MacIntyre argues that St. Thomas' account of practical reasoning should be extended and adapted to account for the embodied vulnerability of all humans. In light of this insight, providers must view patients not only as the subjects of their moral reflection but also as fellow humans upon whom the provider depends for feedback on the effectiveness and relevance of her practical reasoning. The author argues that this account precludes responsive providers from adopting either moral or professional conclusions on the appropriateness of interventions outside the individual circumstances that arise in particular situations. The adoption of this orientation toward patients will neither eradicate provider-patient conflict nor compel providers to perform interventions to which they object. But this account does require that providers attend meaningfully to the suffering of patients and seek feedback on whether their intervention has effectively addressed that suffering.

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Document 81
Tilburt, Jon
Shared decision making after MacIntyre.
The Journal of medicine and philosophy 2011 Apr; 36(2): 148-69

Abstract: This paper explores the practical consequences that Enlightenment ideals had on morality as it applies to clinical practice, using Alisdair MacIntyre's conceptualization and critique of the Enlightenment as its reference point. Taking the perspective of a practicing clinician, I critically examine the historical origins of ideas that made shared decision making (SDM) a necessary and ideal model of clinician-patient relationship. I then build on MacIntyre's critique of Enlightenment thought and examine its implications for conceptions of shared decision-making that use an Enlightenment justification, as well as examining contemporary threats to SDM that the Enlightenment made possible. I conclude by offering an alternative framing of SDM that fits with the clinician's duty to act on behalf of and along with patients but that avoids the tenuous Enlightenment assumptions that MacIntyre's work so vocally critiques.

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The ethical leadership challenge: creating a culture of patient- and family-centered care in the hospital setting.

Abstract: The growing number of medical errors and resulting preventable deaths in hospitals presents an ethical dilemma that must be addressed by health care leaders and managers. These medical errors and deaths raise questions about safety and quality issues resulting in rising public mistrust and patient dissatisfaction. Many of these medical errors and deaths could have been avoided by including the patient and family in the care. The ethical challenge for leadership is creating a culture of patient- and family-centered care as a means to improve quality, safety, patient satisfaction, and public trust. This article addresses ways to improve safety, quality, patient satisfaction, and cost and thereby reduce medical errors and deaths by implementing a patient- and family-centered care culture. The first critical step for improvement is for hospital leaders and managers to answer the ethical call to create a culture centered on patient- and family-centered care in the hospital setting.

Situation testing: the case of health care refusal.

Abstract: Situation testing to assess physicians' refusal to provide healthcare is increasingly used in research studies. This paper aims to explain the relevance and limits of this method.

Should family physicians treat members of the same family?: NO.

Should family physicians treat members of the same family?: YES.

The compassionate care of Dr. DeBakey.
Document 87

Colmenero, M

[The ritual of the lack of beds]. = El ritual de la falta de camas.
Medicina intensiva / Sociedad Española de Medicina Intensiva y Unidades Coronarias 2011 Apr; 35(3): 139-42

Georgetown users check Georgetown Journal Finder for access to full text

Document 88

Ubel, Peter A

Afterword: Giving good advice: it is not what doctors say, but how they say it.
Current problems in pediatric and adolescent health care 2011 Apr; 41(4): 128-30

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Document 89

Tocheport, Pascale

[Ethical principles in the care relationship]. = Principes éthiques dans la relation de soins.
Soins; la revue de référence infirmière 2011 Apr(754): 32-4

Abstract: Ethical principles in the care relationship are at the heart of inter and multi-disciplinary communication quality between all the stakeholders. They give meaning to actions and enable them to be applied in a fairer manner better suited to the person being treated.

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Document 90

Warnet, Sylvie

[Good care at the heart of patients' rights]. = La bientraitance au coeur des droits des patients.
Revue de l'infirmière 2011 Apr(170): 1

Georgetown users check Georgetown Journal Finder for access to full text

Document 91

Szczech, Lynda A

Where is Walter--if he isn't in my office, is he really my responsibility? The 2011 National Kidney Foundation Presidential Address.
American journal of kidney diseases : the official journal of the National Kidney Foundation 2011 Apr; 57(4): 529-31

Georgetown users check Georgetown Journal Finder for access to full text

Document 92

Habiba, Marwan

Should medicine assist a teenager to achieve a pregnancy?
Journal of medical ethics 2011 Apr; 37(4): 201-4

Abstract: This article discusses a scenario of a teenager seeking medical assistance for infertility. Despite its apparent simplicity, the case poses a significant challenge to healthcare professionals. It requires consideration of maternal and child welfare and examination of the legitimate limits of doctors' role vis-à-vis the policy objective of
reducing teenage pregnancy rate. The negative stereotypic representation of teenage pregnancy is an important confounding factor.

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Document 93
Hem, Marit Helene; Pettersen, Tove

**Mature care and nursing in psychiatry: notions regarding reciprocity in asymmetric professional relationships.**


**Abstract:** The idea behind this article is to discuss the importance and to develop the concept of reciprocity in asymmetric professional relationships. As an empirical starting point for an examination of the possible forms of reciprocity between patients and nurses in psychiatry, we chose two qualitative in-depth interviews with two different patients. The manners in which these two patients relate to medical personnel—one is dependent, the other is independent—show that this presents challenges to nurses. The theoretical context is provided by the notion of mature care as it has been developed by feminist-oriented ethics of care, in contrast to the notion of altruistic care. In relation to the concept of mature care, we discuss how nursing can be perceived in demanding relationships with patients in psychiatry. Reciprocity implies that, in principle, the interests of the nurses also matter in a nurse-patient relationship. We show that reciprocity—in practice—is complicated and challenging in a number of different ways. Mature care—with its systematic inclusion of relationships and reciprocity—provides an alternative understanding of what takes place between patients and nurses compared with an altruistic notion of care. As such, mature care can be regarded as an useful paradigm for nurse-patient relationships in psychiatry.

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Document 94
de Groot, Jack; Leget, Carlo

**Moral counselling: a method in development.**

The journal of pastoral care & counseling : JPCC 2011 Spring-Summer; 65(1-2): 2:1-14

**Abstract:** This article describes a method of moral counselling developed in the Radboud University Medical Centre Nijmegen (The Netherlands). The authors apply insights of Paul Ricoeur to the non-directive counselling method of Carl Rogers in their work of coaching patients with moral problems in health care. The developed method was shared with other health care professionals in a training course. Experiences in the course and further practice led to further improvement of the method.

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Document 95
Gilbar, Roy

**Family involvement, independence, and patient autonomy in practice.**

Medical law review 2011 Mar; 19(2): 192-234

**Abstract:** The legal debate about patient autonomy focuses mainly on mental capacity and provision of information. The influence of the family on the decisions of the competent adult patient has scarcely been discussed in English medical law. Dominated by the bioethical principle of individual autonomy, the law concentrates on the patient and takes an exclusionary stand regarding relatives. Hence, the aim of this article is to examine the attitude of English law towards the involvement of relatives when patients make decisions, and to investigate the views and experiences of patients and their relatives in reality. To fulfil this aim, a qualitative study was carried out in six NHS trusts in England. The study was based on in-depth interviews conducted with patients who suffer from long-term illnesses, and their relatives. In the interviews, patients stated that the relatives assisted them in making informed decisions about treatment. Patients said that relatives had an influence on the decision-making process and on the decision itself, but also reported that ultimately relatives left the final decision to the patient. The findings reflect a relational approach to patient autonomy. When making decisions about treatment, patients needed to know that their relatives would support them no matter what they decided. However, exceptional cases which demonstrated
substantial familial influence suggest that the law should secure the patient's interest in making their own decisions. In light of these findings, it is argued that the current exclusionary attitude expressed in English medical law towards the role of relatives should be changed.

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**Document 96**

Nazarko, Linda

**Duty of care.**

Nursing times 2011 Mar 8-14; 107(9): 15

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**Document 97**

Browning, David M; Comeau, Meg; Kishimoto, Sanae; Varrin, Pamela; Ward, Erin; Rider, Elizabeth A; Meyer, Elaine C

**Parents and interprofessional learning in pediatrics: integrating personhood and practice.**


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**Document 98**

Greco, Peter M

**When patients don't pay.**

American journal of orthodontics and dentofacial orthopedics : official publication of the American Association of Orthodontists, its constituent societies, and the American Board of Orthodontics 2011 Mar; 139(3): 294

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**Document 99**

Jerrold, Laurance

**Litigation, legislation, and ethics. When patients lie to their doctors.**

American journal of orthodontics and dentofacial orthopedics : official publication of the American Association of Orthodontists, its constituent societies, and the American Board of Orthodontics 2011 Mar; 139(3): 417-8

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**Document 100**

Chenik, Marie; Bolinder, Gunilla; Juth, Niklas

**[Social media change the professional-patient relation. Clarification of ethical guidelines concerning social networking on the Internet is necessary].** = Sociala medier förändrar relationen mellan patient och vårdgivare. Tydligare etiska riktlinjer behövs i umgänget på Internet.

Läkartidningen 2011 Mar 30-Apr 5; 108(13): 727-9

Georgetown users check [Georgetown Journal Finder](#) for access to full text
Document 101

Cranston, Robert E.

Capitulation to a patient's demands
Ethics & Medicine 2011 Spring; 27(1): 13-16

Georgetown users check Georgetown Journal Finder for access to full text

Document 102

Lippman, Helen; Davenport, John

Patient dismissal: the right way to do it.

Georgetown users check Georgetown Journal Finder for access to full text

Document 103

Will, Jonathan F

A brief historical and theoretical perspective on patient autonomy and medical decision making: Part I: The beneficence model.
Chest 2011 Mar; 139(3): 669-73

Abstract: As part of a larger series addressing the intersection of law and medicine, this essay is the first of two introductory pieces. This article explores the nature of the physician-patient relationship and of the practice of medicine dating from the Hippocratic tradition to the end of the 19th century, a period during which a beneficence-based medical ethic remained relatively stable. The medical literature dating from the Hippocratic texts to the early codes of the American Medical Association did not include a meaningful role for the patient in the decision-making process. In fact, the practice of benevolent deception—the deliberate withholding of any information thought by the physician to be detrimental to the patient's prognosis—was encouraged. However, as philosophers identified an inherent value in respecting patient self-determination and the law imposed a duty on physicians to obtain informed consent, 2,400 years of relative stability under the beneficence model gave way to the autonomy model.

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Document 104

Jones, James W; McCullough, Laurence B

Business dealings with a patient: money never sleeps.

Abstract: Mr M.O. Gul returned for his postoperative visit today after you successfully repaired a leaking abdominal aortic aneurysm. Mr Gul owns most of the cable networks in the state, making him a billionaire. He realizes that he met the bearded reaper and walked away because of your skills. He is pioneering a new technology that will make current Wi-Fi obsolete. Unexpectedly, he offers you the opportunity to invest with the expectation of huge returns. M.O. personally guarantees you will not lose money. What should you do? A Invest. No questions asked. B Do not invest. It is unprofessional. C Do not invest without consulting with your attorney. D Do not invest. You have already been paid for services rendered. E Invest provided you forego future medical relationships with M.O. as the attending physician.

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Document 105

Schreiber, Naalla
Becoming "difficult".
The Hastings Center report 2011 Mar-Apr; 41(2): 49

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Document 106
Loayssa Lara, José Ramón; Ruiz Moral, Roger; García Campayo, Javier
[Scientific perspectives and training models. Reply to the letter "on unethical (bad) doctors"]'). = Perspectivas científicas y modelos de formación. Respuesta a la carta «sobre los médicos malvados»
Atencion primaria / Sociedad Española de Medicina de Familia y Comunitaria 2011 Feb; 43(2): 110-1

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Document 107
Braga, María Laura; Tarantino, María Gabriela
[Communication in Pediatrics: children and adolescents, subjects of right]. = La comunicación en Pediatría: niñas, niños y adolescentes, sujetos de derecho.
Archivos argentinos de pediatría 2011 Feb; 109(1): 36-41

Abstract: We will analyze the patient-family-doctor communication. We suggest that the healthcare professional consider girls and boys subjects of right, in order to generate conditions for dialogue. Letting them speak, be listened to, as well as informed, results essential for them to participate in the decision-making regarding their health. To do so, we will give rise to the need to reflect on self-representations about childhood. Likewise, we will consider doctor's communicative competences and the active role of every single member of this triad.

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Document 108
Leiker, Michelle
When to 'friend' a patient: social media tips for health care professionals.
WMJ: official publication of the State Medical Society of Wisconsin 2011 Feb; 110(1): 42-3

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Document 109
Müller-Engelmann, Meike; Keller, Heidi; Donner-Banzhoff, Norbert; Krones, Tanja
Shared decision making in medicine: the influence of situational treatment factors.
Patient education and counseling 2011 Feb; 82(2): 240-6

Abstract: Although shared decision making (SDM) has become increasingly important in bioethical discussions and clinical practice, it is not clear in which treatment situations SDM is suitable. We address this question by investigating social norms on the appropriateness of SDM in different situations.

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Document 110
Okamoto, Sawako; Kawahara, Kazuo; Algren, Margaret
Transformative possibilities of communication in medical error cases in Japan.
**Abstract:** This study examines perceptions of persons who experienced a medical error and elements that may serve to open communication with those who experienced a medical error in Japan.

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**Document 111**

**Staff pray with patients? Don't fear lawsuits.**

ED management: the monthly update on emergency department management 2011 Feb; 23(2): 22-4

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**Document 112**

Brown, O William

**The role of surgeon-specific experience and results in obtaining informed consent.**


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**Document 113**

Brüggemann, Jelmer; Swahnberg, Katarina

**[The notification obligation concerning violations should be included in lex Maria]. = Anmålningsplikt för kränkningar bör inkluderas i lex Maria.**

Läkartidningen 2011 Feb 2-8; 108(5): 217

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**Document 114**

Manthous, Constantine A

"My advice is . . .": beneficent or veiled paternalism.

Chest 2011 Feb; 139(2): 243-4

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**Document 115**

Swindell, J S; McGuire, Amy L; Halpern, Scott D

**Shaping patients' decisions.**

Chest 2011 Feb; 139(2): 424-9

**Abstract:** Many physicians struggle to strike an acceptable balance between respecting patient autonomy and guiding patients' decisions toward what is in their best interests based on their expressed values and long-term goals. Over the past 40 years, the ethical principle of respect for autonomy has gained primacy in Western medicine, but judgments about the appropriate dose of influence on patient decisions have been clouded by misconceptions about patient autonomy. In this article, we consider three such misconceptions with the goal of helping physicians to optimally promote their patients' interests.
**Document 116**

Walseth, Liv Tveit; Schei, Edvin

**Effecting change through dialogue: Habermas' theory of communicative action as a tool in medical lifestyle interventions.**

Medicine, health care, and philosophy 2011 Feb; 14(1): 81-90

**Abstract:** Adjustments of everyday life in order to prevent disease or treat illness afflict partly unconscious preferences and cultural expectations that are often difficult to change. How should one, in medical contexts, talk with patients about everyday life in ways that might penetrate this blurred complexity, and help people find goals and make decisions that are both compatible with a good life and possible to accomplish? In this article we pursue the question by discussing how Habermas' theory of communicative action can be implemented in decision-making processes in general practice. The theory of deliberative decision-making offers practical guidelines for what to talk about and how to do it. For a decision to be rooted in patients' everyday life it has to take into consideration the patient's practical circumstances, emotions and preferences, and what he or she perceives as ethically right behaviour towards other people. The aim is a balanced conversation, demonstrating respect, consistency and sincerity, as well as offering information and clarifying reasons. Verbalising reasons for one's preferences may increase awareness of values and norms, which can then be reflected upon, producing decisions rooted in what the patient perceives as good and right behaviour. The asymmetry of medical encounters is both a resource and a challenge, demanding patient-centred medical leadership, characterised by empathy and ability to take the patient's perspective. The implementation and adjustments of Habermas' theory in general practice is illustrated by a case story. Finally, applications of the theory are discussed.

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**Document 117**

Stuifbergen, Maria C; Van Delden, Johannes J M

**Filial obligations to elderly parents: a duty to care?**

Medicine, health care, and philosophy 2011 Feb; 14(1): 63-71

**Abstract:** A continuing need for care for elderly, combined with looser family structures prompt the question what filial obligations are. Do adult children of elderly have a duty to care? Several theories of filial obligation are reviewed. The reciprocity argument is not sensitive to the parent-child relationship after childhood. A theory of friendship does not offer a correct parallel for the relationship between adult child and elderly parent. Arguments based on need or vulnerability run the risk of being unjust to those on whom a needs-based claim is laid. To compare filial obligations with promises makes too much of parents' expectations, however reasonable they may be. The good of being in an unchosen relationship seems the best basis for filial obligations, with an according duty to maintain the relationship when possible. We suggest this relationship should be maintained even if one of the parties is no longer capable of consciously contributing to it. We argue that this entails a duty to care about one's parents, not for one's parents. This implies that care for the elderly is not in the first place a task for adult children.

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**Document 118**

Mani, M K

**Boundary violation?**


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**Document 119**

Berbari, Adel E

**The "sacred space" of healing.**


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Leeman, Mark A

**Balancing the benefits and burdens of storytelling among vulnerable people.**
Health communication 2011 Jan; 26(1): 107-9

Taylor, Dan; Mulekar, Madhuri S; Luterman, Arnold; Meyer, Frederick N; Richards, William O; Rodning, Charles B

**Spirituality within the patient-surgeon relationship.**
Journal of surgical education 2011 Jan-Feb; 68(1): 36-43

*Abstract:* To assess the attitudes of general and orthopaedic surgical outpatients regarding inquiry into their religious beliefs, spiritual practices, and personal faith.

Gunderman, Richard B

**Adverse outcomes.**

Kirschner, Kristi L; Mukherjee, Debjani; Gittler, Michelle; Brenner, Lisa; Kelly, James P

**Setting limits: the threat of violence in the health care setting.**
PM & R : the journal of injury, function, and rehabilitation 2011 Jan; 3(1): 68-9; discussion 69-72

Flodin, Thomas

[[The patient has obligations, too]. = Patienten har också skyldigheter.]
Läkartidningen 2011 Jan 26-Feb 1; 108(4): 127

Kaufman, Sharon R

**Toward a phenomenology of boundaries in medicine: chronic illness experience in the case of stroke.**
Topics in stroke rehabilitation 2011 Jan-Feb; 18(1): 6-17

*Abstract:* In this article I explore the ambiguous nature of the boundaries of authority and responsibility in medicine by discussing two dimensions of patients' response to long-term ramifications of stroke. A phenomenological
examination of the chronic illness experience is employed to identify how and the extent to which medicine's power both responds to and affects the individual sufferer. Rather than interpret the illness process as a dichotomy between medical control and patient autonomy, this article presents some assumptions about the boundaries of medical authority that are held by patients and practitioners alike. I suggest that dilemmas that patients face following a stroke are responses to medicine's limits and scope as well as reflections of medicine's goals and values. I argue that phenomenological studies of existential responses to illness are necessary in order to understand cultural sources of unmet expectations resulting from chronic conditions.

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**Document 126**

Gindi, Mark

**The ghost print.**

The Hastings Center report 2011 Jan-Feb; 41(1): 7-8

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**Document 127**

Padela, Aasim I.; del Pozo, Pablo Rodriguez

**Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective**

Journal of Medical Ethics 2011 January; 37(1): 40-44

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**Document 128**

Polack, E. Phillips and Avtgis, Theofore A.

**MEDICAL COMMUNICATION: DEFINING THE DISCIPLINE**


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**Document 129**

Mukhtar, Ghadah Fu'ad Majid

**Huquq al-marid fi 'aqd al-’ilaj al-tibbi fi al-qanun al-madani, dirasah muqaranah [Patients’ rights in the medical treatment contract according to civil law, a comparative study]**


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**Document 130**

Anyfantakis, Dimitrios; Symvoulakis, Emmanouil K

**Medical decision and patient's preference: 'much ethics' and more trust always needed.**


**Abstract:** There is much discussion on medical ethics literature regarding the importance of the patients' right for self-determination. We discuss some of the limitations of patient's autonomy with the aim to draw attention to the ethical complexity of medical decision making in the everyday clinical practice.

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Document 131
Pellerin, Caroline; Rochette, Annie; Racine, Eric
Social participation of relatives post-stroke: the role of rehabilitation and related ethical issues.
Disability and rehabilitation 2011; 33(13-14): 1055-64
Abstract: (1) Describe the challenges facing relatives of persons with stroke in accomplishing their daily activities and social roles (participation). (2) Reflect on the role of rehabilitation for relatives and ethical issues that may emerge following the adoption of a family-centred approach.

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Document 132
Mann, Justin D; Elliott, Richard L
Surgery and the anencephalic baby.
Journal of the Medical Association of Georgia 2011; 100(2): 26-7

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Document 133
Thornton, Hazel
Shared decision-making: personal, professional and political.

Georgetown users check Georgetown Journal Finder for access to full text

Document 134
Flaskerud, Jacquelyn
Revelations on the state of psychiatry today.
Issues in mental health nursing 2011; 32(4): 266-8

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Document 135
Berger, Jeffrey T
Shared and physician-directed decision making in clinical practice.
JAMA : the journal of the American Medical Association 2010 Dec 22; 304(24): 2697-8; author reply 2698

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Document 136
Stafford, Ned
Surgeon who refused to operate on man with swastika tattoo should not be disciplined, says German Medical Association.
BMJ (Clinical research ed.) 2010 December 17; 341: c7279

Georgetown users check Georgetown Journal Finder for access to full text
**Document 137**

Koren, E

**The place for emotions in professional carers' thinking: reflections on two cases.**

Medicine and law 2010 Dec; 29(4): 537-46

*Abstract:* How do carers know what is right for their patient? What can they do further to relying on the two pillars of knowledge and ethics? Knowledge foregrounds rational decision-making based on scientific evidence. It allows cost-benefit rationalization and the choice of the best feasible objective. The steady advance of medical science drives responsible carers to keep their knowledge and skills up-to-date. Bioethics grants primary attention to the prevention of causing harm in general, to pursuant of patients' subjective wellbeing and to allow the latter enjoy their autonomy and to guarantee them the sense of justice. There are, however, cases where these values collide and any care decision violates one principle or another. How are carers expected to act then? This article concerns the choices made by carers, as presented and discussed in two cases. These cases deal with a clash between two principles: parenthood vs. fertility, religious rite vs. social affiliation. This class has generated an ethical dilemma. In each case carers try to justify their choices by expert knowledge and other ethical values, but later reflection reveals that the predominant element in 'solving' these dilemmas was "emotions." Professional training submits that: 'Set aside feelings in order to keep your thinking 'straight.' However, reality proves this simply infeasible. The more complex the medical-ethical situation, it is more likely that "emotions" take over. We have no choice as responsible carers but to allow our emotions the status of a factor of influence in their own right. Nowadays, a basic medical training for doctors and nurses offers an integrated body of knowledge and therapeutic skills. In addition, trainees are introduced to bioethics, supposedly sufficient to guide their future steps in their chosen profession. But how does this training in fact shape their future ethical conduct, if at all? How does it affect their ability to maintain ethical responsibility throughout therapeutic interactions? Perhaps there are other factors which govern the individual's conduct and his/her ethical responsibility? Simulation exercises were conducted, designed to induce healthcare professionals to reflect on the ethics of their own decision-making. The results demonstrated that therapeutic skills and familiarity with bioethical principles are not the sole factors governing the individual's ethical conduct. It turns out that emotions and feelings play a key part: this at once raises the question as to whether a medical training for doctors and nurses, in its current format, concerns itself with emotions and with how emotions shape a therapeutic personality. If not, then our training designers have food for thought. How can such training make trainees more aware of the power of their emotions? And, what are the ramifications on daily practice concerning ethical responsibility? Another question concerns the possible proper methods for mastering the theoretical materials and the practical techniques that promote emotional self-development?

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**Document 138**

Duguet, A-M

[Respect of patient's dignity in the hospital]. = Le respect de la dignité à l'hôpital.


*Abstract:* Every code of ethics of health professionals in France considers the respect of dignity as a fundamental duty. The French 2002 Law on patient rights says that the person has the right to respect of dignity and of private life. After a presentation of the articles of ethics codes regarding dignity, this paper presents recommendations to deliver medical care in situations where dignity might be endangered such as for patients hospitalized in psychiatric services without consent, or for medical examination of prisoners or medical care to vulnerable patients unable to express their will, especially in palliative care or at the end of life. Respect of dignity after death is illustrated by the reflection conducted by the Espace Ethique de l'AP-HP (Paris area hospitals) and in the Chart of the mortuary yard. A survey of the patients' letters of complaint received by the emergency service of the Toulouse University Hospital showed that, in five years, there were 188 letters and 18 pointed out infringements to the dignity of the person. The health professional team is now aware of this obligation, and in the accreditation of the hospitals, the respect of dignity is one of the indicators of the quality of medical care.

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**Document 139**

Maehle, Andreas-Holger

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'Patient trade' in Germany: an ethical issue at the practitioner–clinician interface in 1909 and 2009.
Medical humanities 2010 Dec; 36(2): 84-7

Abstract: In 2009 the German media featured the so-called 'patient trade' scandal. Offending against the rules of the professional code for German doctors, some medical practitioners had accepted bonus payments from specific hospitals for referring patients to them. This article discusses a historical precedent for this scandal, the patient trade affair of 1909, in which several medical professors of the Berlin university clinics were accused of having paid agents for bringing them lucrative private patients. Although the historical contexts were different, then, as in 2009, a commercial attitude towards medical practice clashed with the ethical ideal of the economically disinterested doctor.

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Nursing & health sciences 2010 Dec; 12(4): 402

Patient perceptions of carrying their own health information: approaches towards responsibility and playing an active role in their own health - implications for a patient-held health file.
Health expectations: an international journal of public participation in health care and health policy 2010 Dec; 13(4): 416-26

Abstract: To elicit patients' views on whether they could contribute to improvements in their care by carrying their own health information to clinician encounters; and to consider the implications for the development of a patient-held health file (PHF).

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Therapist awareness and responsibility in working with sexual offenders.
Sexual abuse: a journal of research and treatment 2010 Dec; 22(4): 374-86

Abstract: The article aims to address the ethical implications of therapist reactions to sexual offender treatment and, in doing so, increase awareness and understanding of the interaction between the clinician and the challenges of working with sexual offenders. The effects of providing psychological services in general, and to sexual offenders specifically, are reviewed, including the impact on services provided. Practice implications are also discussed as the authors consider the negative effects (e.g., burnout) that therapists experience due to treatment quality and the ethical issues and responsibilities surrounding clinical reactions. Finally, the authors summarize research on self-care and practice recommendations for effectively and ethically working with sexual offenders.

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Pulling the heartstrings, arguing the case: a narrative response to the issue of moral agency in moral distress.
Journal of medical ethics 2010 Dec; 36(12): 746-9

Abstract: In this paper it is argued that moral distress is an emotional response to an ethical dilemma, and that to
date, the literature has largely failed to address the fundamental questions that need to be answered in response to this emotional response. Firstly, does moral distress accurately identify a wrong being done to patients? Secondly, if it does, can nurses carry out this 'wrong doing', but not be responsible for the consequences of their actions? A narrative that reflects the emotional nature of moral distress is presented, with the aim of providing some answers to these questions.

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**Document 144**

Manson, Neil C

**Why do patients want information if not to take part in decision making?**

Journal of medical ethics 2010 Dec; 36(12): 834-7

**Abstract:** There is empirical evidence that many patients want information about treatment options even though they do not want to take a full part in decision-making about treatment. Such evidence may have considerable ethical implications but is methodologically problematic. It is argued here that, in fact, it is not at all surprising that patients' informational interests should be separable from (and often stronger than) their interests in decision-making. A number of different reasons for wanting information are offered, some to do with the content of information; some with the process, others with the fact or occasion of informing. This philosophical clarification leads to some suggestions for further empirical study.

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**Document 145**

Crisler, William J Cris

**2010 Humanism in Medicine Essay Contest: first place: Bricks of indifference.**

Academic medicine: journal of the Association of American Medical Colleges 2010 Dec; 85(12): 1872-3

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**Document 146**

Grinberg, Max

**[Bioethics at the bedside]. = Acerca da Bioética da beira do leito.**


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**Document 147**

Morrison, Wynne Ellen

"**Is that all you got?**"


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**Document 148**

Balentine, Courtney J; Ayanbule, Funmi; Haidet, Paul; Rogers, John; Thompson, Britta; Chang, Tai; Horwitz, Irwin; Tseng, Ellen; Berger, David H

**The patient-physician relationship in surgical students.**

American journal of surgery 2010 Nov; 200(5): 624-7
Abstract: Students may become less adept at developing strong patient-physician relationships during medical school. We evaluated whether students choosing careers in surgery show a similar negative trend.

Document 149
Landry, Michael; Miller, Chad
Presenteeism: are we hurting the patients we are trying to help?
Journal of general internal medicine 2010 Nov; 25(11): 1142-3

Document 150
Timm, Kami
Who touched me? When non-verbal cues speak louder than words.
Health progress (Saint Louis, Mo.) 2010 Nov-Dec; 91(6): 46-8

Document 151
Solyom, Antal E
In distress.
The Hastings Center report 2010 Nov-Dec; 40(6): 6

Document 152
McLeod, Carolyn
An institutional solution to conflicts of conscience in medicine.

Document 153
McCready, Doug
In distress.
The Hastings Center report 2010 Nov-Dec; 40(6): 6

Document 154
Doctare, Christina; Malmgren, Bengt; Seidal, Tomas
[The Medical Association should give guidance on members' freedom of conscience right]. = Förbundet bör ge besked om medlemmars rätt till samvetsfrihet.
Läkartidningen 2010 Nov 24-30; 107(47): 2980; author reply 2980-1
Document 155
Hügler, Stephanie
[Publicity and election campaigns in the waiting room--allowed or forbidden?]. = Werbung und Wahlkampf im Wartezimmer--erlaubt oder verboten?
Deutsche medizinische Wochenschrift (1946) 2010 Nov; 135(44): p39

Document 156
Prince, Annette
Much ado about nothing.

Document 157
Breen, K J; Greenberg, P B
Difficult physician-patient encounters.
Internal medicine journal 2010 Oct; 40(10): 682-8
Abstract: Consultant physicians encounter patients, and families and carers of patients, who leave us feeling helpless, frustrated, irritated and even angry. There are limited opportunities for trainees and physicians to discuss how to recognize, manage, learn from and prevent these difficult physician-patient encounters. This paper addresses factors, including physician factors, that may contribute to making encounters difficult, categorizes the types of difficult encounters and provides generic and specific suggestions (based in part on published literature and in part on our personal experience) about prevention and management of many of them.

Document 158
Gadit, Amin A Muhammad
Should doctors and patients be friends? Can this lead to an ethical dilemma?
JPMA. The Journal of the Pakistan Medical Association 2010 Oct; 60(10): 875-6

Document 159
Hofmann, Irmgard
[Incontinence taboo - an ethical observation: structural problems delegated to nurses]. = Tabu Inkontinenz--eine ethische Betrachtung: Strukturprobleme auf Pflegende abgewälzt.

Document 160
Wetzel, Tracy Granzyk

**When errors occur, 'I'm sorry' is a big step, but just the first.**

Hospitals & health networks / AHA 2010 Oct; 84(10): 41-2, 44, 2

**Abstract:** When errors occur, telling patients quickly and forthrightly is the right thing to do and can avert lawsuits. It's also the start of true cultural change.

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Rady, Mohamed Y; Verheijde, Joseph L

**Patients' best-interests standard trumps autonomous health-care decisions: paternalism vs self-determination.**

Chest 2010 Oct; 138(4): 1021-2; author reply 1022-3

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Machens, Roman

**[Do you really understand your patients?]:= Verstehen Sie Ihre Patienten wirklich?**

MMW Fortschrritte der Medizin 2010 Sep 23; 152(38): 7

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**Physician, know thyself.**

Lancet 2010 Sep 4; 376(9743): 743

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Sepucha, Karen R; Fagerlin, Angela; Couper, Mick P; Levin, Carrie A; Singer, Eleanor; Zikmund-Fisher, Brian J

**How does feeling informed relate to being informed? The DECISIONS survey.**

Medical decision making : an international journal of the Society for Medical Decision Making 2010 Sep-Oct; 30(5 Suppl): 77S-84S

**Abstract:** An important part of delivering high-quality, patient-centered care is making sure patients are informed about decisions regarding their health care. The objective was to examine whether patients' perceptions about how informed they were about common medical decisions are related to their ability to answer various knowledge questions.

Georgetown users check [Georgetown Journal Finder](#) for access to full text
Document 166
Zikmund-Fisher, Brian J; Couper, Mick P; Singer, Eleanor; Ubel, Peter A; Ziniel, Sonja; Fowler, Floyd J Jr.; Levin, Carrie A; Fagerlin, Angela

**Deficits and variations in patients' experience with making 9 common medical decisions: the DECISIONS survey.**

Medical decision making : an international journal of the Society for Medical Decision Making 2010 Sep-Oct; 30(5 Suppl): 85S-95S

**Abstract:** Although many researchers have examined patient involvement and patient-provider interactions within specific clinical environments, no nationally representative data exist to characterize patient perceptions of decision making and patient-provider communications across multiple common medical decisions.

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Document 167
Höglund, Anna T; Winblad, Ulrika; Arnetz, Bengt; Arnetz, Judith E

**Patient participation during hospitalization for myocardial infarction: perceptions among patients and personnel.**

Scandinavian journal of caring sciences 2010 Sep; 24(3): 482-9

**Abstract:** Patient participation in healthcare decision-making and illness management has been associated with high patient satisfaction ratings and improved treatment outcomes in chronic diseases. Less is known about patient participation in acute illness, such as myocardial infarction (MI).

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Document 168
Power, Zoë; Thomson, Ann M; Waterman, Heather

**Understanding the stigma of hyperemesis gravidarum: qualitative findings from an action research study.**

Birth (Berkeley, Calif.) 2010 Sep; 37(3): 237-44

**Abstract:** Severe nausea and vomiting in pregnancy (hyperemesis gravidarum) can be a distressing and debilitating condition when it is uncontrolled. For all concerned, hyperemesis gravidarum can be difficult to treat satisfactorily, and women tend to be admitted to a hospital several times during early pregnancy. Our research objectives were to describe the experience of hyperemesis gravidarum from the perspective of affected women and to explore with health care professionals the barriers and facilitators to caring for women with the condition.

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Document 169
Ladd, Rosalind Ekman; Forman, Edwin N

**Ethics for the pediatrician: pediatrician/patient/parent relationships.**

Pediatrics in review / American Academy of Pediatrics 2010 Sep; 31(9): e65-7

Georgetown users check **Georgetown Journal Finder** for access to full text

Document 170
American College of Healthcare Executives

**Decisions near the end of life.**

Healthcare executive 2010 Sep-Oct; 25(5): 100-1
Document 171
Karasz, Alison; Sacaju, Galit; Kogan, Misha; Watkins, Liza

**The rational choice model in family decision making at the end of life.**
The Journal of clinical ethics 2010 Fall; 21(3): 189-200

**Abstract:** Most end-of-life decisions are made by family members. Current ethical guidelines for family decision making are based on a hierarchical model that emphasizes the patient's wishes over his or her best interests. Evidence suggests that the model poorly reflects the strategies and priorities of many families.

Georgetown users check [Georgetown Journal Finder](http://georgetownjournalfinder.com) for access to full text

Document 172
Davis, Dena S

**The ambiguous effects of tort law on bioethics: the case of doctor-patient communication.**
The Journal of clinical ethics 2010 Fall; 21(3): 264-71

**Abstract:** Tort law is an important tool in enforcing a minimal level of good behavior. But what is appropriate for law is not necessarily appropriate for ethics or for norms of professional practice.

Georgetown users check [Georgetown Journal Finder](http://georgetownjournalfinder.com) for access to full text

Document 173
Eckstein, Sue

**Communication: illusion or reality?**
Clinical Ethics 2010 September; 5(3): 113-114

Georgetown users check [Georgetown Journal Finder](http://georgetownjournalfinder.com) for access to full text

Document 174
Kon, Alexander A

**The shared decision-making continuum.**
JAMA : the journal of the American Medical Association 2010 Aug 25; 304(8): 903-4

Georgetown users check [Georgetown Journal Finder](http://georgetownjournalfinder.com) for access to full text

Document 175
Olson, Douglas P; Windish, Donna M

**Communication discrepancies between physicians and hospitalized patients.**
Archives of internal medicine 2010 Aug 9; 170(15): 1302-7

**Abstract:** BACKGROUND: Hospital surveys indicate lack of patient awareness of diagnoses and treatments, yet physicians report they effectively communicate with patients. Gaps in understanding and communication could result in decreased quality of care. We sought to assess patient knowledge and perspectives of inpatient care and determine differences from physician assessments. METHODS: Two validated questionnaires assessed the experiences of inpatients treated by house staff from October 10, 2008, through June 23, 2009. We surveyed corresponding internal medicine resident and attending physicians, asking them to report on their care of hospitalized patients and their understanding of their patients' perspectives on the care received. RESULTS: Eighty-nine patients and 43 physicians participated. Although 73% of patients thought there was 1 main physician, 18% correctly named
that physician, compared with 67% of physicians who thought patients knew their names (P<.001). Most physicians (77%) believed patients knew their diagnosis; however, 57% of patients did (P<.001). A total of 58% of patients thought that physicians always explained things in a comprehensible way, compared with 21% of physicians who stated they always provided explanations of some kind (P<.001). Two-thirds of patients reported receiving a new medication in the hospital, yet 90% noted never being told of any adverse effects of these medications. Nearly all physicians (98%) stated that they at least sometimes discussed their patients' fears and anxieties, compared with 54% of patients who said their physicians never did this (P=.001). CONCLUSIONS: Significant differences exist between patients' and physicians' impressions about patient knowledge and inpatient care received. Steps to improve patient-physician communication should be identified and implemented.

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**Document 176**

Madwed, Michael P; Becker, Blair A

**Time to chat.**

American family physician 2010 Aug 1; 82(3): 282

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**Document 177**

Pydah, K L; Howard, J

**The awareness and use of chaperones by patients in an English general practice.**


**Abstract:** To ascertain and improve the understanding and use of chaperones among the patients of an English general practice (GP).

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**Document 178**

Sloane, Peter

Staff of the Center for Ethics at Washington Hospital Center

**Is it ok to agree to let the family withhold information from a patient facing surgery?**

Journal of Hospital Ethics 2010 August; 2(1): 21-23

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**Document 179**

Duncan, Rony E; Sawyer, Susan M

**Respecting adolescents' autonomy (as long as they make the right choice).**


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**Document 180**

Moser, Albine; Houtepen, Rob; Spreeuwenberg, Cor; Widdershoven, Guy

**Realizing autonomy in responsive relationships.**

Medicine, health care, and philosophy 2010 Aug; 13(3): 215-23

**Abstract:** The goal of this article is to augment the ethical discussion among nurses with the findings from empirical
research on autonomy of older adults with type 2 diabetes mellitus. There are many factors influencing autonomy. These include: health conditions, treatment, knowledge, experience and skills, personal approach as well as familial patterns, type of relationship, life history and social context. Fifteen older adults with type 2 diabetes mellitus were interviewed in a nurse-led diabetes clinic. These participants perceive three processes which support autonomy in responsive relationships: preserving patterns of concern and interaction, nurturing collaborative responsibilities and being closely engaged in trustful and helpful family relations. People with diabetes realize autonomy in various responsive relationships in their unique life context. Next, we performed a literature review of care ethics and caring in nursing with regard to relational autonomy. We classified the literature in five strands of care: attitude-oriented, dialogue-oriented, activity-oriented, relationship-oriented and life-oriented. According to our respondents, autonomy in responsive relationships is fostered when patient, nurses, professionals of the health team and family members carry out care activities supported by a relational attitude of care. They can best realize autonomy in relationships with others when several essential aspects of care and caring are present in their lives. Therefore, we advocate a comprehensive approach to care and caring.

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**Document 181**

Ringstad, Oystein

**Interviewing patients and practitioners working together in teams. A multi-layered puzzle: putting the pieces together.**

Medicine, health care, and philosophy 2010 Aug; 13(3): 193-202

**Abstract:** This paper presents and evaluates a methodological approach aiming at analysing some of the complex interaction between patients and different health care practitioners working together in teams. Qualitative health care research describes the values, perceptions and conceptions of patients and practitioners. In modern clinical work patients and professional practitioners often work together on complex cases involving different kinds of knowledge and values, each of them representing different perspectives. We need studies designed to capture this complexity. The methodological approach presented here is exemplified with a study in rehabilitation medicine. In this part of the health care system the clinical work is organized in multi-professional clinical teams including patients, handling complex rehabilitation processes. In the presented approach data are collected in individual in-depth interviews to have thorough descriptions of each individual perspective. The interaction in the teams is analysed by comparing different descriptions of the same situations from the involved individuals. We may then discuss how these perceptions relate to each other and how the individuals in the team interact. Two examples from an empirical study are presented and discussed, illustrating how communication, differences in evaluations and the interpretation of incidents, arguments, emotions and interpersonal relations may be discussed. It is argued that this approach may give information which can supplement the methods commonly applied in qualitative health care research today.

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**Document 182**

ten Have, Henk; Gordijn, Bert

**The language of medicine and bioethics.**

Medicine, health care, and philosophy 2010 Aug; 13(3): 191-2

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**Document 183**

Krestin, Gabriel P

**Commoditization in radiology: threat or opportunity?**

Radiology 2010 Aug; 256(2): 338-42

Georgetown users check [Georgetown Journal Finder](#) for access to full text
Document 184
Oliver, David J; Turner, Martin R

Some difficult decisions in ALS/MND.

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Document 185
Larkin, Gregory L; Hooker, Roderick S

Patient willingness to be seen by physician assistants, nurse practitioners, and residents in the emergency department: does the presumption of assent have an empirical basis?

Abstract: Physician assistants (PAs), nurse practitioners (NPs), and medical residents constitute an increasingly significant part of the American health care workforce, yet patient assent to be seen by nonphysicians is only presumed and seldom sought. In order to assess the willingness of patients to receive medical care provided by nonphysicians, we administered provider preference surveys to a random sample of patients attending three emergency departments (EDs). Concurrently, a survey was sent to a random selection of ED residents and PAs. All respondents were to assume the role of patient when presented with hypothetical clinical scenarios and standardized provider definitions. Despite presumptions to the contrary, ED patients are generally unwilling to be seen by PAs, NPs, and residents. While seldom asked in practice, 79.5% of patients fully expect to see a physician regardless of acuity or potential for cost savings by seeing another provider. Patients are more willing to see residents than nonphysicians.

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Document 186
Paterson, Ron

The Cartwright legacy: shifting the focus of attention from the doctor to the patient.
The New Zealand medical journal 2010 July 30; 123(1319): 6-10

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Document 187
Hill, Terry E

How clinicians make (or avoid) moral judgments of patients: implications of the evidence for relationships and research.
Philosophy, ethics, and humanities in medicine : PEHM 2010 July 9; 5: 11

Abstract: Physicians, nurses, and other clinicians readily acknowledge being troubled by encounters with patients who trigger moral judgments. For decades social scientists have noted that moral judgment of patients is pervasive, occurring not only in egregious and criminal cases but also in everyday situations in which appraisals of patients’ social worth and culpability are routine. There is scant literature, however, on the actual prevalence and dynamics of moral judgment in healthcare. The indirect evidence available suggests that moral appraisals function via a complex calculus that reflects variation in patient characteristics, clinician characteristics, task, and organizational factors. The full impact of moral judgment on healthcare relationships, patient outcomes, and clinicians’ own well-being is yet unknown. The paucity of attention to moral judgment, despite its significance for patient-centered care, communication, empathy, professionalism, healthcare education, stereotyping, and outcome disparities, represents a blind spot that merits explanation and repair. New methodologies in social psychology and neuroscience have yielded models for how moral judgment operates in healthcare and how research in this area should proceed. Clinicians, educators, and researchers would do well to recognize both the legitimate and illegitimate moral appraisals that are apt to occur in healthcare settings.
Tipping their hand. AAMC wants physicians to disclose conflicts of interest to patients.

Abstract: The Association of American Medical Colleges has released a report on clinical-care conflicts of interest and what physicians should disclose to patients. While some doctors are concerned that such reporting would be perceived as negative, others think it's a good idea. "If you ask them (patients) what they wanted to know about their doctors' conflicts, the majority want to know a lot," says Guy Chisolm of the Cleveland Clinic, left.

Communication in oncology and bioethics.

Abstract: Personal autonomy is widely valued. Recognition of its vulnerability in health care contexts led to the inclusion of respect for autonomy as a key concern in biomedical ethics. The principle of respect for autonomy is usually associated with allowing or enabling patients to make their own decisions about which health care interventions they will or will not receive. In this paper, we suggest that a strong focus on decision situations is problematic, especially when combined with a tendency to stress the importance of patients' independence in choosing. It distracts attention from other important aspects of and challenges to autonomy in health care. Relational understandings of autonomy attempt to explain both the positive and negative implications of social relationships for individuals' autonomy. They suggest that many health care practices can affect autonomy by virtue of their effects not only on patients' treatment preferences and choices, but also on their self-identities, self-evaluations and capabilities for autonomy. Relational understandings de-emphasise independence and facilitate well-nuanced distinctions between forms of clinical communication that support and that undermine patients' autonomy. These understandings support recognition of the value of good patient-professional relationships and can enrich the specification of the principle of respect for autonomy.
Document 192
Feldman, Mitchell D
From the editors' desk: patient autonomy and medical decisions: getting it just right.
Journal of general internal medicine 2010 Jul; 25(7): 639
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Document 193
Marin, Maria José Sanches; Storniolo, Luana Vergian; Moravcik, Maria Yvette
Humanization of care from the perspective of the family health strategy teams in a city in the interior of São Paulo, Brazil.
Abstract: This study analyzes the understanding of professionals composing teams of the Family Health Strategy concerning humanization of care. This qualitative survey was carried out in a city in the interior of São Paulo through interviews with 20 professionals. The data analysis method used was Interpretation of Meanings based on the hermeneutic-dialectic perspective. The meaning of humanization according to the interviewed professionals includes an enlarged view, respect for ethical principles and facilitated access. The difficulties refer to the lack of prepared professionals, excessive demand and deficiencies in service organization. The professionals propose to educate and qualify professionals, make activities adequate given the professionals' roles and improve the organization of services. The professionals demonstrate understanding of the meaning of humanization and acknowledge the need to cope with difficulties.
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Document 194
Milton, Constance L
Failing to do the right thing: nurse practice and the family experience.
Nursing science quarterly 2010 Jul; 23(3): 206-8
Abstract: Ethical end of life decisions are increasingly viewed by the global healthcare community as complex and imbued with uncertainty in institutional healthcare settings. Each person experiences health decision-making and the concept of time differently and uniquely. In the context of end of life situations, both the recipients of healthcare and their families may experience complex decision-making in situations where profound questioning and uncertainty surfaces with a struggling of desiring to do the right thing comingling with the possibilities of failing to do the right thing according to the expectations of self and others. This column begins a discussion of possible meanings found in ethical decision-making with families as articulated with the lens of the human-becoming family model.
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Document 195
Casati, Sara; Monti, Paolo; Bonino, Ferruccio;
Nucleo Permanente per la Valutazione e il Miglioramento del Consenso Informato
From actors to authors: a first account about the involvement of patients in the informed consent governance of a major Italian translational research hospital.
The Journal of ambulatory care management 2010 Jul-Sep; 33(3): 231-40
Abstract: From 2007 to 2009 Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, one of the major public research hospitals in Italy, has invested on a participatory action to promote a good practice of informed consent. The project focused on the improvement and innovation of informed consent considered as a participated act through the involvement of all the actors at stake. The main purpose was to improve the informative practices through the participatory innovation of institutional and organizational elements as conditions of possibility. Therefore the project has pursued the involvement of managers, healthcare professionals, patients and their associations in the institutional governance of informed consent. The involvement of citizens and patients within the whole process
meant to put them in charge not just as actors or final evaluators of a good practice, but as co-authors in defining standards, tools and conditions for a good practice. Several actions were taken, including a phase of analysis which involved 20 patients from 8 Associations, a phase of innovation and education where 113 patients and citizens worked together with clinicians from 53 Units in deliberative laboratories, the institution of a multidisciplinary committee inclusive of representatives from 6 associations of patients. The project has produced different outcomes: new institutional guidelines adopted by the hospital; the renewal of consent forms and procedures as part of an explicit shared informative process; an increased implementation of institutional standards of good informative practice; the measure and communication of the outcomes of care and their benchmarking; bottom-up building of paths of validation; the creation of participatory electronic tools; an innovative education on the field for patients and clinicians.

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**Document 196**

Khan, Murad

**Boundary violations and the "curtain of culture".**

Indian journal of medical ethics 2010 Jul-Sep; 7(3): 172

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**Document 197**

Ponte, Carène

**[Propositions about refusing to care at the National Conference of Health]. = Les propositions sur les refus de soins de la Conférence nationale de santé.**

Soins; la revue de référence infirmière 2010 Jul-Aug(747): 8

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**Document 198**

Edwards, Steven

**Editorial comment. Conscientious objection.**

Nursing ethics 2010 Jul; 17(4): 421-3

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**Document 199**

Rowe, John

**Information disclosure to family caregivers: applying Thiroux's framework.**

Nursing ethics 2010 Jul; 17(4): 435-44

**Abstract:** In the UK, community care has led to more complex relationships for mental health nurses. They need to respect the rights of service users to confidentiality while also respecting the rights of family caregivers to information that directly affects them. An unsatisfactory situation has arisen in which utilitarian and legally driven motives have seen family caregivers' interests become subsidiary to those of service users and providers. An ethical case is made for sharing information with family caregivers, even against the wishes of service users. An ethical case is made for sharing information with family caregivers, even against the wishes of service users. An ethical case is made for sharing information with family caregivers, even against the wishes of service users. Through the use of a conceptual framework based on elements proposed by Thiroux - value of life, goodness or rightness, justice or fairness, truth-telling or honesty, and individual freedom - the article concludes that there is an ethical argument for sharing some information with family caregivers and that nurses should respect caregivers' rights through their actions. Nurses' actions are a commitment to seeking what is 'good' by making judgements based on what matters. It is argued that people and their relationships matter more than strict adherence to laws and codes.
Document 200

Yakov, Gila; Shilo, Yehudit; Shor, Tzippy

Nurses' perceptions of ethical issues related to patients' rights law.

Nursing ethics 2010 Jul; 17(4): 501-10

Abstract: August 2006 marked the 10th anniversary of landmark legislation when Israel's parliament passed the unique Patient's Rights Law. This law underscores the importance of medical ethics in Israeli society. During a seminar at the Shaare Zedek School of Nursing, third-year students performed a qualitative research study investigating ethical issues arising in the field of nursing, and how nursing staff dealt with these issues in relation to the law. The research was conducted using semistructured questionnaires. The results showed that the staff participants knew the law, but did not differentiate between legal and ethical problems. The establishment of a framework for dealing with these issues would help to promote professional ethics, encourage broad-based agreements related to ethical decisions, reduce ethical conflict, and increase implementation of the law on patients' rights.

Document 201

Manthous, Constantine A

Fiduciary what?

Chest 2010 Jul; 138(1): 10-1

Document 202

Rogers, Arvey I

Consultation etiquette: a proposed set of guidelines.

The American journal of gastroenterology 2010 Jul; 105(7): 1477-8

Abstract: Too often, actions and decisions affecting patient care are determined by expediency, cost-effectiveness, and time constraints. At risk of sacrifice are ethics and professionalism, pillars essential to the very structure of medical practice. In particular, there appears to be an erosion of consultation etiquette-exchanges between physicians and patients as well as among physicians. While methods to maximize efficiency are essential to medical practice, they should not come at the expense of etiquette. To improve patient care and strengthen relationships between patients and physicians, as well as relationships between referring and consulting physicians, a set of guidelines for improving consultation etiquette is proposed.

Document 203

Rea, Harry; Kenealy, Tim; Sheridan, Nicolette; Gorman, Des

Invisible care: do we need a Code of Rights to protect family and informal carers?

The New Zealand medical journal 2010 June 25; 123(1317): 5-6

Document 204
Response to former HDC's editorial "Lessons from complaints".
The New Zealand medical journal 2010 June 10; 123(1316): 128-9

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Yalden, B Joan; McCormack, Brendan

Constructions of dignity: a pre-requisite for flourishing in the workplace?

Abstract: To explore the relationship between nurses' understanding of dignity and how it is enhanced and developed in their practice environment.

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Andrijevic-Matovac, Vesna

Have you forgotten Hippocrates too?
Croatian medical journal 2010 Jun; 51(3): 274-7

Georgetown users check Georgetown Journal Finder for access to full text

Nicholson, Caroline; Flatley, Mary; Wilkinson, Charlotte

Everybody matters 3: engaging patients and relatives in decision making to promote dignity.
Nursing times 2010 Jun 8-14; 106(22): 10-2

Abstract: Practical interventions are presented around three main themes in this three part series. This third part explores "shared decision making--involve me" (Bridges et al, 2009). This recognises the importance of engaging patients, family and staff in decisions about care and treatment. The article offers a range of interventions to hear the voices of patients, staff and relatives.

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Breitsameter, Christof

Medical decision-making and communication of risks: an ethical perspective.

Abstract: The medical decision-making process is currently in flux. Decisions are no longer made entirely at the physician's discretion: patients are becoming more and more involved in the process. There is a great deal of discussion about the ideal of 'informed consent', that is that diagnostic and therapeutic decisions should be made based on an interaction between physician and patient. This means that patients are informed about the advantages and disadvantages of a treatment as well as alternatives to the treatment; then, based on this information they can decide whether or not they want to undergo the treatment. However, recent studies show that the realisation of the ideal of 'shared decision-making' faces a number of difficulties related to the fact that patients are not provided with complete and accurate information. Using the example of breast cancer screening, this article examines the question of whether, in light of these difficulties, the ideal of informed decision-making is only an illusion or whether concrete steps can be taken towards the realisation of this ideal.

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**Document 209**

Koch, Tom; Jones, Sarah

**The ethical professional as endangered person: blog notes on doctor-patient relationships.**


**Abstract:** In theory, physicians subscribe to and in their actions personify a set of virtues whose performance demands personal engagement. At the same time, they are instructed in their professional roles to remain emotionally and personally distant from those they are called to treat. The result, the authors argue, is an ethical conflict whose nature is described through an analysis of two narratives drawn from an online blog for young physicians. Confusion over professional responsibilities and personal roles were found to affect physicians' perceptions of their clinical duties and their social roles. In addition, it sets in sharp relief contemporary debates on physician training and the ethical nature of medical professionalism. Practically, the authors suggest, the confusion may contribute to early physician burnout. Methodologically, this paper promotes the use of online discussion sites as rich repositories providing an insight into real dilemmas and the actual perception of physicians' attempts to address them. It thus promotes use of such sites as a resource in which assumptions about physicians' own perceptions about the nature of their role in contemporary society can be tested.

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**Document 210**

Mendick, Nicola; Young, Bridget; Holcombe, Christopher; Salmon, Peter

**The ethics of responsibility and ownership in decision-making about treatment for breast cancer: triangulation of consultation with patient and surgeon perspectives.**


**Abstract:** Doctors are widely encouraged to share decision-making with patients. However, the assumption that responsibility for decisions is an objective quantity that can be apportioned between doctors and patients is problematic. We studied treatment decisions from three perspectives simultaneously - observing consultations and exploring patients' and doctors' perspectives on these - to understand how decision-making that we observed related to participants' subjective experience of responsibility. We audio-recorded post-operative consultations in which 20 patients who had undergone initial surgery for breast cancer discussed further treatment with one of eight surgeons in a general hospital serving a socioeconomically diverse urban population in England. We separately interviewed each patient and their surgeon within seven days of consultation to explore their perspectives on decisions that had been made. Qualitative analysis distinguished procedurally different types of decision-making and explored surgeons' and patients' perspectives on each. Surgeons made most decisions for patients, and only explicitly offered choices where treatment options were clinically equivocal. Procedurally, therefore, shared decision-making was absent and surgeons might be regarded as having neglected patients' autonomy. Nevertheless, patients generally felt ownership of decisions that surgeons made for them because surgeons provided justifying reasons and because patients knew that they could refuse. Conversely, faced with choice, patients generally lacked trust in their own decisions and usually sought surgeons' guidance. Therefore, from the perspective of ethical frameworks that conceptualise patient autonomy as relational and subjective, the surgeons were protecting patient autonomy. Studying subjective as well as procedural elements of decision-making can provide a broader perspective from which to evaluate practitioners' decision-making behaviour.

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**Document 211**

Ward, Frances Rieth

**Parents' views of involvement in concurrent research with their neonates.**


**Abstract:** It would be useful to researchers and bioethicists to know more about parents' decision processes and emotional state during the time they are deciding whether to enroll their infant in a clinical trial. The aim of this research study was to discover whether parents who had been previously asked to enroll their neonates in clinical trials would have found concurrent research about their decision-making overly burdensome. Twenty-seven parents of critically ill neonates who had been approached for their child's research participation in a clinical trial were asked what they believed about the potential burden or value of being interviewed during the time of research decision-
making about their infant's participation. For this qualitative descriptive study, interviews were audio-recorded, transcribed, and analyzed using content analysis techniques. Participants considered concurrent research acceptable for them but potentially problematic for others. Theories of risk preferences and social comparison might explain these findings.

Document 212
Müller, Sabine; Arnolds, Judith; van Oosterhout, Ansel
Decision-making of vestibular schwannoma patients.
Acta neurochirurgica 2010 Jun; 152(6): 973-84
Abstract: BACKGROUND: Patients suffering from vestibular schwannoma can choose between four modalities of management: (1) wait-and-scan, (2) tumour resection, (3) radiosurgery and (4) fractionated radiotherapy. METHOD: This study is based on postal questionnaire survey of 739 vestibular schwannoma patients (survey response rate, 78%). It not only investigates the decision-making of patients, especially the medical consultation, but also further influences on the therapy decision and the patients' evaluation of possible side-effects of the treatment. RESULTS: Only a minority of the patients was informed about radiosurgery and radiotherapy at all. CONCLUSION: The praxis of patient counselling of acoustic neuroma patients in Germany is far from the ideal condition of medical consultation: The most important shortcoming is that it is unilateral: About 69% of the patients are informed about only one treatment option, generally surgery. Furthermore, information about side effects is usually insufficient. We recommend to advice all patients on all treatment options by an interdisciplinary team. The counselling should firstly be based on evidence-based medicine and secondly respond to the patients' individual life situation and preferences.

Document 213
Wolff, Jennifer L; Roter, Debra L
Family caregivers, patients, and physicians.
Journal of general internal medicine 2010 Jun; 25(6): 487; author reply 488

Document 214
McClimans, Leah
A theoretical framework for patient-reported outcome measures.
Theoretical medicine and bioethics 2010 Jun; 31(3): 225-40
Abstract: Patient-reported outcome measures (PROMs) are increasingly used to assess multiple facets of healthcare, including effectiveness, side effects of treatment, symptoms, health care needs, quality of care, and the evaluation of health care options. There are thousands of these measures and yet there is very little discussion of their theoretical underpinnings. In her 2008 Presidential address to the Society for Quality of Life Research (ISOQoL), Professor Donna Lamping challenged researchers to grapple with the theoretical issues that arise from these measures. In this paper, I attempt to do so by arguing for an analogy between PROMs and Hans-Georg Gadamer's logic of question and answer. While researchers readily admit that the constructs involved in PROMs are imperfectly understood and lack a gold standard, they often ignore the consequences of this fact. Gadamer's work on questions and their importance to philosophical hermeneutics helps to show that the questions researchers ask about such constructs are also imperfectly understood. I argue that these questions should not be standardized, and I instead propose a theoretical framework that understands PROMs as posing genuine questions to respondents—questions that are open to reinterpretation.
**Document 215**

Stone, John R

**Non-payment and non-care: ethics and continuity of care.**

*Medical care* 2010 Jun; 48(6): 495-7

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**Document 216**

Farber, Neil J; Roche, Charles V 3rd.; Aboff, Brian M; Collier, Virginia U; Weiner, Joan

**When the patient does not pay: a survey of primary care physicians.**

*Medical care* 2010 Jun; 48(6): 498-502

**Abstract:** OBJECTIVE: Despite ethical implications, there are anecdotal reports of health practitioners withholding services from patients who do not pay their bills. We surveyed physicians about their attitudes and experiences regarding nonpaying patients. DESIGN: A cross-sectional mailed survey. PARTICIPANTS: Three hundred seventy-nine of 1000 surveyed primary care physicians participated. MEASUREMENTS AND MAIN RESULTS: We studied how likely participants were to withhold 13 services from hypothetical patients who did not pay the physician's bills based on a 4-point Likert scale. Respondents were asked whether they had actually ever withheld such services from patients. The effects of demographic data on the number of services withheld from hypothetical and actual patients were analyzed by analysis of variance and multiple logistic regression. Most respondents (84%) would have withheld at least 1 item of service from the hypothetical patient, with 41% having ever withheld care from their actual patients. Most services involved administrative actions, but many respondents would be willing to forego other types of medical care. Being younger (P = 0.003), believing that patients are not always entitled to medical care (P = 0.002) and being in an urban practice (P = 0.03) were associated with withholding medical care from patients. CONCLUSIONS: A majority of primary care practitioners responding to our survey would be willing to withhold medical care from patients who do not pay their bills; some have actually done so despite ethical and legal mandates to the contrary. Physicians should be educated about the importance of the patient-physician relationship and their ethical obligations to patients.

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**Document 217**

Crisci, Claudio; Arnone, Biagio;

**Are there 'bad' patients?**

*Nursing ethics* 2010 May; 17(3): 403

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**Document 218**

Rifkin, Dena

**The bargain.**

*The Hastings Center report* 2010 May-Jun; 40(3): 9

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**Document 219**

Bennett, Belinda; Carney, Terry; Saint, Caroline

**Swine flu, doctors and pandemics: is there a duty to treat during a pandemic?**

*Journal of law and medicine* 2010 May; 17(5): 736-47

Georgetown users check [Georgetown Journal Finder](#) for access to full text
Abstract: The swine influenza (H1N1) outbreak in 2009 highlighted the ethical and legal pressures facing general practitioners and health workers in emergency departments in determining the nature and limits of their obligations to their patients and the public. Health workers require guidance on the multiple, overlapping, and at times conflicting legal and ethical duties owed to patients and prospective patients, employers and fellow health workers, and their families. Existing sources of advice on these issues in Australia, by way of statements of medical ethics and other sources of advice, are shown to be in need of further amplification if health workers are to be provided with the certainty and guidance required. Given the complexity of the issues, Australia would therefore benefit from more extensive consultation with the variety of stakeholders involved in these questions if pandemic plans are to smoothly deal with future crises in an ethically and legally sound manner.

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Document 220

de Beaufort, I; Meulenberg, F
Eyewitness in Erewhon academic hospital.
Journal of medical ethics 2010 May ; 36(5): 258-9

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Document 221

Rifkin, Dena
The bargain
Hastings Center Report 2010 May-June; 40(3): 9

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http://www.thehastingscenter.org/Publications/HCR/Archive.aspx (link may be outdated)

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Document 222

Letouzey, V; Fritel, X; Pierre, F; Courtieu, C; Marès, P; de Tayrac, R
[Informing a patient about surgical treatment for pelvic organ prolapse]. = Quelle information délivrer à une patiente avant une chirurgie de prolapus?
Gynécologie, obstétrique & fertilité 2010 Apr; 38(4): 255-60

Abstract: Informed consent is a major objective in the relation patient-physician. Patient's information becomes doubt when it is insufficient. To answer to medical persons asking about patient's information, pretreatment clinical and paraclinical assessment will be discussed. Reflexion delay, surgical alternative therapy and pre-operatory examination will be discussed. Several critical situations, such as associated hysterectomy, patient's comorbidity (tobacco, obesity) or synthetic mesh reinforcement have to be made well-known to inform patient about failures and outcomes.

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Document 223

Sutton, Erica J; Upshur, Ross E G
Are there different spheres of conscience?
Journal of evaluation in clinical practice 2010 Apr; 16(2): 338-43

Abstract: Interest in understanding the meaning of conscience and conscientious objection in medicine has recently emerged in the academic literature. We would like to contribute to this debate in four ways: (1) to underscore and challenge the existing hierarchy of conscientious objection in health care; (2) to highlight the importance of considering the lay public when discussing the role of conscientious objection in medicine; (3) to critique the numerous proposals put forth in favour of implementing review boards to assess whether appeals to conscience are
justifiable, reasonable and sincere; and (4) to introduce the Universal Declaration of Human Rights and the Siracusa Principles into the dialogue around conscience and suggest that perhaps conscientious objection is a human right.

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Document 224

Bill, Aydin Z

A cry for help.

Delaware medical journal 2010 Apr; 82(4): 143-4

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Document 225

Harris, Edward D Jr.

Existentialism, the physician's philosophy.

The Pharos of Alpha Omega Alpha-Honor Medical Society. Alpha Omega Alpha 2010 Spring; 73(2): 1

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Document 226

Howe, Edmund G

"Third generation" ethics: what careproviders should do before they do ethics.


Abstract: The author suggests that a "first generation" task in bioethics is to give patients the information they need; a "second generation" task is to do this in the most effective way; and a "third generation" task is to avoid harming patients by imposing value biases. The author discusses ways to pursue this third generation task.

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Document 227

Lelièvre, Nathalie

[Refusal by nurses, going against medical advice, confusion: what is the difference?] = Refus de soins, sortie contre avis médical, fugue: quelle différence?

Soins; la revue de référence infirmière 2010 Apr; (744): 59-60

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Document 228

Kurpad, Sunita Simon; Machado, Tanya; Galgali, R.B.

Is there an elephant in the room? Boundary violations in the doctor-patient relationship in India.

Indian Journal of Medical Ethics 2010 April-June; 7(2): 76-81

Abstract: An anonymous postal survey on the awareness of the occurrence of nonsexual and sexual boundary violations (NSBV and SBV) in the doctor-patient relationship in India was conducted with psychiatrists and psychologists working in the state of Kamataka in India (n=51). Though this was not designed to be a prevalence study on violations, the results suggest that both NSBV and SBVdo occur and, more importantly, respondents felt that this is an area which needs urgent attention in India. There was disagreement on whether some behaviours in certain situations could be construed as NSBV in the Indian culture. Though several respondents agreed that there was a need to develop guidelines on this issue in India, there was a perception that the problem was not in the
availability of guidelines but in their implementation. The ethical implications of the study are discussed.

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http://www.issuesinmedicalethics.org/ (link may be outdated)

Document 229

Arawi, Thalia

The Lebanese physician: a public's viewpoint.

Developing World Bioethics 2010 April; 10(1): 22-29

Abstract: A physician's lack of humanity is a general complaint in public surveys. The physician-patient relationship is viewed by the public as being reduced to a business relationship where the patient feels that she is merely a 'client' and the physician a healthcare 'practitioner' instead of a 'care giver'. This public perception is not a phenomenon that is peculiar to Lebanon. Yet, the problem has been increasing over the years to the extent that patients feel that physicians are becoming inhumane and business oriented. While this might not characterize all physicians of the 21(st) century, this might be true of at least some. Responses were collected from a study that was undertaken based on a questionnaire distributed to a pool of 650 participants from different geographical areas and different social and educational backgrounds in Lebanon. Participants were all older than 18 years and mentally competent. None were physicians. The questionnaire was open-ended and initially piloted among a random sample. The physician traits most desired by the public were found to be: moral traits (41%), interpersonal traits (36%), scientific traits (19%) and other (4%). The most unwanted traits/behaviours were a lack of interpersonal traits (57%), a lack of moral traits (40%) and a lack of scientific skills (3%). The physician-patient relationship was perceived, in general, as being a flawed one. What can be done to remedy the image of the Lebanese physician that has been projected in the minds of the patients and the public at large? Nine major recommendations are presented.

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Document 230

Hine, Kristen

A reply to the interpretation problem.


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http://journals.cambridge.org/action/displayJournal?jid= cqh (link may be outdated)

Document 231

Deccache, Alain; van Ballekom, Karin

From patient compliance to empowerment and consumer's choice: evolution or regression? An overview of patient education in French speaking European countries.

Patient education and counseling 2010 Mar; 78(3): 282-7

Abstract: This paper presents a historical overview of patient education in French speaking (parts of) countries of Europe, as well as the emergence of new concepts in Health care and education. Further it describes the results of research and studies on current practice and political decisions and positions about patient education, based upon laws and regulations. The present trends will be discussed, and propose an overview of the next possible developmental steps.

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Document 232

Mitnick, Sheryl; Leffler, Cathy; Hood, Virginia L;
American College of Physicians Ethics, Professionalism and Human Rights Committee

**Family caregivers, patients and physicians: ethical guidance to optimize relationships.**
Journal of general internal medicine 2010 Mar; 25(3): 255-60

**Abstract:** Family caregivers play a major role in maximizing the health and quality of life of more than 30 million individuals with acute and chronic illness. Patients depend on family caregivers for assistance with daily activities, managing complex care, navigating the health care system, and communicating with health care professionals. Physical, emotional and financial stress may increase caregiver vulnerability to injury and illness. Geographically distant family caregivers and health professionals in the role of family caregivers may suffer additional burdens. Physician recognition of the value of the caregiver role may contribute to a positive caregiving experience and decrease rates of patient hospitalization and institutionalization. However, physicians may face ethical challenges in partnering with patients and family caregivers while preserving the primacy of the patient-physician relationship. The American College of Physicians in conjunction with ten other professional societies offers ethical guidance to physicians in developing mutually supportive patient-physician-caregiver relationships.

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**Document 233**

Heming, Jonathan

**The legal duties of carers.**
Medical law review 2010 Spring; 18(2): 248-55

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**Document 234**

Picot, Angela; McClanahan, Susan; Conviser, Jenny; Costin, Carolyn; Rabinor, Judith Ruskay; Hornstein, Robin; Murray, Leslie Elaine; Levine, Martha Peaslee; McGilley, Beth Hartman

**The therapist's appearance and recovery: perspectives on treatment, supervision, and ethical implications.**
Eating disorders 2010 Mar; 18(2): 165-75

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**Document 235**

Rosenbloom, Adam Haley; Jotkowitz, Alan

**The ethics of the hospitalist model.**
Journal of hospital medicine : an official publication of the Society of Hospital Medicine 2010 Mar; 5(3): 183-8

**Abstract:** The hospitalist model was founded on the premise that it could improve the quality and reduce the cost of hospital care. Many randomized studies have all but definitively proven this original assertion. Nevertheless, the hospitalist specialty raises lingering classical ethical issues: protecting the patient-physician relationship in an environment of increasing specialization and discontinuity of care, preserving patient autonomy and choice when structural changes are made in the provision of care, and ensuring that a model founded on efficiency and cost-effectiveness does not erode the public trust in hospitalists to always serve their patients' best interests. This work aims to serve as an update of these initial criticisms, showing how some questions have been answered, while some have not.

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**Document 236**

Francis, Leslie Pickering

**The physician-patient relationship and a National Health Information network.**
**Abstract:** The growing use of interoperable electronic health records is likely to have significant effects on the physician-patient relationship. This relationship involves two-way trust: of the physician in patients, and of the patients in their providers. Interoperable records opens up this relationship to further view, with consequences that may both enhance and undermine trust. On the one hand, physicians may learn (from additional records) that information from their patients is - or is not - to be trusted. On the other hand, patients may learn from the increased oversight made possible by electronic records that their trust in their physicians is - or is not - warranted. Release of information through new methods of surveillance may also undermine patient trust. The article concludes that because trust is fragile, attention to transparency and confidentiality in the use of interoperable electronic records is essential.

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**Document 237**

Moulton, Benjamin; King, Jaime S

**Aligning ethics with medical decision-making: the quest for informed patient choice.**


**Abstract:** Clinical evidence suggests that many patients undergo surgery that they would decline if fully informed. Failure to communicate the relevant risks, benefits, and alternatives of a procedure violates medical ethics and wastes medical resources. Integrating shared decision-making, a method of communication between provider and patient, into medical decisions can satisfy physicians' ethical obligations and reduce unwanted procedures. This article proposes a three-step process for implementing a nationwide practice of shared decision-making: (1) create model integration programs; (2) provide legal incentives to ease the transition; and (3) incorporate shared decision-making into medical necessity determinations.

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**Document 238**

Gold, Azgad

**Physicians' "right of conscience"- beyond politics.**


**Abstract:** During the past few months, the discussion over the physicians' "Right of Conscience" (ROC) has been on the rise. The intervention of politics in this issue shifts the discussion to a very specific and narrow area, namely the "reproductive health laws" which bear well-known predisposing attitudes. In this article, the physician's ROC is discussed in the context in which it naturally belongs: the Patient Physician Relationship (PPR). I suggest that the physicians' rights demand is a comprehensible, predictable, and even inevitable step as part of the "evolution" of the PPR. Thus, the most appropriate way to comprehend and tackle the demand for physicians' ROC is within the context of medical professionalism. While searching for practical solutions to the "reproductive health" problems, there is a need to recognize the ethical and practical implications of the change in the PPR and balance between patient and physician rights.

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**Document 239**

Holt, G Richard

**Challenges and rewards.**


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**Document 240**

Howe, Edmund G.

"Third generation" ethics: what careproviders should do before they do ethics.
Journal of Clinical Ethics 2010 Spring; 21(1): 3-13

**Abstract**: The author suggests that a "first generation" task in bioethics is to give patients the information they need; a "second generation" task is to do this in the most effective way; and a "third generation" task is to avoid harming patients by imposing value biases. The author discusses ways to pursue this third generation task.

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**Document 241**

Mahlin, Margaret

Individual patient advocacy, collective responsibility and activism within professional nursing associations.
Nursing Ethics 2010 March;17(2): 247-254

**Abstract**: The systemic difficulties of health care in the USA have brought to light another issue in nurse-patient advocacy - those who require care yet have inadequate or non-existent access. Patient advocacy has focused on individual nurses who in turn advocate for individual patients, yet, while supporting individual patients is a worthy goal of patient advocacy, systemic problems cannot be adequately addressed in this way. The difficulties nurses face when advocating for patients is well documented in the nursing literature and I argue that, through collective advocacy, professional nursing associations ought to extend the reach of individual nurses in order to address systemic problems in health care institutions and bureaucracies.

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**Document 242**

Hanks, Robert G.

Development and testing of an instrument to measure protective nursing advocacy.
Nursing Ethics 2010 March;17(2): 255-267

**Abstract**: Patient advocacy is an important aspect of nursing care, yet there are few instruments to measure this essential function. This study was conducted to develop, determine the psychometric properties, and support validity of the Protective Nursing Advocacy Scale (PNAS), which measures nursing advocacy beliefs and actions from a protective perspective. The study used a descriptive correlational design with a systematically selected sample of 419 medical-surgical registered nurses. Analysis of the 43-item instrument was conducted using principal components analysis with promax rotation, which resulted in the items loading onto four components. The four subscales have sufficient internal consistency, as did the overall PNAS. Satisfactory evidence of construct, content, and convergent validity were determined. Implications for nursing practice include using the PNAS in conjunction with an educational program to enhance advocacy skills, which may help to improve patient outcomes.

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**Document 243**

Mirza, Deen M.

Promoting unprofessionalism in the UAE? [letter]
Education for Primary Care 2010 March; 21(2): 132

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**Document 244**

Henderson, David K.; Dembry, Louise; Fishman, Neil O.; Grady, Christine; Lundstrom, Tammy; Palmore, Tara N.;
Sepkowitz, Kent A.; Weber, David J.
**SHEA guideline for management of healthcare workers who are infected with hepatitis B virus, hepatitis C virus, and/or human immunodeficiency virus.**
Infection Control and Hospital Epidemiology 2010 March; 31(3): 203-232

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**Document 245**

Baruch, Jay

**Hug or ugh?**
Hastings Center Report 2010 March-April; 40(2): 7-8

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**Document 246**

O'Dell, Michael

**Dignity.**
Journal of the Mississippi State Medical Association 2010 Feb; 51(2): 52

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**Document 247**

Le Coz, P; Kachaner, J

**[Justice and equity as determinants of medical decision-making] = Justice et équité dans la décision médicale.**
Archives de pédiatrie : organe officiel de la Société française de pédiatrie 2010 Feb ; 17 Suppl 1(): S32-8

**Abstract:** Every medical decision-making is to do justice to the one who suffers and who considers his pain as nonsensical. This requirement falls into 3 universal ethical principles, governing the patient-doctor relationship: the autonomy of the person even if it is a young child, beneficence and non-maleficence. Adhering to these principles gives medical decision-making its ethical dimension. It implies that the doctor makes the best use of the emotions that he feels in front of his patient and/or in front of his relatives: respect for autonomy, the beneficent compassion and the fear of maleficence in diagnosis and care. If a paediatrician combines these 3 affects harmoniously, his attitude is in keeping with the requirement of justice, which is the quintessence of Ethics. However, reality is often more complex, a source of conflicting emotions and, in fine, a source of an anguish whose benefit is yet to alert on the necessity to carry on looking for the right decision-making: the emotional revision consists of a meta-analysis of the objective and subjective data of the problem. It preciously helps to establish a compromise of justice. Eventually, in order to be just, the doctor must include the concern of equity amongst the criteria of his decision-making, in other words a fair allocation of the goods and of the care services. Unfortunately, this concern is undermined by geopolitical, socio-economic and cultural factors, which vary greatly according to the environmental conditions that might mar what should be optimal ethical decisionmaking. The doctor cannot solve these problems on his own, but he has to know them in order to deal with them.

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**Document 248**

Wendler, David

**Are physicians obligated always to act in the patient's best interests?**
Journal of Medical Ethics 2010 February; 36(2): 66-70

**Abstract:** The principle that physicians should always act in the best interests of the present patient is widely
endorsed. At the same time, and often within the same document, it is recognised that there are appropriate exceptions to this principle. Unfortunately, little, if any, guidance is provided regarding which exceptions are appropriate and how they should be handled. These circumstances might be tenable if the appropriate exceptions were rare. Yet, evaluation of the literature reveals that there are numerous exceptions, several of which pervade clinical medicine. This situation leaves physicians without adequate guidance on when to allow exceptions and how to address them, increasing the chances for unfairness in practice. The present article considers the range of exceptions, illustrates how the lack of guidance poses ethical concern and describes an alternative account of physician obligations to address this concern.

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**Document 249**

Wendler, David

**Are physicians obligated always to act in the patient's best interests?**

Journal of Medical Ethics 2010 February; 36(2): 66-70

**Abstract:** The principle that physicians should always act in the best interests of the present patient is widely endorsed. At the same time, and often within the same document, it is recognised that there are appropriate exceptions to this principle. Unfortunately, little, if any, guidance is provided regarding which exceptions are appropriate and how they should be handled. These circumstances might be tenable if the appropriate exceptions were rare. Yet, evaluation of the literature reveals that there are numerous exceptions, several of which pervade clinical medicine. This situation leaves physicians without adequate guidance on when to allow exceptions and how to address them, increasing the chances for unfairness in practice. The present article considers the range of exceptions, illustrates how the lack of guidance poses ethical concern and describes an alternative account of physician obligations to address this concern.

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[http://jme.bmj.com/content/36/2.toc](http://jme.bmj.com/content/36/2.toc) (link may be outdated)

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**Document 250**

Olsen, Douglas P.

**Want to achieve the 'greatest good'? Listen to your patients.**

American Journal of Nursing 2010 February; 110(2): 66-67

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**Document 251**

White, Brett

**The family doctor's pledge.**

Family Medicine 2010 February; 42(2): 84-85

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**Document 252**

Salomon, Fred

**[Economy and ethics in daily hospital routine - physicians in conflict between the well-being of patients and profitability] = Okonomie und Ethik im Klinikalltag - Der Arzt im Spannungsfeld zwischen Patientenwohl und Wirtschaftlichkeit.**

Anästhesiologie, Intensivmedizin, Notfallmedizin, Schmerztherapie 2010 February; 45(2): 128-131

**Abstract:** Medical decision making is affected by different aims and influencing factors. Nowadays economic aspects are so important that they influence the structure of hospitals, the number and quality of personnel, and the
treatment and care of patients. This leads to conflicts with moral aims, especially when the necessary service cannot be provided due to financial reasons or when doubtful offers are supposed to increase revenues. Examples demonstrate cases in which economic aspects become more important than patients' interests because physicians are corruptible. It is necessary to communicate values. Patients' health should be first and economy should be a subordinated service.

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**Document 253**

Lynöe, Niels; Juth, Niklas; Helgesson, Gert

**How to reveal disguised paternalism.**

Medicine, Health Care, and Philosophy 2010 February; 13(1): 59-65

**Abstract:** In a Swedish setting physicians are unlikely to give explicitly paternalistic reasons when asked about their attitudes towards patients' involvement in decision-making. There is considerable risk that they will disguise their paternalism by giving 'socially correct answers'. We suggest that disguised paternalism can be revealed with the help of indexes based on certain responses in postal questionnaires. The indexes were developed using material from a study examining attitudes of Swedish physicians to physician-assisted suicide (PAS). Apart from being asked about their attitudes, they were asked to prioritize between different arguments for and against PAS. One argument for PAS was: "PAS should be permitted out of respect for patients' autonomy". One argument against PAS was: "PAS should not be permitted since the non-maleficence principle in this case takes precedence over respecting patients' autonomy". Responses to the latter argument formed the cornerstone of a disguised-paternalism index, while an autonomy index was based on answers to the former argument. Applying our indexes to data from the PAS survey, we found that female GPs, surgeons, and older male physicians were least paternalistic. Among female physicians one finds both the most autonomy-respecting groups (female surgeons and GPs) and the least autonomy-respecting groups (female oncologists and psychiatrists); together with older male physicians in general, female GPs are the group displaying least disguised paternalism. We suggest that questionnaires exploring paternalism might be improved by including case-specific questions or statements by which to explore disguised paternalism. Here our indexes might be useful tools.

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**Document 254**

Crombie, H David

**The power of narrative: use it or lose it.**

Connecticut Medicine 2010 February; 74(2): 119-120

Georgetown users check [Georgetown Journal Finder](#) for access to full text

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**Document 255**

Dewitt, Dawn E.; Bhat, Ravi; Ward, Stephanie

"Through a glass, darkly": the clinical and ethical implications of Munchausen syndrome. Comment.

Medical Journal of Australia 2010 January 4; 192(1): 55

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**Document 256**

Tamim, Hani; Hejaili, Fayez; Jamal, Amr; al Shamsi, Huda; Al Sayyari, Abdulla

Professional boundary ethics attitudes and awareness among nurses and physicians in a university hospital in the Kingdom of Saudi Arabia

Document 257

Cohen, Mitchell L

The power of apology.

Family practice management 2010 Jan-Feb; 17(1): 40

Document 258

Fox, F.E.; Taylor, G.J.; Harris, M.F.; Rodham, K.J.; Sutton, J.; Scott, J.; Robinson, B.

"It's crucial they're treated as patients": ethical guidance and empirical evidence regarding treating doctor-patients.

Journal of Medical Ethics 2010 January; 36(1): 7-11

Abstract: Ethical guidance from the British Medical Association (BMA) about treating doctor-patients is compared and contrasted with evidence from a qualitative study of general practitioners (GPs) who have been patients. Semistructured interviews were conducted with 17 GPs who had experienced a significant illness. Their experiences were discussed and issues about both being and treating doctor-patients were revealed. Interpretative phenomenological analysis was used to evaluate the data. In this article data extracts are used to illustrate and discuss three key points that summarise the BMA ethical guidance, in order to develop a picture of how far experiences map onto guidance. The data illustrate and extend the complexities of the issues outlined by the BMA document. In particular, differences between experienced GPs and those who have recently completed their training are identified. This analysis will be useful for medical professionals both when they themselves are unwell and when they treat doctor-patients. It will also inform recommendations for professionals who educate medical students or trainees.

Document 259

Walter, J.K.; Lang, C.W.; Ross, L.F.

When physicians forego the doctor-patient relationship, should they elect to self-prescribe or curbside? An empirical and ethical analysis.

Journal of Medical Ethics 2010 January; 36(1): 19-23

Abstract: BACKGROUND: The American Medical Association, the British Medical Association and the Canadian Medical Association have guidelines that specifically discourage physicians from self-prescribing or prescribing to family members, but only the BMA addresses informal prescription requests between colleagues. OBJECTIVE: To examine the practices of paediatric providers regarding self-prescribing, curbsiding colleagues, and prescribing and refusing to prescribe to friends and family. METHODS: 1086 paediatricians listed from the American Academy of Paediatrics 2007 web-based directory were surveyed. RESULTS: 44% (430/982) of eligible survey respondents returned usable surveys. Almost half (198/407) of respondents had prescribed for themselves. An equal number (198/411) had informally requested a prescription from a colleague. Three-quarters (325/429) stated they had been asked to prescribe a prescription drug for a first-degree or second-degree relative, and 51% (186/363) had been asked by their spouse. Eighty-six per cent (343/397) stated that they had refused to write a prescription on at least one occasion for a friend or family member. The following reasons "strongly influenced" their decision to refuse a prescription request: (1) outside of provider's expertise (88%); (2) patient's need for his or her own physician (70%); (3) not medically indicated (69%); (4) need for a physical examination (65%). CONCLUSION: These data confirm that most physicians have engaged in self-prescribing or curbside requests for prescriptions. It can be argued that curbsiding is more morally problematic than self-prescribing because it implicates a third party, and should be discouraged regardless of whether the requester is a colleague, family member or friend.
Goodspeed, Ron; Lee, Bruce Y.
What if . . . : a patient makes a sexual advance toward you?
Georgetown users check Georgetown Journal Finder for access to full text

Lantos, John D.
Veatch Hates Hippocrates [review of Patient, Heal Thyself: How the "New Medicine" Puts the Patient in Charge, By Robert M. Veatch]
Georgetown users check Georgetown Journal Finder for access to full text

http://muse.jhu.edu/journals/hastings_center_report/toc/hcr.40.1.html (link may be outdated)

Buckman, Robert
PRACTICAL PLANS FOR DIFFICULT CONVERSATIONS IN MEDICINE: STRATEGIES THAT WORK IN BREAKING BAD NEWS
Call number: R727.3 .B835 2010

Legemaate, Johan
[Removing a patient from the practice list]. = De arts die een patiënt de praktijk uit zet.
Nederlands tijdschrift voor geneeskunde 2010; 154(51-52): A2883
Abstract: There are boundaries to what a physician can be expected to tolerate from a patient in terms of behaviour. If a patient approaches or oversteps these boundaries the physician is entitled to take action. Article 460 of the Dutch Medical Treatment Act states that a physician may unilaterally end an agreement to treat if there are important grounds to do so. A 2005 Royal Dutch Medical Association guideline contains concrete recommendations and suggestions for physicians who are seriously considering removing a patient from their practice list. Disease-related powerlessness or inability should not be a reason for breaking off a contract to treat a patient.

Galvin, Kathleen M; Clayman, Marla L
Whose future is it? Ethical family decision making about daughters' treatment in the oncofertility context.
Cancer treatment and research 2010; 156: 429-45
Georgetown users check Georgetown Journal Finder for access to full text

Masadeh, Aymen Khaled
Document 266
Penson, Richard T; Schapira, Lidia; Mack, Sally; Stanzler, Marjorie; Lynch, Thomas J Jr.

**Connection:** Schwartz Center Rounds at Massachusetts General Hospital Cancer Center.

**Abstract:** Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital, founded the Kenneth B. Schwartz Center, a nonprofit organization dedicated to supporting and advancing compassionate health care. The Center sponsors Schwartz Rounds, a multidisciplinary forum in which doctors, nurses, chaplains, social workers, and other staff reflect on important psychosocial issues that arise in caring for patients. Attendees participate in an interactive discussion about issues anchored in a case presentation and share their experiences, thoughts, and feelings. The patient narratives may center on wonderful events and transcendent experiences or tragic stories, during which staff can only bear witness to the suffering. The Rounds focus on caregivers' experiences, and encourage staff to share insights, own their vulnerabilities, and support each other. The primary objective is to foster healing relationships and provide support to professional caregivers, enhance communication among caregivers, and improve the connection between patients and caregivers. Currently, >50,000 clinicians attend monthly Schwartz Rounds at 195 sites in 31 states, numbers that are rapidly growing. In this article we explore the reasons that contribute to the success of this model of multidisciplinary reflection.

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Document 267
Wartensleben, Herbert

**[Shortage of patient rights--from the point of view of attorneys]. = Engpässe bei der Versorgung ambulanter Patienten--aus der Sicht des Anwalts.**

Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen 2010; 104(5): 375-8

**Abstract:** In the public health care sector physicians may apply only those methods that are generally accepted. The result is a lack of confidence. Medical science becomes reduced to natural science. Practical experience will be eliminated.

Georgetown users check [Georgetown Journal Finder](http://heinonline.org/) for access to full text

Document 268
Berglund, Britta; Anne-Cathrine, Mattiasson; Randers, Ingrid

**Dignity not fully upheld when seeking health care: experiences expressed by individuals suffering from Ehlers-Danlos syndrome.**

Disability and Rehabilitation 2010; 32(1): 1-7

**Abstract:** AIM: The principle of human dignity has assumed importance in ethics and constitutional law throughout the 20th century in the Western world. It calls for respect of each individual as unique, and of treating him or her as a subject, never as a mere object. As such, the principle constitutes an ethical cornerstone in health care. Patients suffering from Ehlers-Danlos syndrome (EDS) challenge medical care and knowledge in health-care professionals' as symptoms sometimes are vague. Individuals with this disorder have reported not being respected when seeking health care. PURPOSE: To describe encounters in health-care situations when individuals suffering from EDS experienced that their dignity was not fully upheld. A further aim was to describe the long-term consequences of these experiences. METHOD: A study-specific questionnaire was designed, where individuals with EDS described their encounters with health care from a personal perspective. RESULTS: After qualitative content analysis, the following five categories were identified: 'Being ignored and belittled by health-care professionals,' 'Being assigned psychological and/or psychiatric explanations', 'Being treated and considered merely as an object', 'Being trespassed
in one's personal sphere' and 'Being suspected of family violence'. Consequences of these encounters were 'Mistrusting the physician' and 'Risking bad health'. CONCLUSIONS: The memory of not being respected is substantial for individuals with EDS and can last for years. As a result, lack of trust for the health-care system is created and they may experience difficulties in future encounters with health care. Therefore, health-care professionals should base their actions on norms that protect human dignity and confirm each patient as a unique human being with resources and abilities to master their own life.

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**Document 269**

Feudtner, Chris

*The breadth of hopes.*


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**Document 270**

Finlay, Ilora

*Why I wrote... Handbook of Communication in Oncology and Palliative Care*

Clinical Ethics 2009 December; 5(4): 220-221

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**Document 271**

Eastwood, Gregory L

*When relatives and friends ask physicians for medical advice: ethical, legal, and practical considerations.*

Journal of general internal medicine 2009 Dec; 24(12): 1333-5

**Abstract:** Physicians often are asked for advice about medical matters by relatives and friends. These range from requests for simple information to requests for medical opinion and judgment and more substantial involvement by the physician. I comment on the motivations and expectations of the requester and the physician, and the legal, ethical, and practical considerations related to such requests. I recommend: (1) Be clear about the expectations of the requester and yourself, including whether you are being asked for simple factual information, your medical judgment and opinion, or more substantial involvement in the situation. (2) Treat your interactions with relatives or friends with the same professional expertise and judgment as you would any patient. (3) Be aware that a physical examination and especially charging a fee strengthen the establishment of a legal relationship with the requester as your patient. (4) Respect the requester's autonomy and confidentiality and conform to HIPAA requirements where applicable. (5) Be aware of the potential conflict between your roles as a relative or friend and as a physician.

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**Document 272**

Wittmann-Price, Ruth A.; Fisher, Kathleen M.

*Patient decision aids: tools for patients and professionals*

AJN: American Journal of Nursing 2009 December; 109(12): 60-61, 63

Georgetown users check [Georgetown Journal Finder](http://content.nejm.org/archive/) for access to full text
Document 273

Healy, Bernadine

Get ready to take charge


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http://www.usnews.com (link may be outdated)

Document 274

Al-Gaai, E.A.; Hammami, M.M.

Medical chaperoning at a tertiary care hospital in Saudi Arabia: survey of physicians.

Journal of Medical Ethics 2009 December; 35(12): 729-32

Abstract: BACKGROUND: Medical chaperones (MC) are underutilised. The influence of Islamic culture on the use of MC is not known. AIM: To examine physicians' use and perception of MC in Islamic culture. SETTING: A major tertiary care hospital in Saudi Arabia. METHODS: 315 self-administered questionnaires were distributed to attendees of grand rounds of 13 departments. RESULTS: 186 (59%) questionnaires were completed. 64.5% of the respondents were 30-49 years old, 75.8% were men and 31.2% were in training; 79% had a clinic load of under 50 patients per week and 47.8% had postgraduate training (PGT) in an Islamic country. MC were reported to be infrequently (< or =25% of the time) used by 44.1% (69.2% female vs 39% male physicians, p = 0.001; 58.6% in training vs 36.8% attending, p = 0.007; 52.1% PGT in Islamic vs 35.6% in western countries, p = 0.027), offered by 52.7% (78.9% female vs 46.8% male physicians, p<0.001) and requested by 79% of patients. MC were reported to be commonly (>75% of the time) used, offered by physicians and requested by patients by 38.2%, 29% and 7.5% of respondents, respectively. The most frequently cited reasons for not using MC were privacy/confidentiality (36.6%) and understaffing (30.5%). Equal numbers of respondents perceived MC use as a protection for physicians or patients (67.7% and 65.6%, respectively). CONCLUSIONS: MC are underutilised even in Islamic culture, especially among female physicians. Training in western countries is favourably associated with MC use. Underutilisation appears to be related to privacy/confidentiality, understaffing and failure of patients to request a MC.

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Document 275

Wessel, M.; Helgesson, G.; Lynöe, N.

Experiencing bad treatment: qualitative study of patient complaints concerning their treatment by public health-care practitioners in the County of Stockholm

Clinical Ethics 2009 December; 4(4): 195-201

Abstract: The aim of this study was to investigate patients’ experiences of not being treated well in medical health care in Stockholm County, Sweden. The study was conducted by implementing qualitative content analysis using categorization of empirical material for 2006 and 2007 provided by the Patients’ Advisory Committee (Patientnämnden) in Stockholm. Complaints about not being treated well accounted for 13% of all complaints to the Patients’ Advisory Committee. A sample of those who complained about their medical treatment shows that about 30% of these complaints also involved experiences of being badly received. Categorization of the complaints about being badly treated resulted in the following 11 categories: (1) rude, aggressive or arrogant behaviour; (2) being ignored; (3) being denied examinations or treatments; (4) lack of empathy among personnel; (5) lack of respect for personal integrity; (6) lack of time/waiting time; (7) personnel not separating private issues from their professional role; (8) injustice and discrimination; (9) sexual harassment; (10) coercion and violence and (11) unspecified bad treatment. In relation to the total number of patients, women were over-represented in all categories. In conclusion, what patients react most strongly against is when health-care personnel treat them disrespectfully by not abiding by established social norms. The results indicate that the combination of failure in medical treatment and not receiving an apology often leads patients to complain to the Patients’ Advisory Committee.

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Document 276
Kirklin, Deborah
**Picasso, professionalism and plastic surgery: why privileging the patient's perspective is a moral imperative** [editorial]
Medical Humanities 2009 December; 35(2): 65-66
Georgetown users check [Georgetown Journal Finder](http://mh.bmj.com/content/35/2.toc) for access to full text

Document 277
Qualtere-Burcher, Paul
**The just distance: narrativity, singularity, and relationality as the source of a new biomedical principle.**
Georgetown users check [Georgetown Journal Finder](http://mh.bmj.com/content/35/2.toc) for access to full text

Document 278
Keegan, Michael
**GMC guidance on confidentiality** [letter]
British Medical Journal 2009 November 7; 339(7729): 1046
Georgetown users check [Georgetown Journal Finder](http://www.bmj.com) for access to full text

Document 279
Westra, Anna E.; Willems, Dick L.; Smit, Bert J.
**Communicating with Muslim parents: "the four principles" are not as culturally neutral as suggested**
Georgetown users check [Georgetown Journal Finder](http://www.ncbi.nlm.nih.gov/) for access to full text

Document 280
Chen, Pauline W.
**A tool to strengthen the doctor-patient relationship.**
Georgetown users check [Georgetown Journal Finder](http://www.thehastingscenter.org/Publications/HCR/Default.aspx) for access to full text
Document 281

Schapira, Lidia

A gift of time. [a piece of my mind]

Georgetown users check [Georgetown Journal Finder](http://jama.ama-assn.org/content/vol302/issue16) for access to full text

Document 282

Koppelman-White, Elysa R.

The search for reasons in a unified relationship
Journal of Medicine and Philosophy 2009 October; 34(5): 447-469

Abstract: The paternalism, autonomy debate was influenced by traditional ideas that reasons are either objective (based on values existing independent of any particular person) or subjective (based on values tied to individual's personal histories). This dichotomy has been rewarding for the health care community. However, the tenets of this debate have influenced the nature of deliberation in a way that seriously compromises the ability of health care professionals and patients to bring reflection (the search for justified reasons) to a successful end. It sets up the moral landscape not as one of unity and reciprocity, but as one of divisiveness and distance-where one person (the physician) does something to another (paternalism) or for another (patient autonomy), rather than with another. This distance and divisiveness undermines the unity of wills and genuine reciprocity that I argue is indispensable for genuinely good relationships and necessary for successfully establishing what reasons there are to act. It has created an abyss in communication that even recent suggestions for change cannot bridge. In this paper, I discuss the nature of this abyss and the problems it has created by demonstrating that traditional theoretical ideas about the nature of reasons have influenced the nature of deliberation in health care. I argue that recent suggestions for "justified paternalism" fail to bridge the abyss. Finally, I suggest that to be successful, we must change the framework; we must reject the ideas of objective and subjective value and embrace instead the idea that values are intersubjective.

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Document 283

Lin, Grace A.; Dudley, R. Adams

Patient-centered care: what is the best measuring stick? [editorial]
Archives of Internal Medicine 2009 September 28; 169(17): 1551-1553

Georgetown users check [Georgetown Journal Finder](http://archinte.ama-assn.org) for access to full text

Document 284

Sokol, Daniel K.

Hippocrates, Michael Jackson, and medical ethics [commentary]
BMJ: British Medical Journal 2009 September 5; 339(7720): 541

Georgetown users check [Georgetown Journal Finder](http://www.bmj.com) for access to full text
Document 285
Hoerni, Bernard
Altruism.
Georgetown users check Georgetown Journal Finder for access to full text

Document 286
Stevens, David
The most important bioethical issue you face
Today’s Christian Doctor 2009 Fall; 40(3): 14-16
Georgetown users check Georgetown Journal Finder for access to full text

Document 287
Aultman, Julie M.
When humor in the hospital is no laughing matter.
Journal of Clinical Ethics 2009 Fall; 20(3): 227-234
Georgetown users check Georgetown Journal Finder for access to full text

Document 288
Guseh, J.S., 2nd; Brendel, R.W.; Brendel, David H.
Medical professionalism in the age of online social networking.
Journal of Medical Ethics 2009 September; 35(9): 584-586
Abstract: The rapid emergence and exploding usage of online social networking forums, which are frequented by millions, present clinicians with new ethical and professional challenges. Particularly among a younger generation of physicians and patients, the use of online social networking forums has become widespread. In this article, we discuss ethical challenges facing the patient-doctor relationship as a result of the growing use of online social networking forums. We draw upon one heavily used and highly trafficked forum, Facebook, to illustrate the elements of these online environments and the ethical challenges peculiar to their novel form of exchange. Finally, we present guidelines for clinicians to negotiate responsibly and professionally their possible uses of these social forums.
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http://jme.bmj.com (link may be outdated)

Document 289
Farlow, Barbra
Misgivings
Hastings Center Report 2009 September-October 39(5): 19-21
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Document 290
Landeweer Elleke
Patient, Heal Thyself. How the new medicine puts the patient in charge, by Robert M. Veatch [book review]
EACME Newsletter [electronic] 2009 August; (22): 7-8

Georgetown users check Georgetown Journal Finder for access to full text

Document 291
Ho, Anita
"They just don't get it!" When family disagrees with expert opinion.
Journal of Medical Ethics 2009 August; 35(8): 497-501
Abstract: The notions of "expert" and "expertise" imply that some people have more credibility than others on certain matters. While expert authority is often taken for granted, there are questions as to whether expert power in some cases can be a form of epistemic oppression. Informed by bedside disagreements between family and clinicians as well as feminist discussions of epistemic oppression, this paper argues for a commitment to epistemic humility and the adoption of a two-way collaborative approach between clinicians and families that can help to enhance professionals' own understanding of their theoretical framework and also promote responsive patient care.

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http://jme.bmj.com (link may be outdated)

Document 292
Bolton, Gillie
Writing values.
Lancet 2009 July 4-10; 374(9683): 20-21

Georgetown users check Georgetown Journal Finder for access to full text

http://www.thelancet.com/journals/lancet (link may be outdated)

Document 293
Baum, Neil
Dealing with difficult patients.
Abstract: Every physician and every practice is confronted with difficult patients. How a doctor and a practice manage these difficult patients will ultimately determine the success of the practice. This article will discuss how to recognize the difficult patient, how to treat the difficult patient using the three-step response, and what to do if the patient doesn't comply with the standards of the practice.

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Document 294
Hoerni, Bernard; Avril, Antoine
Bulletin du cancer 2009 July-August; 96(7): 769-775

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Incorporating patients' spirituality into care using Gadow's ethical framework

**Abstract:** Incorporating patients' spiritual beliefs into health care decision making is essential for ethically good care. Gadow's three-level ethical framework of ethical immediacy, ethical universalism, and relational narrative is presented as a tool for enhancing nurses' ability to explore and deepen understandings of patients' spiritual beliefs, given that these and their experiences are often expressed in a language that seems foreign to nurses. The demographic and cultural shifts that lead to the necessity to understand patients who use principles and metaphors that, while commonly understood within their spiritual tradition, may seem incomprehensible to outsiders, are here set in the Canadian context. A case study on palliative sedation is used to illustrate how the ethical framework can help to reveal the spiritual certainties, principles and narratives patients bring to their health care experiences.

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Understanding respect: learning from patients

**Abstract:** BACKGROUND: The importance of respecting patients and participants in clinical research is widely recognised. However, what it means to respect persons beyond recognising them as autonomous is unclear, and little is known about what patients find to be respectful. OBJECTIVE: To understand patients' conceptions of respect and what it means to be respected by medical providers. DESIGN: Qualitative study from an academic cardiology clinic, using semistructured interviews with 18 survivors of sudden cardiac death. RESULTS: Patients believed that respecting persons incorporates the following major elements: empathy, care, autonomy, provision of information, recognition of individuality, dignity and attention to needs. CONCLUSIONS: Making patients feel respected, or valued as a person, is a multi-faceted task that involves more than recognising autonomy. While patients' views of respect do not determine what respect means, these patients expressed important intuitions that may be of substantial conceptual relevance.

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The silent dimension: expressing humanism in each medical encounter.

Schattner, Ami

Archives of Internal Medicine 2009 June 22; 169(12): 1095-1099

Georgetown users check [Georgetown Journal Finder](http://archinte.ama-assn.org) for access to full text

The dangerous practice of empathy.

Macnaughton, Jane

Lancet 2009 June 6-12; 373(9679): 1940-1941

Georgetown users check [Georgetown Journal Finder](http://www.thelancet.com/journals/lancet) for access to full text
Document 299
Volandes, Angelo E.; Paasche-Orlow, Michael K.; Barry, Michael J.; Gillick, Muriel R.; Minaker, Kenneth L.; Chang, Yuchiao; Cook, E. Francis; Abbo, Elmer D.; El-Jawahri, Areej; Mitchell, Susan L.
**Video decision support tool for advance care planning in dementia: randomised controlled trial**
BMJ: British Medical Journal 2009 June 6; 338(7707): 1372
Georgetown users check [Georgetown Journal Finder](http://www.bmj.com) for access to full text

Document 300
Willis, Derek
**In search of true autonomy.**
Journal of primary health care 2009 Jun; 1(2): 152-3
**Abstract:** Patient autonomy is discussed in medical care now both because this is an appropriate ethical practice and also as a reaction against the emphasis that was placed in the past on the medical profession ‘always knowing best’. This article examines where our present understanding and practice of the ethical concept of autonomy may be flawed. It examines both doctors’ and patients’ responsibilities for this flaw and how they may be rectified.

Document 301
León, Tomás R.; Bedregal, Paula; Shand, Beatriz
**[Ethical problems in medical services from the patients' point of view] = Prevalencia de problemas éticos en Servicios de Medicina, desde la perspectiva del paciente.**
Revista médica de Chile 2009 Jun ; 137(6): 759-65
**Abstract:** BACKGROUND: There is a paucity of information on the perception of patients about ethical issues in medical practice. AIM: To determine the type and frequency of ethical problems perceived by patients hospitalized in public and private hospitals. MATERIAL AND METHODS: Eighty eight subjects aged 65 years (48% women), admitted to a public hospital and 44 subjects aged 59 years (52% women) admitted to a private clinic answered a survey about ethical problems. The main issues covered were medical information management, participation in decision making and intimacy of patients. RESULTS: Fifty three percent of patients perceived at least one ethical problem. Patients admitted to the public hospital perceived more communication and intimacy problems than their peers admitted to a private clinic. CONCLUSIONS: Approximately half of the interviewed patients acknowledged the presence of ethical problems, especially in the communication and intimacy areas.

Document 302
**The doctor as a client: the ethics of role reversal.**
Clinical Medicine 2009 June; 9(3): 299-300

Document 303
Seetharam, Sridevi; Zanotti, Renzo
**Patients’ perceptions on healthcare decision making in rural India: a qualitative study and ethical analysis.**
* Document 304
Peppin, John F.
The marginalization of chronic pain patients on chronic opioid therapy.

* Document 305
Segal, Jeffrey
The role of the Internet in doctor performance rating.
Pain Physician 2009 May-June; 12(3): 659-664

* Document 306
Capron, Alexander Morgan
The legacy of Jay Katz: the abiding relevance of the "obligation for conversation" in the physician-patient relationship.
Journal of Health and Life Sciences Law 2009 April; 2(3): 1-27

* Document 307
Buchanan, Brian L.
Bush administration issued, and Obama administration seeks to rescind, 'conscience clause' regulation.
WMJ 2009 April; 108(2): 117-188

* Document 308
Molyneux, David H.
Should healthcare professionals respect autonomy just because it promotes welfare?
Journal of Medical Ethics 2009 April; 35(4): 245-250

Abstract: Respect for autonomy is an important moral principle within medical ethics. However, the question of whether the normative importance of respect for autonomy is derived from other moral principles (such as welfare) or has independent moral value is debatable. In this paper it is argued that the normative importance of autonomy is derived from both welfare and non-welfare considerations. Welfare considerations provide two types of reason to respect autonomy, one related to the role of autonomy in creating welfare and one related to its role in constituting welfare. In addition, autonomy seems to have normative importance that is unrelated to welfare considerations. This type of normative role is difficult to defend within medical ethics, because most non-welfare justifications of autonomy work for only a proportion of the autonomous decisions that patients make and give no clear guidance on how to respond to autonomous yet welfare-reducing treatment requests. A recent account of autonomy (Stephen Darwall's "demand" account) provides a nuanced defence of autonomy that does not rely on welfare considerations. Darwall's approach seems to work well within medical ethics and provides a principled explanation of how to respond to autonomous patient requests for treatment options that may not be in their best medical interests. It is argued that
to fully respect autonomy within a medical consultation, practitioners must consider non-welfare autonomy as well as instrumental and intrinsic welfare-related autonomy.

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http://jme.bmj.com (link may be outdated)

* Article  Document 309
Lawrence, Ryan E.; Curlin, F.A.

**Autonomy, religion and clinical decisions: findings from a national physician survey.**
Journal of Medical Ethics 2009 April; 35(4): 214-218

**Abstract:** BACKGROUND: Patient autonomy has been promoted as the most important principle to guide difficult clinical decisions. To examine whether practising physicians indeed value patient autonomy above other considerations, physicians were asked to weight patient autonomy against three other criteria that often influence doctors' decisions. Associations between physicians' religious characteristics and their weighting of the criteria were also examined. METHODS: Mailed survey in 2007 of a stratified random sample of 1000 US primary care physicians, selected from the American Medical Association masterfile. Physicians were asked how much weight should be given to the following: (1) the patient's expressed wishes and values, (2) the physician's own judgment about what is in the patient's best interest, (3) standards and recommendations from professional medical bodies and (4) moral guidelines from religious traditions. RESULTS: Response rate 51% (446/879). Half of physicians (55%) gave the patient's expressed wishes and values "the highest possible weight". In comparative analysis, 40% gave patient wishes more weight than the other three factors, and 13% ranked patient wishes behind some other factor. Religious doctors tended to give less weight to the patient's expressed wishes. For example, 47% of doctors with high intrinsic religious motivation gave patient wishes the "highest possible weight", versus 67% of those with low (OR 0.5; 95% CI 0.3 to 0.8). CONCLUSIONS: Doctors believe patient wishes and values are important, but other considerations are often equally or more important. This suggests that patient autonomy does not guide physicians' decisions as much as is often recommended in the ethics literature.

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Spooner, Mary Helen

**Patient catechism: no prayers please.**
CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne 2009 March 31; 180(7): E6

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Tang, Paul C.; Lee, Thomas H.

**Your doctor's office or the Internet? Two paths to personal health records [commentary]**

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Pantilat, Steven Z.
Communicating with seriously ill patients: better words to say.
JAMA: The Journal of the American Medical Association 2009 March 25; 301(12): 1279-1281
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Toor, Rachel
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Doctors defend regulations protecting conscience rights [news]
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Atlas, Steven J.; Grant, Richard W.; Ferris, Timothy G.; Chang, Yuchiao; Barry, Michael J.
Patient-physician connectedness and quality of primary care.
Annals of Internal Medicine 2009 March 3; 150(5): 325-335
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Capozzi, James D.; Rhodes, Rosamond; Chen, Darwin
Discussing treatment options.

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Eisenberg, Daniel
Self-endangerment to save others
ASSIA: A Journal of Jewish Medical Ethics and Halacha 2010 March; 7(2): 33-47

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Howsepian, A.A.
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Grimen, Harald
Power, trust, and risk: some reflections on an absent issue.
Medical Anthropology Quarterly 2009 March; 23(1): 16-33

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I often read that patients should find out how much experience a doctor and hospital has with a particular procedure before deciding who should operate on you and where the surgery should be done. How exactly does one do that kind of research? I also hear about the importance of getting a second opinion, but how do you do that without offending your own doctor? Does insurance usually cover second opinions?
Heart Advisor 2009 March; 12(3): 8

Document 323
Gilbar, Roy; Gilbar, Ora
The medical decision-making process and the family: the case of breast cancer patients and their husbands
Bioethics 2009 March; 23(3): 183-192
Abstract: OBJECTIVES: The objectives of the study were (1) to assess similarities and differences between breast
cancer patients and their husbands in terms of doctor-patient/spouse relationships and shared decision making; and (2) to investigate the association between breast cancer patients and husbands in terms of preference of type of doctor, doctor-patient relationship, and shared decision making regarding medical treatment. METHOD: Fifty-seven women with breast cancer, and their husbands, completed questionnaires measuring doctor-patient/spouse relationships (paternalism, autonomy), and decision making regarding medical treatment. RESULTS: Patients believe they have a key role in the medical decision-making process (93%) and that the participation of their husbands, and their agreement with the decision, is important (84% and 89%, respectively). Both breast cancer patients and their husbands prefer a shared decision-making process to paternalistic or autonomy-based approaches. CONCLUSION: In contrast to legal and bioethical approaches, which focus on the patient as the primary decision maker, this study reflects a practical recognition of the role of the breast cancer patient's husband in the decision-making process. It also reflects a relational rather than an individualistic perception of patient autonomy.

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Bezuidenhout, L.; Borry, P.
Examining the role of informal interpretation in medical interviews
Journal of Medical Ethics 2009 March; 35(3): 159-162
Abstract: A linguistic barrier between healthcare professional and patient is a challenging experience for both parties. In many cases, the absence of formally trained medical interpreters necessitates that an informal interpreter, drawn from the immediate environment, be used to facilitate communication. While the presence of an interpreter in a medical interview raises many questions about the effectiveness of the communication between healthcare professional and patient, it also gives rise to new speculations revolving on patient rights, medical ethics and patient privacy. In this article we examine the concept of communication competency in medical interviews, as well as translation theory, and link these theories to Western medical ethics in order to identify potential areas in which informal interpretation could impact on the patient.

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Burke, Greg F.
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Difficult patients, overmedication, and groupthink.
Journal of Clinical Ethics 2009 Spring; 20(1): 64-74
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Halpern, Jodi
Groupthink and caregivers' projections: addressing barriers to empathy.
Journal of Clinical Ethics 2009 Spring; 20(1): 75-78
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* Article  Document 329
Moser, Albine; Houtepen, Rob; van der Bruggen, Harry; Spreeuwenberg, Cor; Widdershoven, Guy
Autonomous decision making and moral capacities.
Nursing Ethics 2009 March; 16(2): 203-218
Abstract: This article examines how people with type 2 diabetes perceive autonomous decision making and which moral capacities they consider important in diabetes nurses' support of autonomous decision making. Fifteen older adults with type 2 diabetes were interviewed in a nurse-led unit. First, the data were analysed using the grounded theory method. The participants described a variety of decision-making processes in the nurse and family caregiver context. Later, descriptions of the decision-making processes were analysed using hermeneutic text interpretation. We suggest first- and second-order moral capacities that nurses specializing in diabetes need to promote the autonomous decision making of their patients. We recommend nurses to engage in ongoing, interactive reflective practice to further develop these moral capacities.
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Dyer, Clare
**GMC consults on handling of vexatious complaints [news]**
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**Rating doctors like restaurants [editorial]**
New York Times 2009 February 18; p. A26

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Reinharth, Daniel
**Patient-physician communication [letter]**
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Martyn, Christopher
**Of mondegreens and misunderstandings. Doctor-patient communication often fails not so much because patients don't understand what doctors say but because doctors aren't aware that how they talk to patients is inappropriate.**
BMJ: British Medical Journal 2009 February 7; 338(7690): 324

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Damie, Anita
**Do patients' preferences matter. Patients' preferences and mental capacity [letter]**
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Taylor, Keith
**Paternalism, participation and partnership - the evolution of patient centeredness in the consultation.**
Patient Education and Counseling 2009 February; 74(2): 150-155
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Wright, James Lee

**Playing god: the role of provider and patient.**


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Langer, Andreas; Schröder-Bäck, Peter; Brink, Alexander; Eurich, Johannes

**The agency problem and medical acting: an example of applying economic theory to medical ethics**

Medicine, Health Care, and Philosophy 2009 February; 12(1): 99-108

**Abstract:** In this article, the authors attempt to build a bridge between economic theory and medical ethics to offer a new perspective to tackle ethical challenges in the physician-patient encounter. They apply elements of new institutional economics to the ethically relevant dimensions of the physician-patient relationship in a descriptive heuristic sense. The principal-agent theory can be used to analytically grasp existing action problems in the physician-patient relationship and as a basis for shaping recommendations at the institutional level. Furthermore, the patients' increased self-determination and modern opportunities for the medical laity to inform themselves lead to a less asymmetrical distribution of information between physician and patient and therefore require new interaction models. Based on the analysis presented here, the authors recommend that, apart from the physician's necessary individual ethics, greater consideration should be given to approaches of institutional ethics and hence to incentive systems within medical ethics.

Document 338

Skirbekk, Helge

**Negotiated or taken-for-granted trust? Explicit and implicit interpretations of trust in a medical setting**

Medicine, Health Care, and Philosophy 2009 February; 12(1): 3-7

**Abstract:** Trust between a patient and a medical doctor is normally both justified and taken for granted, but sometimes it may need to be negotiated. In this paper I will present how trust can be interpreted as both an explicit and implicit phenomenon, drawing on literature from the social sciences and philosophy. The distinction between explicit and implicit interpretations of trust will be used to address problems that may arise in clinical consultations. Negotiating trust in any way very easily brings distrust into a situation, but sometimes this can be helpful for building a more functional patient-doctor relationship.

Document 339

McCullough, Laurence B.

**Tracking the variability of authority and power in the physician-patient relationship**

Naik, Aanand D.; Dyer, Carmel B.; Kunik, Mark E.; McCullough, Laurence B.

**Patient autonomy for the management of chronic conditions: a two-component re-conceptualization**

**Abstract:** The clinical application of the concept of patient autonomy has centered on the ability to deliberate and make treatment decisions (decisional autonomy) to the virtual exclusion of the capacity to execute the treatment plan (executive autonomy). However, the one-component concept of autonomy is problematic in the context of multiple chronic conditions. Adherence to complex treatments commonly breaks down when patients have functional, educational, and cognitive barriers that impair their capacity to plan, sequence, and carry out tasks associated with chronic care. The purpose of this article is to call for a two-component re-conceptualization of autonomy and to argue that the clinical assessment of capacity for patients with chronic conditions should be expanded to include both autonomous decision-making and autonomous execution of the agreed-upon treatment plan. We explain how the concept of autonomy should be expanded to include both decisional and executive autonomy, describe the biopsychosocial correlates of the two-component concept of autonomy, and recommend diagnostic and treatment strategies to support patients with deficits in executive autonomy.

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**Patient autonomy writ large**

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*R DeMarco, Joseph P.; Stewart, Douglas O.

**Expanding autonomy; contracting informed consent**

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*R Casado da Rocha, Antonio

**Towards a comprehensive concept of patient autonomy**

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Barth-Rogers, Yohanna; Jotkowitz, Alan

Executive autonomy, multiculturalism and traditional medical ethics

Scanlan, Camilla; Kerridge, Ian H.

Autonomy and chronic illness: not two components but many

Schmidt, Harald

A new era of responsibility: for the U.S., England's health service constitution, and the broccoli police

Brown, Hilary K.

Information exchange between provider and patient [letter]
CMAJ: Canadian Medical Association Journal = Journal de l'Association Médicale Canadienne 2009 January 20; 180(2): 207

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Bell, Liz; Duffy, Anita
A concept analysis of nurse-patient trust.
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Goodspeed, Ron
What if . . . : you feel the way that a colleague speaks to or about patients is inappropriate?
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Reisman, Anna B.
Rebel without a gauze.
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Pajnkihar, Majda
Nurses’ (un)partner-like relationships with clients.
Nursing Ethics 2009 January; 16(1): 43-56
Abstract: The aim of a previous study was to describe nursing in Slovenia generally, and to identify the most appropriate nursing model for that country. One specific finding was the issue of partner-like relationships; this article deals with that issue only. An interpretive paradigm and qualitative research design were used with a modified grounded theory approach. Interviews were carried out with selected nursing leaders (n = 24) and other professionals (n = 6) in order to draw on their knowledge and experience to describe the reality of nursing phenomena. The results of this research suggest that participants wish to use a theory that emphasizes clients and treats them as equal partners in nursing, promotes health, and rests on interpersonal relationships. The participants described the missing or obscure parts in nursing and their own beliefs and values about human beings and nursing. Descriptions of and the need for partner-like relationships, and the specific elements of such relationships, were of main concern. The participants argued that nurses need high quality and continuing education to ensure competent nursing practice. The indication is that Slovenia should move to graduate and undergraduate nurse education to foster expert reflective practice in order to abolish routinized care carried out in a hierarchical system.
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Koubel, Georgina and Bungay, Hilary, eds.  
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DeMyer, William E.  
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Nuland, Sherwin B.  
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Veatch, Robert M.  
PATIENT, HEAL THYSELF: HOW THE NEW MEDICINE PUTS THE PATIENT IN CHARGE  
Call number: R723.5 .V43 2009

**Document 358**
Blanarsch, Matthias  

Abstract: This paper describes the physician-patient relationship in early modern Thuringia. Its main historical source are a hundred patient records concerning 'mole pregnancies'. The physician Johann Storch (1681-1751) published these records in 1749. Firstly, the quantitative exploration shows that among his patients were not only wealthy people but also wives of craftsmen and day labourers. The paper explores the conceptual history of mole pregnancies since Hippocrates' times. It also describes the social role of healers and patients and addresses the issue of god's role. Although theoretical works of the time emphasize the important role of god, he does not feature strongly in the patient records investigated. The body image of Storch's patients is also thematised in the paper. Storch and his patients had the same perception of body and illness. Unlike today, physicians and patients shared similar notions about illness and healing.

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**Document 359**
Sandman, Lars; Munthe, Christian  
Shared decision-making and patient autonomy.
Theoretical Medicine and Bioethics 2009; 30(4): 289-310

Abstract: In patient-centred care, shared decision-making is advocated as the preferred form of medical decision-making. Shared decision-making is supported with reference to patient autonomy without abandoning the patient or giving up the possibility of influencing how the patient is benefited. It is, however, not transparent how shared decision-making is related to autonomy and, in effect, what support autonomy can give shared decision-making. In the article, different forms of shared decision-making are analysed in relation to five different aspects of autonomy: (1) self-realisation; (2) preference satisfaction; (3) self-direction; (4) binary autonomy of the person; (5) gradual autonomy of the person. It is argued that both individually and jointly these aspects will support the models called shared rational deliberative patient choice and joint decision as the preferred versions from an autonomy perspective. Acknowledging that both of these models may fail, the professionally driven best interest compromise model is held out as a satisfactory second-best choice.

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*  Article  Document 360

Mayes, Christopher

Pastoral power and the confessing subject in patient-centred communication

Abstract: This paper examines the power relations in “patient-centred communication”. Drawing on the work of Michel Foucault I argue that while patient-centred communication frees the patient from particular aspects of medical power, it also introduces the patient to new power relations. The paper uses a Foucauldian analysis of power to argue that patient-centred communication introduces a new dynamic of power relations to the medical encounter, entangling and producing the patient to participate in the medical encounter in a particular manner.

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*  Chapter  Document 361

Thomas-MacLean, Roanne

Embracing the intersubjective: an ethics of care for chronic illness

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Hafemeister, Thomas L; Gulbrandsen, Richard M Jr.

The fiduciary obligation of physicians to "just say no" if an "informed" patient demands services that are not medically indicated.

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Wolpe, Gerald I.

Ethical issues in caregiving

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**Medical decision-making: patient self-determination and deciding for others**  
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Hall, Mark A.  
**Patient, Heal Thyself: How the New Medicine Puts the Patient in Charge, by Robert M. Veatch [book review]**  
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Rule shields health workers who withhold care based on beliefs
Washington Post 2008 December 19; p. A10

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Quality? No, the cattle-market of NHS care [editorial]

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BMJ: British Medical Journal 2008 December 13; 337(7683): 1369-1370

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Morse, Diane S.; McDaniel, Susan H.; Candib, Lucy M.; Beach, Mary Catherine
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Annals of Internal Medicine 2008 December 2; 149(11): 835-837

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Fromme, Erik K.; Farber, Neil J.; Babbott, Stewart F.; Pickett, Mary E.; Beasley, Brent W.
What do you do when your loved one is ill? The line between physician and family member
Annals of Internal Medicine 2008 December 2; 149(11): 825-829

Abstract: Conventional wisdom and professional ethics generally dictate that physicians should avoid doctoring family members because of potential conflicts of interest. Nevertheless, cross-sectional surveys find that the
Practice is commonplace. Physicians have unique opportunities to influence their family member's care because they possess knowledge and status within the health care system; however, when physicians participate in the care of family members, they must not lose objectivity and confuse their personal and professional roles. Because health care systems are complicated, medical information is difficult to understand, and medical errors are common, it can be a great relief for families to have someone "on the inside" who is accessible and trustworthy. Yet, the benefits of becoming involved in a loved one's care are accompanied by risks, especially when a physician takes action that a nonphysician would be incapable of performing. Except for convenience, most if not all of the benefits of getting involved can be realized by physician–family members acting as a family member or an advocate rather than as a physician. Rules about what is or what is not appropriate for physician–family members are important but insufficient to guide physicians in every circumstance. Physician–family members can ask themselves, "What could I do in this situation if I did not have a medical degree?" and consider avoiding acts that require a medical license.
Medical decision making: paternalism versus patient-centered (autonomous) care.
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* Davies, Myfanwy; Elwyn, Glyn
Advocating mandatory patient 'autonomy' in healthcare: adverse reactions and side effects
Abstract: Promoting patient autonomy has become a key imperative in health service encounters. We will examine the potential negative effects of over-promoting patient autonomy and consider the impact on patient access, their experience and the provision of equitable services by focusing on an extreme manifestation of this trend, i.e. calls for patient involvement in health care decision making to be mandatory. Advocates of mandatory autonomy hold that patients have a duty to themselves, to society and to the medical system to make decisions on their health care independently. Models of mandatory autonomy may be contrasted to those of optional autonomy that seek to ascertain patients' decisional preferences and to understand wider limitations on their freedom to choose. Where choice as decisional responsibility becomes mandatory it ceases to promote agency and where autonomous choice is understood as an individualistic practice it will contribute to the cultural dominance of Western values. Moreover, taking a view that principlist ethics needs to take account of the social and cultural contexts of individual lives, we argue that if mandatory autonomy were to be over-emphasised as part of an ongoing move towards patient choice in UK National Health Service (NHS), educated and affluent people would be more able to exercise choices at the expense of people who are experienced in asserting preferences and who have the resources to make use of choices. We will argue that the promotion of autonomy needs to be tempered by steps to enable less powerful social, cultural and economic groups to contribute to decision making and to support individuals who may feel abandoned by having decisional responsibility transferred to them. Until constraints on individual choice can be understood and addressed, we advocate the model of optional autonomy used in shared decision making and make recommendations for practice, policy, education and research.
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Beneken genaamd Kolmer, Deirdre M.; Tellings, Agnes; Gelissen, John
Partnership in health care: views of family caregivers on sharing care responsibility with government, clients and health insurers

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Journal of Religion and Health 2008 December; 47(4): 549-559

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Ambition . . . and humility of the surgeons.
Annals of Surgery 2008 December; 248(6): 899-901

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Professional boundaries in a person-centered paradigm
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What to do in case of disagreement between physician and patient: a few legal and ethical considerations = Que faire en cas de désaccord entre le médecin et le patient: quelques balises juridiques et éthiques.
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**Medical decision-making capacity in mild cognitive impairment: a 3-year longitudinal study**
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Ommen, Oliver; Janssen, Christian; Neugebauer, Edmund; Bouillon, Bertil; Rehm, Klaus; Rangger, Christoph; Erli, Hans Josef; Pfaff, Holger

**Trust, social support and patient type-associations between patients perceived trust, supportive communication and patients preferences in regard to paternalism, clarification and participation of severely injured patients.**
Patient Education and Counseling 2008 November; 73(2): 196-204

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**Document 393**
Redman, Barbara K.

**When is patient education unethical?**
Nursing Ethics 2008 November; 15(6): 813-820

**Abstract:** Although patient education is central to the ethical practice of nursing, it can be practiced in an ethically contested or unethical way. It is sometimes used to: forward a societal goal the individual might not have chosen; assume that patients should learn to accommodate unjust treatment; exclude the views of all except the dominant health care provider group; limit the knowledge a patient can receive; make invalid or unreliable judgments about what a patient can learn; or require a patient to change his or her identity to meet a medical ideal. Both health promotion education and manipulating patient beliefs in situations of uncertainty are ethically contested. Nussbaum's capabilities approach is used here as a moral framework through which to view the goals and practice of patient education. This provides better guidance than the current conception of patient education as an instrument to carry out the directives of medical practice.

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Crausman, Robert S.; Jeha, Jeannine

**Business, gifts and boundaries in the physician patient relationship.**
Medicine and Health, Rhode Island 2008 November; 91(11): 354

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**Beyond the call of duty: compelling health care professionals to work during an influenza pandemic.**
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Schildmann, Jan; Grunke, M.; Kalden, J.R.; Vollmann, J.

**Information and participation in decision-making about treatment: a qualitative study of the perceptions and preferences of patients with rheumatoid arthritis.**

Journal of Medical Ethics 2008 November; 34(11): 775-779

**Abstract:** OBJECTIVES: To elicit the perceptions and preferences of patients with rheumatoid arthritis regarding information and participation in treatment decision-making. To analyse the patients' narratives on the background of the ethical discourse on various approaches to treatment decision-making. DESIGN: In-depth interviews with themes identified using principles of grounded theory. PARTICIPANTS: 22 patients with long-standing rheumatoid arthritis. MAIN OUTCOME MEASURES: Qualitative data on patients' perceptions and preferences regarding information and participation in decision-making about treatment. RESULTS: Decision-making about treatment has been described by the patients as a process consisting of different stages with shifting loci of control and responsibility. Patients initially received one treatment recommendation and were not aware of alternative treatment options. Those participants in this study who wanted information about negative effects of a treatment cited "interest in one's own health" and the potential "use of information" as reasons for their preference. The physicians' expert knowledge and clinical experience regarding the effects of medication were cited as arguments by patients for a treatment recommendation. CONCLUSIONS: The patients' accounts of decision-making about treatment differ from models of physician-patient relationship that have been put forward in ethical discourse. These differences may be relevant with respect to the starting point of an ethical analysis of treatment decision-making. Patients' accounts with respect to a lack of information on treatment alternatives point to ethically relevant challenges regarding treatment decision-making in clinical practice.

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**Thai doctors say they won't treat police who use violence** [news]

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**Mixed-sex wards and patient dignity: nurses' and patients' perspectives**

British Journal of Nursing 2008 October 23 - November 12; 17(19): 1220-1225

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*When all else fails, blaming the patient often comes next*


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Journal of the Royal Society of Medicine 2008 October; 101(10): 480-481

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**From "i'm not staying!" to "i'm not leaving!": ethics, communication, and empathy in complicated medical discharges.**

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**Patient assessments of the most important medical decision during a hospitalization.**

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**California court: doctors can't discriminate on the basis of sexual orientation [news]**

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**Altruisme = Altruism**


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**One Hundred Days: My Unexpected Journey from Doctor to Patient, by Daniel Biro [book review]**

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Decisional conflict among patients who accept or decline participation in phase 1 oncology studies

Abstract: We compare decisional conflict among adults with advanced cancer who had accepted or declined participation in phase I cancer clinical trials. Respondents completed a 121-item questionnaire that included the Decisional Conflict Scale (DCS), which was designed to measure uncertainty in making health decisions. We used standardized effect sizes to compare the DCS scores of accepters (n = 250) and decliners (n = 65). Accepters had lower decisional conflict than decliners overall (d = 0.42; 95% confidence interval, 0.17–0.68) and on all subscales. Whether greater decisional conflict among decliners represents suboptimal decision-making and is reason for bioethical concern depends on how the results are interpreted. We offer three scenarios to explain the differences and describe opportunities for future empirical work.

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A social network for your doctor, pharmacist and insurer
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Anaesthesia 2008 August; 63(8): 803-805
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Doctor-patient communication: a historical overview
Minerva Medica 2008 August; 99(4): 411-415
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*Without consent: moral imperatives, special abilities, and the duty to treat*

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*The duty to care in a pandemic*
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Bailey, Tracy M.; Rosychuk, Rhonda J.; Yonge, Olive; Marrie, Thomas J.
*A duty to treat during a pandemic? The time for talk is now*
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Selgelid, Michael J.; Chen, Yen-Chang
*Specifying the duty to treat*
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Malm, Heidi; May, Thomas; Francis, Leslie P.; Omer, Saad B.; Salmon, Daniel A.; Hood, Robert

**Ethics, pandemics, and the duty to treat**
American Journal of Bioethics 2008 August; 8(8): 4-19

**Abstract:** Numerous grounds have been offered for the view that healthcare workers have a duty to treat, including expressed consent, implied consent, special training, reciprocity (also called the social contract view), and professional oaths and codes. Quite often, however, these grounds are simply asserted without being adequately defended or without the defenses being critically evaluated. This essay aims to help remedy that problem by providing a critical examination of the strengths and weaknesses of each of these five grounds for asserting that healthcare workers have a duty to treat, especially as that duty would arise in the context of an infectious disease pandemic. Ultimately, it argues that none of the defenses is currently sufficient to ground the kind of duty that would be needed in a pandemic. It concludes by sketching some practical recommendations in that regard.
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Davis, John K.

**Futility, conscientious refusal, and who gets to decide**


**Abstract:** Most discussions of medical futility try to answer the Futility Question: when is a medical procedure futile? No answer enjoys universal support. Some futility policies say that the health care provider will answer this question when the provider and patient (or surrogate decisionmaker) cannot agree. This raises the Decision Question: who has the moral authority to decide what to do in cases where futility is disputed? I look for a procedural answer to this question, an answer that does not turn on whether a given party happens to answer the Futility Question correctly. I argue that these policies get it right; the provider should decide because providers have a right of conscientious refusal that extends to refusing procedures on grounds of futility. This is a procedural answer because providers have this right even if they are sincerely mistaken about whether a procedure is futile.

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Paker-Pope, Tara

**Doctor and patient, now at odds**


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Altman, Lawrence K.

**The story behind Kennedy's surgery**

New York Times 2008 July 29; p. F1, F6

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**Reflections: neurology and the humanities. Limelight.**

Neurology 2008 July 22; 71(4): 297-298

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Medrington, Anke

**Manners in medicine: what's in a name? [letter]**

BMJ: British Medical Journal 2008 July 19; 337(7662): 130
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Meerschaert, M. Carmen; Coleman, Carl H.; Reis, Andreas
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JAMA: The Journal of the American Medical Association 2008 July 16; 300(3): 284
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Archives of Internal Medicine 2008 July 14; 168(13): 1368-1370
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BMJ: British Medical Journal 2008 July 5; 337(7660): 30-31
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Making patient responsibility more than skin deep
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**Patient satisfaction and ethics in a public hospital practice.**
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**Doctors in India suffer from a God complex [letter]**
Indian Journal of Medical Ethics 2008 July-September; 5(3): 149

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**Empathy: a vital attribute for doctors**
Indian Journal of Medical Ethics 2008 July-September; 5(3): 128-129

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**Family medicine: a complete relationship.**

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**Paging Dr. Colombo: when physicians become instruments of the law.**
Family Practice Management 2008 July-August; 15(7): 12-13

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Ethics and mandatory reporting laws: emergency physicians' response.
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Treating your mother? A new type of preventable medical error.
Geriatrics 2008 July; 63(7): 10-11
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McCoy, Matthew
Autonomy, consent, and medical paternalism: legal issues in medical intervention.
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Hanks, Robert G.
The lived experience of nursing advocacy
Nursing Ethics 2008 July; 15(4): 468-477
Abstract: Nursing advocacy for patients is considered to be an essential component of nursing practice. This phenomenological qualitative pilot study explored registered nurses’ lived experience of nursing advocacy with patients using a sample of three medical-surgical registered nurses. The guiding research questions were: (1) how do registered nurses practicing in the medical-surgical specialty area describe their experiences with nursing advocacy for their patients; and (2) what reflections on educational preparation for their professional roles do registered nurses identify as related to their practices of nursing advocacy with their patients? Data analysis procedures were based on Moustakas’ data analysis method, and Lincoln and Guba's criteria were applied for rigor. The emergent themes were: speaking out and speaking for patients; being compelled to act on unmet needs of patients; fulfillment and frustration; the patient is changed; primarily learned on the job; and confidence gained through practice. The findings increase the body of knowledge surrounding nursing advocacy as practiced by nurses.

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Negarandeh, Reza; Oskouie, Fateme; Ahmadi, Fazollah; Nikravesh, Mansoure
The meaning of patient advocacy for Iranian nurses
Nursing Ethics 2008 July; 15(4): 457-467
Abstract: Patient advocacy has been a topic of much discussion in the nursing literature for a number of decades. Ambiguities remain, however, concerning definitions of advocacy in nursing. This qualitative grounded theory-type study aimed to inquire into the meaning of patient advocacy from Iranian nurses' perspective. A purposive sample of 24 nurses (staff nurses, head nurses and supervisors) working in a large university hospital in Tehran was used.
Data were collected using in-depth semistructured interviews and reflective diaries kept by the participants. The data were analyzed using elements of Strauss and Corbin's approach. Advocacy was defined by the participants as: informing and educating; valuing and respecting; supporting; protecting; and promoting continuity of care for patients. The participants also believed that advocacy could take place only if there was respect for patients' individuality and their inherent human dignity. Many of the descriptions given by the participants are consistent with previous research in this area and represent a comprehensive account of their perceptions of patient advocacy.

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Stilgoe, Jack

**Handle with care [review of The Logic of Care: Health and the Problem of Patient Choice, by Annemarie Mol]**

*Lancet* 2008 June 28-July 4; 371(9631): 2163-2164

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**Manners in medicine: we should not underestimate the power of caring**

*BMJ: British Medical Journal* 2008 June 21; 336(7658): 1408

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**Doctors can be doubters**

*Washington Post* 2008 June 10; p. F1, F5

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**Product placement in the waiting room**

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Surdin, Ashley

**California] court considers medical rights; justices weigh whether doctors, citing religion, can refuse to treat some patients**
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Kavinya, Thengo

**Opinions on medical ethics. Do you think doctors are practising compassionate medical ethics?**
Malawi Medical Journal 2008 June; 20(2): 71

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Kavinya, Thengo

**Medical Rights Watch promoting safe health care for both patients and practitioners.**
Malawi Medical Journal 2008 June; 20(2): 72

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Sobel, Richard

**Beyond empathy**
Perspectives in Biology and Medicine 2008 Summer; 51(3): 471-478

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**Document 484**
Chetrit-Vatine, Viviane

**Some thoughts related to the ethical seduction of the analytic encounter: a commentary on 'a man who was tied up'.**
International Journal of Psychoanalysis 2008 June; 89(3): 491-496

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**Document 485**
Nortvedt, Per

**Sensibility and clinical understanding**
Medicine, Health Care and Philosophy 2008 June; 11(2): 209-219

**Abstract:** This paper argues that there is a dimension of human consciousness which allows for a pre-intentional and non-cognitive intuition of sensibility. A sensibility which allows for the vulnerability of the human other is by nature characterized by passivity and receptivity. Moreover, sensibility invokes the significance of relating to the human other in an affective way of being touched by his or her pain and suffering. This capacity of being distressed by the distress of another person opens up for ethical responsibility and even in a fundamental sense is a presupposition for full-fledged clinical knowledge in medical care and health care.

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Willson, Barb; Commons, Kathy
What is client abandonment?
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Hood, Virginia L.
Can a physician refuse to help a patient? American perspective.
Polskie Archiwum Medycyny Wewnetrznej 2008 June; 118(6): 368-372
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Schwartz, Michael A.
Deaf patients, doctors, and the law: compelling a conversation about communication
Florida State University law Review 2008 Summer; 35(4): 947-999
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Imbody, Jonathan
CMDA's fight for physician's conscience rights
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Marshall, R.J.; Bleakley, A.
Putting it bluntly: communication skills in the Iliad
Medical Humanities 2008 June; 34(1): 30-34
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http://www.medicalhumanities.com (link may be outdated)

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Kaczor, Christopher
Notes & abstracts: philosophy and theology
National Catholic Bioethics Quarterly 2008 Summer; 8(2): 371-382
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http://ncbcenter.metapress.com/openurl.asp?genre=journal&issn=1532-5490 (link may be outdated)
Caring for risky patients: duty or virtue?
Tomlinson, Tom
Journal of Medical Ethics 2008 June; 34(6): 458-462
Abstract: The emergence several years ago of SARS, with its high rate of infection and death among healthcare workers, resurrected a recurring ethical question: do health professionals have a duty to provide care to patients with deadly infectious diseases, even at some substantial risk to themselves and their families? The conventional answer, repeated on the heels of the SARS epidemic, is that they do. In this paper, I argue that the arguments in support of such a duty are wanting in significant respects, and that the language of duty is simply not adequate to an understanding of all the moral dimensions of professional responses to the care of risky patients. Instead, we should speak the language of virtues and ideals if we want to do justice to the complexity of such harrowing circumstances.

Moral principles and medical practice: the role of patient autonomy in the extensive use of radiological services
Hofmann, Bjørn; Lysdahl, K.B.
Journal of Medical Ethics 2008 June; 34(6): 446-449
Abstract: There has been a significant increase in the use of radiological services in the past 30 years. There are many reasons for this, but one has received little attention: the increased role of patient autonomy in healthcare. Patients demand x rays, CT scans, MRI, and positron emission tomography scans. The key question in this article is how a moral principle, such as respect for patient autonomy, can influence the extension of radiological services. A literature review reveals how patient autonomy is acknowledged in radiology, and how it is used both to explain and to justify the increase in radiological examinations. Furthermore, it also shows how the premises favouring patients' exercise of their autonomy are not always present, which makes patient autonomy subject to adverse side effects and even abuse. Patient autonomy can be used to reduce the professionals' responsibility for radiological examinations (by avoiding complaints and lawsuits), to increase the popularity of the profession (by giving the people what they want), to increase the income of the professionals or their institutions, and to promote professional activity. Patient autonomy intended to reduce paternalism, to legitimise otherwise morally unjustifiable actions (such as exposure to radiation), and to protect patients, can easily be used as a moral means for opposite ends. These adverse effects are not peculiar to radiology. However, they emerge particularly clearly in explanations and justifications of the substantial increase in radiological services, as well as in debates on overuse of radiological services.

Medically valid religious beliefs
Block, Gregory Lawrence
Journal of Medical Ethics 2008 June; 34(6): 437-440
Abstract: Patient requests for "inappropriate" medical treatment (violations of the standard of care) based on religious beliefs should have special standing. Nevertheless, not all such requests should be honored, because some are morally disturbing. The trouble lies in deciding which ones count. This paper proposes criteria that would qualify a religious belief as medically valid to help physicians decide which requests to respect. The four conditions suggested are that the belief (1) is shared by a community, (2) is deeply held, (3) would pass the test of a religious interpreter and (4) does not harm others.
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Sokol, Daniel K.
The essence of medicine
BMJ: British Medical Journal 2008 May 24; 336(7654): 1163
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Greenlaw, Keith
Doctors and Patients: A Relationship Examined, by Mark Hodson [book review]
BMJ: British Medical Journal 2008 May 17; 336(7653): 1135
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Kahn, Michael W.
Etiquette-based medicine
Georgetown users check Georgetown Journal Finder for access to full text

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Deodato, Sérgio
Conflict of rights in the decision of nursing care = Conflito de direitos na decisão de cuidado em enfermagem.
Servir 2008 May-August; 56(3-4): 112-117
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Gunderman, Richard B
Ethics and professionalism: the patient's perspective.
Georgetown users check Georgetown Journal Finder for access to full text

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Abbasi, Yasir I.; Gadit, Amin Ahmed Muhammad

**Accepting gifts from patients: how ethical can this be in the local context?**

JPMA: The Journal of the Pakistan Medical Association 2008 May; 58(5): 281-282

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Raviele, Kathleen M.; Brehany, John F.

**Official CMA correspondence [letter]**

Linacre Quarterly 2008 May; 75(2): 92-95

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Erer, S.; Atici, E.; Erdemir, A.D.

**The views of cancer patients on patient rights in the context of information and autonomy**

Journal of Medical Ethics 2008 May; 34(5): 384-388

**Abstract:** OBJECTIVES: The aim of this study is to evaluate the views of cancer patients on patient rights in the context of the right to information and autonomy according to articles related to the issue in the "Patient Rights Regulation". METHODS: The research was conducted among cancer patients in the medical oncology department of a research and practice hospital using a random sampling method between June and September 2005. Data were collected during face-to-face interviews using a questionnaire. RESULTS: There was a high rate of positive response to the items that the patients have the right to be informed (86.5%), that the physician should inform the patient on the diagnosis and the treatment (92.3%) and that the physician is obliged to inform the patient (76.9%). Only 43.3% of the patients stated that the patient has the right to refuse the treatment recommended by the physician. The participants mostly agreed that the patient should participate in decisions about the treatment and that patient consent should be given (78.8%). CONCLUSIONS: There are extensive efforts in Turkey towards making patient rights a significant supportive component of health services. For patient rights to become a natural part of medical practice it is necessary to give priority to education of both patients and physicians about patient rights and to lay emphasis on an ethical approach in the patient-physician relationship.

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[http://www.jmedethics.com](http://www.jmedethics.com) (link may be outdated)

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Hartzband, Pamela; Groopman, Jerome

**Off the record -- avoiding the pitfalls of going electronic**


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[http://content.nejm.org](http://content.nejm.org) (link may be outdated)

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Breen, Eugene G.

**GMC guidance on beliefs: denies conscientious objection [letter]**

BMJ: British Medical Journal 2008 April 12; 336(7648): 790

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Schonfeld, Toby L.; Damitz, Beth A.
A morally reprehensible patient.
American Family Physician 2008 April 1; 77(7): 1021-1023
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Document 506
Schildkrout, Barbara
Am I looking at a malignant melanoma?
New York Times 2008 April 1; p. F5

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Gessert, Charles E.
The problem with autonomy. An overemphasis on patient autonomy results in patients feeling abandoned and physicians feeling frustrated. [commentary]
Minnesota Medicine 2008 April; 91(4): 40-42
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Austin, Wendy; Lemermeyer, Gillian; Goldberg, Lisa; Bergum, Vangie; Johnson, Melissa S.
Moral distress in healthcare practice: the situation of nurses.
Alberta RN 2008 April; 64(4): 4-5
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Portman, Robert M.; Romanow, Kate
Concierge medicine: legal issues, ethical dilemmas, and policy challenges.
Journal of Health and Life Sciences Law 2008 April; 1(3): 1, 3-38
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Document 510
Johnstone, Megan-Jane
Emergency situations and refusals to care.
Australian Nursing Journal 2008 April; 15(9): 21
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Document 511
Iserson, Kenneth V.; Heine, Carlton E.; Larkin, Gregory Luke; Moskop, John C.; Baruch, Jay; Aswegan, Andrew L.
**Fight or flight: the ethics of emergency physician disaster response.**

Georgetown users check [Georgetown Journal Finder](http://library.georgetown.edu) for access to full text

Document 512
Gadit, Amin A. Muhammad; Patel, Sujay
**Boundary violations in medical practice: what should be done?**

Georgetown users check [Georgetown Journal Finder](http://library.georgetown.edu) for access to full text

Document 513
Cady, Rebecca F.
**Refusal to care**
JONA's Healthcare Law, Ethics, and Regulation 2008 April-June; 10(2): 42-45

**Abstract:** There are many reasons why a nurse might refuse to care for a patient. The nurse manager needs to be aware of the nexus between moral dilemmas in healthcare and the right of providers to refuse to participate in certain controversial procedures, as well as other professional and ethical reasons such as lack of training or fatigue that may lead a staff nurse to refuse a patient care assignment. This article explores each of these situations and outlines federal and state laws that impact this situation. Suggestions are given for the nurse manager to help himself/herself and his/her staff avoid the potential negative consequences of refusals to care.

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Document 514
Gehrs, Margaret; Van Sickle, Christina; Law, Samuel
**Ethical and clinical deliberations on protecting community mental health outreach workers from second hand smoke**

**Abstract:** In the Province of Ontario the right to work in a smoke-free work place was granted when the Smoke-Free Ontario Act was enacted May 31st, 2006 (Ontario Ministry of Health Promotion, 2007). Home health care workers have the right to ask a person not to smoke in their presence and can leave without providing further services, unless doing so would present an immediate, serious danger to the health of any person. While the Act may seem clear, employer guidelines informing home health care workers on how to provide a reasonable level of care to vulnerable and at risk clients in this new safety-focused culture are not. This paper analyzes a case study in which client and staff rights and responsibilities within the context of this legislation are reviewed. A real-life organizational solution triggered by the ethical dilemmas in the case scenario is presented.

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[http://www.jemh.ca](http://www.jemh.ca) (link may be outdated)

Document 515
Seeman, Mary V.
**Duty of care versus safety of a colleague**
Abstract: This case describes a psychiatric patient who stalked and harassed her former psychiatrist. Balancing the safety risk to her physician against the duty to continue to treat this vulnerable patient, what should the current psychiatrist and the treating institution do?

http://www.jemh.ca (link may be outdated)

* Article Document 516

Patient care should come before personal beliefs [editorial]

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http://www.thelancet.com/journals/lancet (link may be outdated)

* Article Document 517

Fullbrook, Suzanne
The duty of care and political expectations. Part 1: a literature review
British Journal of Nursing 2008 March 27-April 9; 17(6): 386-387

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* Article Document 518

Coleman, Carl H.; Reis, Andreas
Potential penalties for health care professionals who refuse to work during a pandemic
JAMA: The Journal of the American Medical Association 2008 March 26; 299(12): 1471-1473

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http://jama.ama-assn.org (link may be outdated)

* Article Document 519

Ebbesen, Mette; Pedersen, Birthe D.
The principle of respect for autonomy -- concordant with the experience of oncology physicians and molecular biologists in their daily work?
http://www.biomedcentral.com/bmcmedethics/1472-6939/9/5 [2008 May 24]

Abstract: Background: This article presents results from a qualitative empirical investigation of how Danish oncology physicians and Danish molecular biologists experience the principle of respect for autonomy in their daily work. Methods: This study is based on 12 semi-structured interviews with three groups of respondents: a group of oncology physicians working in a clinic at a public hospital and two groups of molecular biologists conducting basic research, one group employed at a public university and the other in a private biopharmaceutical company. Results: We found that molecular biologists consider the principle of respect for autonomy as a negative obligation, where the informed consent of patients or research subjects should be respected. Furthermore, molecular biologists believe that very sick patients are constraint [sic; constrained] by the circumstances to a certain choice. However, in contrast to molecular biologists, oncology physicians experience the principle of respect for autonomy as a positive obligation, where the physician in dialogue with the patient performs a medical prognosis based on the patient's wishes and ideas, mutual understanding and respect. Oncology physicians believe that they have a positive obligation to adjust to the level of the patient when providing information making sure that the patient understands.
Oncology physicians experience situations where the principle of respect for autonomy does not apply because the patient is in a difficult situation. Conclusion: In this study we explore the moral views and attitudes of oncology physicians and molecular biologists and compare these views with bioethical theories of the American bioethicists Tom L. Beauchamp & James F. Childress and the Danish philosophers Jakob Rendtorff & Peter Kemp. This study shows that essential parts of the two bioethical theories are reflected in the daily work of Danish oncology physicians and Danish molecular biologists. However, the study also explores dimensions where the theories can be developed further to be concordant with biomedical practice. The hope is that this study enhances the understanding of the principle of respect for autonomy and the way it is practiced.

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http://www.biomedcentral.com/bmcmedethics/1472-6939/9/5 (link may be outdated)

**Document 520**

DasGupta, Sayantani

**Narrative humility**

*Lancet* 2008 March 22-28; 371(9617): 980-981

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http://www.thelancet.com/journals/lancet (link may be outdated)

**Document 521**

Shim, Janet K.; Russ, Ann J.; Kaufman, Sharon R.

**Late-life cardiac interventions and the treatment imperative.**

*PLoS medicine* 2008 March 4; 5(3): e7

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http://www.plosmedicine.org/article/browseVolume.action (link may be outdated)

**Document 522**

Albuquerque, Maria Clara; Roffé, Raquel

**The asymmetrical relationship between the health care professional and the patient in public hospitals**


*Abstract:* The relationship between the health care professional and the patient is universally seen, in medicine, as the core of medical practice. Through it, the doctor acquires professional abilities and pursues the objectives of medicine, among them, that of curing. This relation is contextualized here by using articles 47 and 48, from the chapter on Human Rights, found in the Code of Ethical Medicine of the Federal Council of Medicine of the Federative Republic of Brazil—both in the sense of the transformational link between two people, and as a relationship of interpersonal tolerance. The objectives of this article are: 1) to evaluate the asymmetry present in the clinical doctor-patient encounter, with respect to the doctor's social and political commitment regarding the patient. Recorded testimonies were used, of individuals who utilize medical assistance in Public Hospitals, carried out in the hallways of the 'das Clínicas Hospital' in Recife, Pernambuco; and 2) to weave an analogy with the book "Masters and Slaves" ('Casa Grande & Senzala'): 'Formation of the Brazilian Family under the Regime of a Patriarchal Economy', written by the Pernambucan sociologist Gilberto Freyre. Among the recorded talks, the resentment regarding discrimination and the authority of the doctor's position can be clearly observed. As a result, this power relation was considered the focus of our discussion—the same power relation as that which reigned over the Brazilian colonization period, in the times of "Masters and Slaves" (Casa Grande & Senzala).

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http://www.biomedcentral.com/bmcmedethics/1472-6939/9/5 (link may be outdated)
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Rogers, Wendy; Ballantyne, Angela
Gender and trust in medicine: vulnerabilities, abuses, and remedies
Georgetown users check Georgetown Journal Finder for access to full text

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Loh, K.Y.; Sivalingam, N.
Enhancing doctor-patient relationship: the humanistic approach.
Medical Journal of Malaysia 2008 March; 63(1): 85-87; quiz 88
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Bledsoe, Bryan E.
Is my patient faking? The ethical, objective way to react in the field without ammonia.
JEMS: Journal of Emergency Medical Services 2008 March; 33(3): 40, 43
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Day, Lisa
Commercialism and the professional practice of healthcare providers.
American Journal of Critical Care 2008 March; 17(2): 164-167
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Document 527
Schicktanz, Silke; Schweda, Mark; Franzen, Martina
"In a completely different light"? The role of "being affected" for the epistemic perspectives and moral attitudes of patients, relatives and lay people
Medicine, Health Care and Philosophy 2008 March; 11(1): 57-72
Abstract: In this paper, we explore and discuss the use of the concept of being affected in biomedical decision making processes in Germany. The corresponding German term 'Betroffenheit' characterizes on the one hand a relation between a state of affairs and a person and on the other an emotional reaction that involves feelings like concern and empathy with the suffering of others. An example for the increasing relevance of being affected is the postulation of the participation of people with disabilities and chronic or acute diseases in the discourse, as partly realized in the German National Ethics Council or the Federal Joint Committee. Nevertheless, not only on the political level, the resistance against the participation of affected people is still strong; the academic debate seems to be cross-grained, too. Against this background, we explore the meaning and argumentative role of the concept of being affected as it is used by affected and lay people themselves. Our analysis is based on four focus group discussions in which lay people, patients and relatives of patients discuss their attitudes towards biomedical interventions such as organ transplantation and genetic testing. This setting allows for a comparison of how affected and non-affected people are concerned and deliberate about medical opportunities, but also of how they position themselves as being affected or non-affected with respect to (scientific) knowledge and morality. On this basis, we discuss the normative relevance of being affected for the justification of political participation.
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**Document 528**
Kozishek, David; Bogdan-Lovis, Elizabeth (Libby)

**Beliefs, boundaries, and self-knowledge in professional practice**

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Chervenak, Frank A.; McCullough, Laurence B.

**Professional responsibility and individual conscience: protecting the informed consent process from impermissible bias**

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**Document 530**
Pellegrino, Edmund D.

**Commentary on "Of More than One Mind" [M585]**

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**Document 531**
Curlin, Farr A.; Dinner, Shira N.; Lindau, Stacy Tessler

**Of more that one mind: obstetrician-gynecologists' approaches to morally controversial decisions in sexual and reproductive healthcare**
Journal of Clinical Ethics 2008 Spring; 19(1): 11-21

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**Document 532**
Howe, Edmund G.

**When, if ever, should careproviders give moral advice?**

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**Document 533**
Civaner, Murat; Arda, Berna

**Do patients have responsibilities in a free-market system? A personal perspective**
Nursing Ethics 2008 March; 15(2): 263-273

**Abstract:** The current debate that surrounds the issue of patient rights and the transformation of health care, social insurance, and reimbursement systems has put the topic of patient responsibility on both the public and health care sectors' agenda. This climate of debate and transition provides an ideal time to rethink patient responsibilities, together with their underlying rationale, and to determine if they are properly represented when being called 'patient'
responsibilities. In this article we analyze the various types of patient responsibilities, identify the underlying motivations behind their creation, and conclude upon their sensibleness and merit. The range of patient responsibilities that have been proposed and implemented can be reclassified and placed into one of four groups, which are more accurate descriptors of the nature of these responsibilities. We suggest that, within the framework of a free-market system, where health care services are provided based on the ability to pay for them, none of these can properly be justified as a patient responsibility.

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D'Cruz, O' Neill F.
Reflections: neurology and the humanities. The gift is life
Neurology 2008 February 26; 70(9): 732-733

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Calne, Roy; Calne, Jane; Calne, Suzanne
A poisoned chalice: has patients' choice gone too far? [letter]

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http://www.thelancet.com/journals/lancet (link may be outdated)

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Rieff, David
Miracle workers? Why we expect doctors to do the impossible
New York Times Magazine 2008 February 17; p. 13, 14

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http://www.nytimes.com (link may be outdated)

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Cave, Judith; Dacre, Jane
Dealing with complaints
BMJ: British Medical Journal 2008 February 9; 336(7639): 326-328

Georgetown users check Georgetown Journal Finder for access to full text

http://www.bmj.com (link may be outdated)

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White, Cassandra
Iatrogenic stigma in outpatient treatment for Hansen's disease (leprosy) in Brazil
Health Education Research 2008 February; 23(1): 25-39
**Document 539**

Tsai, Alexander C.

**Public-private distinctions in matters of conscience [letter]**

American Journal of Bioethics 2008 February; 8(2): W7

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[http://bioethics.net](http://bioethics.net) (link may be outdated)

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**Document 540**

Rentmeester, Christy A.

**Moral damage to health care professionals and trainees: legalism and other consequences for patients and colleagues**


**Abstract:** Health care professionals' and trainees' conceptions of their responsibilities to patients can change over time for a number of reasons: evolving career goals, desires to serve different patient populations, and changing family obligations, for example. Some changes in conceptions of responsibility are healthy, but others express moral damage. Clinicians' changes in their conceptions of what they are responsible for express moral damage when their responses to others express a meager, rather than robust, sense of what they owe others. At least two important expressions of moral damage in the context of health care are these: callousness and divestiture. Callousness describes the poor condition of a clinician's capacity for moral perception; when her capacity to accurately appreciate features of moral relevance that configure others' needs, vulnerabilities, and desert of care diminishes, such that she fails to respond with care to those for whom she has duties to care, she is callous. Callousness has been explored in detail elsewhere,1 and so the focus of this paper is divestiture. A clinician divests when the value of responding with care to others becomes less centrally and importantly constitutive of his personal and professional identity. Divestiture has important consequences for patients and health professions education, which I will explore here.

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Lee, Rita S.; Melhado, Trisha V.; Chacko, Karen M.; White, Kelly J.; Huebschmann, Amy G.; Crane, Lori A.

**The dilemma of disclosure: patient perspectives on gay and lesbian providers**

JGIM: Journal of General Internal Medicine 2008 February; 23(2): 142-147

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Auster, Simon; McDaniel, Susan H.; Morse, Diane; Epstein, Ronald; Beckman, Howard; Seabum, Dvid B.; Silberman, Jordan

**Physician self-disclosure [letter and reply]**

Archives of Internal Medicine 2008 January 28; 168(2): 242-244

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Alexander, G. Caleb; Lantos, John; McDaniel, Susan H.; Morse, Diane; Epstein, Ronald; Beckman, Howard; Seaburn, Dvid B.; Silberman, Jordan
The nuances of self-disclosure [letter and reply]
Archives of Internal Medicine 2008 January 28; 168(2): 242-244
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Document 544
Tufts, Annette
Patients escape penalties for not taking doctor's advice [news]
BMJ: British Medical Journal 2008 January 12; 336(7635): 65
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Mitchell, Edward W.
The ethics of passer-by diagnosis
Lancet 2008 January 5-11; 371(9606): 85-87
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Bhugra, Dinesh
Decision making by patients: who gains?. [editorial]
The International Journal of Social Psychiatry 2008 January; 54(1): 5-6
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American College of Obstetricians and Gynecologists [ACOG]. Committee on Ethics
Surgery and patient choice
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Terzi, Angela B.; Aggelidou, Dimitra
Witnessed resuscitation: beneficial or detrimental?
Journal of Cardiovascular Nursing 2008 January-February; 23(1): 74-78
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Document 549
Capozzi, James D.; Rhodes, Rosamond; Gantsoudes, George
**Ethics in practice. Terminating the physician-patient relationship**

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Finkelstein, Daniel
**Medical ethics: the role of religion and spirituality in building the patient-physician relationship.**
Maryland Medicine 2008 Winter; 9(1): 28, 32

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Wai, Debbie; Katsaris, Mythily; Singhal, Rishi
**Chaperones: are we protecting patients?**
British Journal of General Practice 2008 January; 58(546): 54-57; discussion 56-57

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Document 552
Marks, Ray; Shive, Steven E.
**Ethics and patient-provider communication**
Health Promotion Practice 2008 January; 9(1): 29-33

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Milton, Constance L.
**Boundaries: ethical implications for what it means to be therapeutic in the nurse-person relationship**
Nursing Science Quarterly 2008 January; 21(1): 18-21

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Buckley, Lenore, M.
**TALKING WITH PATIENTS ABOUT THE PERSONAL IMPACT OF ILLNESS: THE DOCTOR'S ROLE**

Call number: RA418_B826 2008

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Spinney, Laura
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Sheikh, Aziz and Gatrad, Abdul Rashid, eds.
CARING FOR MUSLIM PATIENTS
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Brownlie, Julie; Greene, Alexandra; and Howson, Alexandra, eds.
RESEARCHING TRUST AND HEALTH
Call number: R725.5 .R47 2008

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Ebbesen, Mette; Pedersen, Birthe D.
The role of ethics in the daily work of oncology physicians and molecular biologists - results of an empirical study
Business and Professional Ethics Journal 2008; 27(1-4): 75-101
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Molewijk, Bert; Stiggelbout, Anne M.; Otten, Wilma; Dupuis, Heleen M.; Kievit, Job
First the facts, then the values? Implicit normativity in evidence-based decision aids for shared decision-making.
Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen 2008; 102(7): 415-420
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Whose decision is it? The microstructure of medical decision making.
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Millenson, Michael L.
The see-through doctor: sitting naked in the exam room.
Medscape Journal of Medicine 2008; 10(8): 186
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Orentlicher, David; Bobinski, Mary Anne; Hall, Mark A.
The treatment relationship
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Guthrie, Bruce
Trust and asymmetry in general practitioner-patient relationships in the United Kingdom
In: Brownlie, Julie; Greene, Alexandra; Howson, Alexandra, eds. Researching Trust and Health. New York: Routledge, 2008: 133-151
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McHale, Jean V.
Health care choices, faith and belief in the light of the Human Rights Act 1998: new hope or missed opportunity?
Medical Law International 2008; 9(4): 331-355
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Ladas, Spiros D.; Axon, Tony; Malfertheiner, Peter
Professional, legal and ethical challenges in gastroenterology. Editorial.
Digestive Diseases 2008; 26(1): 5-6
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Anantham, Devanand; McHugh, Wendy; O'Neill, Stephen; Forrow, Lachlan
Clinical review: influenza pandemic - physicians and their obligations.
Critical Care 2008; 12(3): 217
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Handelman, Mark; Parke, Bob
The beneficial role of a judicial process when "everything" is too much?
Healthcare Quarterly 2008; 11(4): 46-50
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Document 568
Trust is the core of the doctor-patient relationship: from the perspective of traditional Chinese medical ethics

Li, Benfu; Hu, Linying


Call number: R724 .C483 2008

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Nordby, Halvor

Medical explanations and lay conceptions of disease and illness in doctor-patient interaction.

Theoretical Medicine and Bioethics 2008; 29(6): 357-370

Abstract: Hilary Putnam's influential analysis of the 'division of linguistic labour' has a striking application in the area of doctor-patient interaction: patients typically think of themselves as consumers of technical medical terms in the sense that they normally defer to health professionals' explanations of meaning. It is at the same time well documented that patients tend to think they are entitled to understand lay health terms like 'sickness' and 'illness' in ways that do not necessarily correspond to health professionals' understanding. Drawing on recent philosophical theories of concept possession, the article argues that this disparity between medical and lay vocabulary implies that it is, in an important range of cases, easier for doctors to create a communicative platform of shared concepts by using and explaining special medical expressions than by using common lay expressions. This conclusion is contrasted with the view that doctors and patients typically understand each other when they use lay vocabulary. Obviously, use of expressions like 'sickness' or 'illness' does not necessarily lead to poor communication, but it is important that doctors have an awareness of how patients interpret such terms.

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Marcum, James A.

Patient-physician relationships


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Kamangar, Parvez

An open letter to doctors


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Montgomery, Kathryn Key; Harris-Braun, Ellen Key

Information is not enough: the place of statistics in the doctor-patient relationship


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Call number: **R724 .C67 2008**

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**Patients' charters and health responsibilities**  
BMJ: British Medical Journal 2007 December 8; 335(7631): 1187-1189  
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"Our options have changed... we will not call you back": communicating with my primary care physician  
Perspectives in Biology and Medicine 2007 Summer; 50(3): 435-443  
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Berlin, Leonard
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Fulbrook, Paul; Latour, Jos; Albarran, John; de Graaf, Wouter; Lynch, Fiona; Devictor, Denis; Norekvål, Tone
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European Journal of Cardiovascular Nursing 2007 December; 6(4): 255-258

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Document 583
Bensimon, Cécile M.; Tracy, C. Shawn; Bernstein, Mark; Shaul, Randi Z.; Upshur, Ross E.G.
A qualitative study of the duty to care in communicable disease outbreaks
Social Science and Medicine 2007 December; 65(12): 2566-2575

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Mujovic-Zornic, Hajrija
Legislation and patients' rights: some necessary remarks

Abstract: The essence of a patient's rights and legislation framework requires an answer to the question on how legislation can work towards better defining, respecting, protecting and effectiveness of these rights. First, it is necessary to give a short introduction to patients' rights, their definition and different classifications. In the long list of human rights, patients' rights obviously take one of the very important places. Human life and health are the values, which, in comparison with all other human values, are considered as values of the highest rank. Patients' rights represent a legal expression of something, which every person basically and naturally expects from a doctor, medical staff, and from a health care system in general. The subject of the second part of this paper presents the intention, scope and conception of necessary legislation. How should it be considered - in a wider sense or as a special law? Some theoretical and practical questions regarding interaction between medical ethics regulation, confidentiality, and legislation are discussed as well. In the European context there are numerous examples of laws with the specific purpose of protecting patients' rights. Special attention and critical review will be paid to the situation of patients' rights in Serbia. The paper concludes with the point that the role of legislation is evidently important, but the traditional view should be replaced with a new one, due to the reason that modern health law puts
the protection of patients' rights on a higher level. De lege lata, the whole system of health law in its diversity (civil, penal and administrative) is characterized by better understanding of rights, duties and legal relations, either through regulation or the protection of patients' rights.

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Hilliard, Marie T.

**The duty to care: when health care workers face personal risk**

National Catholic Bioethics Quarterly 2007 Winter; 7(4): 673-682

**Abstract:** A pandemic due to the avian flu virus (H5N1) is possible, and if it occurs, the event will not be unfamiliar to health care workers. History provides us with numerous examples. In the twentieth century alone, there were three pandemics, the largest being the 1918 "Spanish" influenza pandemic, in which forty to fifty million people died worldwide within one year. Five hundred thousand persons died in the United States alone. Such crises have generated heroic responses by health care workers. The question that arises today is whether such heroism will prevail in the face of varying perceptions concerning the duty of health care workers to care.

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Evans, H.M.

**Do patients have duties?**

Journal of Medical Ethics 2007 December; 33(12): 689-694

**Abstract:** The notion of patients' duties has received periodic scholarly attention but remains overwhelmed by attention to the duties of healthcare professionals. In a previous paper the author argued that patients in publicly funded healthcare systems have a duty to participate in clinical research, arising from their debt to previous patients. Here the author proposes a greatly extended range of patients' duties grounding their moral force distinctively in the interests of contemporary and future patients, since medical treatment offered to one patient is always liable to be an opportunity cost (however justifiable) in terms of medical treatment needed by other patients. This generates both negative and positive duties. Ten duties-enjoining obligations ranging from participation in healthcare schemes to promoting one's own earliest recovery from illness-are proposed. The characteristics of these duties, including their basis, moral force, extent and enforceability, are considered. They are tested against a range of objections-principled, societal, epistemological and practical-and found to survive. Finally, the paper suggests that these duties could be thought to reinforce a regrettably adversarial characteristic, shared with rights-based approaches, and that a preferable alternative might be sought through the (here unexplored) notion of a "virtuous patient" contributing to a problem-solving partnership with the clinician. However, in defining and giving content to that partnership, there is a clear role for most, if not all, of the proposed duties; their value thus extends beyond the adversarial context in which they might first be thought to arise.

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**Narratives in specialist palliative medicine**

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American Journal of Bioethics 2007 November; 7(11): 5-10

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Applicability of the principle of respect for autonomy: the perspective of Turkey

Journal of Medical Ethics 2007 November; 33(11): 627-630

Abstract: Turkey has a complex character, which has differences from the Western world or Eastern Asia as well as common points. Even after more than a century of efforts to modernise and integrate with the West, Turkish society has values that are different from those of the West, as well as having Western values. It is worth questioning whether ordinary Turkish people show an individualistic character. The principle of respect for individual autonomy arises from a perception of oneself as an individual, and the person's situation may affect the applicability of the principle. Patients who perceive themselves to be members of a community rather than free persons and who prefer to participate in the common decisions of the community and to consider the common interest and the common value system of the community concerning problems of their life (except healthcare or biomedical research) rather than to decide as independent, rational individuals may not be competent to make an autonomous choice. Expectations that such patients will behave as autonomous individuals may be unjustified. The family, rather than the patient, may take a primary role in decisions. A flexible system considering cultural differences in the concept of autonomy may be more feasible than a system following strict universal norms.

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Moroianu Zlatescu, Irina; Popescu, Octav
La science de la communication dans la relation médecin-patient. = The science of communication in the patient-physician relationship
Abstract: The authors dedicate their work to the improvement of inter-human communication within the healthcare system, mainly in the sub-system of the patient-physician relationship, with the aim of respecting human rights in general and in particular, of respecting patient rights. The combined usage of elements of medical ethics, acquired throughout professional training - university and post-university studies - and the knowledge assimilated following some last minute information relative to the science of communication is a permanent responsibility of all healthcare
practitioners with the goal of improving their relationships with patients. The authors believe that this is the only way of increasing the degree of trust and satisfaction of the population towards healthcare providers. The authors are in favor of the implementation, in common medical practice, of this motto of communication: "If you do not communicate, you do not exist. If you do not know, you are at fault", as a founding principle of ethics and of the medical professional ethics, applicable equally in private and public medical practice. Effective patient-physician communication generates reciprocal trust. Its absence or poor communication can lead to distrust, suspicion, animosity and even conflicts which can cause physicians to be called before the College of Physicians of Romania or lead to legal repercussions for both physicians and patients. If it is true that, during medical assistance procedures, patients wish their right to be cared for and treated as dignified humans to be respected, it is also fair for those who care for them to evoke in turn their right to respect and dignity from the side of their patients. National legislation dedicated to issues relating to the professional patient-physician relationship contains provisions strictly in agreement with the regulations of the European Union. Once ethical and legal standards are introduced into national legislation, the next step should be towards the implementation and control of the procedure in which these desiderata are applied to life in Romanian society.

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**Terminating the patient-physician relationship. Abandonment of the patient: what it means and how to avoid it.**
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**What's wrong with deliberately proselytizing patients?**

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**Spirituality: respect but don't reveal**


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Curlin, Farr A.; Roach, Chad J.

**By intuitions differently formed: how physicians assess and respond to spiritual issues in the clinical encounter**

American Journal of Bioethics 2007 July; 7(7): 19-20

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Cohen, Cynthia B.

**Ways of being personal and not being personal about religious beliefs in the clinical setting**

American Journal of Bioethics 2007 July; 7(7): 16-18

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**Religious delusions and the limits of spirituality in decision-making**

American Journal of Bioethics 2007 July; 7(7): 14-15

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Eisen, Arri

**The challenge of spirituality in the clinic: symptom of a larger syndrome**
**Document 672**

Kuczewski, Mark G.

**Talking about spirituality in the clinical setting: can being professional require being personal?**

American Journal of Bioethics 2007 July; 7(7): 4-11

**Abstract:** Spirituality or religion often presents as a foreign element to the clinical environment, and its language and reasoning can be a source of conflict there. As a result, the use of spirituality or religion by patients and families seems to be a solicitation that is destined to be unanswered and seems to open a distance between those who speak this language and those who do not. I argue that there are two promising approaches for engaging such language and helping patients and their families to productively engage in the decision-making process. First, patient-centered interviewing techniques can be employed to explore the patient's religious or spiritual beliefs and successfully translate them into choices. Second, and more radically, I suggest that in some more recalcitrant conflicts regarding treatment plans, resolution may require that clinicians become more involved, personally engaging in discussion and disclosure of religious and spiritual worldviews. I believe that both these approaches are supported by rich models of informed consent such as the transparency model and identify considerations and circumstances that can justify such personal disclosures. I conclude by offering some considerations for curbing potential unprofessional excesses or abuses in discussing spirituality and religion with patients.

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Torjuul, Kirsti; Elstad, Ingunn; Sørlie, Venke

**Compassion and responsibility in surgical care**

Nursing Ethics 2007 July; 14(4): 522-534

**Abstract:** Ten nurses at a university hospital in Norway were interviewed as part of a comprehensive investigation into the narratives of nurses and physicians about being in ethically difficult situations in surgical units. The transcribed interview texts were subjected to a phenomenological-hermeneutic interpretation. The main theme in the narratives was being close to and moved by the suffering of patients and relatives. The nurses' responsibility for patients and relatives was expressed as a commitment to act, and they needed to ask themselves whether their responsibility had been fulfilled, that nothing had been left undone, overlooked or neglected, before they could leave the unit. When there was confirmation by the patients, relatives, colleagues and themselves that the needs of patients and relatives had been attended to in a morally and professionally satisfying manner, this increased the nurses' confidence and satisfaction in their work, and their strength to live with the burden of being in ethically difficult situations.

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Macdonald, Marilyn

**Origins of difficulty in the nurse-patient encounter**

Nursing Ethics 2007 July; 14(4): 510-521

**Abstract:** The purpose of this study was to look beyond the patient as the source of difficulty and to examine the context of care encounters for factors that contributed to the construction of difficulty in the nurse-patient encounter. The study explains the origins of difficulty in the nurse-patient encounter. This explanation broadens the thinking limits previously imposed by locating difficulty within the individual. Key elements of this explanation are: knowing the patient minimizes the likelihood of difficulty in the encounter; and families, availability of supplies and equipment,
who is working, and care space changes are contextual factors that contribute to the construction of difficulty in the nurse-patient encounter. Awareness of these findings has implications for the strategies nurses employ in difficult encounters.

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Abstract: Advocates of "concordance" describe it as a new model of shared decision-making between physicians and patients based on a partnership of equals. "Concordance" is meant to make obsolete the notion of "compliance," in which patients are seen as, ideally, following doctors' orders. This essay offers a critical view of concordance, arguing that the literature itself on concordance, including materials at the web site of Medicines Partnership, the implementation arm in Great Britain of the concordance model, is full of contradiction; concordance, in fact, harbors an ideology of compliance. The essay suggests that an improvement in patient medication use will more likely come from a frank consideration of the relation of compliance issues and commercial ones, and that a key question across domains is, "how are patients/health agents/consumers persuaded to acquire certain drugs and take them as directed?"

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Abstract: Recognising a diminution in his emotional response to patients' deaths, the author analyses in detail his internal reactions in an attempt to understand what he believes is a common phenomenon among doctors. He identifies factors that may erode the connection between patient and physician: an instinct to separate oneself from another's suffering, professional unease in the case of therapeutic failure, the atrophying effect of perceived hopelessness, insincerities in the establishment of the initial relationship, and an inability to imbue the sedated or unconscious patient with human qualities. He concludes that recognition of these negative influences, without necessarily changing behaviours that are natural, may be a first step towards protecting doctors against what might be an otherwise insidious process of dehumanisation.

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The other side of trust in health care: prescribing drugs with the potential for abuse

Bioethics 2007 January; 21(1): 51-60

Abstract: Defining a nonpaternalistic yet achievable form of trust in medicine in an era of simultaneous patient empowerment and institutional control has been and remains an important task of bioethics. The 'crisis of trust' in medicine has been viewed mainly as the problem of getting patients to trust their health care providers, especially physicians. However, since paradigmatic cases of trust are mutual, bioethicists must pay more attention to physician trust in patients. A physician's view of the reasonableness of trust in a particular patient is affected not just by his or her relationship with that patient, but also by what is going on institutionally, professionally, legally and politically with regard to a given treatment or intervention. Since general moral principles are insufficient in
determining the moral value and reasonableness of trust in particular instances, I discuss in detail the role of trust and distrust in the specific case of treating patients with medications implicated in drug abuse. I conclude that it is important to become aware, first, of the clinical significance of physician trust and distrust in patients, and second, of the many factors which inform both of these moral attitudes. These two claims together suggest that a central, but overlooked, virtue of medical practice is reflective, context-responsive trust in patients.

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Abstract: In this paper several reasons as to why framing issues should be of greater interest to both medical ethicists and healthcare professionals are suggested: firstly, framing can help in explaining health behaviours that can, from the medical perspective, appear perverse; secondly, framing provides a way of describing the internal structure of ethical arguments; and thirdly, an understanding of framing issues can help in identifying clinical practices, such as non-directive counselling, which may, inadvertently, be failing to meet their own stated ethical aims. The effect of framing on how individuals interpret information and how healthcare choices are influenced by framing are described. Next, the role of framing in ethical discourse is discussed with specific reference to Judith Jarvis Thomson's philosophical mind experiment about abortion and the violinist. Finally, the implications of this
analysis are examined for the practice of non-directive counselling, which aims at communicating information in a neutral, value-free way and thereby protecting patient autonomy.

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**Should a good healthcare professional be (at least a little) callous?**
**Abstract:** The term "callous" has not, to this point, been studied empirically or considered philosophically in the context of healthcare professionalism. It should be, however, because its uses seem peculiar. Sometimes "callous" is used to suggest that becoming callous confers a benefit of some protection against emotional distress, which might be considered expedient in the healthcare work environment. But, "callous" also refers to a person's unappealing demeanor of hardened insensitivity. The tension between these different moral connotations of "callous" prompts several empirical, psychological, and moral questions; I introduce and entertain a few here. I also suggest a distinction between callousness and inurement and argue for why this distinction is important to appreciate and uphold in health professions education.

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**Abstract:** Although family scholars conceptualize caregiving in terms of networks of carers, little attention has been given to equity within these groups. Siblings comprise a prevalent caregiving network of members who feel responsible for parent care, expect to share these responsibilities with each other, and look to each other to evaluate the fairness of their sharing. In this paper, a multidisciplinary approach is used to examine sibling views of equity in relation to disputes over giving parent care and receiving parent assets. A literary perspective is offered through analysis of stepsibling tensions depicted in the novel Family Matters. Real life disputes among biological siblings that have been pursued through the courts are also examined. Issues arising from these examples are then analysed through the lens of legal doctrines of equity. Siblings evaluating fairness undertake careful comparisons of their respective relationships with parents in terms of biological links to parents and type and extent of influence in interactions with parents.

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Journal of Medical Humanities 2006 Fall; 27(3): 135-149
Abstract: This article deploys sadomasochism as a framework for understanding medical practice on an institutional level. By examining the case of the factitious illness Munchausen syndrome, this article analyzes the operations of power in the doctor-patient relationship through the trope of role-playing. Because Munchausen syndrome causes a disruption to the dyadic relationship between physicians and patients, a lens of sadomasochism highlights dynamics of power in medical practice that are often obscured in everyday practice. Specifically, this article illustrates how classification and diagnosis are concrete manifestations of the mobilization of medical power.
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**A betrayal of their sacred trust: rabbis, cantors, and chaplains who violate sexual boundaries**
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**Beyond respect for autonomy**
Journal of Clinical Ethics 2006 Fall; 17(3): 195-206

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Dickens, Bernard M.
**Ethical misconduct by abuse of conscientious objection laws**

Abstract: This paper addresses laws and practices urged by conservative religious organizations that invoke conscientious objection in order to deny patients access to lawful procedures. Many are reproductive health services, such as contraception, sterilization and abortion, on which women's health depends. Religious institutions that historically served a mission to provide healthcare are now perverting this commitment in order to deny care. Physicians who followed their calling honourably in a spirit of self-sacrifice are being urged to sacrifice patients' interests to promote their own, compromising their professional ethics by conflict of interest. The shield tolerant societies allowed to protect religious conscience is abused by religiously-influenced agencies that beat it into a sword to compel patients, particularly women, to comply with religious values they do not share. This is unethical unless accompanied by objectors' duty of referral to non-objecting practitioners, and governmental responsibility to ensure supply of and patients' access to such practitioners.
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Hastings Center Report 2006 September-October; 36(5): 8-9

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Conditions for patient participation and non-participation in health care
Nursing Ethics 2006 September; 13(5): 503-514

Abstract: This study explored patients' experiences of participation and non-participation in their health care. A questionnaire-based survey method was used. Content analysis showed that conditions for patient participation occurred when information was provided not by using standard procedures but based on individual needs and accompanied by explanations, when the patient was regarded as an individual, when the patient's knowledge was recognized by staff, and when the patient made decisions based on knowledge and needs, or performed self-care. Thus, to provide conditions for true patient participation, professionals need to recognize each patient's unique knowledge and respect the individual's description of his or her situation rather than just inviting the person to participate in decision making.

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Nurses' fears and professional obligations concerning possible human-to-human avian flu
Nursing Ethics 2006 September; 13(5): 455-470

Abstract: This survey aimed to illustrate factors that contribute to nurses' fear when faced with a possible human-to-human avian flu pandemic and their willingness to care for patients with avian flu in Taiwan. The participants were nursing students with a lesser nursing credential who were currently enrolled in a bachelor degree program in a private university in southern Taiwan. Nearly 42% of the nurses did not think that, if there were an outbreak of avian flu, their working hospitals would have sufficient infection control measures and equipment to prevent nosocomial infection in their working environment. About 57% of the nurse participants indicated that they were willing to care for patients infected with avian influenza. Nurses' fear about an unknown infectious disease, such as the H5N1 influenza virus, could easily be heightened to levels above those occurring during the 2003 severe acute respiratory syndrome outbreak in Taiwan.
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The moral nature of patient-centeredness: is it "just the right thing to do"?
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The promise and limits of racial / ethnic concordance in physician-patient interaction
Abstract: Although some scholars suggest that racial/ethnic concordance between physicians and patients will do much to eliminate disparities in medical care, the evidence for concordance effects is mixed. Using nationally representative data with an oversample of blacks and Latinos, this study examines a variety of topics, including beliefs about and preferences for concordance, the effects of concordance on patient experiences, and interactions
between expectations and experiences. The results point to the limited effects of concordance in general but illuminate for whom concordance matters most. The results encourage more nuanced and contingent theories. They suggest that racial/ethnic concordance holds little salience in the minds of most black and Latino patients and that discordance has little effect. Nevertheless, there is some evidence that concordance has a positive effect among those who prefer concordance—thus the apparent effects of concordance might reflect the effects of patient choice more than concordance per se. The conclusion sketches policy implications, including the merits of promoting concordance among targeted groups of patients, even in the absence of overall effects on disparities.

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A matter of perspective: choosing for others differs from choosing for yourself in making treatment decisions
Helft, Paul R.

An intimate collaboration: prognostic communication with advanced cancer patients
Journal of Clinical Ethics 2006 Summer; 17(2): 110-121

Clayton, Ellen Wright

The web of relations: thinking about physicians and patients
Yale Journal of Health Policy, Law and Ethics 2006 Summer; 6(2): 465-477

Henry, M.S.

Uncertainty, responsibility, and the evolution of the physician / patient relationship

Abstract: The practice of evidence based medicine has changed the role of the physician from information dispenser to gatherer and analyser. Studies and controlled trials that may contain unknown errors, or uncertainties, are the primary sources for evidence based decisions in medicine. These sources may be corrupted by a number of means, such as inaccurate statistical analysis, statistical manipulation, population bias, or relevance to the patient in question. Regardless of whether any of these inaccuracies are apparent, the uncertainty of their presence in physician information should be disclosed to the patient. These uncertainties are not, however, shared by physicians with patients, and have caused a direct increase in patient responsibilities and mistrust. Only when disclosure of uncertainty becomes commonplace in medical practice will the physician/patient relationship evolve to a level of greater understanding and satisfaction for both the physician and patient.

Murtagh, F.E.M.; Thorns, A.

Evaluation and ethical review of a tool to explore patient preferences for information and involvement in decisions making
Journal of Medical Ethics 2006 June; 32(6): 311-315

Abstract: AIM: To improve clinical and ethical understanding of patient preferences for information and involvement in decision making. OBJECTIVES: To develop and evaluate a clinical tool to elicit these preferences and to consider the ethical issues raised. DESIGN: A before and after study. SETTING: Three UK hospices. PARTICIPANTS: Patients with advanced life-threatening illnesses and their doctors. INTERVENTION: Questionnaire on information and decision-making preferences. MAIN OUTCOME MEASURES: Patient-based outcome measures were satisfaction with the amount of information given, with the way information was given, with family or carer information, and confidence about future decision making. Doctor-based outcome measures were confidence in matching information to patient preference, matching family or carer communication to patient preference, knowing
RESULTS: Of 336 admissions, 101 patients (mean age 67.3 years, 47.5% men) completed the study (control, n = 40; intervention, n = 61). Patient satisfaction with the way information was given (chi2 = 6.38, df = 2, p = 0.041) and family communication (chi2 = 14.65, df = 2, p < 0.001) improved after introduction of the tool. Doctor confidence improved across all outcome measures (all p values < 0.001). CONCLUSIONS: Patient satisfaction and doctor confidence were improved by administering the questionnaire, but complex ethical issues were raised by implementing and applying this research. The balance of ethical considerations were changed by advanced life-threatening illness, because there is increased risk of harm through delivery of information discordant with the patient's own preferences. The importance of truly understanding patient preferences towards the end of life is highlighted by this study.

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**Does professional autonomy protect medical futility judgments?**
Bioethics 2006 April; 20(2): 92-104
**Abstract:** Despite substantial controversy, the use of futility judgments in medicine is quite common, and has been backed by the implementation of hospital policies and professional guidelines on medical futility. The controversy arises when health care professionals (HCPs) consider a treatment futile which patients or families believe to be worthwhile: should HCPs be free to refuse treatments in such a case, or be required to provide them? Most physicians seem convinced that professional autonomy protects them from being forced to provide treatments they judge mentally futile, given the lack of patient benefit as well as the waste of medical resources involved. The argument from professional autonomy has been presented in a number of articles, but it has not been subjected to much critical scrutiny. In this paper I distinguish three versions of the argument: 1) that each physician should be free to exercise his or her own medical judgment; 2) that the medical profession as a whole may provide futility standards to govern the practice of its members; and 3) that the moral integrity of each physician serves as a limit to treatment demands. I maintain that none of these versions succeeds in overcoming the standard objection that futility determinations involve value judgments best left to the patients, their designated surrogates, or their families. Nor do resource considerations change this fact, since they should not influence the properly patient-centered judgment about futility.

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Abstract: In order to care ethically nurses need to care holistically; holistic care includes religious/spiritual care. This research attempted to answer the question: Do nurses have the resources to offer religious care? This article discusses only one aspect—the provision of religious care within the Taiwanese health care system. It is assumed that, if hospitals do not provide enough religious services, nurses working in these hospitals cannot be fully ethical beings or cannot respect patients' religious needs. The relevant literature was reviewed, followed by a survey study on the provision of religious facilities and services. Aspects considered are: the religions influences in and on Taiwanese society; the religious needs of patients and their families; strategies that patients use to enable them to cope with their health care problems; professional motives for attuning to patients' religious needs; and hospital provision for meeting the religious and spiritual needs of patients. A survey of nursing executives showed differences between religious service provision in hospitals with and without a hospice ward. The practical implications for hospital management and nursing practice are discussed.
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Abstract: The idea that nurses should be trustworthy seems to be accepted as generally unproblematic. However, being trustworthy as a nurse is complicated because of the diverse range of expectations from patients, relatives, colleagues, managers, peers, professional bodies and the institutions within which nursing takes place. Nurses are often faced with competing demands and an action perceived by some as trustworthy can be seen by others as untrustworthy. In this article some of the reasons for the importance of being trustworthy are offered together with a preliminary discussion about how being a trustworthy nurse is far from straightforward.
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**The doctor-patient relationship in the post-managed care era**


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**A profession selling out: lamenting the paradigm shift in physician advertising**


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**What should we say?**

Journal of Medical Ethics 2006 January; 32(1): 7-12

Abstract: Abstract ethics mostly focuses on what we do. One form of action is a speech act. What we say can have profound effects. We can and should choose our words and how we speak wisely. When someone close to us suffers an injury or serious illness, a duty of beneficence requires that we support that person through beneficial words or actions. Though our intentions are most often benign, by what we say we often make the unfortunate person feel worse. Beginning with two personal accounts, this article explains what can go wrong in the compassionate speech of wellwishers, and uncovers some of the reasons why people say things that are hurtful or harmful. Despite a large body of clinical evidence, there is no perfect strategy for comforting a friend or relative who is ill, and sometimes even the best thing to say can still be perceived as insensitive and hurtful. In some cases, we may have good reason to knowingly say a hurtful or insensitive thing. Saying these 'wrong' things can sometimes be the best way to help a person in the long term. To complicate matters, there can be moral reasons for overriding what is good for the patient. What kind of admonishments should we make to a badly behaved patient? What is the value of authenticity in our communication with the people we love? These questions demand an ethical defence of those speech acts which are painful to hear but which need to be said, and of those which go wrong despite the best efforts of the wellwisher. We offer an ethical account, identifying permissible and impermissible Justifications for the things we say to a person with a serious injury or illness.

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*Abstract*: In this analysis I apply a Foucauldian approach to ethics to examine the politically prescribed moral and ethical character required of carers of aged persons at home in Australia and the role of nurses in shaping these behaviours. The work that spousal carers provide, although often founded on love and/or obligation, has been formalized through a variety of policy initiatives and technologies that serve to construct the moral approach they must adopt. This shaping of conduct at the most personal level takes place through the application of codes of behaviour policed largely by nurses. These codes redefine the mode of coexistence between an aged husband and wife and propose a new form of relationship that is derived from and supports policies of the deinstitutionalization of care services for elderly persons. In this way modern carer policy has drawn on knowledge and governance of the self to produce a morality of caring that is both authentative and scientific.  
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**Kant's assessment of motivation in the fulfillment of social obligations**
Penn Bioethics Journal 2006; 2(2): 29-32
**Abstract:** This paper explores the motivations of physicians who promote the health of their communities through the fulfillment of social obligations beyond the boundaries of their own patients. Based on the assumption that physicians do not have social obligations, this paper looks at the normative, motivational question, namely "How should physicians be motivated to fulfill social obligations?" The paper traces the Kantian view of morality and motivation. The distinctions between required, merely permissible, and forbidden actions is drawn. Furthermore, Kant's view that required actions done in accordance with duty are of no moral worth is critiqued from three stand points. First, it is argued that just because motivations outside of Kantian-based duty are not as good, it does not follow that these motivations are of no moral worth. Second, it is argued that there are some motivations behind required actions that are clearly better than other motivations. Third, it is argued that required actions done in accordance with duty are clearly better than those actions done without relevance to duty. The paper concludes that many required actions done in accordance with duty are performed from motivations that do have moral worth.
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Informal medicine: ethical analysis

Journal of Medical Ethics 2005 December; 31(12): 689-692

**Abstract:** CONTEXT: Doctors have been known to treat or give consultation to patients informally, with none of the usual record keeping or follow up. They may wish to know whether this practice is ethical. OBJECTIVE: To determine whether this practice meets criteria of medical ethics. DESIGN: Informal medicine is analysed according to standard ethical principles: autonomy, beneficence and non-maleficence, distributive and procedural justice, and caring. SETTING: Hospital, medical school, and other settings where patients may turn to physicians for informal help. CONCLUSION: No generalisation can be made to the effect that informal medicine is or is not ethical. Each request for informal consultation must be considered on its own merits. GUIDELINES: Informal medicine may be ethical if no payment is involved, and when the patient is fully aware of the benefits and risks of a lack of record keeping. When an informal consultation does not entail any danger to the patient or others, the physician may agree to the request. If, however, any danger to the patient or others is foreseen, then the physician must insist on professional autonomy, and consider refusing the request and persuading the patient to accept formal consultation. If a reportable infectious disease, or other serious danger to the community, is involved, the physician should refuse informal consultation or treatment, or at least make a proper report even if the consultation was informal. If agreeing to the request will result in an unfair drain on the physician's time or energy, he or she should refuse politely.

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**Professional promises and limits on the scope of practice**

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**Promising, professional obligations, and the refusal to provide service**

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**Two women with multiple sclerosis and their caregivers: conflicting normative expectations**

Nursing Ethics 2005 September; 12(5): 479-492

**Abstract**: It is not uncommon that nurses are unable to meet the normative expectations of chronically ill patients. The purpose of this article is to describe and illustrate Walker's expressive-collaborative view of morality to interpret the normative expectations of two women with multiple sclerosis. Both women present themselves as autonomous persons who make their own choices, but who also have to rely on others for many aspects of their lives, for example, to find a new balance between work and social contacts or to find work. We show that their narratives of identity, relationship and value differ from the narratives that others use to understand and identify them. Since identities, relationships and values give rise to normative expectations, in both cases there is a conflict between what the women expect of their caregivers and vice-versa. The narratives also show that two similar persons with
multiple sclerosis may need very different care. This implies that nurses caring for such persons should listen carefully to their stories and reflect on their own perceptions of self.

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O'Connor, Tom; Kelly, Billy
Bridging the gap: a study of general nurses' perceptions of patient advocacy in Ireland
Nursing Ethics 2005 September; 12(5): 453-467
Abstract: Advocacy has become an accepted and integral attribute of nursing practice. Despite this adoption of advocacy, confusion remains about the precise nature of the concept and how it should be enacted in practice. The aim of this study was to investigate general nurses' perceptions of being patient advocates in Ireland and how they enact this role. These perceptions were compared with existing theory and research on advocacy in order to contribute to the knowledge base on the subject. An inductive, qualitative approach was used for this study. Three focus group interviews with a total of 20 practising nurses were conducted with a sample representing different grades in a general hospital setting. Data analysis was carried out using elements of Strauss and Corbins' approach to concept development. The findings indicate that the principal role of the nurse advocate is to act as an intermediary between the patient and the health care environment. The results highlight that advocacy did, however, result in nurses becoming involved in conflict and confrontation with others and that it could be detrimental to nurses both professionally and personally. It was also clear that when enacting advocacy, nurses distinguished between 'clinical advocacy' (acting directly for patients in the clinical environment) and organizational advocacy (acting on an organizational level for one or more patients).

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I shouldn't have had to beg for a prognosis: with all the conflicting reports on Doug's health, I didn't know if he was holding steady or dying
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**The ethics of relation: public health nurses and child protection clients**


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**Diminishing returns? Risk and the duty to care in the SARS epidemic**

Bioethics 2005 August; 19(4): 348-361

**Abstract:** The seriousness of the risk that healthcare workers faced during SARS, and their response of service in the face of this risk, brings to light unrealistic assumptions about duty and risk that informed the debate on duty to care in the early years of HIV/AIDS. Duty to care is not based upon particular virtues of the health professions, but arises from social reflection on what response to an epidemic would be consistent with our values and our needs, recognizing our shared vulnerability to disease and death. Such reflection underwrites a strong duty of care, but one not to be borne solely by the altruism and heroism of individual healthcare workers.

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**Compassion** [editorial]


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**Strategies for enhancing the nurse's role in assessing and promoting a patient's decisional capacity**
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**The human form: accepting the prioritization of patient values**
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Instilling hope and respecting patient autonomy: reconciling apparently conflicting duties
Abstract: In contemporary American medical practice, certain physicians are critical and wary of the current emphasis on patient autonomy in medicine, questioning whether it really serves the complex needs of severely ill patients. Physicians such as Eric Cassell and Thomas Duffy argue that the duty of beneficence should override the duty to respect autonomy when conflicts arise in clinical situations. After evaluating their claim that severe illness
robs patients of their autonomy, I will argue that this perceived conflict between beneficence and autonomy is ill-conceived, resting on misperceptions about both the capacity for autonomy and the meaning of hope. Considering insights on hope from phenomenologist Gabriel Marcel and theologian William Lynch, as well as drawing upon a case study involving a bone marrow patient, I claim that respecting and nurturing patients’ capacity for autonomy is a necessary condition for acting beneficently and fostering authentic hope.

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The virtue of moral responsibility and the obligations of patients
Journal of Medicine and Philosophy 2005 April; 30(2): 153-166
Abstract: The American Medical Association has provided a list of patient responsibilities, said to be derived from patient autonomy, without providing any justification for this derivation. In this article, the virtue of moral responsibility is proposed as a way to justify these kinds of limits on respect for individual autonomy. The need for such limits is explained by examining the traditional principles of health care ethics. What is missing in health care decision making, and can be provided by the virtue of moral responsibility, is a careful consideration of the impact of individual decisions on particular others and the community, as a whole. The concept of moral responsibility as a virtue is then developed and examples of its application to health care decision making are provided. Finally, the roles of both physicians and health care ethicists in promoting the morally responsible exercise of individual autonomy are explored.
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Moral obligations of patients: a clinical view
Journal of Medicine and Philosophy 2005 April; 30(2): 139-152
Abstract: After a unilateral focus on medical professional obligations to patients in most of the 20th century, there is a growing, if modest, interest in patient responsibility. This article critiques some public assertions, explores the ethics literature, and attempts to find some consensus and moral grounds for positions taken on the question, "Does a patient have moral obligations in the process of interactions with medical and other professional caregivers?" There
is widespread agreement on a few responsibilities, such as "truth telling" and "avoiding harm to others," but no apparent consensus either on the list of duties or on the appropriate justification for such duties. The context and clinical realities of patient interactions are noted to suggest that feasibility is important in making judgments of patient obligations.

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Freudenheim, Milt

**Digital Rx: take two aspirins and e-mail me in the morning**


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Clinical empathy as emotional labor in the patient-physician relationship

Abstract: Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (ie, management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's The Managed Heart in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (ie, generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (ie, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

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Patients with cancer: their approaches to participation in treatment plan decisions
Nursing Ethics 2005 March; 12(2): 143-155

Abstract: The aim of this study was to explore experiences of participation in treatment planning decisions from the perspective of patients recently treated for colorectal cancer. Ten patients were purposively selected and interviewed. Constant comparative analysis, the core concept of grounded theory, was used. The dimensions were developed and organized into the main theme of 'compliant participation in serious decisions', which was composed of the two variations: complying with participation; and complying without participation. Complying with participation was characterized by feelings of self-confidence and self-competence and by open dialogue between the participants, significant others and the physician. Complying without participation was characterized by participants' feelings of uncertainty and distress, and of being rushed into submitting to decisions without having time to reflect on the information provided or the opportunity to influence the treatment and care process. To participate (or choosing not to participate) builds on open and affirming dialogue, information and knowledge about the illness. Patient participation in treatment and care decision making is interpreted as a health promoting way of coping with illness.

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Meeting ethical challenges in acute nursing care as narrated by registered nurses
Nursing Ethics 2005 March; 12(2): 133-142

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Karkkainen, Oili; Bondas, Terese; Eriksson, Katie
Documentation of individualized patient care: a qualitative metasynthesis
Nursing Ethics 2005 March; 12(2): 123-132

Abstract: The aim of this study was to increase understanding of how individual patient care and the ethical principles prescribed for nursing care are implemented in nursing documentation. The method used was a metasynthesis of the results of 14 qualitative research reports. The results indicate that individualized patient care is not visible in nurses' documentation of care. It seems that nurses describe their tasks more frequently than patients' experiences of their care. The results also show that the structure of nursing documentation and the forms or manner of recording presupposed by the organization may prevent individual recording of patient care. In order to obtain visibility for good patient-centred and ethical nursing care, an effort should be made to influence how the content of nursing care is documented and made an essential part of individual patient care. If the content of this documentation does not give an accurate picture of care, patients' right to receive good nursing care may not be realized.

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How does race matter, anyway? [editorial]
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In harm's way: AMA physicians and the duty to treat
Abstract: In June 2001, the American Medical Association (AMA) issued a revised and expanded version of the Principles of Medical Ethics (last published in 1980). In light of the new and more comprehensive document, the present essay is geared to consideration of a longstanding tension between physician's autonomy rights and societal obligations in the AMA Code. In particular, it will be argued that a duty to treat overrides AMA autonomy rights in social emergencies, even in cases that involve personal risk to physicians (e.g., bioterrorist attack, HIV infection, SARS). The argument will be made by way of the logic and language of the AMA Code through its history, commentaries, and precedents. It also will be shown that there are substantial reasons to believe that the logic of the Code is sound in morally relevant ways. The essay will conclude with some philosophical proposals suggesting a framework for the duty to render aid and the extension of those duties to physicians facing personal risks.
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Private or intimate relations between doctor and patient: is zero tolerance warranted?
Journal of Medical Ethics 2005 January; 31(1): 27-28
Abstract: This article reviews and comments on the five categories of arguments used to defend zero tolerance with regard to sexual contacts resulting from the physician-patient relationship as summarised by Cullen. In addition it puts forward a hypothesis- "fear of loss by third party"-as a psychological explanation for the collective insistence on a zero tolerance policy.
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Physician offered prayer and patient satisfaction

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Commentary: two sides to every story -- the need for objectivity and evidence

Gutheil, Thomas G.

Boundaries, blackmail, and double binds: a pattern observed in malpractice consultation

Pellegrino, Edmund D.

Some things ought never be done: moral absolutes in clinical ethics [M572]

Abstract: Moral absolutes have little or no moral standing in our morally diverse modern society. Moral relativism is far more palatable for most ethicists and to the public at large. Yet, when pressed, every moral relativist will finally admit that there are some things which ought never be done. It is the rarest of moral relativists that will take rape, murder, theft, child sacrifice as morally neutral choices. In general ethics, the list of those things that must never be done will vary from person to person. In clinical ethics, however, the nature of the physician-patient relationship is such that certain moral absolutes are essential to the attainment of the good of the patient - the end of the
relationship itself. These are all derivatives of the first moral absolute of all morality: Do good and avoid evil. In the clinical encounter, this absolute entails several subsidiary absolutes - act for the good of the patient, do not kill, keep promises, protect the dignity of the patient, do not lie, avoid complicity with evil. Each absolute is intrinsic to the healing and helping ends of the clinical encounter.

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Understanding trust and confidence: two paradigms and their significance for health and social care
Abstract: Trusting agents characteristically anticipate beneficial outcomes, under conditions of uncertainty, in their engagement with others. However, debates about trust incorporate different interpretations of risk, uncertainty, calculation, affect, morality and motivation in explaining when trust is appropriate and how it operates. This article argues that discussions about trust have produced a concept without coherent boundaries and with little operational value. Two paradigms are identified, which distinguish the characteristics of trust and confidence. It is argued that a reliance on confidence in human affairs makes trust redundant and that this has undesirable moral consequences. Discussion is illustrated by the UK Government's 'modernisation' policy in health and social care, which privileges confidence in systems over trust in moral agents.

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Tolich, Martin; Baldwin, Kate Mary
Unequal protection for patient rights: the divide between university and health ethics committees
Abstract: Despite recommendations from the Cartwright Report ethical review by health ethics committees has continued in New Zealand without health practitioners ever having to acknowledge their dual roles as health practitioners researching their own patients. On the other hand, universities explicitly identify doctor/research-patient
relations as potentially raising conflict of role issues. This stems from the acknowledgement within the university sector itself that lecturer/research-student relations are fraught with such conflicts. Although similar unequal relationships are seen to exist between health researchers and their patients, the patient/subjects are not afforded the levels of protection that are afforded student/subjects. In this paper we argue that the difference between universities and health research is a result of the failure of the Operational Standard Code for Ethics Committees to explicitly acknowledge the vulnerability of the patient and conflict of interests in the dual roles of health practitioner/researcher. We end the paper recommending the Ministry of Health consider the rewriting of the Operational Standard Code for Ethics Committees, in particular in the rewriting of section 26 of the Operational Standard Code for Ethics Committees. We also identify the value of comparative ethical review and suggest the New Zealand's Health Research Council's trilateral relationship with Australia's NHMRC (National Health and Medical Research Council) and Canada's CIHR (Canadian Institute of Health Research) as a useful starting point for such a process.

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*In my chosen doctor I trust*[editorial]


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**Abstract:** Following a personal experience of transformation as a result of washing the feet of a terminally ill patient, an exploratory study was undertaken to investigate nurses' experience of washing patients' feet. Seven
postregistration student nurses participated in the study by washing the feet of as many patients as they could over a defined period of time. They were then interviewed about the experience. The transcribed interviews were analysed using the heuristic enquiry approach. Symbolically, washing feet is an act of humility. In washing feet in the manner required for this study I suggest that the nurses were practising beyond role definition of duty of care. As a result of this they experienced interconnectedness and changes in their relationship with the patients whose feet they had washed that could be interpreted as a response to humility.

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**When hope makes us vulnerable: a discussion of patient-healthcare provider interactions in the context of hope**
Bioethics 2004 September; 18(5): 428-447

*Abstract:* When hope is discussed in bioethics' literature, it is most often in the context of 'false hopes' and/or how to maintain hope while breaking bad news to patients. Little or no time is generally devoted to the description of hope that supports these analyses. In this paper, I present a detailed description of hope, one designed primarily for the healthcare context. Noting that hope is an emotional attitude, four key aspects are explored. In particular, the function of imagination in hope is discussed in depth. Through an examination of the relationship between hope and vulnerability, I demonstrate how adequately describing hope can broaden the normative inquiry into the role of hope in healthcare. Three ways in which persons with hope can be vulnerable are illustrated, and the challenge of how healthcare providers can attend in moral ways to the hopes of patients is identified.

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Epstein, Ronald M.; Alper, Brian S.; Quill, Timothy E.

**Communicating evidence for participatory decision making**

**Abstract:** CONTEXT: Informed patients are more likely to actively participate in their care, make wiser decisions, come to a common understanding with their physicians, and adhere more fully to treatment; however, currently there are no evidence-based guidelines for discussing clinical evidence with patients in the process of making medical decisions. OBJECTIVE: To identify ways to communicate evidence that improve patient understanding, involvement in decisions, and outcomes. DATA SOURCES AND STUDY SELECTION: Systematic review of MEDLINE for the period 1966-2003 and review of reference lists of retrieved articles to identify original research dealing with communication between clinicians and patients and directly addressing methods of presenting clinical evidence to
patients. DATA EXTRACTION: Two investigators and a research assistant screened 367 abstracts and 2
investigators reviewed 51 full-text articles, yielding 8 potentially relevant articles. DATA SYNTHESIS: Methods for
communicating clinical evidence to patients include nonquantitative general terms, numerical translation of clinical
evidence, graphical representations, and decision aids. Focus-group data suggest presenting options and/or
equipoise before asking patients about preferred decision-making roles or formats for presenting details. Relative risk
reductions may be misleading; absolute risk is preferred. Order of information presented and time-frame of outcomes
can bias patient understanding. Limited evidence supports use of human stick figure graphics or faces for single
probabilities and vertical bar graphs for comparative information. Less-educated and older patients preferred
proportions to percentages and did not appreciate confidence intervals. Studies of decision aids rarely addressed
patient-physician communication directly. No studies addressed clinical outcomes of discussions of clinical
evidence. CONCLUSIONS: There is a paucity of evidence to guide how physicians can most effectively share
clinical evidence with patients facing decisions; however, basing our recommendations largely on related studies and
expert opinion, we describe means of accomplishing 5 communication tasks to address in framing and
communicating clinical evidence: understanding the patient's (and family members') experience and expectations;
building partnership; providing evidence, including a balanced discussion of uncertainties; presenting
recommendations informed by clinical judgment and patient preferences; and checking for understanding and agreement.

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Keating, Nancy L.; Gandhi, Tejal K.; Orav, E. John; Bates, David W.; Ayanian, John Z.
Patient characteristics and experiences associated with trust in specialist physicians
Archives of Internal Medicine 2004 May 10; 164(9): 1015-1020
Abstract: BACKGROUND: Nearly half of all medical visits are to specialist physicians, yet little is known about
patients' outpatient experiences with specialists or how patients' characteristics and experiences are related to trust
in specialist physicians. METHODS: We surveyed patients who had a new patient visit with a cardiologist,
neurologist, nephrologist, gastroenterologist, or rheumatologist practicing in hospital-based practices (response rate,
73%; N = 417) and inquired about their experiences with care and trust in the specialist physician. We used
multivariable models to assess associations of patients' characteristics and experiences with trust. RESULTS: Most
patients reported good experiences, and 79% reported complete confidence and trust in the specialist. Black
patients were less trusting than white patients (risk ratio [RR], 0.5; 95% confidence interval [CI], 0.2-0.8). Patients
were more trusting if they reported that the consultant listened (RR, 1.8; 95% CI, 1.0-2.5), received as much
information as they wanted (RR, 1.6; 95% CI, 1.1-1.9), were told what to do if problems or symptoms continued, got
worse, or returned (RR, 1.4; 95% CI, 1.2-1.5), were involved in decisions as much as they wanted (RR, 1.5; 95% CI,
1.2-1.8), and spent as much time as they wanted with the specialist (RR, 1.8; 95% CI, 1.3-2.2). CONCLUSIONS:
Patients reported high levels of trust in specialist physicians after an initial visit. Several specific experiences were
associated with higher trust, suggesting that efforts to improve patient-physician interactions may be successful at
achieving trust. Such efforts should especially aim to optimize physicians’ interactions with black patients, who were
less trusting of specialist physicians.

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Levine, Carol
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Journey into hope: a therapeutic relationship

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Coates, Madelaine Louise

Do unto others... when you'd rather not

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Clarke, Greg; Hall, Robert T.; Rosencrance, Greg

Physician-patient relations: no more models

Abstract: Currently, the common theoretical models of preferred decision-making relationships do not correspond well with clinical experience. This interview study of congestive heart failure (CHF) patients documents the variety of patient preferences for decision-making, and the necessity for attention to family involvement. In addition, these findings illustrate the confusion as to the designation of surrogate decision-makers and physicians in charge. We conclude that no single model of physician-patient decision-making should be preferred, and that physicians should first ask patients how they want medical information and decision-making to be handled.

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Luu, Nghe S.

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Journal of Dental Education 2004 March; 68(3): 306-315

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Sorlie, Venke; Larsson Kihlgren, Annica; Kihlgren, Mona

Meeting ethical challenges in acute care work as narrated by enrolled nurses
Abstract: Five enrolled nurses (ENs) were interviewed as part of a comprehensive investigation into the narratives of registered nurses, ENs and patients about their experiences in an acute care ward. The ward opened in 1997 and provides patient care for a period of up to three days, during which time a decision has to be made regarding further care elsewhere or a return home. The ENs were interviewed concerning their experience of being in ethically difficult care situations and of acute care work. The method of phenomenological-hermeneutic interpretation inspired by the French philosopher Paul Ricoeur was used. The most prominent feature was the focus on relationships, as expressed in concern for society's and administrators' responsibility for health care and the care of older people. Other themes focus on how nurse managers respond to the ENs' work as well as their relationships with fellow ENs, in both work situations and shared social and sports activities. Their reflections seem to show an expectation of care as expressed in their lived experiences and their desire for a particular level and quality of care for their own family members. A lack of time could lead to a bad conscience over the 'little bit extra' being omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.

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Haddad, Amy

**Ethics in action. Warning a patient**

RN 2004 March; 67(3): 21-24

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Connelly, Julia E.

**The power of touch in clinical medicine**

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**Contextualizing medical decisions to individualize care -- lessons from the qualitative sciences**


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**The V.I.P.: hazard and promise in treating "special" patients**


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Patients' preferences for involvement in treatment decision making in Japan
BMC Family Practice 2004 March 1; 5(1): 1

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Do we have the right to share our faith?

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A reflection of patient-physician relationship in the novel of "Current"
Formosan Journal of Medical Humanities 2004 March; 5(12): 109- 120

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Bernstein, Mark
You made a "technical" error. Should you tell your patient?

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The importance of the nurse-patient relationship
British Journal of Nursing 2004 February 26-March 10; 13(4): 231

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*  Article  Document 1298
Charon, Rita
Narrative and medicine [opinion]
New England Journal of Medicine 2004 February 26; 350(9): 862- 864
Document 1299
Little, Paul; Dorward, Martina; Warner, Greg; Stephens, Katharine; Senior, Jane; Moore, Michael
Importance of patient pressure and perceived pressure and perceived medical need for investigations, referral, and prescribing in primary care: nested observational study
BMJ: British Medical Journal 2004 February 21; 328(7437): 444-446

Abstract: OBJECTIVE: To assess how pressures from patients on doctors in the consultation contribute to referral and investigation. DESIGN: Observational study nested within a randomised controlled trial. SETTING: Five general practices in three settings in the United Kingdom. PARTICIPANTS: 847 consecutive patients, aged 16-80 years. MAIN OUTCOMES MEASURES: Patient preferences and doctors' perception of patient pressure and medical need. RESULTS: Perceived medical need was the strongest independent predictor of all behaviours and confounded all other predictors. The doctors thought, however, there was no or only a slight indication for medical need among a significant minority of those who were examined (89/580, 15%), received a prescription (74/394, 19%), or were referred (27/125, 22%) and almost half of those investigated (99/216, 46%). After controlling for patient preference, medical need, and clustering by doctor, doctors' perceptions of patient pressure were strongly associated with prescribing (adjusted odds ratio 2.87, 95% confidence interval 1.16 to 7.08) and even more strongly associated with examination (4.38, 1.24 to 15.5), referral (10.72, 2.08 to 55.3), and investigation (3.18, 1.31 to 7.70). In all cases, doctors' perception of patient pressure was a stronger predictor than patients' preferences. Controlling for randomisation group, mean consultation time, or patient variables did not alter estimates or inferences. CONCLUSIONS: Doctors' behaviour in the consultation is most strongly associated with perceived medical need of the patient, which strongly confounds other predictors. However, a significant minority of examining, prescribing, and referral, and almost half of investigations, are still thought by the doctor to be slightly needed or not needed at all, and perceived patient pressure is a strong independent predictor of all doctor behaviours. To limit unnecessary resource use and iatrogenesis, when management decisions are not thought to be medically needed, doctors need to directly ask patients about their expectations.

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*Practices for reporting and responding to test results during medical consultations: enacting the roles of paternalism and independent expertise*
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**Document 1306**
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**A prescription for protecting the doctor-patient relationship**
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Spickerman, Frances
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Kvale, Gerd; Milgrom, Peter; Getz, Tracy; Weinstein, Philip; Johnsen, Tom Backer
**Beliefs about professional ethics, dentist-patient communication, control and trust among fearful dental patients: the factor structure of the revised Dental Beliefs Survey**

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**Document 1309**
Davis, John K.
**Conscientious refusal and a doctor's right to quit**
Journal of Medicine and Philosophy 2004 February; 29(1): 75-91

**Abstract:** Patients sometimes request procedures their doctors find morally objectionable. Do doctors have a right of conscientious refusal? I argue that conscientious refusal is justified only if the doctor's refusal does not make the patient worse off than she would have been had she gone to another doctor in the first place. From this approach I derive conclusions about the duty to refer and facilitate transfer, whether doctors may provide 'moral counseling,' whether doctors are obligated to provide objectionable procedures when no other doctor is available, why the moral consensus among doctors seems relevant even though it does not determine whether something is morally acceptable, and whether doctors should stay out of fields whose standard procedures they find morally unacceptable.

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Karliner, Leah S.; Perez-Stable, Eliseo J.; Gildengorin, Ginny
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Fernandez, Alicia; Schillinger, Dean; Grumbach, Kevin; Rosenthal, Anne; Stewart, Anita L.; Wang, Frances; Perez-Stable, Eliseo J.
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Fallowfield, Lesley; Jenkins, Valerie
**Communicating sad, bad, and difficult news in medicine**
Lancet 2004 January 24; 363(9405): 312-319

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Sobel, Rachel K.
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Grady, Denise

**Ambiguous gifts: when patients give and doctors take**

New York Times 2004 January 11; p. WK2

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* Article Document 1317

Ferris, Lorraine E.

**Patient protection laws and the issue of consensual sexual relationships with physicians**


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* Article Document 1318

Whitney, Simon N.; McGuire, Amy L.; McCullough, Laurence B.

**A typology of shared decision making, informed consent, and simple consent [opinion]**

Annals of Internal Medicine 2004 January 6; 140(1): 54-59

**Abstract:** Enhancing patient choice is a central theme of medical ethics and law. Informed consent is the legal process used to promote patient autonomy; shared decision making is a widely promoted ethical approach. These processes may most usefully be seen as distinct in clinically and ethically important respects. The approach outlined in this article uses a model that arrays all medical decisions along 2 axes: risk and certainty. At the extremes of these continua, 4 decision types are produced, each of which constrains the principal actors in predictable ways. Shared decision making is most appropriate in situations of uncertainty, in which 2 or more clinically reasonable alternatives exist. When there is only 1 realistic choice, patient and physician may gather and exchange information; however, the patient cannot be empowered to make choices that do not exist. In contrast, informed consent does not require the presence of clinical choice; it is appropriate for all decisions of significant risk, even if there is only one option. When a clinical decision contains both risk and uncertainty, shared decision making and informed consent are both appropriate. For decisions of lower risk, consent should still be present, but it can be simple rather than informed. Clinicians may use this analysis as a guide to their own interactions with patients. In the continuing effort to provide patients with appropriate decisional authority over their own medical choices, shared decision making, informed consent, and simple consent each has a distinct role to play.

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* Article Document 1319

McCabe, Catherine

**Nurse-patient communication: an exploration of patients' experiences**


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Lussier, Marie-Therese; Richard, Claude

**Doctor-patient communication: introduction to series**

Canadian Family Physician 2004 January; 50: 43, 45
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Tomlinson, Tom; Clark, Chalmers C.
SARS and the duty to treat: remember AIDS? [letter and reply]
Hastings Center Report 2004 January-February; 34(1): 4

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Burke, Greg F.
The conscience of the physician
Ethics and Medics 2004 January; 29(1): 2-3

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Social invitations, time constraints, and professional distance
American Journal of Hospice and Palliative Care 2004 January-February; 21(1): 17-18

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Rose, Abigail; Peters, Nikki; Shea, Judy A.; Armstrong, Katrina
Development and testing of the health care system distrust scale

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Cronqvist, Agneta; Theorell, Tores; Burns, Tom; Lutzen, Kim
Caring about -- caring for: moral obligations and work responsibilities in intensive care nursing
Nursing Ethics 2004 January; 11(1): 63-76
Abstract: The aim of this study was to analyse experiences of moral concerns in intensive care nursing. The theoretical perspective of the study is based on relational ethics, also referred to as ethics of care. The participants were 36 intensive care nurses from 10 general, neonatal and thoracic intensive care units. The structural characteristics of the units were similar: a high working pace, advanced technology, budget restrictions, recent reorganization, and shortage of experienced nurses. The data consisted of the participants' examples of ethical situations they had experienced in their intensive care unit. A qualitative content analysis identified five themes: believing in a good death; knowing the course of events; feelings of distress; reasoning about physicians' 'doings' and tensions in expressing moral awareness. A main theme was formulated as caring about--caring for: moral obligations and work responsibilities. Moral obligations and work responsibilities are assumed to be complementary dimensions in nursing, yet they were found not to be in balance for intensive care nurses. In conclusion there is a need to support nurses in difficult intensive care situations, for example, by mentoring, as a step towards developing
moral action knowledge in the context of intensive care nursing.

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* **Document 1326**

Cameron, Brenda L.

**Ethical moments in practice: the nursing 'how are you?' revisited**

Nursing Ethics 2004 January; 11(1): 53-62

**Abstract:** In seeking for an understanding of ethical practices in health care situations, our challenge is always both to recognize and respond to the call of individuals in need. In attuning ourselves to the call of the vulnerable other an ethical moment arises. Asking 'how are you?' in health care practice is our very first possibility to learn how a particular person finds herself or himself in this particular situation. Here, 'how are you?' shows itself as an ethical question that opens up a relational space that calls forth a response. It is a way to understand the situated moments in which we are already that enables us to act respectfully. Our ethical frameworks assist us in trying to decide what is the right thing to do given a set of circumstances. Yet there is a prior step that already calls us to ethical attention; this is when we ask 'how are you?', which transforms a seemingly small interaction into an ethical moment. 'How are you?' is a question that turns us back to who we are as health care professionals and calls us to be more deeply attentive to the moment. When we sincerely ask 'how are you?' we enact our ethical commitments to one another.

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Provis, Chris; Stack, Sue

**Caring work, personal obligation and collective responsibility**

Nursing Ethics 2004 January; 11(1): 5-14

**Abstract:** Studies of workers in health care and the care of older people disclose tensions that emerge partly from their conflicting obligations. They incur some obligations from the personal relationships they have with clients, but these can be at odds with organizational demands and resource constraints. One implication is the need for policies to recognize the importance of allowing workers some discretion in decision making. Another implication may be that sometimes care workers can meet their obligations to clients only by taking collective action.

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Woods, David, ed.

**COMMUNICATION FOR DOCTORS: HOW TO IMPROVE PATIENT CARE AND MINIMIZE LEGAL RISKS**


Call number: [R118 .C66 2004](https://catalog.georgetown.edu/record=b1919845)

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Kirk, Timothy W.

**THE MORAL SIGNIFICANCE OF INTIMACY IN NURSE-PATIENT RELATIONSHIPS**


Call number: [RT86.3 .K57 2004a](https://catalog.georgetown.edu/record=b1919846)

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Morrow, Jason
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National Health and Medical Research Council [NHMRC] (Australia)
GENERAL GUIDELINES FOR MEDICAL PRACTITIONERS ON PROVIDING INFORMATION TO PATIENTS [and]
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IL MEDICO: IDENTITÀ E RUOLI NELLA SOCIETÀ DI OGGI

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BASIC QUESTIONS ON HEALTHCARE: WHAT SHOULD GOOD CARE INCLUDE?

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Hurwitz, Brian; Greenhalgh, Trisha; and Skultans, Vieda, eds.
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Document 1336
Kavanagh, Kathryn Hopkins and Krowden, Virginia, eds.
MANY VOICES: TOWARD CARING CULTURE IN HEALTHCARE AND HEALING
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Frank, Arthur W.
**THE RENEWAL OF GENEROSITY: ILLNESS, MEDICINE, AND HOW TO LIVE**
Call number: R727.3 .F66 2004

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Zaner, Richard
**Physicians and patients in relation: clinical interpretation and dialogues of trust**
Call number: R725.5 .H36 2004

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Peniston, Reginald L.
**Does an African American perspective alter clinical ethical decision making at the bedside?**
Call number: R724 .S937 2004

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Switankowsky, Irene
**The importance of empathy in medical practices and some of its difficulties**
Humane Health Care International 2004; 4(1): 7p
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In his: Legal Aspects of Health Care Administration. 9th edition. Sudbury, MA: Jones and Bartlett Publishers, 2004: 365-374
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**Investigating sports medicine: medical anthropology in context.**
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**The ethics of communication.**
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Journal of Documentation 2004; 60(3): 245-265
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Gemeinsame Entscheidungsfindung aus Patientenperspektive / Shared decision making – the patients' perspective
Deutsche Medizinische Wochenschrift 2004 October 29; 129(44): 2343-2347
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Ethical aspects of determining and communicating prognosis in critical care
Neurocritical Care 2004; 1(1): 107-117
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Healy, Tara C.
Levels of directiveness: a contextual analysis
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Valimaki, Mariita; Leino-Kilpi, Helena; Gronroos, Matti; Dassen, Theo; Gasull, Maria; Lemonidou, Chryssoula; Scott, P. Anne; Arndt, Marianne Benedicta
Self-determination in surgical patients in five European countries
Journal of Nursing Scholarship 2004; 36(4): 305-311
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Reed, Julie

*Cybermedicine: defying and redefining patient standards of care*

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Carvajal, Jorge Enrique Jimenez

*The role of the family faced with depression*
Dolentium Hominum 2004; 19(1): 140-141

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Hanssen, Ingrid

*From human ability to ethical principle: an intercultural perspective on autonomy*
Medicine, Health Care and Philosophy: A European Journal 2004; 7(3): 269-279

**Abstract:** Based on an empirical study regarding ethical challenges within intercultural health care, the focus of this article is upon autonomy and disclosure, discussed in light of philosophy and anthropology. What are the consequences for patients if the patients' right to be autonomous and to participate in treatment and care decisions by health care workers is interpreted as an obligation to participate? To force a person to make independent choices who is socio-culturally unprepared to do so, may violate his/her integrity. This may in turn jeopardise the respect, integrity and human worth the principle of autonomy was meant to ensure, and if so, may damage any relationship of trust that may exist between patient and health care worker. There is necessarily a link between autonomy and disclosure. Western disclosure practices may make the relationship between patients and health care workers difficult—even distrustful. To confront a patient with a very serious diagnosis may be seen not only as a tactless action, but also an unforgivable one. Hence, among many ethnic groups it is a family member's duty to shield patients from bad or disquieting news, e.g., a cancer diagnosis. If a family member is used to interpret in such situations, will the information given equal the information communicated by that interpreter? Even though respect for a person's autonomy is part of the respect for a person, one's respect for the person in question should not depend on his/her ability or aptitude to act autonomously.

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Sandman, Lars

*On the autonomy turf. Assessing the value of autonomy to patients*
Medicine, Health Care and Philosophy: A European Journal 2004; 7(3): 261-268

**Abstract:** Within the western health-care context autonomy is a central value. Still, as it is used within this context it is far from clear what we are actually talking about. In this article the author outlines four different uses or aspects of autonomy: self-determination, freedom, desire-fulfilment and independence. One important conclusion will be that in order to be able to respect autonomy in a way that actually brings value to the patient's life we need to clearly assess what aspect of autonomy the patient values and for what reason it is valued by the patient.

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Whitbeck, Caroline
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Annas, George J.
Patients' rights: I. Origin and nature of patients' rights.
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Lebacqz, Karen
Patients' responsibilities: II. Virtues of patients.
Call number: QH332 .E52 2004 v.4
Brody, Howard

Patients' responsibilities: I. Duties of patients.
Call number: QH332 .E52 2004 v.4

Sherman, Nancy

Emotions.
Call number: QH332 .E52 2004 v.2

Switankowsky, Irene

Empathy as a foundation for the biopsychosocial model of medicine
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Schattner, Ami; Rudin, Dan; Jellin, Navah

Good physicians from the perspective of their patients
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National Health and Medical Research Council [NHMRC] (Australia)

General guidelines for medical practitioners on providing information to patients
Call number: special collection
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National Health and Medical Research Council [NHMRC] (Australia)

Communicating with patients: advice for medical practitioners
Call number: special collection
http://www7.health.gov.au/nhmrc/publications/subjects/clinical.htm (link may be outdated)
Barnes, Adrian

Am I a carer and do I care?

Medicine, Health Care and Philosophy: A European Journal 2004; 7(2): 153-161

Abstract: A number of dichotomies bedevil the concept of care, among them, the question of whether healthcare is posited on care or cure. On one side the question is whether it is enough to cure without caring (to cure is to care) and on the other whether caring is sufficient without a cure. This has received attention in recent years from feminists, particularly in the nursing profession, and from renewed interest in virtue ethics. This paper describes a study that was undertaken to explore what a group of experienced United Kingdom based osteopaths understand care to be. Following interviews and transcript analysis using Grounded Theory, a number of themes were identified: Care as communication; Care as understanding the patient; Care as the therapeutic relationship; Care as action; Care as most beneficial outcome. The relationships between the various themes were explored and a 'model of osteopathic care' was proposed. Most of the respondents put beneficial outcome of some kind at the heart of their understanding but the process of caring was not regarded as particularly important on its own. In fact the expressed intention of osteopathic care was to facilitate a beneficial outcome. However, beneficial outcome was described in very broad terms and was not confined to the resolution of patients' presenting symptoms. In placing beneficial outcome at the heart of their model of care, respondents did not appear to recognize the dichotomy between care and cure, a finding that contrasts sharply with a number of nursing studies. The paper concludes by suggesting how it may be possible to differentiate between care and good practice.

Widder, Joachim

The origins of medical evidence: communication and experimentation

Medicine, Health Care and Philosophy: A European Journal 2004; 7(1): 99-104

Abstract: BACKGROUND: The experimental method to acquire knowledge about efficacy and efficiency of medical procedures is well established in evidence-based medicine. A method to attain evidence about the significance of diseases and interventions from the patients' perspectives taking into account their right to self-determination about their lives and bodies has however not been sufficiently characterized. DESIGN: Identification of a method to acquire evidence about the clinical significance of disease and therapeutic options from the patients' perspectives. ARGUMENTS: Communication between patient and physician is analyzed as the method to attain evidence about what is at stake for individual patients in disease and therapy. It is the method that enables physicians to directly take into account patients' disease experiences and their aims regarding treatments. These patients' perspectives in turn determine the clinical significance of diagnoses and therapeutic options, if patient-autonomy is taken seriously. CONCLUSIONS: A full account of evidence-based medicine needs to include experimentation and communication between physician and patient as equally important methods to attain evidence necessary to practice patient-oriented medicine. The communicative method is especially important for primary physicians as they direct patients within the medical system to have their medical problems most effectively and efficiently addressed.

American Healthways, Inc.; Johns Hopkins University

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The risk of treating friends and family
Medical Economics 2003 December 19; 80(24): 72
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Hewitt-Taylor, Jaqui
Issues involved in promoting patient autonomy in health care
British Journal of Nursing 2003 December 11-2004 January 7; 12(22): 1323-1330
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Cooper, Lisa A.; Roter, Debra L.; Johnson, Rachel L.; Ford, Daniel E.; Steinwachs, Donald M.; Powe, Neil R.
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Communicating with patients in cancer care; what areas do nurses find most challenging?
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Nursing Inquiry 2003 December; 10(4): 207-208
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Blum, John D.  
**Internet medicine and the evolving legal status of the physician-patient relationship**  
Journal of Legal Medicine 2003 December; 24(4): 413-455  
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**The communication patterns of internal medicine and family practice physicians**
Journal of the American Board of Family Practice 2003 November-December; 16(6): 485-493

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DeKeyser, Freda G.; Wruble, Anna Woloski; Margalith, Ilana
Patients voice issues of dress and address
Holistic Nursing Practice 2003 November-December; 17(6): 290-294
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Paron, Debra
When fetal defects are discovered [letter]
AJN: American Journal of Nursing 2003 November; 103(11): 14
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Tools of the trade [opinion]
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Lanier, David C.; Roland, Martin; Burstin, Helen; Knottnerus, J. Andre
Doctor performance and public accountability
Abstract: Public concern about the quality of health care has motivated governments, health-care funders, and clinicians to expand efforts to improve professional performance. In this paper, we illustrate such efforts from the perspective of three countries, the UK, the USA, and the Netherlands. The earliest strategies, which included continuing professional education, clinical audits, and peer review, were aimed at the individual doctor, and produced only modest effects. Other efforts, such as national implementation of practice guidelines, effective use of information technologies, and intensive involvement by doctors in continuous quality-improvement activities, are aimed more broadly at health-care systems. Much is yet unknown about whether these or other strategies—such as centralised supervision or regulation of quality improvement, or use of financial incentives—are effective. As demands for greater public accountability rise, continuing performance improvement efforts of each of our countries offer us opportunities to learn from one another.

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**Communicating risk: the main work of doctors [editor's choice]**
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**Patienten-zentrierte Medizin und Ethik / Patient-centered medicine and ethics**

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**Patients put their relationship with their doctors as second only to that with their families [news]**
BMJ: British Medical Journal 2003 September 13; 327(7415): 581

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Say, Rebecca E.; Thomson, Richard
**The importance of patient preferences in treatment decisions - - challenges for doctors**
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Baker, Dixie B.
Provider-patient e-mail: with benefits come risks

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van Dis, Jane
The gift
JAMWA: Journal of the American Medical Women's Association 2003 Fall; 58(4): 285-286

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Schwartz, Marlene B.; Chambliss, Heather O'Neal; Brownell, Kelly D.; Blair, Steven N.; Billington, Charles
Weight bias among health professionals specializing in obesity
Obesity Research 2003 September; 11(9): 1033-1039

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Davidson, H.; Birmingham, C. Laird
Directives in anorexia nervosa: use of the "Ulysses Agreement"
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**The promise and peril of direct-to-consumer prescription drug promotion on the Internet**
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Tauber, Alfred I.
**Sick autonomy**
Perspectives in Biology and Medicine 2003 Autumn; 46(4): 484-495
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Lyles, Alan
**Research results: balancing access with relevance for patient decisions [editorial]**
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Haddad, Amy
"Fess up" to patients?
RN 2003 September; 66(9): 27-28, 30
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Purkey, Kelly
**Standards for physicians' expert endorsements in advertisements: are the current standards adequate to protect consumers?**
Journal of Legal Medicine 2003 September; 24(3): 379-394
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Spiotta, Vickilyn Luria
**Legal concerns surrounding e-mail use in a medical practice**
JONA's Healthcare Law, Ethics, and Regulation 2003 September; 5(3): 53-59
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Surbone, Antonella; Lowenstein, Jerome

Exploring asymmetry in the relationship between patients and physicians

Journal of Clinical Ethics 2003 Fall; 14(3): 183-188

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Howe, Edmund G.

Overcoming the downside of asymmetry

Journal of Clinical Ethics 2003 Fall; 14(3): 137-151

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Altun, Insaf; Ersoy, Nermin

Undertaking the role of patient advocate: a longitudinal study of nursing students

Nursing Ethics 2003 September; 10(5): 462-471

Abstract: Patient advocacy has been claimed as a new role for professional nurses and many codes of ethics for nurses state that they act as patient advocates. Nursing education is faced with the challenge of preparing nurses for this role. In this article we describe the results of a study that considered the tendencies of a cohort of nursing students at the Kocaeli University School of Nursing to act as advocates and to respect patients' rights, and how their capacities to do so changed (or not) as a result of their nursing education. This longitudinal study used a questionnaire consisting of 10 statements relating to patient care. It was performed both at the start (1998) and at the end (2002) of the nursing training. At the beginning of their course 77 students participated; in the study. After four years, only 55 students participated, the reason for this drop in number being unknown. The questions asked nurses if patients should have: the right to receive health care; the right to participate in the decision-making process about their treatment; the right always to be told the truth; and the right to have access to their own medical records. They were also asked: if quality of life should be a criterion for discontinuing treatment; if patients have the right to die and the right to refuse treatment; if patients should be assisted to die or helped to undergo active euthanasia; and if severely disabled newborn babies should be allowed to die. The student nurses demonstrated considerable insight into contemporary nursing issues and were ready to act as patient advocates. Professional responsibility demands that good nurses advocate strongly for patients' choices.

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O'Driscoll, B. Ronan; Koch, Jan; Paschalides, Constantinos

Copying letters to patients: most patients want copies of letters from outpatient clinics and find them useful

BMJ: British Medical Journal 2003 August 23; 327(7412): 451

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Document 1428

Dale, Jenny; Tadros, George; Adams, Susan; Deshpande, Nikhila
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Abstract: The thesis of this paper is that because the significance of Western medicine lies in its ability to enhance the health of persons within a society, the practice of medicine is foremost an ethic and only thereafter a science. In support of the priority of an ethical perspective in medical practice, the paper explores the socio-cultural nature of knowledge, upon which science itself is constructed. Next, it draws from Levinas' philosophy, which illumines the problem of ontological and epistemological priority. Specifically, it examines Levinas' rendering of the human face and of language, as they found the case for the priority of justice, or ethics. Finally, the paper offers the practice of narrative discourse as one solution that elevates the status of ethics within the institution of medicine and that has the potential to counteract the tendency in medical practice to employ a universalizing methodology based in science's power to control the human Other.
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The impact of health information on the internet on the physician-patient relationship
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Abstract: BACKGROUND: Use of the Internet for health information continues to grow rapidly, but its impact on health care is unclear. Concerns include whether patients' access to large volumes of information will improve their health; whether the variable quality of the information will have a deleterious effect; the effect on health disparities; and whether the physician-patient relationship will be improved as patients become more equal partners, or be damaged if physicians have difficulty adjusting to a new role. METHODS: Telephone survey of nationally representative sample of the American public, with oversample of people in poor health. RESULTS: Of the 3209 respondents, 31% had looked for health information on the Internet in the past 12 months, 16% had found health information relevant to themselves and 8% had taken information from the Internet to their physician. Looking for information on the Internet showed a strong digital divide; however, once information had been looked for, socioeconomic factors did not predict other outcomes. Most (71%) people who took information to the physician wanted the physician's opinion, rather than a specific intervention. The effect of taking information to the physician on the physician-patient relationship was likely to be positive as long as the physician had adequate communication skills, and did not appear challenged by the patient bringing in information. CONCLUSIONS: For health information on the Internet to achieve its potential as a force for equity and patient well-being, actions are required to overcome the digital divide; assist the public in developing searching and appraisal skills; and ensure physicians have adequate communication skills.

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**Sacrifice: an ethical dimension of caring that makes suffering meaningful**

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**Abstract:** This article is intended to raise the question of whether sacrifice can be regarded as constituting a deep ethical structure in the relationship between patient and carer. The significance of sacrifice in a patient-carer relationship cannot, however, be fully understood from the standpoint of the consistently utilitarian ethic that characterizes today's ethical discourse. Deontological ethics, with its universal principles, also does not provide a suitable point of departure. Ethical recommendations and codices are important and serve as general sources of knowledge when making decisions, but they should be supplemented by an ethic that takes into consideration contextual and situational factors that make every encounter between patient and carer unique. Caring science research literature presents, on the whole, general agreement on the importance of responsibility and devotion with regard to sense of duty, warmth and genuine engagement in caring. That sacrifice may also constitute an important ethical element in the patient-carer relationship is, however, a contradictory and little considered theme. Caring literature that deals with sacrifice/self-sacrifice indicates contradictory import. It is nevertheless interesting to notice that both the negative and the positive aspects bring out importance of the concept for the professional character of caring. The tradition of ideas in medieval Christian mysticism with reference to Levinas' ethic of responsibility offers a deeper perspective in which the meaningfulness of sacrifice in the caring relationship can be sought. The theme of sacrifice is not of interest merely as a carer's ethical outlook, but sacrifice can also be understood as a potential process of transformation health. The instinctive or conscious experience of sacrifice on the part of the individual patient can, on a symbolic level, be regarded as analogous to the cultic or religious sacrifice aiming at atonement. Sacrifice appears to the patient as an act of transformation to achieve atonement and healing. Atonement then implies finding meaningfulness in one's suffering. The concept of sacrifice, understood in a novel way, opens up a deeper dimension in the understanding of suffering and makes caring in 'the patient's world' possible.

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Archives of Internal Medicine 2002 November 25; 162(21): 2458-2463

Abstract: BACKGROUND: Investigators have voiced concerns that distrust of research and the medical community impedes successful recruitment of African Americans into clinical research. OBJECTIVES: To examine possible differences in distrust by race and to determine to what extent other sociodemographic factors explain any racial differences in distrust. METHODS: We analyzed data from 527 African American and 382 white respondents of a national telephone survey on participation in clinical research. Our main outcome measure was a 7-item index of distrust. RESULTS: African American respondents were more likely than white respondents not to trust that their physicians would fully explain research participation (41.7% vs 23.4%, P<.01) and to state that they believed their physicians exposed them to unnecessary risks (45.5% vs 34.8%, P<.01). African American respondents had a significantly higher mean distrust index score than white respondents (3.1 vs 1.8, P<.01). After controlling for other sociodemographic variables in a logistic regression model, race remained strongly associated with a higher distrust score (prevalence odds ratio, 4.7; 95% confidence interval, 2.9-7.7). CONCLUSIONS: Even after controlling for markers of social class, African Americans were less trusting than white Americans. Racial differences in distrust have important implications for investigators as they engage African Americans in research.

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"How can they act like that?" Clinicians and patients as characters in each other's stories
Abstract: When clinician-patient relationships go wrong, the problem may not be merely that one person is knowingly mistreating the other. More likely, they are caught up in different stories, and animated by different moral visions. The first task in working toward a better relationship is for each to see the point of the other's story and grasp the other's vision. The task lies more heavily on the clinician because of the vulnerability of the patient.
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**Physician empathy: definition, components, measurement, and relationship to gender and specialty**
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**The modification of emotional responses: a problem for trust in nurse-patient relationships?**
Nursing Ethics 2002 September; 9(5): 465-471

**Abstract:** This article examines one aspect of the criticism of inauthenticity that can be levelled against the trustworthiness of professional relationships in general and nurse-patient relationships in particular. The overall question is: are such relationships inherently trustworthy or untrustworthy, from the patient's point of view? The author concludes that, in spite of legitimate grounds for concern, and while it remains true that nurse-patient relationships may be untrustworthy, they are not inherently so for reasons of inauthenticity relating to emotional labour. The arguments used to defend this claim take their force from the idea that different criteria may be needed to assess the authenticity of nurse-patient relationships from those used to evaluate authenticity in ordinary social relationships. The utility of Hochschild's idea of 'deep' acting, as offering a useful model for the management of emotions in nursing, is examined and rejected.

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**Patient autonomy and the challenge of clinical uncertainty**
Kennedy Institute of Ethics Journal 2002 September; 12(3): 245-264

**Abstract:** Bioethicists have articulated an ideal of shared decision making between physician and patient, but in doing so the role of clinical uncertainty has not been adequately confronted. In the face of uncertainty about the patient's prognosis and the best course of treatment, many physicians revert to a model of nondisclosure and
nondiscussion, thus closing off opportunities for shared decision making. Empirical studies suggest that physicians find it more difficult to adhere to norms of disclosure in situations where there is substantial uncertainty. They may be concerned that acknowledging their own uncertainty will undermine patient trust and create additional confusion and anxiety for the patient. We argue, in contrast, that effective disclosure will protect patient trust in the long run and that patients can manage information about uncertainty. In situations where there is substantial uncertainty, extra vigilance is required to ensure that patients are given the tools and information they need to participate in cooperative decision making about their care.

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Abstract: It is commonplace today to deplore the dissatisfaction of patients with the physician-patient relationship. Furthermore, historical investigation shows that this problem is not really new. We investigated an important source of patients' views in the 18th century, namely the letters of patients received by the famous Swiss physician, Samuel Tissot, and noted remarkably similar feelings of frustration. Yet the medical paradigms of today and of Tissot's times are considerably different. We propose that the persisting problems in the physician-patient relationship are due to a basic dissonance between the patient's ordinary modes of perception and the systematic way of perceiving reality characteristic of the physician. In addition, they reflect the unavoidable chasm between the ultimately private and singular nature of the illness experience, and the general and anonymous stance of medical theory. This chasm is therefore a permanent feature of the patient-physician relationship, predating the advent of scientific medicine, even if the latter reinforced it. In line with the current medical humanities movement, we believe that the engagement of physicians and medical students with literature and the arts helps them explore, and to some extent overcome, the existential divide between the patient's experiential self knowledge and the systematic, impersonal knowledge that plays a central role in medicine. We suggest a few examples of contemporary fiction that may be relevant and useful in this respect.
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**Epilepsy and the doctor's duty of care: ethical and legal issues**


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**Epilepsy -- a legal perspective on obligations owed to patients by medical practitioners**


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**The impact of factitious disorder on the physician-patient relationship. An epistemological model**

Medicine, Health Care and Philosophy: A European Journal 2002; 5(3): 253-261

**Abstract:** Theoretical models for physician-patient communication in clinical practice are described in literature, but none of them seems adequate for solving the communication problem in clinical practice that emerges in case of factitious disorder. Theoretical models generally imply open communication and respect for the autonomy of the patient. In factitious disorder, the physician is confronted by lies and (self)destructive behaviour of the patient, who in one way or another tries to involve the physician in this behaviour. It is no longer controversial that the physician should communicate his consideration of a factitious disorder without insistence that the patient accepts this diagnosis. However, the balance between patient autonomy and open communication on the one hand, and the preservation of the patient's health, physician integrity and of a constructive physician-patient relationship on the other is easily disrupted. In this article, an epistemological model is described to facilitate a positive outcome of confrontation in treatment of factitious disorder. Analysing the problem in terms of systems theory will help the physician to assess what information is appropriate to use in which phase of the patient's treatment, while preserving the physician-patient relationship.

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Frank, Arthur W.

**The painter and the cameraman: boundaries in clinical relationships**

Theoretical Medicine and Bioethics 2002; 23(3): 219-232

**Abstract:** The issue of boundaries in clinician-patient encounters is considered through narrative analysis of four clinical stories in which boundaries crossings are a self-conscious topic. One story is by a physician as patient, two are by physicians, and one is by a palliative care nurse. The stories are discussed using Walter Benjamin's distinction between the painter, who maintains distance and sees the whole, and the cameraman, who uses technology to penetrate realities and then reassembles fragments. The essay argues that distance and closeness are ethical issues that constitute the possibility of clinical encounters but the encounter also changes the clinician's sense of boundaries. The relevant ethics of boundary decisions in most clinical encounters are not procedural ethics but an ethics of self-creation: in orienting to boundaries as doctors do, they create themselves in their relations to others.

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**Relationships, not boundaries**
Theoretical Medicine and Bioethics 2002; 23(3): 203-217

**Abstract:** The authors find it more useful to pay attention to relationships than to boundaries. By focusing attention on bounded, individual psychological issues, the metaphor of boundaries can distract helping professionals from thinking about inequities of power. It oversimplifies a complex issue, inviting us to ignore discourses around gender, race, class, culture, and the like that support injustice, abuse, and exploitation. Making boundaries a central metaphor for ethical practice can keep us from critically examining the effects of distance, withdrawal, and non-participation. The authors describe how it is possible to examine the practical, moral, and ethical effects of our participation in relationships by focusing on just relationships rather than on boundaries. They give illustrations and clinical examples of relationally-focused ethical practices that derive from a narrative approach to therapy.

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**Boundaries in the doctor-patient relationship**
Theoretical Medicine and Bioethics 2002; 23(3): 191-201

**Abstract:** Boundaries in the doctor-patient relationship is an important concept to help health professionals navigate the complex and sometimes difficult experience between patient and doctor where intimacy and power must be balanced in the direction of benefiting patients. This paper reviews the concept of boundary violations and boundary crossings in the doctor-patient relationship, cautions about certain kinds of boundary dilemmas involving dual relationships, gift giving practices, physical contact with patients, and self-disclosure. The paper closes with some recommendations for preventing boundary violations.

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**Professionalism and boundaries**
Theoretical Medicine and Bioethics 2002; 23(3): 185-189

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**Nursing students' right to refuse to treat patients and the relationship between year of study and attitude towards patient care**
Medicine and Law 2002; 21(3): 549-566

**Abstract:** Nursing students are taught the nursing code of ethics and how to deal with ethical questions and dilemmas. After graduation, they are expected to adhere to this code, but as students do they? We examined student nurses' and their instructors' position regarding students' obligations in treating patients. In order to identify the students' perspectives towards these obligations, students and instructors were asked if a student has the right to refuse to treat a patient. A cross-sectional descriptive design was used in examining 162 academic nursing students and 16 faculty members' attitudes towards refusing to treat a patient. The results of this study indicate that significant relationships exist between clinical and ethical knowledge and the perception of obligations to ensure and protect patients' rights. Clinical and ethical knowledge are significantly related to the development of ethical conduct in nursing students.

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In the patient's best interest -- a call to action, a call to balance
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Abstract: Nurses, physicians, and other healthcare professionals often complain that a loss of freedom or other obstacles hinder their ability to act in the best interest of the patient. These barriers cause professional burnout and moral outrage, and may contribute to a migration away from medicine or, more broadly, healthcare. Understanding the historical underpinnings of the phrase "in the patient's best interest," and realizing that healthcare, which is fundamentally a moral enterprise must be built on sound business principles can help healthcare professionals reframe the issue, and reclaim their original commitment to a difficult path.

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Moral distress or moral comfort
Bioethics Forum 2002; 18(1-2): 7-14

Abstract: Moral distress in healthcare results from a professional's inability to provide compassionate care to patients because of individual, or societal barriers. Research suggests that moral distress is a growing concern among nurses, and may be a major reason why nurses leave one job for another or abandon the profession of nursing. Some professionals, however, have identified strategies that help them work though [sic] their moral distress toward an experience of moral comfort. These strategies may be individual, organization, or societal. The focus of this paper is to identify examples of strategies professionals have used to alleviate distressful feelings and enhance moral comfort.

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