EthxWeb Search Results

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Documents: 1 - 325 of 727

Document 1
Gianakos, Dean
Breaking bad news: what poetry has to say about it.
The Pharos of Alpha Omega Alpha Honor Medical Society. Alpha Omega Alpha 2011 Winter; 74(1): 24-6
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Document 2
Skipper, Eric R; Accola, Kevin D; Sade, Robert M
Must surgeons tell mitral valve repair candidates about a new percutaneous repair device that is only available elsewhere?
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Document 3
Vess, James
Ethical practice in sex offender assessment: consideration of actuarial and polygraph methods.
Sexual abuse: a journal of research and treatment 2011 Sep; 23(3): 381-96
Abstract: The current generation of community protection laws represents a shift in priorities that may see the individual rights of sex offenders compromised for the goal of public safety. At the center of many judicial decisions under these laws are the risk assessment reports provided by mental health practitioners. The widespread enactment of laws allowing for additional sanctions for sex offenders, and a burgeoning research literature regarding the methods used to assess risk have served to heighten rather than resolve the ethical concerns associated with professional practice in this area. This article examines ethical issues inherent in the use of two assessment methods commonly used with sex offenders in the correctional context, focusing on actuarial measures and polygraph tests. Properly conducted and adequately reported actuarial findings are considered to provide useful information of sufficient accuracy to inform rather than mislead judicial decision makers, although careful consideration must be given to the limitations of current measures in each individual case. Despite its increasing use, polygraph testing is considered controversial, with little consensus regarding its accuracy or appropriate applications. On the basis of the current state of the professional literature regarding the polygraph, its use with sex offenders raises unresolved ethical concerns.
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Document 4
Chaffin, Mark
The case of juvenile polygraphy as a clinical ethics dilemma.
Sexual abuse: a journal of research and treatment 2011 Sep; 23(3): 314-28
Abstract: Polygraph interrogations are used by half of all surveyed juvenile sex offender (JSO) treatment programs in the United States. This is a distinctive and controversial practice that is rarely if ever used with other juvenile delinquent populations, and that is rarely used or is banned from JSO treatment programs in other countries. Clinical polygraphy is an ethically sensitive issue because it involves mental health therapists in involuntary coercive interrogations of minors. This article reviews core mental health professional ethics principles for juveniles. JSO polygraphy is used as an illustrative issue for applying human rights principles to a practice in light of its benefits, risks, and available alternatives.

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Document 5
Grant-Kels, Jane M; Kels, Barry D
The empty specimen bottle: legal, moral, and ethical considerations for the dermatologist and dermatopathologist.
Journal of the American Academy of Dermatology 2011 Sep; 65(3): 621-3

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Document 6
Robeznieks, Andis
‘Disclosure optional’. Financial conflict rule not strong enough, many say.
Modern healthcare 2011 Aug 29; 41(35): 14

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Document 7
Wang, Dian-can; Guo, Chuan-bin; Peng, Xin; Su, Yan-jie; Chen, Fan
Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer 2011 Aug; 19(8): 1191-5

Abstract: The objectives are to study cancer patients’ awareness of their diagnosis and to determine who tends to disclose bad news to cancer patients.

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Document 8
Lo, Gin-Ho
The ethics of placebo treatment for patients with acute exacerbation of chronic hepatitis B.
Hepatology (Baltimore, Md.) 2011 Aug; 54(2): 740; author reply 741-2

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Document 9
Kupferschmidt, Kai
More placebo use promoted in Germany.
CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne 2011 Jul 12; 183(10): E633-4
Document 10
Enck, Paul; Klosterhalfen, Sibylle; Weimer, Katja; Horing, Björn; Zipfel, Stephan

The placebo response in clinical trials: more questions than answers.
Philosophical transactions of the Royal Society of London. Series B, Biological sciences 2011 Jun 27; 366(1572): 1889-95

Abstract: Meta-analyses and re-analyses of trial data have not been able to answer some of the essential questions that would allow prediction of placebo responses in clinical trials. We will confront these questions with current empirical evidence. The most important question asks whether the placebo response rates in the drug arm and in the placebo arm are equal. This "additive model" is a general assumption in almost all placebo-controlled drug trials but has rarely been tested. Secondly, we would like to address whether the placebo response is a function of the likelihood of receiving drug/placebo. Evidence suggests that the number of study arms in a trial may determine the size of the placebo and the drug response. Thirdly, we ask what the size of the placebo response is in 'comparator' studies with a direct comparison of a (novel) drug against another drug. Meta-analytic and experimental evidence suggests that comparator studies may produce higher placebo response rates when compared with placebo-controlled trials. Finally, we address the placebo response rate outside the laboratory and outside of trials in clinical routine. This question poses a serious challenge whether the drug response in trials can be taken as evidence of drug effects in clinical routine.

Document 11
Linde, Klaus; Fässler, Margrit; Meissner, Karin

Placebo interventions, placebo effects and clinical practice.

Abstract: This article reviews the role of placebo interventions and placebo effects in clinical practice. We first describe the relevance of different perspectives among scientists, physicians and patients on what is considered a placebo intervention in clinical practice. We then summarize how placebo effects have been investigated in randomized controlled trials under the questionable premise that such effects are produced by placebo interventions. We further discuss why a shift of focus from the placebo intervention to the overall therapeutic context is necessary and what research methods can be used for the clinical investigation of the relevance of context effects. In the last part of the manuscript, we discuss why placebo or context effects are seen as positive in clinical practice when they are associated with active treatments, while placebo interventions pose major ethical and professional problems and have to be avoided.

Document 12
Everett, Jo P; Walters, Clifford A; Stottlemyer, Debra L; Knight, Curtis A; Oppenberg, Andrew A; Orr, Robert D

To lie or not to lie: resident physician attitudes about the use of deception in clinical practice.

Abstract: Physicians face competing values of truth-telling and beneficence when deception may be employed in patient care. The purposes of this study were to assess resident physicians' attitudes towards lying, explore lie types and reported reasons for lying.
A survey of disclosure of diagnosis to patients with glioma in Japan.

Abstract: There have been few studies investigating neuro-oncologists' attitudes toward the disclosure of the diagnosis. This study aimed to determine the current status of disclosure to glioma patients in Japan and to analyze the factors associated with disclosure.

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Baumrucker, Steven J; Stolick, Matt; Mingle, Paige; Vandekieft, Gregg; Morris, Gerald M; Harrington, Dianne; Oertli, Karrie A

Placebo: medicine or deception?


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Leka, Niko

Truth telling dilemma.


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Yuji, Koichiro; Narimatsu, Hiroto; Tanimoto, Tetsuya; Komatsu, Tsune; Kami, Masahiro

Sharing information on adverse events.

Lancet 2011 May 14; 377(9778): 1654

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Vail, Laura; Sandhu, Harbinder; Fisher, Joanne; Cooke, Heather; Dale, Jeremy; Barnet, Mandy

Hospital consultants breaking bad news with simulated patients: an analysis of communication using the Roter Interaction Analysis System.

Patient education and counseling 2011 May; 83(2): 185-94

Abstract: To explore how experienced clinicians from wide ranging specialities deliver bad news, and to investigate the relationship between physician characteristics and patient centredness.

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Tieying, Zeng; Haishan, Huang; Meizhen, Zhao; Yan, Li; Pengqian, Fang

Health professionals' attitude towards information disclosure to cancer patients in China.

Nursing ethics 2011 May; 18(3): 356-63

Abstract: A self-designed questionnaire was given to 634 health professionals in a large teaching hospital in Hubei Province in mainland China, to clarify the participants’ attitude towards information disclosure to cancer patients. Statistic description was used to analyze the data. The item 'inappropriate information about cancer easily leads to
medical disputes' scored highest at 3.86, while the scores of such items as 'advantages of fully informing patients outweigh disadvantages', 'if their family members demand nondisclosure, you will find it difficult to cooperate in good faith with patients', and 'telling white lies to patients disturbs you a lot' were less than 3. The health care staff placed a high value on both the desire and priority of patients to know the truth, though most of them did not think that patients had received enough information about their disease. In order to improve cancer patients' current state of knowledge, health professionals should learn more about informed consent, and special methods and guidelines compatible with Chinese culture are urgently required in China.

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Document 19

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

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Document 20

Bayley, Carol
Case study. To tell or not to tell. Commentary.
The Hastings Center report 2011 May-Jun; 41(3): 16

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Document 21

Kirsch, Irving
The use of placebos in clinical trials and clinical practice.

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Document 22

Shorter, Edward
A brief history of placebos and clinical trials in psychiatry.

Abstract: The history of placebos in psychiatry can be understood only in the context of randomized controlled trials (RCTs). Placebo treatments are as old as medicine itself, and are particularly effective in dealing with psychosomatic symptoms. In psychiatry, placebos have mainly been featured in clinical drug trials. The earliest controlled trial in psychiatry (not involving drugs) occurred in 1922, followed by the first crossover studies during the 1930s. Meanwhile the concept of randomization was developed during the interwar years by British statistician Ronald A Fisher, and introduced in 3 trials of tuberculosis drugs between 1947 and 1951. These classic studies established the RCT as the gold standard in pharmaceutical trials, and its status was cemented during the mid-1950s. Nevertheless, while the placebo became established as a standard measure of drug action, placebo treatments became stigmatized as unethical. This is unfortunate, as they constitute one of the most powerful therapies in psychiatry. In recent years, moreover, the dogma of the placebo-controlled trial as the only acceptable data for drug licensing is also being increasingly discredited. This backlash has had 2 sources: one is the recognition that the US Food and Drug Administration has been too lax in permitting trials controlled with placebos alone, rather than also using an active agent as a test of comparative efficacy. In addition, there is evidence that in the hands of the pharmaceutical industry, the scientific integrity of RCTs themselves has been degraded into a marketing device. The once-powerful placebo is thus threatened with extinction.

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Document 23
Raz, Amir; Campbell, Natasha; Guindi, Daniella; Holcroft, Christina; Déry, Catherine; Cukier, Olivia
**Placebos in clinical practice: comparing attitudes, beliefs, and patterns of use between academic psychiatrists and nonpsychiatrists.**
Canadian journal of psychiatry. Revue canadienne de psychiatrie 2011 Apr; 56(4): 198-208

**Abstract:** Controversial and ethically tenuous, the use of placebos is central to medicine but even more pivotal to psychosocial therapies. Scholars, researchers, and practitioners largely disagree about the conceptualization of placebos. While different professionals often confound the meanings of placebo effects with placebo responses, physicians continue to prescribe placebos as part of clinical practice. Our study aims to review attitudes and beliefs concerning placebos outside of clinical research. Herein we compare patterns of placebo use reported by academic psychiatrists with those reported by physicians from different specialties across Canadian medical schools. Using a web-based tool, we circulated an online survey to all 17 Canadian medical schools, with a special emphasis on psychiatry departments therein and in university-affiliated teaching hospitals. A variation on earlier efforts, our 5-minute, 21-question survey was anonymous. Among the 606 respondents who completed our online survey, 257 were psychiatrists. Our analysis revealed that psychiatrists prescribed significantly more subtherapeutic doses of medication than physicians in other specialties, although about 20% of both psychiatrists and nonpsychiatrists prescribed placebos regularly as part of routine clinical practice. However, compared with 6% of nonpsychiatrists, only 2% of psychiatrists deemed placebos of no clinical benefit. In addition, more than 60% of psychiatrists either agreed or strongly agreed that placebos had therapeutic effects relative to fewer than 45% of other practitioners. Findings from this pan-Canadian survey suggest that, compared with other physicians, psychiatrists seem to better value the influence placebos wield on the mind and body and maintain more favourable beliefs and attitudes toward placebo phenomena.

Document 24
Vegni, Elena; Leone, Daniela; Canevini, Maria Paola; Tinuper, Paolo; Moja, Egidio Aldo
**Sudden unexpected death in epilepsy (SUDEP): a pilot study on truth telling among Italian epileptologists.**

**Abstract:** Sudden unexpected death in epilepsy (SUDEP) is a syndrome where a person with epilepsy dies suddenly and no other cause of death is found. The question of informing patients and their families about SUDEP remains a problematic issue. The aim of this study is to explore whether Italian physicians interested in epilepsy believe that they should discuss SUDEP with patients and/or their families. A total of 315 questionnaires were distributed, of which 195 (61.9%) were returned. Seventeen respondents (8.76%) discussed SUDEP with all of their patients, 38 (19.59%) with the majority of patients, 120 (61.85%) with very few of their patients and 15 (7.73%) with none of their patients. No statistical differences among groups were found for gender, professional age (≤ 10 years; 11 years ≤ 20 years; 21 years ≤ 30 years; > 31 years) and medical specialty (neurologists vs. others). Open questions offered insights into the physicians' problem of managing the negative emotions of patients/family and why the physicians decided to give information.

Document 25
Almond, Cathy
**Right to choose.**
Australian nursing journal (July 1993) 2011 Apr; 18(9): 3
**Document 26**

Schildmann, J; Schwarz, C; Schildmann, E; Klambeck, A; Ortwein, H; Vollmann, J

"Truth at the bedside". = "Wahrheit am Krankenbett"

Deutsche medizinische Wochenschrift (1946) 2011 Apr; 136(15): 757-61

**Abstract:** BACKGROUND AND RESEARCH QUESTION: Discussions with seriously ill patients are part of physicians’ tasks. These discussions are very demanding with respect to communication skills. In this paper we present the concept of an obligatory postgraduate course for physicians on breaking bad news and the results of the course evaluation. RESEARCH PARTICIPANTS AND METHODS: Physicians of 4 German hospitals in which the module was offered as an obligatory inhouse course. An interventional study without control group was carried out in which a questionnaire (closed-ended questions and Likert scales as well as open-ended questions) was distributed before and immediately after the course. RESULTS: 186 physicians (response rate: 88.6 %) participated in the study. 102 respondents (54.8 %) had broken bad news more than five times per month. 75 physicians (40.3 %) indicated that they had never participated in a teaching module on this topic prior to the course. Discussions about the end of life and disclosure about recurrence of the disease were rated most frequently as very difficult communication situations. Compared with the beginning of the course the respondents rated their communication skills significantly better at the end of the course. The course's relevance for clinical practice, teaching methods and the organisation of the course were rated positively. CONCLUSION: The feedback of the participants indicates the practical relevance of professional training on difficult communication situations such as breaking bad news. The improved rating of communication skills may be interpreted as a positive effect of the course. In our view, observational studies as well as interprofessional teaching modules contribute to improved professional communication with patients about diagnosis, prognosis and treatment options.

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**Document 27**

Abdulhameed, Hunida E.; Hammami, Muhammad M.; Mohamed, Elbushra A. Hameed

Disclosure of terminal illness to patients and families: diversity of governing codes in 14 Islamic countries


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[http://jme.bmj.com/content/early/2011/03/22/jme.2010.038497.full.pdf](http://jme.bmj.com/content/early/2011/03/22/jme.2010.038497.full.pdf) (link may be outdated)

**Document 28**

Austin, Juliana; Tamar-Mattis, Anne; Mazur, Tom; Henwood, Maria J; Rossi, Wilma C

Disorders of sex development-when and how to tell the patient.

Pediatric endocrinology reviews : PER 2011 Mar; 8(3): 213-7; quiz 223

**Abstract:** Physicians and other providers are often confronted with difficult decisions in the area of disclosure. This article examines a hypothetical situation relevant to the practice of pediatric endocrinology. The parents of a child with a disorder of sex development (DSD) wish the physician to treat their child, but without revealing key medical information to the child. Herein, we will explore the legal and ethical responsibilities of a provider to disclose information to an under-age DSD patient and to provide insight on when and how to tell the patient.

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**Document 29**

Johnston, Donna L; Appleby, Wendy

Pediatric oncologists opinions on breaking bad news.

Pediatric blood & cancer 2011 Mar; 56(3): 506

Georgetown users check **Georgetown Journal Finder** for access to full text
Department of Veterans Affairs

Disclosure of medical information to the surrogate of a patient who lacks decision-making capacity. Final rule.

Federal register 2011 Feb 8; 76(26): 6694-6

Abstract: This document amends Department of Veterans Affairs (VA) regulations to reflect changes made by section 504 of the Caregivers and Veterans Omnibus Health Services Act of 2010. Section 504 authorizes a VA practitioner, when the practitioner deems it necessary to ensure an informed medical decision, to share certain, otherwise protected medical information with the representative of a patient who lacks decision-making capacity. This rulemaking amends VA regulations consistent with this new authority.

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Wienke, A

[New Obligations to Inform at not Curative Performances for Doctors and Hospitals]. = Neue Informationspflichten bei nicht kurativen Leistungen ab dem 12.05.2010 für Ärzte und Krankenhäuser.
Laryngo-rhino-otologie 2011 Feb; 90(2): 102

Georgetown users check Georgetown Journal Finder for access to full text

Black, Beth Perry

Truth telling and severe fetal diagnosis: a virtue ethics perspective.

Abstract: Increased use of prenatal technologies has increased the numbers of women and partners whose fetus is diagnosed with a severe impairment. Virtue ethics provides a useful perspective to consider truth telling in this context, specifically how couples and providers interpret the diagnosis and prognosis to create truth. Virtue ethics is person-centered rather than act-centered, with moral actions guided by how a virtuous person would act in the same circumstance. Phronesis (practical wisdom) guides these actions.

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Hemick, Ann D; Brown, M Kathryn; Pinney, Susan M; Biro, Frank M; Ball, Kathleen M; Bomschein, Robert L

Sharing unexpected biomarker results with study participants.

Abstract: The Breast Cancer and the Environment Research Centers (BCERCs) include collaborators from basic sciences, epidemiology, and the community, conducting studies to investigate whether environmental exposures are associated with the timing of puberty. A pilot study of a subset of the study participants assessed the feasibility of measuring selected biomarkers of exposure in blood and urine in girls 6-8 years of age. In the Greater Cincinnati study population, we found an elevated serum concentration of perfluorooctanoate (PFOA) among > 90% of young girls living in a small community.

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Blease, Charlotte
Deception as treatment: the case of depression.

**Abstract:** Is it ever right to prescribe placebos to patients in clinical practice? The General Medical Council is ambivalent about the issue; the American Medical Association asserts that placebos can be administered only if the patient is (somehow) 'informed'. The potential problem with placebos is that they may involve deception: indeed, if this is the case, an ethical tension arises over the patient's autonomy and the physician's requirement to be open and honest, and the notion that medical care should be the primary concern. This paper examines the case of depression as an entry point for understanding the complexities of the prescription of placebos. Recent important meta-analyses of antidepressants claim that they are not significantly more effective in a clinical setting than placebos. Given that antidepressants have numerous adverse side effects and are hugely expensive, this provocative research has serious potential ethical and practical implications for patients and medical providers. Should placebos be prescribed in place of antidepressants? The case of depression highlights another important issue which medical ethical codes have hitherto overlooked: well-being is not synonymous with being realistic about oneself, one's circumstances and the future. While severely depressed individuals are unduly pessimistic about themselves and the world around them, treatment of depressed individuals can be deemed successful when patients have successfully attained those positive illusions that are indicative of psychological health. This is exactly what successful psychological treatments of depression seem to achieve. It is therefore possible that there may be a limited unavoidable role for deception in medicine.

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Document 35

Justman, Stewart

**From medicine to psychotherapy: the placebo effect.**

History of the human sciences 2011; 24(1): 95-107

**Abstract:** If placebos have been squeezed out of medicine to the point where their official place in in clinical trials designed to identify their own confounding effect, the placebo effect nevertheless thrives in psychotherapy. Not only does psychotherapy dispose of placebo effects that are less available to medicine as it becomes increasingly technological and preoccupied with body parts, but factors of the sort inhibiting the use of placebos in medicine have no equivalent in psychology. Medicine today is disturbed by the placebo effect in a way psychotherapy is not. Psychotherapy does not have to grapple with such a disconcerting paradox as successful sham surgery, and unlike those physicians who once pretended to treat the patient's body while actually attempting to treat the mind, the psychotherapist can treat the mind in all frankness. Perhaps it is because psychotherapy is less burdened by doubts about the placebo effect that it was able to come to its aid when it was orphaned by medicine. It is vain to expect something with so long a history as the placebo effect to disappear from the practices of healing.

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Document 36

Schofield, Peter; Butler, Tony; Hollis, Stephanie; D'Este, Catherine

**Are prisoners reliable survey respondents? A validation of self-reported traumatic brain injury (TBI) against hospital medical records.**


**Abstract:** To compare prisoners' self-reported history of TBI associated with hospital attendance with details extracted from relevant hospital medical records and to identify factors associated with the level of agreement between the two sources.

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Document 37

Fässler, M

**[Placebo interventions in medical practice]. = Placebointerventionen in der medizinischen Praxis.**

Praxis 2010 Dec 1; 99(24): 1495-501
Abstract: Surveys of physicians showed that they use placebo interventions with different intentions in practice. The ongoing debate whether this is ethically acceptable requires to engage in this topic. More and more results from research have shown that placebo or contextual effects can be clinically relevant. It is worthwhile to think about the utilization of these effects for patients. For that purpose there are no ready-made solutions. Every physician has to decide for his or her own self whether and which therapy with doubtful specific efficacy he or she uses. This article may assist physicians to deal with this topic and to find an own well-grounded position.

Dickens, Bernard

Disclosing adverse outcomes in medical care: FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health.


Helmchen, Lorens A; Richards, Michael R; McDonald, Timothy B

How does routine disclosure of medical error affect patients' propensity to sue and their assessment of provider quality? Evidence from survey data.

Medical care 2010 Nov; 48(11): 955-61

Abstract: Although strongly favored by patients and ethically imperative for providers, the disclosure of medical errors to patients remains rare because providers fear that it will trigger lawsuits and jeopardize their reputation. To date little is known how patients might respond to their providers' disclosure of a medical error even when paired with an offer of remediation.

Kermen, Rachel; Hickner, John; Brody, Howard; Hasham, Irma

Family physicians believe the placebo effect is therapeutic but often use real drugs as placebos.

Family medicine 2010 Oct; 42(9): 636-42

Abstract: Few national data exist on physicians' use of and beliefs about placebos in routine health care.

Coffey, Maitreya; Thomson, Kelly; Tallett, Susan; Matlow, Anne

Pediatric residents' decision-making around disclosing and reporting adverse events: the importance of social context.

Academic medicine : journal of the Association of American Medical Colleges 2010 Oct; 85(10): 1619-25

Abstract: Although experts advise disclosing medical errors to patients, individual physicians' different levels of knowledge and comfort suggest a gap between recommendations and practice. This study explored pediatric residents' knowledge and attitudes about disclosure.
Document 42

Dudzinski, Denise M; Hébert, Philip C; Foglia, Mary Beth; Gallagher, Thomas H

The disclosure dilemma—large-scale adverse events.
The New England journal of medicine 2010 Sep 2; 363(10): 978-86

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Document 43

Shahidi, J

Not telling the truth: circumstances leading to concealment of diagnosis and prognosis from cancer patients.
European journal of cancer care 2010 Sep; 19(5): 589-93

Abstract: While autonomy has gradually become a key concept in the doctor-patient relationship, truth-telling is far from being the norm in many countries in the world. Despite the general agreement on the benefits of open communication between physicians and cancer patients, there is still strong resistance against disclosure of cancer diagnosis and prognosis in many cultures. Although fear of causing psychological morbidity to patients and their reluctance to find out the truth are two main justifications of non-disclosure attitudes, there are other important contributing factors that need to be further explored and better understood including those related to the relatives, doctors and healthcare systems. Cultural disparities in attitudes towards truth-telling persist; however, these differences should not be used as excuses not to respect the rights and individual preferences of cancer patients by making assumptions based on their age, sex, type of cancer, language and/or cultural background.

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Document 44

Stark, Laura

Journal of the history of the behavioral sciences 2010 Fall; 46(4): 337-70

Abstract: This paper has two aims. The first is to shed light on a remarkable archival source, namely survey responses from thousands of American psychologists during the 1960s in which they described their contemporary research practices and discussed whether the practices were "ethical." The second aim is to examine the process through which the American Psychological Association (APA) used these survey responses to create principles on how psychologists should treat human subjects. The paper focuses on debates over whether "deception" research was acceptable. It documents how members of the committee that wrote the principles refereed what was, in fact, a disagreement between two contemporary research orientations. The paper argues that the ethics committee ultimately built the model of "the resilient self" into the APA's 1973 ethics code. At the broadest level, the paper explores how prevailing understandings of human nature are written into seemingly universal and timeless codes of ethics.

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Document 45

Turner, Cori C; Phillips, Megan C

New patient disclosure requirements for physician offices providing MRI, CT & PET imaging services.
Missouri medicine 2010 Sep-Oct; 107(5): 295-7

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Document 46

Fontana, Marian
Communicating disclosure risk in informed consent statements.

Singer, Eleanor; Couper, Mick P
Journal of empirical research on human research ethics : JERHRE 2010 Sep; 5(3): 1-8

Abstract: For several years, we have experimented with various ways of communicating disclosure risk and harm to respondents in order to determine how these affect their willingness to participate in surveys. These experiments, which used vignettes administered to an online panel as well as a mail survey sent to a national probability sample, have demonstrated that (a) the probability of disclosure alone has no apparent effect on people's willingness to participate in the survey described, (b) the sensitivity of the survey topic has such an effect, and (c) making explicit the possible harms that might result from disclosure also reduces willingness to participate, in both the vignette and the mail experiments. As a last study in this series, we experimented with different ways of describing disclosure risk in informed consent statements that might more plausibly be used in real surveys, again using vignettes administered to an online panel. As suggested by our earlier work, we found that the precise wording of the confidentiality assurance had little effect on respondents' stated willingness to participate in the hypothetical survey described. However, the experimental manipulations did have some effect on perceptions of the risks and benefits of participation, suggesting that they are processed by respondents. And, as we have found in our previous studies, the topic of the survey has a consistent and statistically significant effect on stated willingness to participate. We explore some implications of these findings for researchers seeking to provide adequate information to potential survey respondents without alarming them unnecessarily.

Ethical issues of diagnosis disclosure and treatment in patients with genital or breast cancer.

Primo, Walquiria Quida Salles Pereira; Garrafa, Volnei

Abstract: To verify how communication between physicians and patients takes place during diagnosis, treatment and prognosis of women with genital or breast cancer, using bioethics as a reference for analysis.

Multidimensional results reporting to participants in genomic studies: getting it right.

Kohane, Isaac S; Taylor, Patrick L
Science translational medicine 2010 Jun 23; 2(37): 37cm19

Abstract: Recent surveys about participation in cohort studies reconfirm that participants value and desire the return of research results to a degree that is out of step with the restrictive recommendations of various ethics advisory
groups, which have historically limited disclosure based on clinician value judgments and the severity and treatability of the disease in question, among other factors. Rather than framing the current inconclusive ethics discussion as a standstill among competing ethical principles and their potential applicability, we introduce a new element, communicability (that is, those properties of a message that will determine how likely it is that its informational intent will be grasped by the study participant), as the subject of empirical research to align participants' goals with beneficent and responsible results reporting. Structural changes in research design, combined with governance changes in assessing impact, allow us to move beyond a binary construction of report/do not report and to create a structure in which the communicability of the message and the participants' preferences are variables in a function that affects results reporting. Here we illustrate this structure and its principles.

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**Document 51**

Waz, Wayne R.

**The need to know: disclosure of information on pediatric patients**

Ethics & Medicine 2010 Summer; 26(2): 75-80

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**Document 52**

Richard, Claude; Lajeunesse, Yvette; Lussier, Marie-Thérèse

**Therapeutic privilege: between the ethics of lying and the practice of truth.**


*Abstract:* The 'right to the truth' involves disclosing all the pertinent facts to a patient so that an informed decision can be made. However, this concept of a 'right to the truth' entails certain ambiguities, especially since it is difficult to apply the concept in medical practice based mainly on current evidence-based data that are probabilistic in nature. Furthermore, in some situations, the doctor is confronted with a moral dilemma, caught between the necessity to inform the patient (principle of autonomy) and the desire to ensure the patient's well-being by minimising suffering (principle of beneficence). To comply with the principle of beneficence as well as the principle of non-maleficence 'to do no harm', the doctor may then feel obliged to turn to 'therapeutic privilege', using lies or deception to preserve the patient's hope, and psychological and moral integrity, as well as his self-image and dignity. There is no easy answer to such a moral dilemma. This article will propose a process that can fit into reflective practice, allowing the doctor to decide if the use of therapeutic privilege is justified when he is faced with these kinds of conflicting circumstances. We will present the conflict arising in practice in the context of the various theoretical orientations in ethics, and then we will suggest an approach for a 'practice of truth'. Last, we will situate this reflective method in the broader clinical context of medical practice viewed as a dialogic process.

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**Document 53**

Kakizaki, Hiroshi; Kurota, Yuta; Sibasaki, Tomohiro; Nakano, Yuko; Kaneko, Hisashi; Hosoya, Noriyuki; Sakurai, Toshihiko; Naito, Sei; Muto, Akinori; Kato, Tomoyuki; Tomita, Yoshihiko

**[Fourteen-year attitude survey on cancer disclosure to new outpatients of urology department]**

Nippon Hinyokika Gakkai zasshi. The japanese journal of urology 2010 May ; 101(4): 585-91

*Abstract:* PURPOSE: To investigate if timing of first visit, ages, sex, family history of cancer, and smoking history would cause any differences in patients' attitude toward cancer disclosure. SUBJECTS AND METHODS: Subjects were 10,552 patients who first visited Urology Department of Nihonkai Hospital between 1993 and 2007, and were asked to fill in the questionnaire. The questionnaire contents are as follows: "If you were diagnosed as having cancer, would you like to be informed about the diagnosis of your disease?", and "If your families were diagnosed as having cancer, would you like to inform them about the diagnosis of their disease?". The subjects were asked to select their answers from the following options: (1) "fully informed", (2) "informed only when it is curable", (3) "not informed", and (4) "can not decide now". The relation of patients' attitude toward cancer disclosure with the timing of first visit, ages, sex, family history of cancer, and smoking history was investigated. RESULTS: The response rate
was approximately 80%. If the subjects would have cancer, 71.5% preferred to be informed ("fully informed" or "informed if it is curable"), and 9.2% did not. If the subjects' family would have cancer, 55.5% preferred their family to be informed ("fully informed" or "informed if it is curable"), and 14.9% did not. As it became more recent, both the rate of subjects who did not prefer to be informed (11.5% in 1993-1995, and 8.0% in 2005-2007) and the rate of those who did not prefer their family to be informed (18.6% in 1993-1995, and 11.0% in 2005-2007) decreased. Young subjects, men, and smokers more preferred to be informed. The subjects who had family history of cancer more preferred to inform them, but less to inform their family. CONCLUSIONS: As it became more recent, both the subjects who did not prefer to be informed and those who did not prefer their family to be informed decreased. The idea that cancer disclosure was necessary to select the treatment methods based on each patient's preference and decision had been pervasive.

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**Brown, Samuel**

**Distinguishing messenger from message in delivering bad news.**

American journal of respiratory and critical care medicine 2010 Apr 15; 181(8): 873; author reply 873-4

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**Document 55**

**Kazdaglis, G A; Amaoutoglou, C; Karypidis, D; Memekidou, G; Spanos, G; Papadopoulos, O**

**Disclosing the truth to terminal cancer patients: a discussion of ethical and cultural issues.**


**Abstract:** One of the most difficult ethical dilemmas facing health care professionals working in oncology is whether, when, how and how much to tell terminal cancer patients about their diagnosis and prognosis. The aim of this article is to review the trends in this issue worldwide. While a majority of physicians in both developed and developing countries tell the truth more often today than in the past, the assumption that truth-telling is always beneficial to patients can be questioned. The issue of truth-telling is still approached differently in different countries and cultures and there is a need for an increased awareness of cultural differences to truth-telling among patients from ethnic minorities.

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**Document 56**

**Kazdaglis, G.A.; Amaoutoglou, C.; Karypidis, D.; Memekidou, G.; Spanos, G.; Papadopoulos**

**Disclosing the truth to terminal cancer patients: a discussion of ethical and cultural issues**


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[http://www.emro.who.int/](http://www.emro.who.int/) (link may be outdated)

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**Document 57**

**Knifed, Eva; Goyal, Aunshu; Bernstein, Mark**

**Moral angst for surgical residents: a qualitative study.**

American Journal of Surgery 2010 April; 199(4): 571-576

**Abstract:** BACKGROUND: The ethical dilemmas that residents experience throughout their training have not been explored qualitatively from surgical residents' perspectives. METHODS: Grounded theory methodology was used. All
University of Toronto surgical, otolaryngology, and obstetrics and gynecology residents were invited to participate. Twenty-eight face-to-face interviews were conducted. Interviews were transcribed and analyzed by 3 reviewers.

**RESULTS:** Five encompassing themes emerged: (1) residents prefer operating with another resident while the staff watches; (2) residents felt that patients were rarely well informed about their role; (3) residents develop good relationships with patients; (4) residents felt ethically obliged to disclose intraoperative errors; and (5) residents experience ethical distress in certain teaching circumstances. **CONCLUSIONS:** Residents encounter ethical dilemmas leading to moral angst during their surgical training and need to feel safe to discuss these openly. Staff and residents should work together to establish optimal communication and teaching situations.

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Lynch, Thomas G.

**Editorial comment: regarding "Moral angst for surgical residents: a qualitative study".**

American Journal of Surgery 2010 April; 199(4): 577-579

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**Document 59**

Guven, Tolga

**Truth-telling in cancer: examining the cultural incompatibility argument in Turkey.**

Nursing Ethics 2010 March;17(2): 159-166

**Abstract:** This article aims to examine critically the 'cultural incompatibility' argument, which asserts that disclosure of cancer-related information to patients is incompatible with Turkey's cultural context. For this purpose, a brief overview of the approach to truth-telling in Turkey will first be provided, followed by the claims of two different Turkish authors on the issue and a critical analysis of their approach. It will be contended that this argument has actually been formulated with paternalistic concerns and it may be playing an important role in shaping the approach of Turkish health care professionals to the issue. The article will then examine, in the light of study findings and case reports from Turkey, the concept of patient autonomy as it applies to truth-telling issues. It will be concluded that truth-telling can be compatible with Turkey's cultural context, provided that health care professionals place more emphasis on good communication with their patients.

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Epstein, Ronald M.; Korones, David N.; Quill, Timothy E.

**Withholding information from patients -- when less is more [commentary]**


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**Document 61**

Blinderman, Craig D.

**Opioids, iatrogenic harm and disclosure of medical error.**

Abstract: The safety of patients in U.S. hospitals is a serious problem, with adverse events because of medical error affecting a significant proportion of hospitalized patients. Patients at the end of life are particularly vulnerable and are at risk of potential adverse events. This article presents a case in which opioids were rapidly titrated to neurotoxic doses in a patient who was terminally extubated. The patient was profoundly sedated and was noted to have Cheyne-Stokes breathing. The possibility of opioid-related iatrogenic harm is raised, and a discussion of what counts as medical error in these circumstances is explored. Palliative care specialists have a unique responsibility to provide guidance and establish a standard of care that clinicians should adhere to. Prevention of harm in dying patients should be a priority in the hospital setting.

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Grady, Denise
Facing end-of-life talks, doctors choose to wait
New York Times 2010 January 12; p. D1, D6

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Singer, Natasha
Is 'sorry' the hardest word in health care?
New York Times 2010 January 10; p. BU 4

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

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Karim, Ahmed A; Schneider, Markus; Lotze, Martin; Veit, Ralf; Sauseng, Paul; Braun, Christoph; Birbaumer, Niels
The truth about lying: inhibition of the anterior prefrontal cortex improves deceptive behavior.

Abstract: Recent neuroimaging studies have indicated a predominant role of the anterior prefrontal cortex (aPFC) in deception and moral cognition, yet the functional contribution of the aPFC to deceptive behavior remains unknown. We hypothesized that modulating the excitability of the aPFC by transcranial direct current stimulation (tDCS) could reveal its functional contribution in generating deceitful responses. Forty-four healthy volunteers participated in a thief role-play in which they were supposed to steal money and then to attend an interrogation with the Guilty Knowledge Test. During the interrogation, participants received cathodal, anodal, or sham tDCS. Remarkably, inhibition of the aPFC by cathodal tDCS did not lead to an impairment of deceptive behavior but rather to a significant improvement. This effect manifested in faster reaction times in telling lies, but not in telling the truth, a decrease in sympathetic skin-conductance response and feelings of guilt while deceiving the interrogator and a significantly higher lying quotient reflecting skillful lying. Increasing the excitability of the aPFC by anodal tDCS did not affect deceptive behavior, confirming the specificity of the stimulation polarity. These findings give causal support to recent correlative data obtained by functional magnetic resonance imaging studies indicating a pivotal role of the aPFC in deception.

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Erichsen, Eva; Danielsson, Elisabeth Hadd; Friedrichsen, Maria
A phenomenological study of nurses’ understanding of honesty in palliative care.
Nursing Ethics 2010 January;17(1): 39-50
Abstract: Honesty is essential for the care of seriously ill and dying patients. The current study aimed to describe how nurses experience honesty in their work with patients receiving palliative care at home. The interviews in this phenomenological study were conducted with 16 nurses working with children and adults in palliative home-based care. Three categories emerged from analyses of the interviews: the meaning of honesty, the reason for being honest and, finally, moral conflict when dealing with honesty. The essence of these descriptions was that honesty is seen as a virtue, a good quality that a nurse should have. The nurses' ethical standpoint was shown in the moral character they show in their work and in their intention to do good. This study could help nurses to identify different ways of looking at honesty to promote more consciousness and openness in ethical discussions between colleagues and other staff members.

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Document 66
Hill, C.M.; Wheeler, R.; Merredew, F.; Lucassen, A.
Family history and adoption in the UK: conflicts of interest in medical disclosure.
Archives of Disease in Childhood 2010 January; 95(1): 7-11
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Document 67
Fallowfield, Lesley
Communication with patients after errors.
Abstract: The study, published in 2003, looks at more than 120 sources of existing research, studies, and policies to consider errors and adverse incidents, particularly involving doctors, and the quality of communication with patients after an incident has happened. The researchers, however, said the research evidence was inadequate and nothing was clear cut.
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Bonifacio, Herbert J.; Janvier, Annie
Case study. Just another test? and commentaries.
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)

Document 69
Moumtzoglou, Anastasius
Factors that prevent physicians reporting adverse events.
International journal of health care quality assurance 2010; 23(1): 51-8
Abstract: The purpose of this paper is to explore the reasons why Greek doctors are reluctant to report adverse events.
Georgetown users check Georgetown Journal Finder for access to full text
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Antoun, Jumana; Saab, Basem Roberto
A culturally sensitive audiovisual package to teach breaking bad news in a Lebanese setting [letter]
Medical Teacher 2010; 32(10): 868-869
Georgetown users check Georgetown Journal Finder for access to full text

Document 71
Fässler, Margrit; Meissner, Karin; Schneider, Antonius; Linde, Klaus
Frequency and circumstances of placebo use in clinical practice—a systematic review of empirical studies.
BMC Medicine 2010; 8: 15
Abstract: BACKGROUND: The use of placebo interventions outside clinical trials is ethically, professionally and legally controversial. Little is known about the frequency and circumstances of placebo use in clinical practice. Our aim was to summarize the available empirical studies addressing these issues. METHODS: We searched PubMed and EMBASE from inception to July 2009 in order to identify cross-sectional surveys, qualitative or longitudinal studies among health care professionals, students or patients which investigated at least one of the following issues—frequency of placebo use or attitudes to, or motivations for, the use of placebo interventions. At least two reviewers extracted information on the study methods, participants and findings. Descriptive summaries were prepared in an iterative process by at least two reviewers per study. RESULTS: Twenty-two studies from 12 different countries met the inclusion criteria. Most studies had relevant shortcomings. The proportion of respondents reporting that they had applied 'pure' placebos (for example, saline injection) during their professional life varied between 17% and 80% among physicians and between 51% and 100% among nurses, but it seems that the actual frequency of such use seems to be rare. The use of 'impure' or 'active' placebos (for example, antibiotics for viral infections) is likely to be much more frequent. However, it is impossible to make a reliable estimation because there is no agreement of what an impure placebo might be. Studies using qualitative methods or asking participants to judge case examples suggest that motivations and attitudes towards placebo use are complex and health care providers are often faced with a dilemma. CONCLUSIONS: Although the available evidence is incomplete and confusing at times there can be little doubt that the prevalence of placebo use outside of clinical trials is not negligible and that views and attitudes on placebo use differ considerably among individuals, both health care professionals and patients. Further research is needed to clarify these issues.

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Sharma, Rashmi
Ethics of placebo use.
Indian journal of medical sciences 2009 Dec; 63(12): 563
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Slowther, Anne
Truth-telling in health care
Clinical Ethics 2009 December; 4(4): 173-175
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* Document 74
Howe, Edmund G.
**Should careproviders go ethically "off label"?**
Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

* Document 75
Foddy, Bennett
**A duty to deceive: placebos in clinical practice.**
American Journal of Bioethics 2009 December; 9(12): 4-12
**Abstract:** Among medical researchers and clinicians the dominant view is that it is unethical to deceive patients by prescribing a placebo. This opinion is formalized in a recent policy issued by the American Medical Association (AMA [Chicago, IL]). Although placebos can be shown to be always safe, often effective, and sometimes necessary, doctors are now effectively prohibited from using them in clinical practice. I argue that the deceptive administration of placebos is not subject to the same moral objections that face other forms of deception in clinical practice and medical research. Although deception is normally objectionable on the grounds that it limits autonomy and breaches trust, these grounds do not apply to placebos when they are prescribed within appropriate ethical limits. Patients have reason to prefer that doctors can prescribe placebos in ethically responsible ways. Hence, the AMA has an obligation to endorse and to promote the responsible use of deceptive placebos in clinical practice.
Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

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Brody, Howard
**Medicine's continuing quest for an excuse to avoid relationships with patients.**
Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

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Shah, Kavita R.; Goold, Susan Dorr
**The primacy of autonomy, honesty, and disclosure -- Council on Ethical and Judicial Affairs' placebo opinions.**
American Journal of Bioethics 2009 December; 9(12): 15-17
Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

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Rorty, Mary V.; Frankel, Lorry R.
**The paradoxical placebo.**
American Journal of Bioethics 2009 December; 9(12): 17-20
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Berger, Jeffrey
**Paternalistic assumptions and a purported duty to deceive.**
American Journal of Bioethics 2009 December; 9(12): 20-21

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Hester, D. Micah; Talisse, Robert B.
**Physician deception and patient autonomy.**
American Journal of Bioethics 2009 December; 9(12): 22-23

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Powell, Tia; Bailey, Jason
**Against placebos.**

Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

* Document 82
Kolber, Adam
**How placebo deception can infringe autonomy.**

Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text

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Duffy, James D.
**The placebo response: the shared construction of reality and the illusion of autonomy.**

Georgetown users check [Georgetown Journal Finder](http://www.bioethics.net/journal/issues.php) for access to full text
Miller, Franklin G.; Colloca, Luana

**The legitimacy of placebo treatments in clinical practice: evidence and ethics.**

**Abstract:** Physicians commonly recommend 'placebo treatments', which are not believed to have specific efficacy for the patient's condition. Motivations for placebo treatments include complying with patient expectations and promoting a placebo effect. In this article, we focus on two key empirical questions that must be addressed in order to assess the ethical legitimacy of placebo treatments in clinical practice: 1) do placebo treatments have the potential to produce clinically significant benefit? and 2) can placebo treatments be effective in promoting a therapeutic placebo response without the use of deception? We examine evidence from clinical trials and laboratory experiments bearing on these two questions. The conclusion is reached that based on currently available evidence, it is premature to judge whether placebo treatments are ethically justifiable, with the possible exception of acupuncture for pain relief.

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Nunn, Robin

**Placebo effects without placebos? More reason to abandon the paradoxical placebo.**
American Journal of Bioethics 2009 December; 9(12): 50-52

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Raz, Amir; Harris, Cory S. de Jong, Veronica; Braude, Hillel

**Is there a place for (deceptive) placebos within clinical practice?**
American Journal of Bioethics 2009 December; 9(12): 52-54

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López, Lenny; Weissman, Joel S.; Schneider, Eric C.; Weingart, Saul N.; Cohen, Amy P.; Epstein, Arnold M.

**Disclosure of hospital adverse events and its association with patients' ratings of the quality of care.**
Archives of Internal Medicine 2009 November 9; 169(20): 1888-1894

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Aggarwal, Sourabh

**The placebo therapy.**
Indian journal of medical sciences 2009 Nov; 63(11): 519

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Jaspers, Andrew  
**Benign misleading: permissible deception in clinical practice?**  
Linacre Quarterly 2009 November; 76(4): 408-416

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Olson, Douglas P.  
**Improvisation.**  
Hastings Center Report 2009 November-December; 39(6): 6

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Shah, Kartik N; Panchal, Dhaval J; Vyas, Bhavesh M; Patel, Varsha J  
**Use of placebo: knowledge, attitude and practice among medical practitioners.**  
Indian journal of medical sciences 2009 Oct; 63(10): 472-3

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Fernandes, Colin  
**Coming to know the limits of healing**  
New York Times 2009 September 8; p. D5

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McRae, Leon  
**Withholding medical records without explanation: a Foucauldian reading of public interest.**  
Medical law review 2009 Autumn; 17(3): 438-46

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Mehler, Gordon; Zwang, Ariel  
**Medical mystery, medical humility.**  
Annals of Internal Medicine 2009 August 18; 151(4): 283-284

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Messer, Michael J.
The moment of truth.
Journal of Clinical Oncology 2009 August 1; 27(22): 3723-3724
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Document 101
Louhiala, Pekka
The ethics of the placebo in clinical practice revisited
Journal of Medical Ethics 2009 July; 35(7): 407-409
Abstract: Three recent empirical studies on the use of placebos and two papers arguing for the deliberate use of placebos in clinical practice are analysed. Empirical studies demonstrate that placebos are commonly used. The concept of the placebo is currently understood in different ways, many of which do not refer to inert substances or treatments. The papers arguing for the use of placebos are shown to fail to make their case.
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Ben Natan, Merav; Shahar, Irit; Garfinkel, Doron
Disclosing bad news to patients with life-threatening illness: differences in attitude between physicians and nurses in Israel.
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Minkoff, Howard; Lyerly, Anne Drapkin
"Doctor, what would you do?".
Obstetrics and Gynecology 2009 May; 113(5): 1137-1139
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Brody, Howard A.
Placebo Effects: Understanding the Mechanisms in Health and Disease, by Fabrizio Benedetti [book review]
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Seki, Yukiko; Yamazaki, Yoshihiko; Mizota, Yuri; Inoue, Yoji
How families in Japan view the disclosure of terminal illness: a study of iatrogenic HIV infection.
AIDS Care 2009 April; 21(4): 422-430
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Berkman, Cathy S.; Ko, Eunjeong
Preferences for disclosure of information about serious illness among older Korean American immigrants in New York City.
Journal of Palliative Medicine 2009 April; 12(4): 351-357
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Dintzis, Suzanne M.; Gallagher, Thomas H.
Disclosing harmful pathology errors to patients.
American Journal of Clinical Pathology 2009 April; 131(4): 463-465
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Fujimori, Maiko; Uchitomi, Yosuke
Preferences of cancer patients regarding communication of bad news: a systematic literature review.
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Pierce, Samuel R.; Lauer, Richard T; Prosser, Laura A.; Mohamed, Feroze B.; Dougherty, Jaimie B.; Faro, Scott H.; Betz, Randall R.
Incidental findings during functional magnetic resonance imaging: ethical and procedural issues.
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Iedema, Rick; Jorm, Christine; Wakefield, John; Ryan, Cherie; Dunn, Stewart
Practising open disclosure: clinical incident communication and systems improvement.
Sociology of Health and Illness 2009 March; 31(2): 262-277
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Barilan, Y.M.
Responsibility as a meta-virtue: truth-telling, deliberation and wisdom in medical professionalism
Journal of Medical Ethics 2009 March; 35(3): 153-158
Abstract: The article examines the new discourse on medical professionalism and responsibility through the prism of conflicts among moral values, especially with regard to truth-telling. The discussion is anchored in the renaissance of English-language writing on medical ethics in the 18(th) century, which paralleled the rise of humanitarianism and the advent of the word "responsibility". Following an analysis of the meanings of the value of responsibility in general and in medical practice in particular, it is argued that, similarly to the Aristotelian notion of equity, responsibility of care is a second-order value, which corrects virtues, laws and norms in exceptional circumstances. Virtues and practices of the second order, such as responsibility and deliberation, bear especially on professional doctoring, which includes a commitment to give priority to the good of the patient over one's own good. It is argued that, in situations of conflict, and particularly conflicts between personal moral identity and the good of patients, the fundamental professional commitment is to critical and rational deliberation and to the cultivation of psycho-moral flexibility. This leads indirectly to moral growth and strengthening of professional character.

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http://jme.bmj.com (link may be outdated)
Prescribing placebos ethically: the appeal of negatively informed consent.
Journal of Medical Ethics 2009 February; 35(2): 97-99

Abstract: Kihlbom has recently argued that a system of seeking negatively informed consent might be preferable in some cases to the ubiquitous informed consent model. Although this theory is perhaps not powerful enough to supplant informed consent in most settings, it lends strength to Evans' and Hungin's proposal that it can be ethical to prescribe placebos rather than "active" drugs. This paper presents an argument for using negatively informed consent for the specific purpose of authorising the use of placebos in clinical contexts.

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Disclosure of cancer diagnosis and quality of life in cancer patients: should it be the same everywhere?
BMC Cancer 2009; 9: 39

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Medical errors, apologies and apology laws [editorial]

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Should patients be told of better care elsewhere?
New York Times 2009 January 6; p. D1, D6

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Commentary: Disclosure in oncology -- to whom does the truth belong?
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Capuano, Alexandra
Patient information, in advance of good practices = Information des patients, promouvoir de bonnes pratiques.
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Cavanna, Luigi; Di Nunzio, Camilla; Seghini, Pietro; Anselmi, Elisa; Biasini, Claudia; Artioli, Fabrizio; Mordenti, Patrizia
Elderly cancer patients' preferences regarding the disclosure of cancer diagnosis. Experience of a single institution in Italy.
Tumori 2009 January-February; 95(1): 63-67
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*  Article  Document 123
Innes, S.; Payne, S.
Advanced cancer patients' prognostic information preferences: a review.
Palliative Medicine 2009 January; 23(1): 29-39
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Book  Document 124
Benedetti, Fabrizio
PLACEBO EFFECTS: UNDERSTANDING THE MECHANISMS IN HEALTH AND DISEASE
Call number: RM331 .B46 2009

*  Article  Document 125
Goihman-Yahr, Mauricio
Parable: from the gospel according to Saint Matthew.
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*  Chapter  Document 126
Padon, Alisa A.; Handler, Steven D.
"This won't hurt a bit": truth-telling to children
Call number: QH332 .P46 2009

*  Chapter  Document 127
Higgs, Roger
Truth-telling
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Boume, Richard W.

**Medical malpractice: should courts force doctors to confess their own negligence to their patients?**


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**Document 129**

Levine, Carol

**A team meeting without the quarterback**


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**Document 130**

Apatira, Latifat; Boyd, Elizabeth A.; Malvar, Grace; Evans, Leah R.; Luce, John M.; Lo, Bernard; White, Douglas B.

**Hope, truth, and preparing for death: perspectives of surrogate decision makers**

Annals of Internal Medicine 2008 December 16; 149(12): 861-868

**Abstract:** Background: Although many physicians worry that openly discussing a poor prognosis will cause patients and families to lose hope, surrogate decision makers' perspectives on this topic are largely unknown. Objective: To determine surrogate decision makers' attitudes toward balancing hope and telling the truth when discussing prognosis. Design: Prospective, mixed-methods cohort study. Setting: 4 intensive care units at the University of California, San Francisco, Medical Center, San Francisco, California. Participants: 179 surrogate decision makers for incapacitated patients at high risk for death. Measurements: One-on-one, semistructured interviews with surrogates were conducted on the patients' 5th day of receiving mechanical ventilation. Constant comparative methods were used to inductively develop a framework to describe participants' responses. Validation methods included multidisciplinary analysis and member checking. Results: Overall, 93% (166 of 179) of surrogates felt that avoiding discussions about prognosis is an unacceptable way to maintain hope. The main explanatory theme was that timely discussion of prognosis is essential to allow family members to prepare emotionally and logistically for the possibility of a patient's death. Other themes that emerged included surrogates' belief that an accurate understanding of a patient's prognosis allows them to better support the patient and each other, a moral aversion to the idea of false hope, the perception that physicians have an obligation to discuss prognosis, and the notion that some surrogates look to physicians primarily for truth and seek hope elsewhere. A few surrogates (6 of 179) felt that physicians should withhold prognostic information because of a belief that discussing death could be emotionally damaging to the family or could negatively affect the patient's health. Limitation: The authors did not longitudinally assess whether early disclosure about prognosis predicts fewer adverse bereavement outcomes. Conclusion: Most surrogates of critically ill patients do not view withholding prognostic information as an acceptable way to maintain hope, largely because timely discussions about prognosis help families begin to prepare emotionally, existentially, and practically for the possibility that a patient will die.

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Journal of the American College of Radiology 2008 December; 5(12): 1186-1190

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Should all patients be told about sudden unexpected death in epilepsy (SUDEP)? Pros and Cons.
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Disclosure of dementia diagnosis and the need for advance care planning in individuals with Alzheimer's disease [letter]
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Truth-telling, honesty and compassion: a virtue-based exploration of a dilemma in practice.
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How should a nurse approach truth-telling? A virtue ethics perspective
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Factors associated with reporting of medication errors by Israeli nurses.
Journal of Nursing Care Quality 2008 October-December; 23(4): 353-361

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When does the 'learning curve' of innovative interventions become questionable practice?
European Journal of Vascular and Endovascular Surgery 2008 September; 36(3): 253-257

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Martin, Adrienne M.

Hope and exploitation

Abstract: How do we encourage patients to be hopeful without exploiting their hope? A medical researcher or a pharmaceutical company can take unfair advantage of someone's hope by much subtler means than simply giving misinformation. Hope shapes deliberation, and therefore can make deliberation better or worse, by the deliberator's own standards of deliberation.

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The power of belief
New Scientist 2008 August 23-29; 199(2670): 36-39

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Patient, heal thyself: there's more to a drug than the chemicals in the pill [editorial]
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Providing information for patients is insufficient on its own to improve clinical outcomes [editorial]
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Brown, Chris

Kant and therapeutic privilege

Abstract: Given Kant's exceptionless moral prohibition on lying, one might suspect that he is committed to a similar prohibition on withholding diagnostic and prognostic information from patients. I confirm this suspicion by adapting arguments against therapeutic privilege from his arguments against lying. However, I show that all these arguments are importantly flawed and submit that they should be rejected. A more compelling Kantian take on informed consent and therapeutic privilege is achievable, I argue, by focusing on Kant's duty of beneficence, which requires us to aim at furthering others' ends. But I show that there are some cases in which furthering a patient's ends requires withholding material medical information from her. Although I concede that these cases are probably quite rare, I conclude that the best Kantian thinking agrees with that of therapeutic privilege's advocates.

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Disclosure of incurable illness to spouses: do they want to know? A Swedish population-based follow-up study.
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Surgery 2008 July; 144(1): 99-100

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**Placebo pills for children**

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**When disclosing a serious diagnosis to a minor conflicts with family values.**

Journal of Developmental and Behavioral Pediatrics 2008 June; 29(3): 231

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**Alzheimer's disease diagnosis disclosure in Brazil: a survey of specialized physicians' current practice and attitudes.**


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Laakkonen, Marja-Liisa; Raivio, M.M.; Eloniemi-Sulkava, U.; Saarenheimo, M.; Pietilä, M.; Tilvis, R.S.; Pitkälä, K.H.

**How do elderly spouse caregivers of people with Alzheimer disease experience the disclosure of dementia diagnosis and subsequent care?**

Journal of Medical Ethics 2008 June; 34(6): 427-430

**Abstract:** OBJECTIVES: To examine the experiences of spousal care givers of Alzheimer patients to disclosure of dementia diagnosis and subsequent care. METHODS: A random sample of 1943 spousal care givers of people receiving medication for Alzheimer disease (AD) was sent a cross-sectional postal survey about their opinions on the disclosure of dementia and follow-up care. A smaller qualitative study (n = 63) included open-ended questions concerning their experiences of the same topics. RESULTS: The response rate for the survey was 77%. Of the respondents, 1214 of 1434 acknowledged themselves as their spouse's care giver. The mean age of the care givers was 78.2 years, and that of demented spouses, 80.5 years. Of the care givers, 63% were women. The couples had long-lasting marriages (mean 52 years). Of the care givers, 93% reported that dementia had been disclosed openly to their spouse; 97% also preferred that physicians openly inform the patients of the dementia diagnosis, although 55% of their spouses with AD had developed depressive symptoms after the disclosure. Of the care givers, 71% felt they had received sufficient information about dementia. However, only 50% estimated that their spouses' follow-up care had been well organised. The responses in the qualitative study indicated that many care givers felt grief and anxiety. They also expressed feelings of loneliness and uncertainty about how to deal with follow-up care for dementia. CONCLUSIONS: Elderly spousal care givers were quite satisfied with the information given them about dementia. However, the support with regard to the follow-up care of care-giving families failed to meet their needs adequately.

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New York Times 2008 May 27; p. F5, F7

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**Is truth a supreme value?**
Journal of Medical Ethics 2008 May; 34(5): 325-326

**Abstract:** Is truth a supreme value? At times, we doctors have to contend with a complex dilemma in which we face the value of truth on the one hand and conflict with another value on the other. Is it sometimes permissible and even necessary not to report the truth in favour of another, more important value? This is a description of an experience in which a doctor had to handle such an issue when a pregnant Muslim woman asked for a document that she wasn't pregnant when in fact she was, in order to avert the possibility of being murdered to preserve the honour of the family. The doctor decided that the value of life was more important than the value of truth.

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**The National Open Disclosure Pilot: evaluation of a policy implementation initiative.**
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Winter, Robin O.; Birnberg, Bruce A.
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Lebanese cancer patients: communication and truth telling preferences.
Doumit, Myrna Abi Abdallah; Abu-Saad, Huda Huijer
Contemporary Nurse 2008 April; 28(1-2): 74-82

Truth-telling at the end of life: a pilot study on the perspective of patients and professional caregivers.
Deschepper, Reginald; Bernheim, Jan L.; Vander Stichele, Robert; Van den Block, Lieve; Michiels, Eva; Van Der Kelen, Greta; Mortier, Freddy; Delliens, Luc
Patient Education and Counseling 2008 April; 71(1): 52-56

The impact of different criteria for selecting information to be provided to women undergoing diagnostic breast tests.
Davey, Heather M.; Barratt, Alexandra L.; Butow, Phyllis N.; Houssami, Nehmat

Information disclosure and decision-making: the Middle East versus the Far East and the West
Journal of Medical Ethics 2008 April; 34(4): 225-229

Abstract: Objectives: to assess physicians' and patients' views in Saudi Arabia (KSA) towards involving the patient versus the family in the process of diagnosis disclosure and decision-making, and to compare them with views from the USA and Japan. Design: A self-completion questionnaire (used previously to study these issues in Japan and the USA) was translated to Arabic and validated. Participants: Physicians (n = 321) from different specialties and ranks and patients (n = 264) in a hospital or attending outpatient clinics from 6 different regions in KSA. Results: In the case of a patient with incurable cancer, 67% of doctors and 51% of patients indicated that they would inform the patient in preference to the family of the diagnosis (p = 0.001). Assuming the family already knew, 56% of doctors and 49% of patients would tell the patient even if family objected (p NS). However, in the case of HIV infection, 59% of physicians and 81% of patients would inform the family about HIV status without the patient's consent (p = 0.001). With regards to withholding ventilatory support, about 50% of doctors and over 60% of patients supported the use of
mechanical ventilation in a patient with advanced cancer, regardless of the wishes of the patient or the family. Finally, the majority of doctors and patients (>85%) were against assisted suicide. Conclusions: Although there was more recognition for a patient's autonomy amongst physicians, most patients preferred a family centred model of care. Views towards information disclosure were midway between those of the USA and Japan. Distinctively, however, decisions regarding life prolonging therapy and assisted suicide were not influenced to a great extent by wishes of the patient or family, but more likely by religious beliefs.

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Commercial features of placebo and therapeutic efficacy [letter]
JAMA: The Journal of the American Medical Association 2008 March 5; 299(9): 1016-1017

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Journal of Clinical Oncology 2008 March 1; 26(7): 1175-1177

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Berry, Philip A.
The withholding of truth when counselling relatives of the critically ill: a rational defence
Clinical Ethics 2008 March; 3(1): 42-45

Abstract: In cases of sudden, life-threatening illness where the chance of survival appears negligible to the admitting physician, this opinion is not always revealed during the initial meeting with the patient's relatives. Reasons as to why this withholding of the truth may be acceptable are explored through review of available evidence and personal reflection. Factors identified include: the importance of hope in families' coping mechanisms, and the instinct to preserve it; the fallibility of physicians' perception of poor prognosis in the early phase of illness; the need to avoid large swings in relatives' expectations that occur when patients appear to rally during initial resuscitation; and the adverse effect that an atmosphere of hopelessness can have on the provision of medical care. A strategy for the staged disclosure of information and the confirmation of hopelessness is then described, the aim being to find a compromise between providing a true opinion about a patient's prognosis, and regard for the opposing factors described.
Crawford, G.C.; Lucassen, A.M.

**Disclosure of genetic information within families: a case report**

Clinical Ethics 2008 March; 3(1): 7-10

**Abstract:** There has been much discussion about what, if any, legal and moral duties professionals have to disclose relevant genetic information to the family members of someone with an identified disease predisposing mutation. Here, we present a case report where dissemination of such a genetic test result did not take place within a family. In contrast to previous literature, there appeared to be no deliberate withholding of information, instead distant relatives were unable to communicate relevant information appropriately. When communication was facilitated through the follow-up of a chance remark, the patient was able to avoid planned major surgery, with its attendant morbidity, and her high anxiety levels were much reduced. We believe this case highlights the need for an ongoing debate on how genetic services can best support patients and their families with disclosing relevant genetic information to other family members.

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**Conflict of interest: in the eye of the beholder?**

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Alexander, G. Caleb

**Commentary on "The case of Mr. A.B."; dilemmas for a reason**

Journal of Clinical Ethics 2008 Spring; 19(1): 70-71

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Corbin, James R.

**Disclosure of HIV status to an infected child: confidentiality, duty to warn, and ethical practice**


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Disclosure of HIV status to an infected child: medical, psychological, ethical, and legal perspectives in an era of "super-vertical" transmission
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Ethical issues concerning disclosures of HIV diagnoses to perinatally infected children and adolescents
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Patient race/ethnicity, age, gender and education are not related to preference for or response to disclosure.
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Patient Education and Counseling 2008 February; 70(2): 220-226
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What’s your doctor really giving you? Many admit to prescribing placebos
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Jauhar, Sandeep

**Explain a medical error? Sure. Apologize too?**

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Shehab, Dena; Duff, Julia; Pasch, Lauri A.; Mac Dougall, Kirstin; Scheib, Joanna E.; Nachtigall, Robert D.

**How parents whose children have been conceived with donor gametes make their disclosure decision: contexts, influences, and couple dynamics**

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**Parents' perspectives on physician-parent communication near the time of a child's death in the pediatric intensive care unit.**

*Pediatric Critical Care Medicine* 2008 January; 9(1): 2-7

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Demirsoy, Nilufer; Elcioglu, Omur; Yildiz, Zeki

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*JGIM: Journal of General Internal Medicine* 2008 January; 23(1): 7-10

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"Don't tell her she's on hospice": ethics and pastoral care for families who withhold medical information.

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**Truth telling and openness create ethical tension: a response to Gentry.**

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**Telling the truth: Bonhoeffer revisited in response to Gentry's discussion.**
Journal of Pastoral Care and Counseling 2008; 62(5 Suppl): 429-430

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Sarvaananda, Swami

**"First, cause no harm": a response to Gentry.**
Journal of Pastoral Care and Counseling 2008; 62(5 Suppl): 431-432

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**Off the radar: truth telling in psychiatry.**
Harvard Review of Psychiatry 2008; 16(6): 381-387

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**Discussing life expectancy with surgical patients: do patients want to know and how should this information be delivered?**
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Grainger, Rebecca; Stuckey, Stephen; O'Sullivan, Richard; Davis, Susan R.; Ebeling, Peter R.; Wluka, Anita E.

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"Telling the painful truth" – nurses and physicians in the nineteenth century.

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**Disclosure of medical error**


Call number: QH332 .C36 2008

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**Truth telling**


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**A survey of suppression of public health information by Australian governments**


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Clemente, Ignasi

**Clinicians' routine use of non-disclosure: prioritizing "protection" over the information needs of adolescents with cancer**

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Haddad, Amy

**Ethics in action. What the family needs to know.**

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Hallenbeck, James; Arnold, Robert

**A request for nondisclosure: don't tell mother.**

Journal of Clinical Oncology 2007 November 1; 25(31): 5030-5034

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Vandergrift, Ellen

**Professional obligations to disclose adverse events: a changed regulatory landscape following patient safety initiatives**

Health Law in Canada 2007 November; 28(2): 39-55

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Page, Cameron

**Hope**

Hastings Center Report 2007 November-December; 37(6): 12

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Evans, H.M.; Hungin, A.P.S.

**Uncomfortable implications: placebo equivalence in drug management of a functional illness**

Journal of Medical Ethics 2007 November; 33(11): 635-638

**Abstract:** Using a fictional but representative general practice consultation, involving the diagnosis of irritable bowel syndrome in a patient who is anxious for some relief from the discomfort his condition entails, this paper argues that when both (a) a drug fails to out-perform placebo and (b) the condition in question is a functional illness with no demonstrable underlying pathology, then the action of the drug is not only no better than placebo, and it is also no different from it either. The paper also argues that, in the circumstances of the consultation described, it is striking that current governance deems it ethical for a practitioner to prescribe either a drug or a placebo, both of which appear to rely for their effectiveness on a measure of concealment on the part of the doctor, yet deems it unethical for a practitioner openly to prescribe a harmless and enjoyable substance which (in equivalent conditions of transparency and information) is likely to be no less effective than either drug or placebo and is also likely to be better-tolerated and cheaper than the drug.
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Hari, D.; Mark, Z.; Bharati, D.; Khadka, P.

*Patients' attitude towards concept of right to know*

Kathmandu University Medical Journal (KUMJ) 2007 October-December; 5(4): 591-595

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Jiang, Yu; Liu, Chiang; Li, Jun-Ying; Huang, Mei-Juan; Yao, Wen-Xiu; Zhang, Ru; Yao, Bing; Du; Xiao-Bo; Chen, Jing; Xie, Ke; Zhao, Xia; Wei, Yu-Quan

*Different attitudes of Chinese patients and their families toward truth telling of different stages of cancer*

Psycho-Oncology 2007 October; 16(1): 928-936

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Kershaw, Sarah

*In bid for transparency, city puts hospital error data online*


**Document 225**

Lee, Christopher

*Medicare to reveal data about doctors; group sued to find out about procedures*
**Document 226**

Byk, Christian

*Truth telling and informed consent: is "primum docere" the new motto of clinical practice?*


**Abstract:** Autonomy has become in many countries a key concept in the patient-physician relationship, leaving the old paternalistic medical attitude out of the realm of common good clinical practice. Consequently, the validity of the informed consent procedure which is related to any medical intervention, should imply that the information given is true. Raising the question as such obliges us to consider the truth not for itself but in regard to the validity of the consent to a medical intervention. Although a clinical approach reveals that loyalty should guide the patient-physician relationship, there are still some situations in which informed consent and truth telling may be controversial: in some circumstances, the physician should or may not tell the truth, in others he can simply forget to tell.

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*Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review.*

Palliative Medicine 2007 September; 21(6): 507-517

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*How often do BRCA mutation carriers tell their young children of the family's risk for cancer? a study of parental disclosure of BRCA mutations to minors and young adults.*
Dilemmas in the (un)veiling of the diagnosis of Alzheimer's disease: walking an ethical and professional tight rope.


The art of letting go

The art of letting go


Limited relevance of the right not to know -- reflections on a screening study

Accountability in Research 2007 July-September; 14(3): 197-209

Epidemiological and ethical aspects of multiplex autoantibody testing.

Autoimmunity Reviews 2007 June; 6(6): 354-358

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Psycho-oncology 2007 June; 16(6): 573-581
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**Placebos: the nurse and the iron pills**
Journal of Medical Ethics 2007 June; 33(6): 325-328

Abstract: In sub-Saharan Africa, a nurse gives iron pills as placebos to terminally ill patients. She tells them, acting in what she believes is in their best interests, “these will make you feel better”. The patients believe it will help their AIDS and their well-being improves. Do the motive and the patient's positive outcome in well-being make the deceit justifiable when other issues such as consent, autonomy and potential consequences regarding the patient and the wider community are considered? Is there a difference between lying and non-lying deception when the end result is the same? The patients feel better, but at what cost if the deceit was found out? It will be argued that although the actions of the nurse are understandable and to some extent defensible, they are unethical. It is not ethically acceptable to take away the patient's autonomy and risk the health of the community even though the risk of deceit being discovered is a small one.

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Aging and Mental Health 2007 May; 11(3): 273-280
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*Confronting medical errors in oncology and disclosing them to cancer patients.*
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Streiner, David L.

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Ayers, Tressie A. Dutchyn

A partnership in like-minded thinking generating hopefulness in persons with cancer

Medicine, Health Care and Philosophy 2007 March; 10(1): 65-80

Abstract: A conceptual model of a partnership in 'like-minded thinking' consists of the following components: a relationship, a shared goal with mutual agreement to work toward that goal, and reciprocal encouragement between two people. A like-minded alliance is a relationship that offers support while at the same time encourages hope and establishes a reciprocating emotional attitude of hopefulness. The discussion focuses on the principles of such a model that is designed primarily as a lay intervention for anyone who has a close friend with cancer and who wants to assist the friend in maintaining a hopeful attitude in the face of illness. While this model is not directed at healthcare professionals it may be transferable into psychosocial interventions to assist persons toward sustaining hopefulness in the context of the cancer trajectory. Much has been written in the literature about how hopelessness spawns despair for individuals who have cancer and in those near the end of life; it may even create a desire for hastened death (Breitbart W., Heller K.S.: 2003, 'Reframing Hope: Meaning-Centered Care for Patients Near the End of Life'. Journal of Palliative Medicine 6, 979-988; Jones J.M., Huggins M.A., Rydall A.C., Rodin G.M.: 2003, 'Symptomatic distress, hopelessness, and the desire for hastened death in hospitalized cancer patients', Journal of Psychosomatic Research 55, 411-418). Therefore, the aim of this paper is to explore how like-minded thinking for a person with cancer and his or her support person provides a framework for a personal shared worldview that is hope-based, meaningful and coherent.

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Preparing ourselves, our trainees, and our patients: a commentary on truthtelling
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Nothing but the truth? On truth and deception in dementia care
Bioethics 2007 January; 21(1): 13-22
Abstract: Lies and deception are often used in the care for demented elderly and often with the best intentions. However, there is a strong moral presumption against all forms of lying and deceiving. The goal of this article is to examine and evaluate concrete examples of deception and lies in dementia care, while addressing some fundamental issues in the process. It is argued that because dementia slowly diminishes the capacities one needs to distinguish between truths and falsehoods, the ability to be lied to also disappears. When the moral reasons to reject lying are explored, it becomes clear that most of them also hold where demented patients are concerned, though this also depends on the capacities of the patient. Lying, though prima facie wrong, can sometimes be justified with an appeal to well-being. The relationship between well-being and the truth is further explored. Two examples of deceiving demented patients for reasons of beneficence are discussed, from which it can be concluded that although in some cases beneficent lies or deception will not enhance patients’ well-being, there are circumstances in which they do. In general, methods that enhance the well-being of the patient without deception or lies should be favored above options that use deceit, and methods of getting the truth across without hurting the patient should be favored above blunt honesty. Finally it is important to note that not only the patient but also the nursing and medical staff can be affected by the use of lies and deception.

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Truth telling, autonomy and the role of metaphor
Journal of Medical Ethics 2007 January; 33(1): 11-14

Abstract: This paper examines the potential role of metaphors in helping healthcare professionals to communicate honestly with patients and in helping patients gain a richer and more nuanced understanding of what is being explained. One of the ways in which doctors and nurses may intentionally, or unintentionally, avoid telling the truth to patients is either by using metaphors that obscure the truth or by failing to deploy appropriately powerful and revealing metaphors in their discussions. This failure to tell the truth may partly account for the observation by clinicians that patients sometimes make decisions that, from the perspective of their clinician, and given all that the clinician knows, seem unwise. For example, patients with advanced cancer may choose to undergo further, aggressive, treatment despite the fact that they are likely to accrue little or no benefit as a result. While acknowledging that the immediate task of telling patients the truth can be difficult for all those concerned, I argue that the long-term consequences of denying patients autonomy at the end of life can be harmful to patients and can leave doctors and nurses distressed and confused.

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Sutton, Erica J.; Young, Jessica; McInerney-Leo, Aideen; Bondy, Carolyn A.; Gollust, Sarah E.; Biesecker, Barbara B.

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* Disclosure of cancer diagnosis to patients and their relatives in Turkey: views of accompanying persons and influential factors in reaching those views


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Taking families seriously enough
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Complications of culture in obtaining informed consent
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Culture and communication: medical disclosure in Japan and the U.S.A. Akabayashi and B.T. Slingsby
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Akabayashi, Akira; Slingsby, Brian Taylor
*Informed consent revisited: Japan and the U.S.*
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**Document 331**
Godkin, D.
*Should children's autonomy be respected by telling them of their imminent death? [commentary]*
Journal of Medical Ethics 2006 January; 32(1): 24-25
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**Document 332**
Vince, T.; Petros, A.
*Should children's autonomy be respected by telling them of their imminent death?*
Journal of Medical Ethics 2006 January; 32(1): 21-23
Abstract: Respect for an individual's autonomy determines that doctors should inform patients if their illness is terminal. This becomes complicated when the terminal diagnosis is recent and death is imminent. The authors examine the admission to paediatric intensive care of an adolescent with terminal respiratory failure. While fully ventilated, the patient was kept sedated and comfortable but when breathing spontaneously he was capable of non-verbal communication and understanding. Once resedated and reintubated, intense debate ensued over whether to wake the patient to tell him he was going to die. The authors discuss the ethical arguments that surrounded their decision.
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**Exploiting placebo effects for therapeutic benefit**

**Abstract:** It is widely believed that medically inert treatments ("placebos") can bring about therapeutic benefits. There is also evidence that medically active treatments may also have "placebo" effects. Since anything that has the potential to benefit patients ought to be exploited, subject to appropriate ethical standards, it has been suggested that more should be done to investigate and exploit the power of the placebo for therapeutic benefit. I explore the acute epistemic and ethical constraints that such exploitation is likely to face, and conclude that effective exploitation is unlikely.
Advance directives for truth disclosure
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Disclosure preferences regarding cancer diagnosis and prognosis: to tell or not to tell?
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Whose information is it anyway? Informing a 12-year-old patient of her terminal prognosis

Abstract: OBJECTIVE: To examine students' attitudes and potential behaviour towards informing a 12-year-old patient of her terminal prognosis in a situation in which her parents do not wish her to be told, as they pass through a modern medical curriculum. DESIGN: A cohort study of students entering Glasgow University's new medical curriculum in October 1996. METHODS: Students' responses obtained before year 1 and at the end of years 1, 3, and 5 to the "childhood leukaemia" vignette of the Ethics in Health Care Survey Instrument (EHCI) were examined quantitatively and qualitatively. Analysis of the students' multichoice answers enabled measurement of the movement towards professional consensus opinion. An analysis of their written justifications for their answers helped to determine whether their reasoning was consistent with professional consensus and enabled measurement of changes in knowledge content and recognition of the values inherent in the vignette. Themes on the students' reasoning behind their decision to tell the patient or not were also identified. RESULTS: Unlike other vignettes of the EHCI in which autonomy was a main theme, few students chose the consensus answer before year 1 and there was no significant movement towards consensus at any point during the course. In defence of their decision to withhold information, the students expressed strong paternalistic opinions. The patient's age was seen as a barrier to respecting her autonomy. CONCLUSIONS: It is important to identify students' perceptions on entry to medical school. Transformative learning theory may provide the basis for an approach to foster doctors who consider the rights of young people. Small-group teaching is most conducive to this approach. The importance of positive role modelling is also emphasised.

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The nature of relative subjectivity: a reflexive mode of thought
Abstract: Ethical principles including autonomy, justice and equality function in the same paradigm of thought, that is, logocentrism—an epistemological predilection that relies on the analytic power of deciphering between binary oppositions. By studying observable behavior with an analytical approach, however, one immediately limits any recognition and possible understanding of modes of thought based on separate epistemologies. This article seeks to reveal an epistemological predilection that diverges from logocentrism yet continues to function as a fundamental component of ethical behavior. The issue of cancer disclosure in Japan is used to exemplify the nature of relative subjectivity (kankeiteki-shukansei), a term I define and believe to be an epistemological predisposition fundamental to ethical behavior. Relative subjectivity denotes an epistemology quintessential to the behavior of individuals who attend to the respective tides of each particular situation, each interpersonal relationship or, in the context of clinical medicine, to the needs and values of each patient.
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Abstract: While discussions of the ethics of the placebo have usually dealt with their use in a research context, the authors address here the question of the placebo in clinical practice. It is argued, firstly, that the placebo can be an effective treatment. Secondly, it is demonstrated that its use does not always entail deception. Finally guidelines are presented according to which the placebo may be used for clinical purposes. It is suggested that in select cases, use of the placebo may even be morally imperative. The argument is illustrated by three case vignettes.
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**Medical humanities and medical informatics: an unlikely alliance? Is there a role for patients' voices in the modern case record? [editorial]**

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Nitzan, Uriel; Lichtenberg, Pesach

**Questionnaire survey on use of placebo**

BMJ: British Medical Journal 2004 October 23; 329(7472): 944-946

**Abstract:** OBJECTIVES: To gauge the frequency and circumstances of use of placebo in clinical practice and the attitudes towards its use among those who administer it. DESIGN: Retrospective questionnaire. SETTING: Two large hospitals and various community clinics in the Jerusalem area. PARTICIPANTS: 31 physicians working in hospital inpatient and outpatient departments, 31 head nurses working in hospital inpatient departments, and 27 family physicians working in community clinics. MAIN OUTCOME MEASURES: Self report of frequency and circumstances of, and attitudes towards, use of placebo. RESULTS: Among the 89 respondents, 53 (60%) used placebos (95% confidence interval 49% to 70%). Among users, 33 (62%) prescribed a placebo as often as once a month or more; 36 (68%) told patients they were receiving actual medication; 15 (28%) considered that placebos were a diagnostic tool; and 48/51 (94%) reported that they found placebos generally or occasionally effective. CONCLUSION: Most practitioners questioned in this study continue to use placebos. Used wisely, placebos might have a legitimate place in therapeutics. Wider recognition of the practice and debate about its implications are imperative.

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Archives of Internal Medicine 2004 September 27; 164(17): 1841-1844

Abstract: Published reports indicate that physicians sometimes use deceptive tactics with third-party payers. Many physicians appear to be willing to deceive to secure care that they perceive as necessary, particularly when illnesses are severe and appeals procedures for care denials are burdensome. Physicians whose practices include larger numbers of Medicaid or managed care patients seem more willing to deceive third-party payers than are other physicians. The use of deception has important implications for physician professionalism, patient trust, and rational health policy development. If deception is as widespread as these studies suggest, there may be serious problems in the medical profession and the health care financing systems at the interface between physicians and third-party payers. Deception may be a symptom of a flawed system, in which physicians are asked to implement financing policies that conflict with their primary obligation to the patient.

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**Un-informed consent [editorial]**
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Tuckett, Anthony G.

Truth-telling in clinical practice and the arguments for and against: a review of the literature
Nursing Ethics 2004 September; 11(5): 500-513

Abstract: In general, most, but not necessarily all, patients want truthfulness about their health. Available evidence indicates that truth-telling practices and preferences are, to an extent, a cultural artefact. It is the case that practices among nurses and doctors have moved towards more honest and truthful disclosure to their patients. It is interesting that arguments both for and against truth-telling are established in terms of autonomy and physical and psychological harm. In the literature reviewed here, there is also the view that truth-telling is essential because it is an intrinsic good, while it is argued against on the grounds of the uncertainty principle. Based on this review, it is recommended that practitioners ought to ask patients and patients' families what informational requirements are preferred, and research should continue into truth-telling in clinical practice, particularly to discover its very nature as a cultural artefact, and the other conditions and contexts in which truth-telling may not be preferred.

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Mazor, Kathleen M.; Simon, Steven R.; Gurwitz, Jerry H.

Communicating with patients about medical errors -- a review of the literature
Archives of Internal Medicine 2004 August 9-23; 164(15): 1690-1697

Abstract: BACKGROUND: Ethical and professional guidelines recommend disclosure of medical errors to patients. The objective of this study was to review the empirical literature on disclosure of medical errors with respect to (1) the decision to disclose, (2) the process of informing the patient and family, and (3) the consequences of disclosure or nondisclosure. METHODS: We searched 4 electronic databases (MEDLINE, CINAHL, PsycINFO, and Social Sciences Citations Index) and the reference lists of relevant articles for English-language studies on disclosure of medical errors. From more than 800 titles reviewed, we identified 17 articles reporting original empirical data on disclosure of medical errors to patients and families. We examined methods and results of the articles and extracted study designs, data collection procedures, populations sampled, response rates, and definitions of error. RESULTS: Available research findings suggest that patients and the public support disclosure. Physicians also indicate support for disclosure, but often do not disclose. We found insufficient empirical evidence to support conclusions about the disclosure process or its consequences. CONCLUSIONS: Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure. Fewer have considered the disclosure process, the consequences of disclosure, or the relationship between the two. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process, and to help all involved anticipate the consequences of disclosure.

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Abstract: This research explored the ethical issues that nurses reported in the process of elaboration and further disclosure after an initial diagnosis of a terminal illness had been given. One hundred and six hospice nurses in Norway and Denmark completed a questionnaire containing 45 items of forced-choice and open-ended questions. This questionnaire was tested and used in three countries prior to this study; for this research it was tested on Danish and Norwegian nurses. All respondents supported the ethics of ongoing disclosure to terminally ill patients based on ethical principles embedded in their country's Patients' Rights Acts. Truth, as an intrinsic value, proved foundational to patient autonomy, the most frequent ethical principle these nurses reported to justify their ethical position on information disclosure to terminally ill people. Telling the truth about a diagnosis was not the end of ethics in hospice care, but rather the beginning because what occurs ethically in dealing with prognosis issues became central to these hospice nurses, the patients and their families. Coupled with truth-telling, compassionate interaction and care become extensions of patients' rights.
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**Abstract:** OBJECTIVES: To evaluate relatives' attitudes towards informing patients with Alzheimer's disease (AD) about their diagnosis. SETTING: A university hospital in Italy. METHODS: The closest relatives of each of 71 subjects diagnosed for the first time as having AD were interviewed, using a semistructured questionnaire. Spontaneous requests by relatives not to communicate issues concerning the diagnosis were also recorded. RESULTS: Forty three (60.6%) relatives spontaneously requested that patients not be fully informed. After being interviewed, nobody thought that the patient should be given all the information. Justifications were related to the fear of the onset or worsening of depressive symptoms in the patient. CONCLUSIONS: In Italy relatives' opposition to informing AD patients appears to be common. Knowledge of the relatives' attitudes may be useful for clinicians but disclosure of diagnosis should be based on the clinical evaluation of the patient and on a prudent evaluation of the relationship between the patient and her/his relative caregiver.

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Abstract: The ethics of medical management are not always straightforward. There are many contributing factors: the condition treated; its effects on the patient; the required treatment; the effects of that treatment; and a cost/benefit ratio. Treatment of epilepsy with vigabatrin (VGB) exemplifies these problems. VGB has recently been reported to cause constricted visual fields. Formal testing of visual fields of patients attending an outpatient epilepsy service showed constriction with tunnel vision, even in patients who are asymptomatic. The ethical questions include: Should all reports of adverse events be subjected to tests of validity and subsequent quality assurance? Should treatment with VGB be stopped, risking recurrence of seizures? What are the legal consequences of continuing VGB? Does informed consent protect the doctor? After stopping VGB can the patient drive?

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