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Acharnement thérapeutique

☐ **The development of "medical futility": towards a procedural approach based on the role of the medical profession**
Auteur(s) : Moratti S
Source : Journal of Medical Ethics 2009; 35:369-72.

Over the past 50 years, technical advances have taken place in medicine that have greatly increased the possibilities of life-prolonging intervention. The increased possibilities of intervening have brought along new ethical questions. Not everything that is technically possible is appropriate in a specific case: not everything that could be done should be done. In the 1980s, a new term was coined to indicate a class of inappropriate interventions: "medically futile treatment". A debate followed, with contributions from the USA and several western European countries. A similar debate later took place in Mediterranean countries, although with a different terminology. The purpose of this article is to provide an up-to-date and systematic analysis of the concept of futility, and to draw some conclusions on its operationalisation in medical practice. While the concept of "medical futility" in theory applies to all kinds of medical intervention that might be performed without being medically indicated-things such as certain medical screenings and cosmetic surgery-in practice the literature on "futility" deals only with life-saving and life-sustaining medical interventions. This article deals with this more limited application of the concept of "futility".

Anesthésie

☐ **Anesthesiology trainees face ethical, practical, and relational challenges in obtaining informed consent**
Auteur(s) : Waisel DB, Lamiani G, Sandrock NJ, Pascucci R, Truog RD, Meyer EC
Source : Anesthesiology 2009 ; 110(3) : 480-86

BACKGROUND: Categorizing difficulties anesthesiologists have in obtaining informed consent may influence education, performance, and research. This study investigated the trainees' perspectives and educational needs through a qualitative analysis of narratives. METHODS: The Program to Enhance Relational and Communication Skills-Anesthesia used professional actors to teach communication skills and relational abilities associated with informed consent. Before attending the program, participants wrote about a challenging informed consent experience. Narratives were analyzed by two researchers following the principles of grounded theory. The researchers independently read the narratives and marked key words and phrases to identify reoccurring challenges described by anesthesiologists. Through rereading of the narratives and discussion, the two researchers reached consensus on the challenges that arose and calculated their frequency. RESULTS: Analysis of the 39 narratives led to the identification of three types of challenges facing anesthesiologists in obtaining informed consent. Ethical challenges included patient wishes not honored, conflict between patient and family wishes and medical judgment, patient decision-making capacity, and upholding professional standards. Practical challenges included the amount of information to provide, communication barriers, and time limitations. Relational challenges included questions about trainee competence, mistrust associated with previous negative experiences, and misunderstandings between physician and patient or family. CONCLUSIONS: The ethical, practical, and relational challenges in obtaining informed consent colored trainees' views of patient care and affected their interactions with patients. Using participant narratives personalizes education and motivates participants. The richness of narratives may help anesthesiologists to appreciate the qualitative aspects of informed consent.

Assistance au suicide

☐ **Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians**
Auteur(s) : Fischer S, Huber CA, Furter M, Imhof L, Mahrer Imhof R, Schwarzenegger C, Ziegler SJ, Bosshard G
Source : Journal suisse de médecine 2009; 139(23-34):333-38

BACKGROUND: Assisted suicide is permitted in Switzerland provided that assistance is not motivated by selfish reasons. Suicides are commonly performed with the assistance of right-to-die organisations and the use of a lethal dose of barbiturates prescribed by a participating physician. We examined the reasons physicians provided for writing the prescription and the reasons patients gave for requesting assistance in dying.METHODS: We analysed all reported cases of assisted suicide that were facilitated by right-to-die organisations between 2001 and 2004 in the city of Zurich, and for which both the medical report and the optional letter written by the decedent providing information on their reasons for seeking assistance in suicide (N = 165). RESULTS: The reasons most often reported by physicians (ph), as well as persons who sought help (p), were: pain (ph: 56% of all assisted suicides, p: 58%), need for long-term care (ph: 37%, p: 39%), neurological symptoms (ph: 35%, p: 32%), immobility (ph: 23%, p: 30%) and dyspnoea (ph: 23%, p: 23%). Control of circumstances over death (ph: 12%, p: 39%); loss of dignity (ph: 6%, p: 38%); weakness (ph: 13%, p: 26%); less able to engage in activities that make life enjoyable (ph: 6%, p: 18%); and insomnia and loss of concentration (ph: 4%, p: 13%) were significantly more often mentioned by decedents than by physicians. CONCLUSIONS: Both prescribing physicians and patients provided with assistance to die quite often mentioned pain and other concerns, many of which were objectively assessable and related to unbearable suffering or unreasonable disability. Concerns referable to autonomy and individual judgement were more often noted by people seeking help than by the prescribing physicians.

Cardiologie

☐ **Ethical considerations in cardiovascular prevention**
Auteur(s) : Follath, F
Source : Fundamental & Clinical Pharmacology 2009 June 4

The fundamental values in medical ethics include the following aspects of professional conduct: (i) actions in the best interest of patients; (ii) first, do no harm; (iii) patients' right to refuse or choose treatments; (iv) fairness and equality in the distribution of healthcare resources; and (v) truthfulness and honesty (informed consent). These values have to be considered in all diagnostic steps and therapeutic decisions. They should also form the basis for discussions of potential conflicts of interest among patients, doctors, healthcare financers and politicians. Cardiovascular (CV) diseases represent the most frequent cause of death and a major healthcare problem in most regions of the world. CV prevention is therefore an important task both in individual subjects and as a means to improve health in the general population. While the merits of treatment in patients with established CV diseases, i.e. secondary prevention, are widely accepted and regarded as necessary, primary prevention with drugs in apparently healthy individuals at an increased risk of future CV events is not free of controversies. The different types of prevention envisaged also give rise to ethical questions: Should all the growing number of classical and newly recognised CV risk markers be a reason for intervention or should they be preferably used for calculating a total risk score? What are the compelling or only relative indications for anti-hypertensive, cholesterol-lowering, anti-diabetic or platelet-inhibiting drugs? Are pre-hypertension, pre-diabetes and marginally elevated cholesterol levels early diseases justifying drug treatment, regardless of the possibility that some prophylactic interventions may be associated with adverse events? Discussions also often arise concerning the role of age, gender and of non-CV co-morbidities for decisions about long-term prevention with drugs. How reliable and applicable are 'evidence-based' guidelines derived from trials in highly selected patients and healthy subjects for the general population seen in everyday practice? Increasingly, the economic aspects of long-term prevention and problems of a fair allocation of limited healthcare resources are also important issues giving rise to contrasting views among patients, doctors, insurance providers and politicians. What are the priorities and who should decide? Ethical considerations relating to the above questions in CV prevention are discussed in this article.

☐ **Do cardiologists and cardiac surgeons need ethics? Achieving happiness for a drug user with endocarditis**
Auteur(s) : Bromage DI, McLauchlan DJ, Nightingale AK
Source : Heart 2009;95:885-887

Ethical dilemmas are commonplace in clinical cardiology. There has been a recent focus on ethical behaviour of cardiologists and debate about resource allocation and cost-effectiveness of new technologies. The case of an intravenous drug addict, with native aortic valve endocarditis

complicated by a cerebral abscess and severe aortic regurgitation, is presented to illustrate some common ethical and moral dilemmas. The predominant theories in medical ethics, including the "Four-Principles Approach," is discussed, and a model to translate these ethical theories into a clinical decision-making tool is presented.

Chirurgie

☐ **Ethical obligation of surgeons to noncompliant patients : can a surgeon refuse to operate on an intravenous drug-abusing patient with recurrent aortic valve prosthesis infection ? Pro and con**
Auteur(s) : DiMaio JM, Salerno TA, Bernstein R, Araujo K, Ricci M, Sade RM
Source : Ann Thorac Surg 2009 ; 88(1) :1-8

☐ **Ethics of surgical complications**
Auteur(s) : Adedeji S, Sokol DK, Palser T, McKneally MF
Source : World Journal of Surgery 2009; 33: 732-37

The purpose of this overview is to delineate the key ethical issues relating to surgical complications. As space is limited and the scope of the subject vast, we consider the issues from the surgeon's perspective rather than that of other members of the surgical team.

☐ **Unravelling ethical challenges in surgery**
Auteur(s) : McCullough LB, Jones JW
Source : The Lancet 2009; 374:1058-1059

The history of surgical medical ethics and the new challenges it faces in regard to conflict of interests and surgical innovation.

Confidentialité

☐ **Factors influencing attitudes towards medical confidentiality among Swiss physicians**
Auteur(s) : Elger, B. S.
Source : Journal of Medical Ethics 2009 ;35(8):517-24.

Medical confidentiality is a core concept of professionalism and should be an integral part of pregraduate and postgraduate medical education. The aim of our study was to define the factors influencing attitudes towards patient confidentiality in everyday situations in order to define the need for offering further education to various subgroups of physicians. All internists and general practitioners who were registered members of the association of physicians in Geneva or who were working in the department of internal medicine or in the medical polyclinic of the University Hospital of Geneva in 2004 received a standardised questionnaire. Physicians were asked to indicate for seven vignettes whether a violation of confidentiality had occurred and whether the violation was not important, important or serious (scores 1-3; no violation = 0). 508 completed questionnaires were returned (participation rate 55%). Physicians who had worked in the hospital for more than 20 years identified violations of confidentiality more often than physicians with less hospital experience. Binary logistic regression showed that ethics education, total years of professional experience, being an internist, having a private practice, the length of working in private practice and gender were factors associated with correct identification of violations and their severity. However, each factor played a specific role only for single cases or a small number of situations (Cronbach alpha <0.6). Postgraduate education programs on confidentiality should be offered to a wide range of physicians and should address specific hypothetical situations in which there is a risk of avoidable breaches of confidentiality.

Conflits d'intérêts

☐ **Même chez les médecins la publicité est efficace !**
Auteur(s) : Strebel U, Michaud A
Source : Bull Med Suisses. 2009 ; 90(38) :1455-1457

Article de la série « Collaboration corps médical – industrie » de l'ASSM.

DRG

☐ **Les DRG: l'éthique contre l'économie?**
Auteur(s) : Wild V, Pfister E, Biller-Andorno N
Source : Bulletin ASSM 2009 ;1 : 1-5.

L'introduction en Suisse des forfaits par cas - également appelés DRG (diagnosis related groups) ou GHM (groupes homogènes de malades) - correspond à un changement de système: ce n'est plus la planification des infrastructures et des lits qui se trouve placée au premier plan, mais une

rémunération liée aux prestations, qui se conforme aux activités caractérisitiques définies pour le diagnostic correspondant. On espère réaliser des économies substantielles dans le domaine de la santé grâce à ce changement de système. Mais en même temps, des craintes de voir les DRG conduire à une baisse de la qualité des soins se font jour. Dans l'article suivant, Dr Verina Wild, lic. phil. Eliane Pfister et la Professeure Nikola Biller-Andorno de l'Institut d'éthique biomédicale de l'Université de zurich présentent le contexte de l'introduction des GHM, examinent les conséquences possibles pour les patients et les professionnels de la santé et expliquent pourquoi une recherche éthique d'accompagnement s'impose.

Etat végétatif

☐ **Functional neuroimaging and withdrawal of life-sustaining treatment from vegetative patients**
Auteur(s) : Wilkinson DJ, Kahane G, Horne M, Savulescu J
Source : Journal of Medical Ethics 2009; 35(8):508-11.

Recent studies using functional magnetic resonance imaging of patients in a vegetative state have raised the possibility that such patients retain some degree of consciousness. In this paper, the ethical implications of such findings are outlined, in particular in relation to decisions about withdrawing life-sustaining treatment. It is sometimes assumed that if there is evidence of consciousness, treatment should not be withdrawn. But, paradoxically, the discovery of consciousness in very severely brain-damaged patients may provide more reason to let them die. Although functional neuroimaging is likely to play an increasing role in the assessment of patients in a vegetative state, caution is needed in the interpretation of neuroimaging findings.

Fin de vie

☐ **Deactivating cardiac pacemakers and implantable cardioverter defibrillators in terminally ill patients**
Auteur(s) : Beca JP, Rosselot E, Asenjo R, Anguita V, Quevedo R
Source : Camb Q Healthc Ethics 2009; 18(3):236-240

Suspending mechanical ventilation is one of the most difficult decisions in limiting treatment, given that death cacn happen shortly after the ventilator is removed, generating the deceiving impression of causing death. Even if the foundations for withdrawing assisted ventilation are clear, experience shows that it is always a troublesome decision. This is very similar in the case of terminally ill patients with CPMs, because it is assumed that such a device could prolong life.

☐ **The death of DNR : can a change of terminology improve end of life care?**
Auteur(s) : Sokol DK
Source : British Medical Journal 2009; 338: 1043

Should we use AND (allow natural death) instead of DNR (do not resuscitate)?

☐ **Are physicians' recommendations to limit life support beneficial or burdensome?**
Auteur(s) : White DB, Evans LR, Bautista CA, Luce JM, Lo B
Source : Am J Respir Crit Care Med 2009; 180:320-325

RATIONALE: Although there is a growing belief that physicians should routinely provide a recommendation to surrogates during deliberations about withdrawing life support, there is a paucity of empirical data on surrogates' perspectives on this topic. OBJECTIVES: To understand the attitudes of surrogate decision-makers toward receiving a physician's recommendation during deliberations about whether to limit life support for an incapacitated patient. METHODS: We conducted a prospective, mixed methods study among 169 surrogate decision-makers for critically ill patients. Surrogates sequentially viewed two videos of simulated physician-surrogate discussions about whether to limit life support, which varied only by whether the physician gave a recommendation. MEASUREMENTS AND MAIN RESULTS: The main quantitative outcome was whether surrogates preferred to receive a physicians' recommendation. Surrogates also participated in an in-depth, semistructured interview to explore the reasons for their preference. Fifty-six percent (95/169) of surrogates preferred to receive a recommendation, 42% (70/169) preferred not to receive a recommendation, and 2% (4/169) felt that both approaches were equally acceptable. We identified four main themes that explained surrogates' preferences, including surrogates' perceptions of physicians' appropriate role in life or death decisions and their perceptions of the positive or negative consequences of a recommendation on the physician-surrogate relationship, on the decision-making process, and on long-term regret for the family. CONCLUSIONS: There is no consensus among surrogates about whether physicians should routinely provide a recommendation regarding life support decisions for incapacitated patients. These findings suggest that physicians should ask surrogates whether they wish to receive a recommendation regarding life support decisions and should be flexible in their approach to decision-making.

☐ **Contradictions in end-of-life decisions for self and other, expressed by relatives of chronically ventilated patients**

Auteur(s) : Sviri S, Garb Y, Stav I, Rubinow A., Linton DM, Caine,YG, Marcus, EL
Source : Journal of Critical Care 2009; 24: 293-301.

OBJECTIVES: In certain populations, social, legal, and religious factors may influence end-of-life decisions in ventilator-dependent patients. This study aims to evaluate attitudes of first-degree relatives of chronically ventilated patients in Israel, toward end-of-life decisions regarding their loved ones, themselves, and unrelated others. MATERIALS AND METHODS: The study was conducted in a chronic ventilation unit. First-degree family members of chronically ventilated patients were interviewed about their end-of-life attitudes for patients with end-stage diseases. Distinctions were made between attitudes in the case of their ventilated relatives, themselves, and unrelated others; between conscious and unconscious patients; and between a variety of interventions. RESULTS: Thirty-one family members of 25 patients were interviewed. Median length of ventilation at the time of the interview was 13.4 months. Most interviewees wanted further interventions for their ventilated relatives, yet, for themselves, only 21% and 18% supported chronic ventilation and resuscitation, respectively, and 48% would want to be disconnected from the ventilator. Interventions were more likely to be endorsed for others (vs self), for the conscious self (vs unconscious self), and for artificial feeding (vs chronic ventilation and resuscitation). Interviewees were reluctant to disconnect patients from a ventilator. CONCLUSIONS: Family members often want escalation of treatment for their ventilated relatives; however, most would not wish to be chronically ventilated or resuscitated under similar circumstances. Advance directives may reconcile people's wishes at the end of their own lives with their reticence to make decisions regarding others.

Gériatrie

☐ **Video decision support tool for advance care planning in dementia: randomised controlled trial**

Auteur(s) : Volandes AE, Paasche-Orlow MK, Barry MJ, Gillick MR, Minaker KL, Chang Y, Cook EF, Abbo ED, El-Jawahri A, Mitchell SL
Source : British Medical Journal 2009; 338: b2159 (8p.)

OBJECTIVE: To evaluate the effect of a video decision support tool on the preferences for future medical care in older people if they develop advanced dementia, and the stability of those preferences after six weeks. DESIGN: Randomised controlled trial conducted between 1 September 2007 and 30 May 2008. Setting Four primary care clinics (two geriatric and two adult medicine) affiliated with three academic medical centres in Boston. PARTICIPANTS: Convenience sample of 200 older people (>or=65 years) living in the community with previously scheduled appointments at one of the clinics. Mean age was 75 and 58% were women. INTERVENTION: Verbal narrative alone (n=106) or with a video decision support tool (n=94). MAIN OUTCOME MEASURES: Preferred goal of care: life prolonging care (cardiopulmonary resuscitation, mechanical ventilation), limited care (admission to hospital, antibiotics, but not cardiopulmonary resuscitation), or comfort care (treatment only to relieve symptoms). Preferences after six weeks. The principal category for analysis was the difference in proportions of participants in each group who preferred comfort care. RESULTS: Among participants receiving the verbal narrative alone, 68 (64%) chose comfort care, 20 (19%) chose limited care, 15 (14%) chose life prolonging care, and three (3%) were uncertain. In the video group, 81 (86%) chose comfort care, eight (9%) chose limited care, four (4%) chose life prolonging care, and one (1%) was uncertain (chi(2)=13.0, df=3, P=0.003). Among all participants the factors associated with a greater likelihood of opting for comfort care were being a college graduate or higher, good or better health status, greater health literacy, white race, and randomisation to the video arm. In multivariable analysis, participants in the video group were more likely to prefer comfort care than those in the verbal group (adjusted odds ratio 3.9, 95% confidence interval 1.8 to 8.6). Participants were re-interviewed after six weeks. Among the 94/106 (89%) participants re-interviewed in the verbal group, 27 (29%) changed their preferences (kappa=0.35). Among the 84/94 (89%) participants re-interviewed in the video group, five (6%) changed their preferences (kappa=0.79) (P<0.001 for difference). CONCLUSION: Older people who view a video depiction of a patient with advanced dementia after hearing a verbal description of the condition are more likely to opt for comfort as their goal of care compared with those who solely listen to a verbal description. They also have more stable preferences over time.

Greffe d'organes

☐ **Des critères médicaux suffisent-ils pour allouer équitablement les organes?**

Auteur(s) : Kauffmann AE
Source : Bulletin des médecins suisses 2009 ; 90(24):971-72.

Gynécologie - Obstétrique

☐ **What do medical students experience as moral problems during their obstetric and gynaecology clerkship?**
Auteur(s) : Olthuis G, Dukel L
Source : Journal of Medical Ethics 2009; 34(9):e2

This article reports on moral problems that were raised by medical students as the basis for an ethical case-conference in an obstetrics and gynaecology clerkship. After introducing the issue of teaching clinical ethics, the method of our case-conference is explained. Next, the variety of topics and related moral problems are presented. The article continues with a discussion of three distinct and challenging aspects that characterise obstetrics and gynaecology as a domain for teaching clinical ethics. The conclusion puts forward three significant points our review raises.

☐ **Practical and ethical considerations of noninvasive prenatal diagnosis**
Auteur(s) : Benn PA, Chapman AR
Source : Journal of the American Medical Association 2009; 301(20):2154-56

☐ **Is the non-respect of ethical principles by health professionals during first-trimester sonographic Down syndrome screening damaging to patient autonomy?**
Auteur(s) : Favre R, Guige V, Weingertner A-S, Vayssière C, Kohler M, Nisand I, Hervé C, Moutel G
Source : Ultrasound Obstet Gynecol 2009, 34(1):25-32

OBJECTIVES: To evaluate the understanding of health professionals involved in first-trimester ultrasound screening of the ethical stakes involved by addressing three questions regarding: how much these professionals know about Down syndrome screening by nuchal translucency thickness measurement; their personal opinion with respect to this screening test; and their attitude with respect to their patients, in order to answer the question: 'Are ethical principles respected when women are proposed ultrasound screening during the first trimester of pregnancy?' METHODS: We studied the medical population in the east part of France by sending a questionnaire to each of 460 medical correspondents. This questionnaire attempted to evaluate the respondent's level of medical knowledge, their personal opinion with respect to first-trimester screening and their attitude towards their patients. We adapted the three-dimensional diagram designed by Marteau et al. to develop a measure of informed choice regarding screening. Only health professionals who were relatively well informed and adopted an autonomy-oriented approach were considered to be in a position to obtain true consent from their patients, respecting ethical principles in terms of competence and the autonomy of patients. RESULTS: We received 276 (60%) responses to the questionnaire. Only 31.9% of health professionals had an approach that facilitated obtaining true consent from their patients and respected the ethical principles of competence and patient autonomy; 46% were in favor of the screening test and adopted an autonomy-oriented approach but were poorly informed; and 15.4% had a directive-authoritarian approach combined with poor knowledge. Regression analysis showed that two independent factors (speciality ($P = 0.031$) and location of practice ($P = 0.034$)) affected the level of medical knowledge, and two independent factors (location of practice ($P = 0.034$) and the type of medical practice i.e. public or private ($P < 0.05$)) affected the opinion of health professionals about the screening test. Two independent factors (speciality ($P < 0.001$) and the age of the health professional ($P = 0.02$)) affected the attitudes of health professionals towards their patients. CONCLUSION: The answer to the question 'Are ethical principles respected when women are proposed ultrasound screening during the first trimester of pregnancy?' is clearly 'No'. Major effort is required to ensure that the decisions made by patients are based on a possibility of true choice.

Oncologie

☐ **Ethical issues regarding fertility preservation in adolescents and children**
Auteur(s) : Cohen CB
Source : Pediatr Blood Cancer 2009 ; 53(2) : 249-253

Certain forms of treatment for cancer in children and adolescents may significantly affect their fertility. Oncologists and specialists in reproductive medicine are attempting to use various methods of fertility preservation to address this problem. However, major medical/biological issues must be resolved before many of these methods can be considered accepted medical treatments. In addition, ethical considerations that such treatments bring to the fore, including those relevant to assent by children and the provision of experimental treatment to children, must be taken into account. This article addresses the current and future medical and ethical status of the development of fertility-preserving treatment for adolescents and children who are to receive cancer treatment

Pédiatrie

☐ **Ethics in everyday pediatrics**
Auteur(s) : Jacobson RM, Antiel RM, Fischer PR
Source : J Pediatr 2009 ; 154(6) :781-82

In pediatric practice, ethical implications are frequently considered with end-of-life care, research, and genomic screening. Less often recognized, however, are the substantial ethical concerns that regularly arise within general pediatric practice. In this brief commentary, we wish to draw attention to the ethical questions underlying common clinical situations and provide some framework to guide our deliberations.

☐ **La recherche sur les enfants : présentation de la récente prise de position de la NEK-CNE**
Auteur(s) : NEK-CNE
Source : Bulletin des médecins suisses 2009 ; 90(17) :655-58.

☐ **Clinical report - Forgoing medically provided nutrition and hydration in children**
Auteur(s) : Diekema DS, Botkin JR; Committee on Bioethics; American Academy of Pediatrics.
Source : Pediatrics. 2009 Aug;124(2):813-22

There is broad consensus that withholding or withdrawing medical interventions is morally permissible when requested by competent patients or, in the case of patients without decision-making capacity, when the interventions no longer confer a benefit to the patient or when the burdens associated with the interventions outweigh the benefits received. The withdrawal or withholding of measures such as attempted resuscitation, ventilators, and critical care medications is common in the terminal care of adults and children. In the case of adults, a consensus has emerged in law and ethics that the medical administration of fluid and nutrition is not fundamentally different from other medical interventions such as use of ventilators; therefore, it can be forgone or withdrawn when a competent adult or legally authorized surrogate requests withdrawal or when the intervention no longer provides a net benefit to the patient. In pediatrics, forgoing or withdrawing medically administered fluids and nutrition has been more controversial because of the inability of children to make autonomous decisions and the emotional power of feeding as a basic element of the care of children. This statement reviews the medical, ethical, and legal issues relevant to the withholding or withdrawing of medically provided fluids and nutrition in children. The American Academy of Pediatrics concludes that the withdrawal of medically administered fluids and nutrition for pediatric patients is ethically acceptable in limited circumstances. Ethics consultation is strongly recommended when particularly difficult or controversial decisions are being considered.

☐ **Addressing ethical concerns regarding pediatric palliative care research**
Auteur(s) : Rapoport A
Source : Archives of Pediatrics & Adolescent Medicine 2009; 163(8):688-91

Some of the principal factors hindering the development and conduct of pediatric palliative care (PPC) research - which ranges from observational to interventional study designs involving children with life-threatening conditions, their parents, or their siblings - stem from ethical concerns. This article reviews these ethical concerns, which may be divided into 2 domains: (1) the balance of risk and benefits and (2) informed consent and autonomy. We will examine the evidence regarding the validity of these concerns and consider how forseeable ethical challenges might be resolved through thoughtful study design.

Réanimation

☐ **Code status discussions and goals of care among hospitalised adults**
Auteur(s) : Kaldjian LC, Erekson ZD, Haberle TH, Curtis AE, Shinkunas LA, Cannon KT, Forman-Hoffman VL
Source : Journal of Medical Ethics 2009; 35:338-42.

BACKGROUND AND OBJECTIVE: Code status discussions may fail to address patients' treatment-related goals and their knowledge of cardiopulmonary resuscitation (CPR). This study aimed to investigate patients' resuscitation preferences, knowledge of CPR and goals of care.
Design, setting, patients and measurements: 135 adults were interviewed within 48 h of admission to a general medical service in an academic medical centre, querying code status preferences, knowledge about CPR and its outcome probabilities and goals of care. Medical records were reviewed for clinical information and code status documentation. RESULTS: 41 (30.4%) patients had discussed CPR with their doctor, 116 (85.9%) patients preferred full code status and 11 (8.1%) patients expressed code status preferences different from the code status documented in their medical record. When queried about seven possible goals of care, patients affirmed an average of 4.9 goals; their

single most important goals were broadly distributed, ranging from being cured (n = 36; 26.7%) to being comfortable (n = 8; 5.9%). Patients' mean estimate of survival to discharge after CPR was 60.4%. Most patients believed it was helpful to discuss goals of care (n = 95; 70.4%) and the chances of surviving in hospital CPR (n = 112; 83.0%). Some patients expressed a desire to change their code status after receiving information about survival following in hospital CPR (n = 11; 8.1%) or after discussing goals of care (n = 2; 1.5%). CONCLUSIONS: Doctors need to address patients' knowledge about CPR and take steps to avoid discrepancies between treatment orders and patients' preferences. Addressing CPR outcome probabilities and goals of care during code status discussions may improve patients' knowledge and influence their preferences.

Santé publique

☐ **Responsibility as an ethical framework for public health interventions**
Auteur(s) : Turoldo, F
Source : Am J Public Health 2009 ; 99(7):1197-1202

Bioethical debate has been characterized from the beginning by the central importance placed on autonomy. This is because bioethics has, until now, been concerned with the relationship between doctor and patient in a clinical context or, alternatively, with the rights of individuals involved in biomedical research. The increased involvement of bioethics in the domain of public health, however, makes it necessary to refer to other principles and values, thus shaping a new responsibility-focused bioethics that extends itself beyond the early boundaries of this discipline.

Soins intensifs

☐ **The principle of justice in patient priorities in the intensive care unit: the role of significant others**
Auteur(s) : Halvorsen K, Forde R, Nortvedt P
Source : Journal of Medical Ethics 2009; 35(8):483-87

BACKGROUND: Theoretically, the principle of justice is strong in healthcare priorities both nationally and internationally. Research, however, has indicated that questions can be raised as to how this principle is dealt with in clinical intensive care. OBJECTIVE: The objective of this article is to examine how significant others may affect the principle of justice in the medical treatment and nursing care of intensive care patients. METHOD: Field observations and in-depth interviews with physicians and nurses in intensive care units (ICU). Emphasis was placed on eliciting the underlying rationale for prioritisations in clinical intensive care with particular focus on clinicians' considerations when limiting ICU treatment. RESULTS: Significant others could induce an unintentional discrimination of ICU patients. Family members who were demanding received more time and attention for both the patient and themselves. Patients' and families' status and position and/or an interesting medical diagnosis seemed to govern the clinicians' priorities of patients and families-consciously as well as unconsciously. The clinicians emphasised that patient information given through families was important. However, patients' preferences and values conveyed to clinicians through their families were not always taken seriously. This even applied in cases with very serious prognoses and an explicit patient wish to forego life-prolonging treatment. CONCLUSION: The principle of justice was violated when qualified attention was given to significant others, and through this also to patients. Attention given to significant others was influenced by the healthcare workers' professional and personal values, attitudes and interests.

☐ **To transfer or not to transfer, that is the question**
Auteur(s) : Jones JW, McCullough LB
Source : J Vasc Surg 2009; 49(5): 1337-38

An elderly patient who underwent a complex emergency abdominal aneurysmectomy two weeks ago is in coma, ventilator dependent, and in severe multisystem organ failure with a deteriorating prognostic index score. The family has become increasingly hostile towards Dr S. Cold, the consultants, the ICU nurses, and the janitorial staff. An estranged wife has called once to defer decision-making to the children. Three children intermittently visit and are openly critical of the medical care. One child is an ICU nurse supervisor at a small local suburban hospital. Dr Cold spoke to the family yesterday about instituting DNR orders and discontinuing some supportive therapy that was not working. The family first required another consultation and then demanded that Dr Cold transfer the patient to the hospital where the daughter works. The hospital does not provide tertiary care. A physician there is willing to assume responsibility. How should Dr Cold respond? A. Do as they request. B. Refuse outright. C. Call the accepting physician and explain why the case is futile. D. Take the matter to the ethics committee to prevent transfer. E. Call the wife and children to schedule an exploratory family conference and insist they come to a decision.