



Revue bibliographique médicale No 3 Avril 2010

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Nom : Service :

Lieu :

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

Auteur(s) : Wendler, D.

Source : Journal of Medical Ethics. 2010, 36 (2):66-70

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

Medical professionalism in the age of online social networking

Auteur(s) : Guseh II, J. S., Brendel, R. W., and Brendel, D. H.

Source : Journal of Medical Ethics. 2009, 35 (9) :584-586

The rapid emergence and exploding usage of online social networking forums, which are frequented by millions, present clinicians with new ethical and professional challenges. Particularly among a younger generation of physicians and patients, the use of online social networking forums has become widespread. In this article, we discuss ethical challenges facing the patient-doctor relationship as a result of the growing use of online social networking forums. We draw upon one heavily used and highly trafficked forum, Facebook, to illustrate the elements of these online environments and the ethical challenges peculiar to their novel form of exchange. Finally, we present guidelines for clinicians to negotiate responsibly and professionally their possible uses of these social forums.

L'acceptation et l'implémentation des directives de l'ASSM dans le quotidien médical et infirmier

Auteur(s) : Pfister, E.

Source : Bulletin des médecins suisses. 2010 ; 91:520-521

Les directives « Prise en charge de patientes et patients en fin de vie », « Soins palliatifs », « Problèmes éthiques aux soins intensifs » et « Diagnostic de la mort dans la transplantation d'organes » ont été choisies pour cette évaluation menée par l'institut d'éthique biomédicale de l'Université de Zurich sur demande de l'Académie Suisse des Sciences Médicales. Un questionnaire anonyme a été envoyé à 1933 médecins (généralistes et internistes) et infirmiers. Une faible majorité de médecins connaît certains contenus des directives « Prise en charge des patientes et patients en fin de vie ». Environ un sixième n'en a jamais entendu parler et un tiers en a entendu parler, mais connaît à peine leur contenu. A peu près un cinquième des médecins est familiarisé avec la totalité du contenu des directives sur la prise en charge en fin de vie. Les résultats concernant les directives « Soins palliatifs » et « « Problèmes éthiques aux soins intensifs » sont très similaires. Les directives « Diagnostic de la mort dans la transplantation d'organes » semblent par contre mieux connues.

Anesthésie - Antalgie

Undertreating pain violates ethical principles

Auteur(s) : Macpherson, C.

Source : Journal of Medical Ethics. 2009, 35 :603-606

Disabling pain or symptoms can occur at any age from many different causes. Pain and palliative specialists are able to relieve most pain and symptoms, although repeated adjustments to modalities, medications and doses may be needed. Because pain and palliative specialists comprise only a small

percentage of physicians, many patients find it difficult to access them or obtain pain relief. Globally, there are too few such specialists to meet existing needs. Most are affiliated with hospice and palliative units, so their accessibility to patients without terminal conditions is negligible. Doctors outside pain and palliative specialties are often unfamiliar with pain guidelines and sceptical about patient reports of unrelieved pain. They are therefore likely to undertreat it. Undertreating pain, however, violates respect for persons and beneficence. This paper reviews literature supporting these claims and offers a narrative description of the author's attempts to find relief from shingles and postherpetic neuralgia. It argues that physicians in most specialties are not, but should be, familiar with palliative evidence and guidelines so that they are equipped to relieve pain and symptoms quickly and effectively. Such information should be routinely introduced in medical curricula to encourage the mastery of knowledge, attitudes and skills necessary to upholding ethical principles and to ensure that more doctors in any discipline are willing to believe and be compassionate to patients whose pain is unresponsive to initial treatments. Routinely exposing students to such information would better prepare them to fulfil their professional duties to patients and society.

Ethical concerns in the management of pain in the neonate

Auteur(s) : Mancuso, T. and Burns, J.

Source : Pediatric Anesthesia. 2009, 19 :953-957

The debate about the management of pain in the neonate has continued to evolve over the past 30 years. This controversy can be understood as evolving through now three eras of thought about the effect of pain and its management in newborns and infants. The first generation was characterized by a widespread belief that newborns lacked the complete development of the neuroanatomical and neuroendocrine components necessary to perceive pain. During this period, newborns often received inadequate anesthesia and analgesia for painful procedures, if not no treatment at all. The second generation was heralded by research that demonstrated that newborns did demonstrate similar or even exaggerated physiological and hormonal responses to pain compared with those observed in older children and adults and that exposure to prolonged or severe pain may increase neonatal morbidity. Controversy in this generation focused around the dosage of analgesia to newborns as well as the risks and benefits of pain management techniques. We are now in a third generation of thought about pain in the neonate, defined by intense debate over the significance of a growing number of studies in immature animal models that demonstrate degenerative effects of several anesthetics on neuronal structure. The challenge of this era is to integrate the advances in diagnosis and treatment achieved in previous generations with ongoing adaptation of clinical practice as dictated by research advances in the field. In this review, we examine the evolution of medical thought and ethical concerns regarding pain treatment in the neonate.

Chirurgie

The perils of commercially driven surgical innovation

Auteur(s) : Wall, L. L. and Brown, D.

Source : American Journal of Obstetrics and Gynecology. 2010 (202) :30.e1-30.e4

The practice of gynecological surgery is being reshaped by commercial interests that are promoting the use of trochar-and-mesh surgical kits for the treatment of stress incontinence and pelvic organ prolapse. In this article, we review the recent history of these surgical innovations and discuss the implications of changes in surgical practice that are driven by commercial interests of this kind. We situate this phenomenon within the general "life cycle" of surgical innovation and point out the dangers inherent in the adoption of new procedures without adequate evidence to support their safety and efficacy. We highlight the ethical responsibilities surgeons and their professional organizations have in making sure such innovations are safe and effective before they come into widespread use. Finally, we offer some policy suggestions to ensure that this process has proper oversight.

Consentement

Assessment of the capacity to consent to treatment in patients admitted to acute medical wards

Auteur(s) : Fassassi, S., Bianchi, Y., Stiefel, F., and Waeber, G.

Source : BMC Medical Ethics. 2009, 10 (15) :[8 p.]

Background: Assessment of capacity to consent to treatment is an important legal and ethical issue in daily medical practice. In this study we carefully evaluated the capacity to consent to treatment in patients admitted to an acute medical ward using an assessment by members of the medical team, the specific Silberfeld's score, the MMSE and an assessment by a senior psychiatrist.

Methods: Over a 3 month period, 195 consecutive patients of an internal medicine ward in a university hospital were included and their capacity to consent was evaluated within 72 hours of admission.

Results: Among the 195 patients, 38 were incapable of consenting to treatment (unconscious patients or severe cognitive impairment) and 14 were considered as incapable of consenting by the psychiatrist

(prevalence of incapacity to consent of 26.7%). Agreement between the psychiatrist's evaluation and the Silberfeld questionnaire was poor (sensitivity 35.7%, specificity 91.6%). Experienced clinicians showed a higher agreement (sensitivity 57.1%, specificity 96.5%). A decision shared by residents, chief residents and nurses was the best predictor for agreement with the psychiatric assessment (sensitivity 78.6%, specificity 94.3%). Conclusion: Prevalence of incapacity to consent to treatment in patients admitted to an acute internal medicine ward is high. While the standardized Silberfeld questionnaire and the MMSE are not appropriate for the evaluation of the capacity to consent in this setting, an assessment by the multidisciplinary medical team concurs with the evaluation by a senior psychiatrist

Directives anticipées / Représentant thérapeutique

- Are advance directives legally binding or simply the starting point for discussion on patient's best interests ?**

Auteur(s) : Bonner, S., Tremlett, M., and Bell, D.

Source : British Medical Journal. 2009, 339 :1230-1234

Following advance directives in emergencies throws up some complicated problems, as Stephen Bonner and colleagues found. We asked an emergency doctor, a medical defence adviser, and an ethicist what they would do in the circumstances.

- Reconceptualizing the experience of surrogate decision making: reports vs genuine decisions**

Auteur(s) : Braun, U. K., Naik, A. D., and McCullough, L. B.

Source : Annals of Family Medicine. 2009, 7 (3) :249-253

BACKGROUND: We propose a reconceptualization of surrogate decision making when patients lack an advance directive stating their preferences about life-sustaining treatment. This reconceptualization replaces the current 2-standard model of substituted judgment (based on the patient's prior preferences and values) and best interests (an assessment of how best to protect and promote the patient's health-related and other interests). METHODS: We undertook a conceptual analysis based on the ethics of informed consent, a qualitative study of how surrogates of seriously ill patients experience the surrogate's role, and descriptions of decision making. RESULTS: When the surrogate can meet the substituted judgment standard, the experience of the surrogate should be understood as providing a report, not making a decision. Surrogate decisions based on the best interest standard are experienced as genuine decisions, and the label "surrogate decision making" should be reserved to characterize only these experiences. CONCLUSIONS: Physicians should identify clinically reasonable options and elicit the surrogate's sense of decision-making burden. Some surrogates will be able to make reports, and the physician should make a clear recommendation that implements the patient's reported preference. Some surrogates will confront genuine decisions, which should be managed by negotiating treatment goals. Requests by the surrogate that everything be done may represent a psychosocially burdensome decision, and support should be provided to help the surrogate work through the decision-making process.

- Substituted misjudgment**

Auteur(s) : Woo, J. A. and Prager, K. M.

Source : Clinical Ethics. 2009, 4 :208-210

Substituted judgement is often used in the absence of advanced directives to guide decision-making when patients lack decisional capacity. We present a remarkable case of family members exercising substituted misjudgement for a 42-year-old man hospitalized with multiorgan failure on life support. Feeling that their loved one would rather die than face severe disability, they elected to withdraw life support. Although this was done, the patient remained alive and recovered enough to clearly indicate his preference for life, even with severe disability. This case suggests that in instances of unusual quality-of-life judgements where the patient's wishes cannot be known with reasonable certainty, families and physicians should be very wary using substituted judgement to refuse life support. Unless there are strong considerations based on the patient's prior statements, actions and values to decline life support, it would seem ethically appropriate to continue treatment, even with substantial disability the likely outcome

DRG

- L'introduction des DRG et la situation des patients dans une perspective éthique**

Auteur(s) : Kiefer, B.

Source : SGBE Bulletin. 2009 (59) :9-10

L'introduction des DRG s'inscrit au sein d'une évolution toujours plus paradoxale de la médecine hospitalière. D'un côté, s'impose un mouvement qui revendique que les patients soient mieux reconnus, considérés selon une vision holistique et non comme de simples porteurs d'une maladie. Et de l'autre

côté, s'affirme avec force une tendance contraire : celle du management centralisé. On n'y parle pas de patients, mais d' « itinéraires cliniques », de « coûts-efficacité », de « disease management », etc.

L'introduction des DRG et leur influence sur le personnel médical dans une perspective éthique

Auteur(s) : Hurst, S.

Source : SGBE Bulletin. 2009 (59) :24-26

Les enjeux éthiques au niveau institutionnel, où s'appliquent les Diagnosis Related Groups (DRG), et clinique, où se situe l'activité du personnel médical, sont distincts. Mais ces deux strates du système de santé ne fonctionnent pas isolément. Leurs caractéristiques, et les décisions qui y sont prises, s'influencent mutuellement, y compris sur le plan éthique. On sait que les systèmes de santé dans lesquels ils travaillent influencent les décisions des médecins. Des outils d'évaluation ont également été développés pour estimer l'impact probable des politiques de santé sur l'équité pour les patients. Ces deux approches permettent de se faire une idée, imparfaite il est vrai, de l'influence possible de l'introduction des DRG sur le personnel médical.

Fin de vie

Décisions médicales en fin de vie : discussion de cas : les aspects éthiques

Auteur(s) : Bosshard, G. and Riesen, E.

Source : PrimaryCare. 2009, 9 (17) :320-322

Etude de cas.

Demandes d'aide au décès (assistance au suicide et euthanasie) en médecine palliative

Auteur(s) : Moynier-Vantieghem, K., Weber, C., Espolio-Desbaillet, Y., Pautex, S., and Zulian, G.

Source : Revue Médicale Suisse. 3-2-2010, 6 (234) :261-265

Dans une étude prospective ouverte sur douze mois de patients hospitalisés, 44 demandes d'aide au décès ont été recensées pour 39 patients (25 cancers, six affections cardiovasculaires, deux Parkinson, trois arthroses, une BPCO, une démence et une dépression sévère). Quatorze étaient déprimés. 28 demandaient une euthanasie, seize un suicide assisté. A un mois, trois persistaient, seize avaient renoncé, seize étaient décédés et quatre n'étaient pas interrogés. A six mois, sept étaient en vie mais avaient renoncé, deux s'étaient suicidés à domicile. La majorité des demandes d'aide au décès correspondent à une euthanasie, soit à un homicide au sens du code pénal. En présence d'une telle demande, des objectifs réalistes à court terme doivent être fixés. De nombreux patients renoncent à leur projet ce qui témoigne d'une grande incertitude face aux soins et d'une non moins grande ambivalence face à la vie.

Using sedation without the consent of the terminally ill

Auteur(s) : Raftery, A. and Willard, C.

Source : European Journal of Palliative Care. 2009, 16 (4) :178-182

Anne-Marie Raftery and Carole Willard consider the arguments for and against using terminal sedation without the patient's consent, and ask whether it can be regarded as an appropriate and ethically justifiable act to control distress in the context of end-of-life care

Information au patient

Clinical ethics committee case 9: should we inform our patient about animal products in his medicine?

Auteur(s) : Newson, A. J.

Source : Clinical Ethics. 2010, 5 (1) :7-12

Truth-telling in health care

Auteur(s) : Slowther, A.

Source : Clinical Ethics. 2009, 4 :173-175

The moral importance of telling the truth is recognized in both moral theory and in the practical reality of everyday living. In the context of health care, the duty of a health professional to be honest with her patient is articulated in professional codes of conduct. There has been a gradual move over recent years in health care, particularly Western health care, to give more weight to patient autonomy, shared decision-making and better communication with patients. However, empirical studies continue to show that health-care professionals identify the question of truth-telling and disclosure as a source of moral and psychological discomfort in many situations. Clinicians may bring these dilemmas to a clinical ethics committee for advice. In this five-minute focus I will consider the moral arguments that inform the discussion of truth-telling in health care and explore the range of contexts in which difficulties might arise.

Oncologie

Prostate cancer screening: the controversy continues

Auteur(s) : Stark, J. R., Mucci, L., Rothman, K. J., and Adami, H.-O.
Source : British Medical Journal. 3-10-2009, 339 :784-786

Two long awaited randomised trials of PSA have reported this year. However, the results are unlikely to end the controversy over the benefits and harms of testing

Pédiatrie

Parental Views on Withdrawing Life-Sustaining Therapies in Critically Ill Children

Auteur(s) : Michelson, K. N., Koogler, T., Sullivan, C., del Pilar Ortega, M., Hall, E., and Frader, J.
Source : Archives of Pediatrics & Adolescent Medicine. 2009, 163 (11) :986-992

Objective : To broaden existing knowledge of pediatric end-of-life decision making by exploring factors described by parents of patients in the pediatric intensive care unit (PICU) as important/influential if they were to consider withdrawing life-sustaining therapies.

Design : Quantitative and qualitative analysis of semi-structured one-on-one interviews.

Setting : The PICUs at 2 tertiary care hospitals.

Participants : English- or Spanish-speaking parents who were older than 17 years and whose child was admitted to the PICU for more than 24 hours to up to 1 week.

Intervention : Semi-structured one-on-one interviews.

Results : Forty of 70 parents (57%) interviewed said they could imagine a situation in which they would consider withdrawing life-sustaining therapies. When asked if specific factors might influence their decision making, 64% of parents said they would consider withdrawing life-sustaining therapies if their child were suffering; 51% would make such a decision based on quality-of-life considerations; 43% acknowledged the influence of physician-estimated prognosis in their decision; and 7% said financial burden would affect their consideration. Qualitative analysis of their subsequent comments identified 9 factors influential to parents when considering withdrawing life-sustaining therapies: quality of life, suffering, ineffective treatments, faith, time, financial considerations, general rejection of withdrawing life-sustaining therapies, mistrust/doubt toward physicians, and reliance on self/intuition.

Conclusion : Parents describe a broad range of views regarding possible consideration of withdrawing life-sustaining therapies for their children and what factors might influence such a decision.

Everyday ethics issues in the outpatient clinical practice of pediatric residents

Auteur(s) : Moon, M., Taylor, H. A., McDonald, E. L., Hughes, M. T., and Carrese, J. A.
Source : Archives of Pediatrics & Adolescent Medicine. 2010, 163 (9) :838-843

OBJECTIVE: To describe the ethics issues that pediatric residents encounter during routine care in an outpatient teaching clinic. DESIGN: Qualitative study including in-depth interviews with pediatric residents and direct observation of interactions between preceptors and residents in a pediatric teaching clinic. SETTING: The Johns Hopkins Harriet Lane Pediatric Primary Care Clinic, March 20 through April 11, 2006. PARTICIPANTS: A convenience sample including all pediatric faculty preceptors supervising at the clinic during the 19 half-day sessions that occurred during the observation period (N = 15) and the pediatric residents seeing patients during these clinic sessions (N = 50). Main Outcome Measure Field notes of preceptor-resident discussions about patient care were made and transcribed for qualitative analysis. RESULTS: Qualitative analysis of the ethics content of cases presented by residents in this pediatric teaching clinic identified 5 themes for categorizing ethics challenges: (1) promoting the child's best interests in complex and resource-poor home and social settings; (2) managing the therapeutic alliance with parents and caregivers; (3) protecting patient privacy and confidentiality; (4) balancing the dual roles of learner and health care provider; and (5) using professional authority appropriately. CONCLUSIONS: Qualitative analysis of the ethics content of directly observed preceptor-resident case discussions yielded a set of themes describing the ethics challenges facing pediatric residents. The themes are somewhat different from the lists of residents' ethics experiences developed using recall or survey methods and may be very different from the ideas usually included in hospital-based ethics discussions. This may have implications for improving ethics education during residency training.

Clinical ethics committee case 7: our young patient is in heart failure but has multiple comorbidities. How can we best care for him and his family?

Auteur(s) : Newson, A. J.
Source : Clinical Ethics. 2009, 4 (3) :111-115

Compassionate and innovative treatments in children: a proposal for an ethical framework

Auteur(s) : Brierley, J. and Larcher, V.
Source : Archives of Disease in Childhood. 2009, 94 :651-654

Ethics and innovative therapies in children's medicine.

Withholding and withdrawing life-sustaining treatment in children

Auteur(s) : Wellesley,H.and Jenkins,I.A.
Source : Paediatr Anaesth. 19(10):972-8.

Modern medicine gives us the ability to prolong life even in situations where it may not be right to do so. This article discusses some of the complex ethical and legal issues surrounding withholding and withdrawing life-sustaining treatment in children, including the concepts of futility, best interests and intolerability. We advocate the use of a structured framework to help guide decision-making, particularly in the more difficult situations. The lack of a morally or legally significant difference between withholding and withdrawing treatment is discussed, as is the role of the doctrine of double effect (particularly in relation to the use of neuromuscular blocking agents during withdrawal of ventilatory support).

Radiologie

Ethical problems in radiology: medical error and disclosure

Auteur(s) : Magnavita N, Magnavita G, Fileni A, Bergamaschi A..
Source : Radiol Med. 2009 Dec;114(8):1345-55

In radiological practice, as in any medical activity, errors are inevitable despite being foreseeable and preventable. The approach to managing medical error and relations with patients prompt the need for resolving the ethical dilemma arising from conflicting legitimate interests. The solution to this dilemma is particularly complex in an environment in which the tendency to sue physicians for civil liability or incriminate them for criminal liability appears to be particularly high. The disclosure of error is undeniably useful in raising patient awareness, reducing their suffering, improving the quality of care and limiting the consequences of the damage. There does not appear to be any evidence to suggest disclosure modifies the probability of litigation against the physician.

Ethical problems in radiology: radiological consumerism

Auteur(s) : Magnavita N and Bergamaschi A..
Source : Radiol Med. 2009 Dec;114(7):1173-1181

One of the causes of the increasing request for radiological examinations occurring in all economically developed countries is the active role played by the patient-consumer. Consumerism places the radiologist in an ethical dilemma, between the principle of autonomy on the one hand and the ethical principles of beneficence, nonmaleficence and justice on the other. The choice made by radiologists in moral dilemmas is inspired by an adherence to moral principles, which in Italy and elsewhere refer to the Judaeo-Christian tradition or to neo-Darwinian relativism. Whatever the choice, the radiologist is bound to adhere to that choice and to provide the patient with all the relevant information regarding his or her state of health.

Recherche

La recherche clinique entre industrie et médecins

Auteur(s) : Obrist, R. and Biollaz, J.
Source : Bulletin des médecins suisses. 2009, 90 (41) :1569-1571

La recherche sponsorisée par l'industrie participe aux progrès de la médecine, à l'augmentation de nos connaissances et à la mise à disposition de nouveaux médicaments. Mais les conflits d'intérêts pour les médecins chercheurs et leurs institutions sont multiples. Les abus connus montrent les effets négatifs sur la qualité de la recherche clinique et ses conséquences pour les patients et les ressources des systèmes de santé et – le point peut-être le plus dramatique – pour l'intégrité éthique et la crédibilité de toute la recherche clinique. Cet article souhaite montrer comment on pourrait y remédier (du moins partiellement) en suivant les directives de l'Académie Suisse des Sciences Médicales (ASSM) et en illustrant quelques points pertinents par des références à des études scientifiques. Si cet article s'intéresse plus particulièrement aux relations avec les industriels du médicament, la majorité des points soulevés s'applique également aux autres industries de la santé (medical devices, en particulier).

Refus de traitement

Refus de traitement, refus d'hospitalisation: que faire?

Auteur(s) : Ducor, P.
Source : Revue Médicale Suisse. 2010, 6 (Supplément) :S37-S38

Le médecin confronté à un refus de traitement ou d'hospitalisation est partagé entre le devoir de soulager la souffrance de son patient et celui de respecter son autodétermination. Depuis une trentaine d'années, la priorité est clairement donnée à l'autodétermination du patient capable de discernement. Lui seul est habilité à déterminer, après avoir été informé de façon appropriée, ce qui est "bien" pour lui. N'étant pas en mesure de se déterminer valablement, le patient incapable de discernement fait l'objet d'une réglementation différente.