



Ethique Médicale – Bibliographie No 4 Octobre 2010

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Julia Mills, Communauté d'Intérêts de la Côte, Commission d'éthique, Ch. du Crêt 2, 1110 Morges

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How clinicians make (or avoid) moral judgments of patients : implications of the evidence for relationship and research

3235

Auteur(s) : Hill, T. E.

Source : Philosophy, ethics, and humanities in medicine. 2010, 5 (11) :14 pp

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

Anesthésie - Antalgie

Palliative care and involvement of anaesthesiology : current discussions

3264

Auteur(s) : Kettler, D. and Nauck, F.

Source : Current Opinion in Anaesthesiology. 2010, 23 (2) :173-176

PURPOSE OF REVIEW: To summarize various developments related to palliative care, especially related to ethical issues. To emphasize the involvement of anaesthesiology in palliative care. RECENT FINDINGS: Euthanasia has been legalized in Belgium, the Netherlands and Luxemburg (BENELUX countries). A group from Belgium has now proposed using euthanasia in patients in whom palliative care has been deemed 'futile'. This practice of so-called 'integral palliative care' is strongly rejected in a study from Germany. Palliative sedation is an ethically different approach with no intention to kill the patient. The European Association of Palliative Care has proposed a framework for individual guidelines for palliative sedation. The important role of anaesthesiology in palliative care teams is emphasized.

SUMMARY: Palliative care is a powerful approach to patient care during terminal illness, emphasizing quality of life even if it may shorten the length of life. Traditionally, palliative care has been contrasted with active euthanasia, but a group from Belgium has challenged this concept recently, advocating the use of euthanasia in circumstances in which palliative care has become 'futile'. This new approach led to strong reactions by a group from Germany, stressing that killing on demand in palliative care should under no circumstances be justified. In contrast, palliative sedation is a common method in special cases to reduce intractable symptoms. A new framework for palliative sedation produced by the European Association of Palliative Care may encourage institutions to set up their own palliative sedation guidelines. Worldwide, anaesthesiologists have a significant role in palliative care due to their unique complex expertise mainly in pain therapy and including transient sedation of patients.

Chirurgie

Moral angst for surgical residents : a qualitative study

3248

Auteur(s) : Knifed, E., Goyal, A., and Bernstein, M.

Source : American Journal of Surgery. 2010, 199 (4) :571-576

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.

Surgical "buy-in": the contractual relationship between surgeons and patients that influences decisions regarding life-supporting therapy

3204 Auteur(s) : Schwarze, M. L., Bradley, C. T., and Brasel, K. J.
Source : Critical Care Medicine. 2010, 38 (3) :843-848

OBJECTIVE: There is a general consensus by intensivists and nonsurgical providers that surgeons hesitate to withdraw life-sustaining therapy on their operative patients despite a patient's or surrogate's request to do so. The objective of this study was to examine the culture and practice of surgeons to assess attitudes and concerns regarding advance directives for their patients who have high-risk surgical procedures. **DESIGN:** A qualitative investigation using one-on-one, in-person interviews with open-ended questions about the use of advance directives during perioperative planning. Consensus coding was performed using a grounded theory approach. Data accrual continued until theoretical saturation was achieved. Modeling identified themes and trends, ensuring maximal fit and faithful data representation. **SETTING:** Surgical practices in Madison and Milwaukee, WI. **SUBJECTS:** Physicians involved in the performance of high-risk surgical procedures. **INTERVENTIONS:** None. **MEASUREMENTS AND MAIN RESULTS:** We describe the concept of surgical "buy-in," a complex process by which surgeons negotiate with patients a commitment to postoperative care before undertaking high-risk surgical procedures. Surgeons describe seeking a commitment from the patient to abide by prescribed postoperative care, "This is a package deal, this is what this operation entails," or a specific number of postoperative days, "I will contract with them and say, 'look, if we are going to do this, I am going to need 30 days to get you through this operation.'" "Buy-in" is grounded in a surgeon's strong sense of responsibility for surgical outcomes and can lead to surgeon unwillingness to operate or surgeon reticence to withdraw life-sustaining therapy postoperatively. If negotiations regarding life-sustaining interventions result in treatment limitation, a surgeon may shift responsibility for unanticipated outcomes to the patient. **CONCLUSIONS:** A complicated relationship exists between the surgeon and patient that begins in the preoperative setting. It reflects a bidirectional contract that is assumed by the surgeon with distinct implications and consequences for surgeon behavior and patient care.

To sleep or not to sleep, that is the question : [surgical ethics challenges]

3257 Auteur(s) : Jones, J. W. and McCullough, L. B.
Source : Journal of Vascular Surgery. 2010, 51 (4) :1033-1034

Case study : The chief of surgery finds a recently boarded vascular surgeon, Dr B.R. Ash, on the couch in the doctor's lounge where a resident is trying to awaken him for permission to start the elective schedule. Dr Ash had finished an arduous all-nighter emergency case less than an hour ago and mumbles for the resident to proceed. The chief surgeon knows that the case about to be started is a type IV thoracoabdominal aneurysm repair to be followed by a carotid endarterectomy.

- A. The chief of surgery should cancel the cases
- B. The less demanding case should be moves to be the first case
- C. The chief surgeon should appoint another rested surgeon to do the case
- D. Dr Ash should drink a coffee and re-evaluate before starting the case
- E. Dr Ash should be told to postpone the case until he has rested

Capacité de discernement et consentement

Practical considerations for determining patient capacity and consent

3259 Auteur(s) : Giordano, J. and Duffy, J.
Source : American Family Physician. 2010, 81 (9) :1090-1092
Case scenario

Capacité de discernement des adolescents mineurs : étude qualitative sur les représentations en Suisse romande

3200 Auteur(s) : Henninger, S., Michaud, P. A., and Akre, C.
Source : Revue Médicale Suisse. 2010 (253)

Cette recherche qualitative et exploratoire par focus groups investigate les représentations en matière de confidentialité et de capacité de discernement à l'adolescence. Quatre groupes de trois à huit personnes (deux groupes d'adolescentes, un groupe de parents et un groupe de médecins pédiatres) ont participé à une discussion semi-structurée de 60-90 minutes, transcrite verbatim puis analysée par grands thèmes. Si le concept du secret professionnel semble bien connu, les bases légales de la confidentialité mériteraient d'être mieux divulguées dans le public et parmi les professionnels de la santé. Adultes et adolescents admettent qu'à quatorze ans, la capacité de discernement est habituellement acquise, mais elle doit être, dans diverses situations, revisitée, et les médecins se sentent mal outillés pour évaluer cette capacité de cas en cas.

Compromised autonomy and the seriously ill patient

3240 Auteur(s) : Tonelli, M. R. and Misak, C. J.
Source : Chest. 2010, 137 (4) :926-931

Respect for patient autonomy has become the preeminent principle of medical ethics, to the point that tools have been developed, such as instructive directives, in an attempt to preserve a semblance of autonomy even when it has become clearly and irretrievably lost. Much of the practice around the respect for autonomy, however, mistakenly supposes that the capacity for autonomous choice is an all-or-nothing proposition. But seriously ill patients may retain some ability to participate in discussion of medical care yet have their autonomy profoundly compromised by physical duress, cognitive dysfunction, or delirium. The choices of individuals with compromised autonomy do not carry the same moral weight as those of the fully autonomous. Clinicians, therefore, cannot rely on such choices for guiding medical decisions and are obligated to evaluate them more fully before acting. We argue that clinicians should compare the choices of individuals with compromised autonomy to a medical assessment of the patient's best interest. When the patient's choice and the best-interests assessment are discordant, acting in the patient's best interest may, at times, rightly override the requests of the patient. Such an approach, under a tightly constrained set of circumstances, would permit both the provision and the withholding of medical interventions despite patient requests to the contrary.

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

3213 Auteur(s) : Breitsameter, C.
Source : Journal of Medical Ethics. 2010, 36 (6) :349-352

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

Erreurs médicales

L'erreur après l'erreur : la communication avec les patients à la suite d'un incident de traitement

3243 Auteur(s) : Schwappach, D. L. B.
Source : PrimaryCare. 2010, 10 (12) :223-224

Les erreurs commises dans le cadre des soins prodigués aux patients représentent souvent des situations extrêmes pour ces derniers, pour leurs proches, de même que pour les soignants impliqués. En plus des séquelles directes - des lésions physiques par exemple, ce qui se produit (ou ne se produit pas) après ces erreurs peut également s'avérer très pénible. Peur, colère, déception et anéantissement de la confiance du côté du patient, honte, sentiment de culpabilité et doute de soi du côté des personnels impliqués. L'attention et la sensibilité manifestées dans les rapports au patient peuvent tout au moins permettre d'éviter l'"erreur après l'erreur", et donc toute une série de crises.

Fin de vie

Sedation for the imminently dying : survey from the AAN Ethics Section

3262 Auteur(s) : Russell, J. A., Williams, M. A., and Drogan, O.
Source : Neurology. 2010, 74 :1303-1309

OBJECTIVES: Sedation for the imminently dying (SFTID) is a controversial practice that involves the provision of sedation to imminently dying patients with the intent of relieving their suffering when symptoms are refractory to other interventions. The goal of this research was to ascertain the opinions

regarding SFTID that are held by neurologists who are interested in ethics and end-of-life care. **METHODS:** Members of the American Academy of Neurology Ethics Section were surveyed regarding their familiarity and experience with SFTID and their opinions pertaining to it. To determine whether their opinions varied in relationship to clinical context, a single stem question for 5 different case scenarios was used. **RESULTS:** A total of 96% of respondents agreed or strongly agreed that the primary purpose of SFTID was to relieve suffering, 83% disagreed or strongly disagreed that SFTID was morally equivalent to euthanasia, and 85% disagreed or strongly disagreed that SFTID was legally equivalent to euthanasia. For the case scenarios, 92% agreed or strongly agreed that SFTID was acceptable for imminently dying patients with metastatic cancer, while 50% agreed or strongly agreed that SFTID was acceptable for patients with end-stage amyotrophic lateral sclerosis, and only 7% agreed or strongly agreed that SFTID was acceptable for posttraumatic quadriplegic patients not at risk for imminent death. **CONCLUSIONS:** The overwhelming majority of neurologists surveyed endorse the concept that sedation for the imminently dying differs morally and legally from euthanasia and that it is an acceptable therapeutic option for some but not all patients who are imminently dying of a terminal illness.

Extubation versus tracheostomy in withdrawal of treatment - ethical, clinical, and legal perspectives

3256 Auteur(s) : Chotirmall, S. H., Flynn, M. G., Donegan, C. F., Smith, D., O'Neill, S. J., McElvaney, N.G
Source : Journal of Critical Care. 2010, 25 :360.e1-360.e8

The provision of life-sustaining ventilation, such as tracheostomy to critically ill patients, is commonly performed. However, the utilization of tracheostomy or extubation after a withdrawal of treatment decision is debated. There is a dearth of practical information available to aid clinical decision making because withdrawal of treatment is a challenging scenario for all concerned. This is further complicated by medicolegal and ethical considerations. Care of the "hopelessly ill" patient should be based on daily evaluation and comfort making it impossible to fit into general algorithms. Although respect for autonomy is important in healthcare, it is limited for patients in an unconscious state. Beneficence remains the basis for withdrawing treatment in futile cases and underpins the "doctrine of double effect." This article presents a relevant clinical case of hypoxic brain injury where a question of withdrawal of treatment arose and examines the ethical, clinical, and medicolegal considerations inherent in such cases, including beneficence, nonmaleficence, and the "sanctity of life doctrine." In addition, the considerations of prognosis for recovery, patient autonomy, patient quality of life, and patient family involvement, which are central to decision making, are addressed. The varying legal frameworks that exist internationally regarding treatment withdrawal are also described. Good ethics needs sound facts, and despite the lack of legal foundation in several countries, withdrawal of treatment remains practiced, and the principles described within this article aim to aid clinician decision making during such complex and multifaceted end-of-life decisions.

Rethinking guidelines for the use of palliative sedation

3263 Auteur(s) : Berger, J. T.
Source : Hastings Center Report. 2010, 40 (3) :32-38

Current guidelines treat palliative sedation to unconsciousness as an effective medical treatment for terminally ill patients who need relief from severe symptoms, yet also restrict its use in ways that are extraordinary for medical treatments. A closer look at the kinds of cases in which palliative sedation is used suggests a way of adjusting the guidelines to resolve this seeming contradiction.

Gériatrie

Comfort feeding only : a proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia

3232 Auteur(s) : Palecek, E. J., Teno, J. M., Casarett, D. J., Hanson, L. C., Rhodes, S. L., and Mitchell, S. L.
Source : J Am Geriatr Soc. 2010, 58 (3) :580-584

Feeding and eating difficulties leading to weight loss are common in the advanced stages of dementia. When such problems arise, family members are often faced with making a decision regarding the placement of a percutaneous endoscopic gastrostomy tube. The existing evidence based on observational studies suggests that feeding tubes do not improve survival or reduce the risk of aspiration, yet the use of feeding tubes is prevalent in patients with dementia, and the majority of nursing home residents do not have orders documenting their wishes about the use of artificial hydration and nutrition. One reason is that orders to forgo artificial hydration and nutrition get wrongly interpreted as "do not feed," resulting in a reluctance of families to agree to them. Furthermore, nursing homes fear regulatory scrutiny of weight loss and wrongly believe that the use of feeding tubes signifies that everything possible is being done. These challenges might be overcome with the creation of clear language that stresses the patient's goals of care. A new order, "comfort feeding only," that states what steps are to be taken to ensure the patient's comfort through an individualized feeding care plan, is proposed. Comfort feeding only through careful hand feeding, if possible, offers a clear goal-oriented

alternative to tube feeding and eliminates the apparent care-no care dichotomy imposed by current orders to forgo artificial hydration and nutrition.

Gynécologie - Obstétrique

Ethical challenges in providing noninvasive prenatal diagnosis

3254 Auteur(s) : Benn, P. A. and Chapman, A. R.
Source : Current Opinion in Obstetrics and Gynecology. 2010, 22 :128-134

PURPOSE OF REVIEW: Noninvasive prenatal diagnosis (NIPD) can potentially allow early detection of fetal genetic disorders, sex, other nonmedical traits, and paternity. We review ethical concerns associated with the imminent introduction of this testing. RECENT FINDINGS: There has been inadequate scientific and medical review of some NIPD tests under development or already available as direct-to-consumer products. Test introduction is largely unregulated and this has prompted calls for greater oversight. As a replacement for current prenatal screening and diagnosis, NIPD may not necessarily identify the same spectrum of disorders. Ethicists are also concerned how women can receive adequate pretest counseling and provide a truly informed consent. Widespread use of NIPD for minor disorders, predispositions, sex, normal human variation and paternity could result in a trivialization of pregnancy termination. Other concerns include the equitable access to testing by all population subgroups. NIPD has the potential to significantly reduce the prevalence of some genetic disorders and thereby change public attitudes about the handicapped and their families. SUMMARY: Striking the correct balance between providing only worthwhile testing and ensuring individual patients' reproductive choice will be a major challenge and it is important to begin to address the many ethical issues that NIPD raises.

Ethical considerations in first-trimester Down syndrome risk assessment

3253 Auteur(s) : Chervenak, F. A. and McCullough, L. B.
Source : Current Opinion in Obstetrics and Gynecology. 2010, 22 :135-138

PURPOSE OF REVIEW: First-trimester risk assessment has now become sophisticated and of increasing relevance and applicability to decision-making by pregnant woman about invasive diagnosis. Ethics is an essential dimension of understanding this relevance and applicability. This paper addresses the ethical dimensions of first-trimester risk assessment for trisomy 21. RECENT FINDINGS: It is now well established in the ethics and law of the informed consent process that physicians are obligated to offer to patients all medically reasonable alternatives for managing the patient's condition. This disclosure should be guided by the reasonable person standard: the physician should provide clinically important information about the patient's condition or diagnosis, the medically reasonable alternatives for managing it, and the clinical benefits and risks of each such alternative. SUMMARY: On the basis of the ethics of informed consent, we argue that routinely offering first-trimester risk assessment in centers qualified to provide it is ethically obligatory. We describe how pregnant women can be expected to respond to this offer. We then argue that routinely withholding the results of first-trimester risk assessment is ethically unjustified. The ethics of informed consent is an essential dimension of first-trimester risk assessment for trisomy 21.

Time of birth and risk of neonatal death at term : retrospective cohort study

3225 Auteur(s) : Pasupathy, D., Wood, A. M., Pell, J. P., Mechan, H., Fleming, M., and Smith, G. C. S.
Source : British Medical Journal. 2010, 341 :c3498

OBJECTIVE : To determine the effect of time and day of birth on the risk of neonatal death at term. DESIGN : Population based retrospective cohort study. SETTING : Data from the linked Scottish morbidity records, Stillbirth and Infant Death Survey, and birth certificate database of live births in Scotland, 1985-2004. SUBJECTS : Liveborn term singletons with cephalic presentation. Perinatal deaths from congenital anomalies excluded. Final sample comprised 1 039 560 live births. MAIN OUTCOME MEASURE : All neonatal deaths (in the first four weeks of life) unrelated to congenital abnormality, plus a subgroup of deaths ascribed to intrapartum anoxia. RESULTS : The risk of neonatal death was 4.2 per 10 000 during the normal working week (Monday to Friday, 0900-1700) and 5.6 per 10 000 at all other times (out of hours) (unadjusted odds ratio 1.3, 95% confidence interval 1.1 to 1.6). Adjustment for maternal characteristics had no material effect. The higher rate of death out of hours was because of an increased risk of death ascribed to intrapartum anoxia (adjusted odds ratio 1.7, 1.2 to 2.3). Though exclusion of elective caesarean deliveries attenuated the association between death ascribed to anoxia and delivery out of hours, a significant association persisted (adjusted odds ratio 1.5, 1.1 to 2.0). The attributable fraction of neonatal deaths ascribed to intrapartum anoxia associated with delivery out of hours was 26% (95% confidence interval 5% to 42%). CONCLUSIONS : Delivering an infant outside the normal working week was associated with an increased risk of neonatal death at term ascribed to intrapartum anoxia.

Information au patient

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

3211 Auteur(s) : Richard, C., Lajeunesse, Y., and Lussier, M.-T.
Source : Journal of Medical Ethics. 2010, 36 (6) :353-357

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.

Oncologie

Réflexion éthique dans le cadre de la prise en charge des patients âgés atteints de cancer

3207 Auteur(s) : Moulias, S., Cudennec, T., and Teillet, L.
Source : Cancer/Radiothérapie. 2009, 13 :632-633

L'éthique médicale s'intéresse aux pratiques de soins, à leurs finalités, à leurs possibilités de réalisation. Elle permet de s'interroger sur la prise en soin des patients âgés atteints de cancer. Les critères de décision d'une exploration à la recherche d'un cancer, mais aussi de traitement d'un cancer confirmé sont nombreux. Certains sont d'ordre médical (bénéfice de survie, polypathologie, répercussion sur l'organisme, pronostic lié aux "comorbidités") d'autres sont plus subjectifs (qualité de vie, difficulté d'information, prise en charge plus lourde ou plus longue, âgisme). L'âge semble être le premier blocage, les troubles cognitifs le deuxième. Un dépassement des a priori actuels semble nécessaire pour améliorer la prise en soins des patients âgés atteints de cancer. Cela d'autant plus que de nombreuses publications oncologiques indiquent que les traitements anticancéreux sont le plus souvent bien supportés et bénéfiques chez ces patients.

Pédiatrie

Réflexions et propositions autour des soins palliatifs en période néonatale : 1ère : partie considérations générales

3241 Auteur(s) : Bétrémieux, P., Gold, F., Parat, S., Caeymaex, L., Danan, C., De Dreuzy, P., Vernier, D., Viillard, M.-L., and Kuhn, P.
Source : Archives de Pédiatrie. 2010, 17 (4) :409-412

En France, la loi du 22 avril 2005 a imposé à tous les médecins le recours aux soins palliatifs en alternative à l'obstination déraisonnable. La pratique de soins palliatifs en période néonatale n'est pas évidente même si de tout temps obstétriciens et néonatalogistes se sont souciés du confort du nouveau-né qui va mourir. La décision de mettre en route des soins palliatifs passe d'abord par la reconnaissance de l'obstination déraisonnable, puis vient le renoncement thérapeutique et enfin la mise en oeuvre d'un plan de soins qui ne présume pas de la durée de vie. L'application de ces différents concepts au nouveau-né est développée dans cette 1ère partie.

Construction d'un projet de soins palliatifs chez le nouveau-né : 2e partie des réflexions et propositions autour des soins palliatifs en période néonatale

3242 Auteur(s) : Bétrémieux, P., Gold, F., Parat, S., Moriette, G., Huillery, M.-L., Chabernaude, J.-L., Storme, L., Narcy, P., Deruelle, P., and Kracher, S.
Source : Archives de Pédiatrie. 2010, 17 (4) :413-419

Pediatric research ethics: evolving principles and practices

3239 Auteur(s) : Boss, R. D.
Source : Pediatrics in Review. 2010, 31 (4) :163-165

Evidence-based medicine requires a foundation of excellent research. Yet, research in infants and children inherently poses potential risks to these vulnerable populations. The academic pediatrician may experience an ethical conflict in his or her dual roles as a clinician, with a primary interest in benefiting the individual child, and as a researcher, with an interest in advancing science and benefiting society.

Understanding the evolution of ethical principles for pediatric research permits insight into current principles and the challenges of putting such principles into practice. This information is critical for both the pediatrician designing human research protocols and the pediatrician whose patients are enrolled in those protocols.

Placebos

Biological, clinical, and ethical advances of placebo effects

3187 Auteur(s) : Finniss, D. G., Kaptchuk, T. J., Miller, F., and Benedetti, F.
Source : Lancet. 2010, 375 (9715) :686-695

For many years, placebos have been defined by their inert content and their use as controls in clinical trials and treatments in clinical practice. Recent research shows that placebo effects are genuine psychobiological events attributable to the overall therapeutic context, and that these effects can be robust in both laboratory and clinical settings. There is also evidence that placebo effects can exist in clinical practice, even if no placebo is given. Further promotion and integration of laboratory and clinical research will allow advances in the ethical use of placebo mechanisms that are inherent in routine clinical care, and encourage the use of treatments that stimulate placebo effects.

Santé publique

Nul n'est censé ignorer... les conséquences juridiques de l'arrivée d'une grippe ou d'une pandémie dans le monde du travail

3153 Auteur(s) : Cereghetti, A and Pelet, O.
Source : Revue Médicale Suisse. 2010, 6 (244) :779-781

L'arrivée d'un virus tel que celui de la grippe A(H1N1) amène son lot de questions, qu'elles soient médicales, politiques, éthiques ou juridiques. Les messages souvent alarmistes des médias et les communiqués en général plus rassurants de certaines autorités sanitaires sèment souvent le trouble dans les esprits sur la manière dont les travailleurs et les employeurs doivent se comporter lorsque la pandémie est déclarée. Il n'est donc pas inutile de répondre à quelques-unes des questions juridiques les plus fréquentes qui se posent en lien avec le monde du travail.

Soins intensifs

Justice-based obligations in intensive care

3238 Auteur(s) : McMillan, J. and Hope, T.
Source : Lancet. 2010, 375 :1156-1157

Health professionals who work in intensive care units (ICUs) are often called upon to make difficult moral decisions. On some occasions, these involve trying to determine what it is that an unconscious patient would have wanted when their prognosis is uncertain. On other occasions, it can involve difficulties around confidentiality when there are good reasons for sharing information, but it's unclear whether this is something that a patient would have wanted. The allocation of scarce ICU resources raises a different set of challenging ethical questions. For example, it is not uncommon for all the beds on a unit to be occupied and if another patient arrives it can necessitate some careful deliberation about the relative prognoses of patients. If a patient urgently needs to be admitted, when there are no beds available, then it would be appropriate to see if a patient who is presently in intensive care could be moved to a general ward. Which ethical principles should inform this decision making?

CURVES: a mnemonic for determining medical decision-making capacity and providing emergency treatment in the acute setting

3154 Auteur(s) : Chow, G. V., Czarny, M. J., Hughes, M. T., and Carrese, J. A.
Source : Chest. 2010, 137 (2) :421-427

The evaluation of medical decision-making capacity and provision of emergency treatment in the acute care setting may present a significant challenge for both physicians-in-training and attending physicians. Although absolutely essential to the proper care of patients, recalling criteria for decision-making capacity may prove cumbersome during a medical emergency. Likewise, the requirements for providing emergency treatment must be fulfilled. This article presents a mnemonic (CURVES: Choose and Communicate, Understand, Reason, Value, Emergency, Surrogate) that addresses the abilities a patient must possess in order to have decision-making capacity, as well as the essentials of emergency treatment. It may be used in conjunction with, or in place of, lengthier capacity-assessment tools, particularly when time is of the essence. In addition, the proposed tool assists the practitioner in deciding whether emergency treatment may be administered, and in documenting medical decisions made during an acute event.