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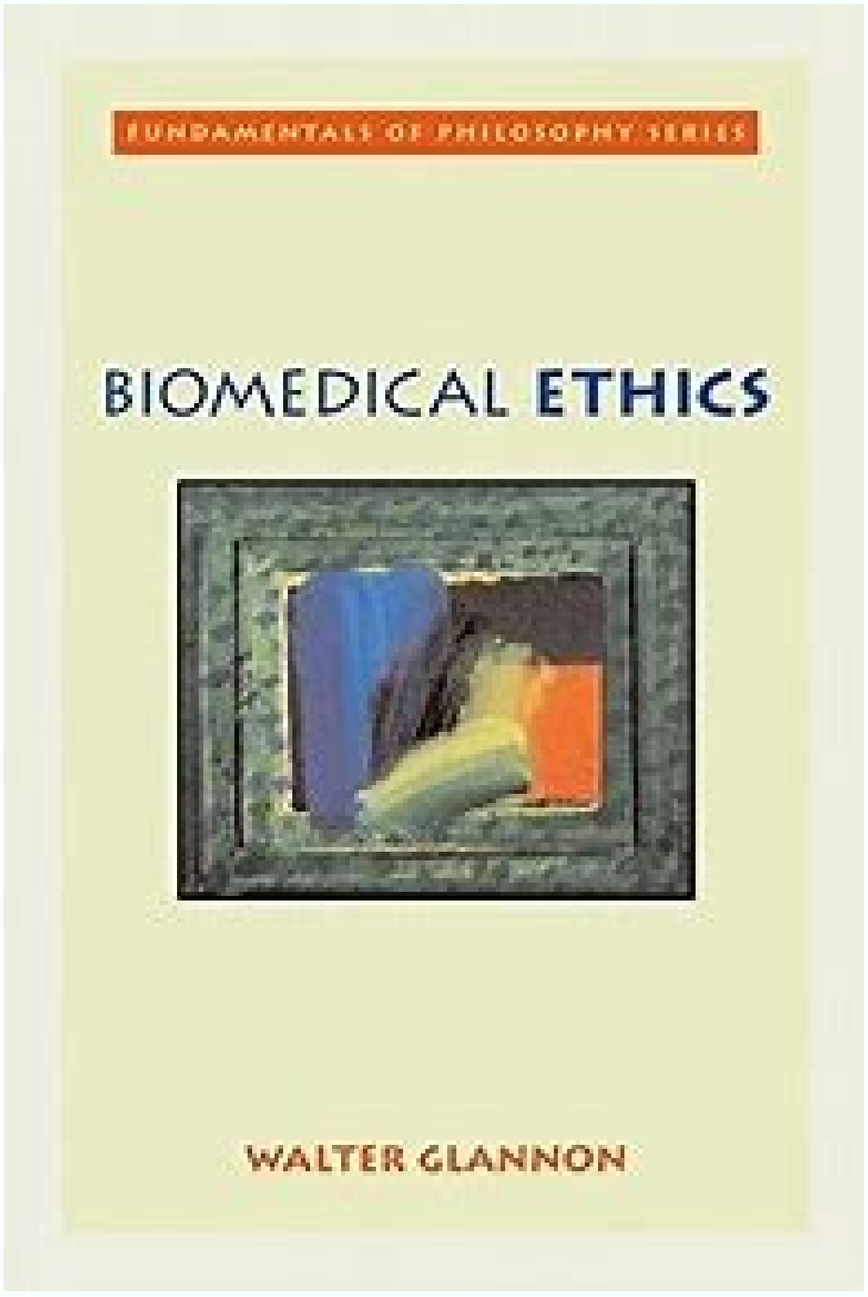

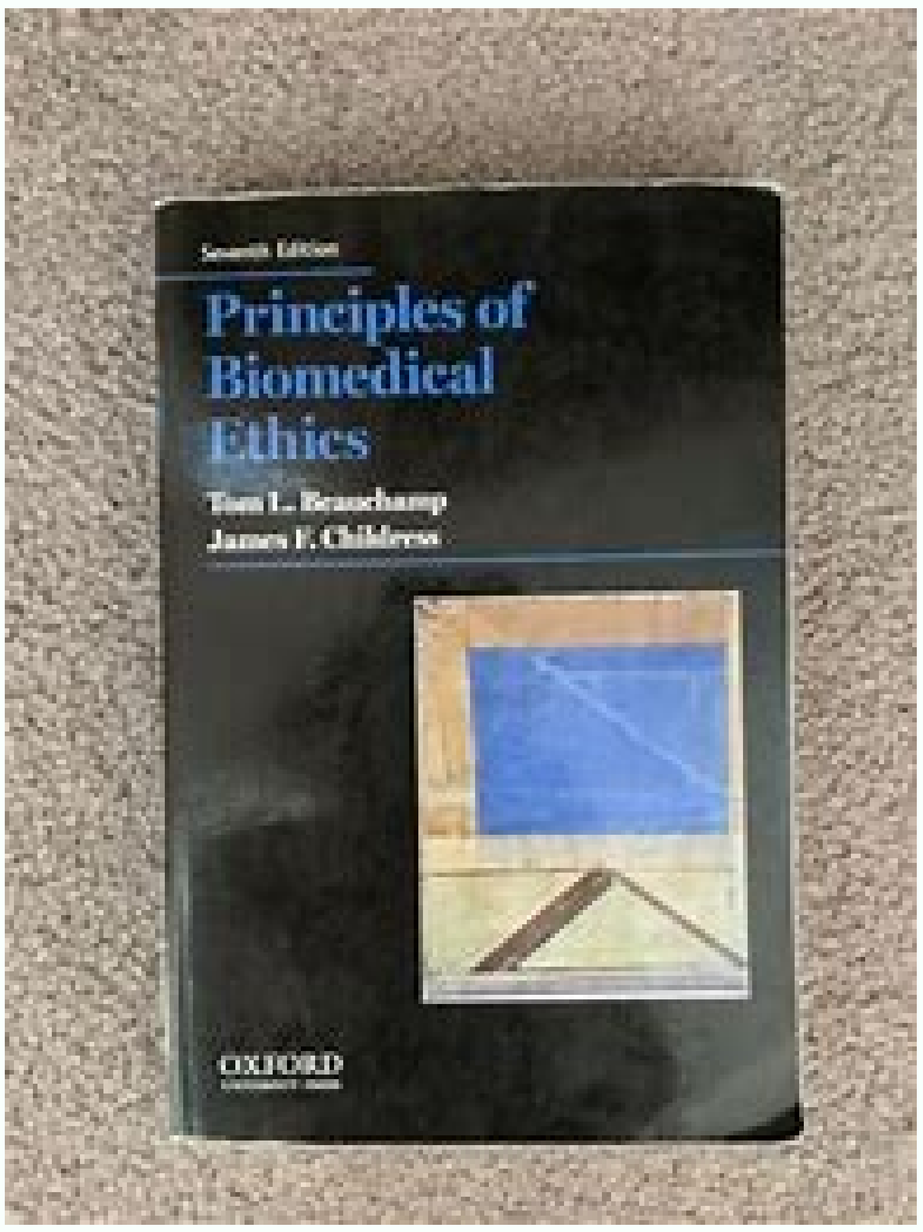

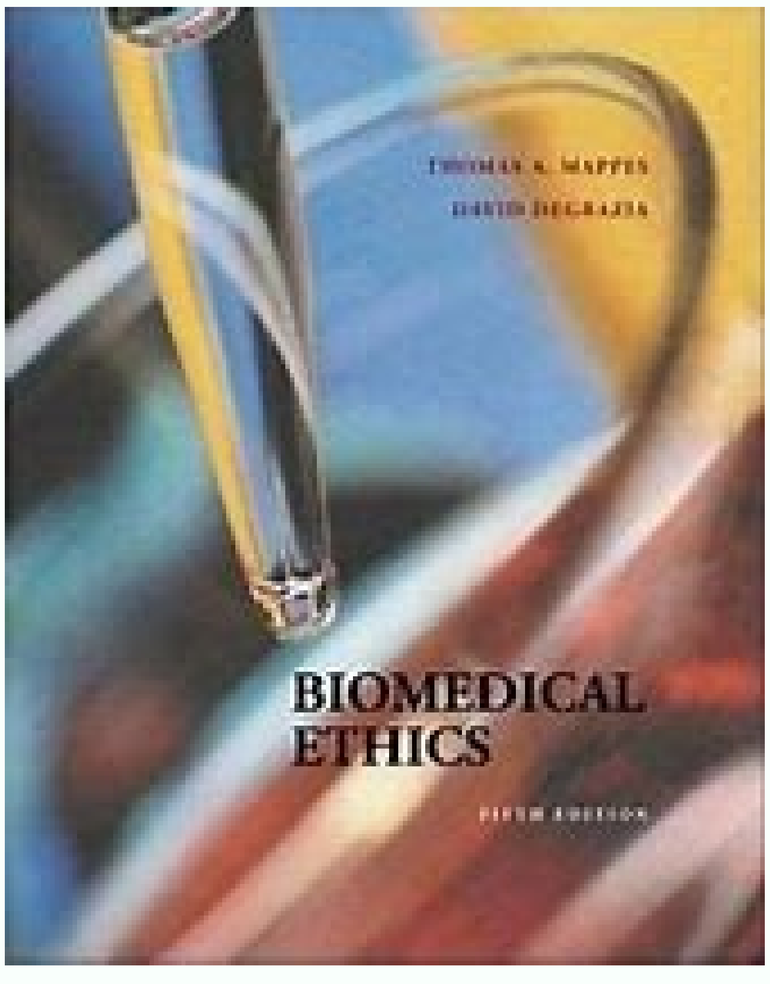

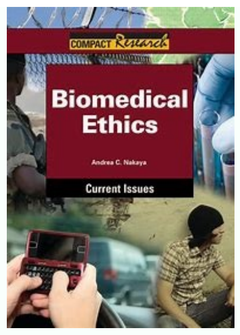

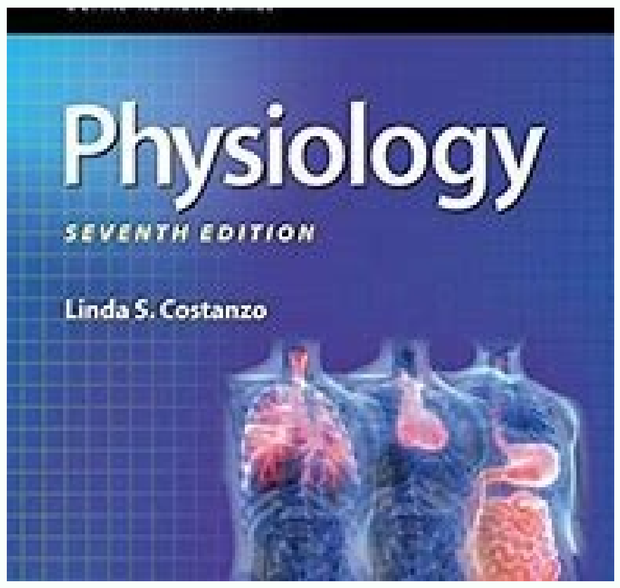

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This best-selling reading anthology with case studies provides an acute and comprehensive treatment of ethical issues in medicine. Suitable for courses in philosophy, bioethics, medical schools and health care, the collection covers such provocative topics as biomedical valorization, clinical studies in developing countries, animal research, physician-assisted suicide and health reform. sketches of topics, explanations of medical terms, explanatory notes and annotated bibliographies. This best-selling reading anthology with case studies provides an acute and comprehensive treatment of ethical issues in medicine. Suitable for courses in philosophy, bioethics, medical schools and health care, the collection covers such provocative topics as biomedical valorization, clinical studies in developing countries, animal research, physician-assisted suicide and health reform. sketches of topics, explanations of medical terms, explanatory notes and annotated bibliographies. The Graefe Archive for Clinical and Experimental Ophthalmology is 160; 250, 160; 159¢ 128; (2012) Cite This Article This is a preview of the subscription content, access through your institution. 37,40 âĀ¬ the price includes VAT (Germany) the calculation of the tax will be completed during the checkout. Author:194; 160; Thomas R. McCormick, D.Min., Senior Lecturer Emeritus, Dept. Bioethics and Humanity, School of Medicine, University of Washington The Place of Principles in Bioethics Choices Ethics, both minor and important, We confront each other daily in providing health care to people with different values who live in a pluralistic and multicultural society. Faced with such diversity, where can we moral action guides when there is confusion or conflict about what should be done? These guidelines should be Acceptable among religious and non-religious and for people through many different cultures. Due to the numerous variables that exist in the context of clinical cases and the fact that in health care there are several ethical principles that seem to be applicable in many situations these principles are not considered absolute, but they serve as powerful guides of action in clinical medicine. Some of the principles of medical ethics have been used for centuries. For example, in the 4th century ECB, hippocrates, a doctor-philosopher, direct doctors Ã ¢ â € â € â € ¢ to help and do not do damage Ã ¢ â € â € Ã; Â (epidemici, 1780). Similarly, since the early days there were considerations of respect for people and justice in the development of societies. However, in particular with regard to ethical decisions in the medical field, in 1979 Tom Beauchamp and James Childress published the first edition of principles of ethical biomedical, now in its seventh edition (2013), making the use of the principle popularly in efforts To solve ethical questions in clinical medicine. In the same year, in the Belmont report (1979) three principles of respect for people, benefit and justice were identified as guidelines for responsible research on the use of human subjects. Therefore, both in clinical medicine and scientific research it is generally believed that these principles can be applied, even under unique circumstances, to provide indications to discover our moral duties in that situation. How do principles apply to a given case? Intuitively, the principles of current use in the healthcare ethics seem to be of evident value and clear application. For example, the notion that the doctor "should not harm" any patient is on his convincing face for most people. O, the idea that the doctor must develop a treatment plan designed to provide the most "benefit" to the patient in of other competing alternatives, seems both rational and obvious. In addition, before implementing the medical, medical care plan, It is now commonly accepted that the patient must have an opportunity to make an informed choice about his or her care. Finally, medical benefits should be distributed equitably, so that people with similar needs and under similar circumstances will be treated equitably, an important concept in light of scarce resources such as solid organs, bone marrow, expensive diagnostics, procedures and drugs. The four principles referred to here are non-hierarchical, which means no principle of routine routine â˜ ÅTtramps¯. Another one. It could be argued that we are required to consider all of the above principles when they are applicable to the clinical case under consideration. However, when you apply two or more principles, we might find that they are conflicting. For example, consider a patient diagnosed with an acutely infected appendix. Our medical goal should be to provide maximum benefit to the patient, an indication for immediate surgery. On the other hand, surgery and general anaesthesia carry a small degree of risk for an otherwise healthy patient, and we are under obligation to “not harm” the patient. Our rational calculation holds that the patient is largely larger for the damage from a broken appendix if we don’t act, than from the procedure and surgical anesthesia if we proceed quickly to surgery. Moreover, we are willing to put this working hypothesis to the test of rational speech, believing that other people acting on a rational basis will agree. Therefore, weighing and balancing potential risks and benefits becomes an essential part of the reasoning process in applying the principles. In other words, in the face of no other competing claims, we have a duty to support each of these principles (a Prima Facie Duty). However, in the present situation, we must balance the requirements of these principles by determining the Bring more weight in the particular case. Moral philosopher, W.D. Ross, states that first facie duties are always binding unless they are in contrast to stronger or more stringent obligations. The actual duty of a legal person is determined by the weighting and balancing of all prima facie competing duties in each particular case (Frankena, 1973). Since the principles are devoid of content, the application of the principle is focused by understanding the peculiarities and facts that provide the context of the case. Therefore, obtaining relevant and accurate facts is an essential component of this decision-making approach. What are the basic principles of medical ethics? Four commonly accepted principles of health ethics, taken from Beauchamp and Childress (2008), include: Principle of Respect for Autonomy, Principle of Non-maleficence, Principle of Charity and Principle of Justice. 1. Respect for Autonomy Any notion of moral decision-making presupposes that rational agents are involved in making informed and voluntary decisions. In health decisions, our respect for the autonomy of the patient would imply, in common parlance, that the patient has the ability to act intentionally, with understanding and without control influences that would attenuate free and voluntary action. This principle underlies the practice of “informed consent” in the doctor-patient transaction concerning healthcare. (See also Informed Consent.) Case 1 At first glance, we should always respect the patientâs autonomy. Respect is not just a matter of attitude, but a way of acting to recognize and even promote the patientâs autonomous action. The autonomous person can freely choose values, fidelity or religious belief systems that limit the other freedoms of the person. For example, Jehovah’s Witnesses believe it is wrong to accept a blood transfusion. Therefore, in a life-threatening situation where a blood transfusion is required save the patient's life, the patient should be informed. The consequences of refusing a blood transfusion must be: made clear to the patient at risk of dying from blood loss. is that he wanted to “benefit” the patient, the doctor can strongly fortify provide a blood transfusion, believing it to be a clear “medical benefit.” If properly and compassionately informed, the particular patient is then free to buy to accept blood transfusion in line with a strong desire to live, or whether to refuse blood transfusion in giving higher priority to his religious beliefs on the veracity of blood transfusions, even to the point of accepting death as a predictable result. This communication process should be compassionate and respectful of the patient’s unique values, even if they differ from standard biomedicine objectives. Discussion In analyzing the above case, the physician had a Prima Facie duty to respect the patient’s autonomous choice, as well as a Prima Facie duty to avoid harm and provide medical benefit. In this case, informed by community practice and the provisions of the law for the free exercise of one’s religion, the doctor gave greater priority to respecting the patient’s autonomy over other duties. However, some ethicists argue that while respecting the patient’s choice not to receive blood, the principle of unfitness also applies and must be interpreted in light of the patient’s belief system about the nature of the damage, in this case a spiritual damage. Conversely, in an emergency, if the patient in question is a ten-year-old child, and parents refuse permission for a life-saving blood transfusion, even in Washington State and other United States, there is a legal precedence for pre-empting the wishes of parents appealing to the state-authorized juvenile court judge to protect life of its citizens, in particular minors, until they reach majority of the majority and can make such choices independently. Thus, in the case of a vulnerable minor child, the principle of avoiding harm Death and principle of providing a medical benefit that can restore the child to health and life, would be given precedence over the autonomy of the child's parents as Responsible Surrogate Decisions (McCormick, 2008). (See the decision-making process of parents) 2. The principle of non-suitable the principle of non-fitness requires that we do not intentionally create damage or injury to the patient, both through commission or omission acts. In the common language, we consider negligent if an enlarged or unreasonable risk of damage is imposed on another. Provide an adequate care standards that avoids or minimizes the risk of damage is supported not only by our commonly held moral sentences, but also by the laws of society (see the law and medical ethics). This principle affirms the need for medical skills. It is clear that medical errors may occur; However, this principle articulates a fundamental commitment to the part of health professionals to protect their patients from the damage. Case 2 During the care of patients, there are situations in which some kind of damage seems inevitable, and usually morally meant to choose the minor of the two evils, even if the minor of the evils can be determined by the circumstances. For example, most would be willing to experience a little pain if the procedure in question would prolong life. However, in other cases, as the case of a patient who dies of painful intestinal carcinoma, the patient could choose to face the CPR in the event of a heart or respiratory arrest, or the patient could choose to renounce the livelihood technology as Dialysis or a respirator. The reason for this choice is based on the conviction of the prolonged patient living with a painful and debilitating condition is worse than death, greater damage. It is also important to note in this case that this has been performed by the patient, who alone is the authority on the interpretation of the "greater" or "lesser" harm to himself ©. Yes ©. Suspension or suspension of life-support treatment). Discussion There is another category of cases that creates confusion, as a single action can have two effects, one considered positive and the other negative. How do we direct our duty towards the principle of non-evil in such cases? The formal designation of the principle governing this category of causes is generally called the principle of double effectiveness. A typical example could be the question of how best to treat a pregnant woman with new diagnoses of uterine cancer. The usual treatment, removal of the uterus is considered a life-saving treatment. However, this procedure would result in the death of the fetus. What action is morally acceptable, or what is our duty? In this case, it is claimed that the woman has the right to self-defence, and the action of the hysterectomy is aimed at defending and preserving her life. The foreseeable unintended consequence (even if unwanted) is the death of the foetus. The principle of double effectiveness applies in principle to four conditions: the nature of the act. The action itself © it must not be inherently wrong; It must be a good act or at least morally neutral. The agent's intention. The agent only means the good effect, not the negative effect, even if it is foreseen. The distinction between means and effects. The negative effect must not be the means of the good effect, proportionality between the good effect and the bad effect. The good effect must prevail over the allowed evil, in other words the negative effect. (Beauchamp & Childress, 1994, p. 207) The reader can apply these four criteria to the above case, and find that the principle of double effect applies and the four conditions are not violated by the prescribed treatment plan. Three. The principle of benefit The common meaning of this principle is that healthcare providers have a duty to benefit patient, and © take positive measures to prevent and eliminate damage caused by healthcare. health. These duties are considered rational and obvious and are widely accepted as the right goals of medicine. Āƒ, this principle is the culmination of health care that implies that a suffering supplicant (the patient) can enter a relationship with those who licensed as competent to provide medical assistance, trusting that the main objective The doctor is Help.Āƒ, the goal of providing benefits can be applied to both individual patients and the good of society as a whole. For example, the good health of a particular patient is an appropriate goal of medicine, and the prevention of the disease through the research and use of vaccines is the same goal expanded to the population in general. Sometimes it is considered that nonmalificence is a constant duty, that is, it should never damage another individual, while charity is a limited duty. A doctor has a duty to look for the benefit of anyone or all his patients, however, a doctor can also choose who to admit his practice, and does not have a rigorous duty to benefit from patients not recognized in the panel. This duty becomes complex if two patients turn to treatment at the same time. Some urgency criteria of need could be used, or a first principle of the first arrived first served, to decide who should be helped at the moment. Case 3 A clear example exists in health care in which the principle of charity is given to the principle of respect for the patient's autonomy. This example comes from emergency medicine. When the patient is incapable of the serious nature of the accident or disease, we assume that the reasonable person would like to be treated aggressively, and we will prestict you to provide a beneficial intervention resulting from bleeding, repairing the wounded. Discussion in this culture, when the It acts from a benevolent spirit in providing beneficial treatment than in the advice of the doctor is in the best interest of the patient, without consultation consultation The most obvious case of justified paternalism is found in the treatment of suicidal patients, who represent an obvious and present danger to themselves. In this case, the duty of charity requires that the doctor intervene to save the patient’s life or to place him in a protective environment, believing that the patient is compromised and cannot act in his or her best interests at the moment. As always, the facts of the case are extremely important in judging whether the patientâs autonomy is compromised. 4. Principle of Justice Justice in health is usually defined as a form of equity, or as Aristotle said, “giving everyone what is due to him”. This implies an equitable distribution of goods in society and requires consideration of the role of rights. The issue of distributive justice also seems to depend on the fact that some goods and services are scarce, there is not enough to turn around, so it is necessary to determine fair means to allocate scarce resources. It is generally believed that equal persons should have the right to equal treatment. This is confirmed by the Medicare application, which is accessible to all people over the age of 65. This category of people is identical with regard to this factor, their age, but the criteria chosen do not say anything about needs or other noteworthy factors. In fact, our society uses a number of factors as criteria for distributive justice, including: To every person an equal share To every person according to need To every person according to effort To every person according to contribution To every person according to merit To every person according to free market trade (Beauchamp & Childress, 1994, p. 330) John Rawls (1999) and others argue that many of the distributive justice Experience equality are the result of a “lottery” or a one The lottery for which the individual concerned is not responsible, therefore, the company should also help the playing field by providing resources to help overcome the disadvantaged situation. One of the most controversial issues in modern health care is the question of “who has the right to health care? “Or, to put it another way, perhaps as a society we want to be beneficial and fair and provide a decent minimum level of health care to all citizens, regardless of their ability to pay. Medicaid is also a program that aims to help fund health care for those living at the poverty level. However, in times of recession, thousands of families below the poverty level have been purged by Medicaid rollers as a cost-saving maneuver. The principle of justice is a strong motivation for reforming our health care system so as to take into account the needs of the entire population. The demands of the principle of justice must apply to the bedside of individual patients, but also systematically in the laws and policies of society that regulate a population’s access to health care. There is still a lot of work to be done in this arena. Summary and Criticism The four principles currently operating in health ethics had a long history in the common morality of our society even before becoming widely popular as guides of moral action in medical ethics in the last forty years through the work of ethics such as Beauchamp and Childress. Faced with morally ambiguous situations in healthcare, the nuances of their use have been refined through countless applications. Some bioethicists, such as Bernard Gert et al. (1997), argue that, with the exception of non-malefic, principles are defective as guides to moral action as such non-specific, seem to simply remind the decision-maker considerations to be taken into account. In fact, Beauchamp and Childress do not claim that principalism provides a general moral theory, but rather, they say of these principles in reflecting on moral problems and moving to an ethical resolution. Gert also charges that the Most Prince fails to distinguish between moral rules and moral ideals and, as mentioned above, that there is no agreed method for resolving conflicts when two different principles are in conflict over what should be done. He states that his approach, common morality, attractive to rational reflection and open to transparency and publicity is a more useful approach (Gert, Culver & Clouser, 1997). Furthermore, Bioethicst Albert Jonsen and Colleagues (2010) claim in their work that to strictly apply these principles in clinical situations their applicability must begin with the context of a given case. (See Bioethics Tools).. This article is intended to be a brief introduction to the use of ethical principles in health ethics. Students of clinical ethics will find further information and deeper analysis in the suggested readings below. References Beauchamp T, Childress J. Principles of Biomedical Ethics, 7thÂ, edition. New York: Oxford University Press, 2013. Frankena, wk. Ethics, 2nd edition. Gliffs Englewood, NJ: Prentice-Hall, 1973. Gert B, Culver cm, clouser kd, bioethics a return to basics. New York: Oxford University Press, 1997. Hippocrats. The history of epidemics. Samuel Farr (trans.) London: T. 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