Ethics in health-care institutions

Understanding the ethical issues in health-care institutions has a pivotal role in the understanding and practice of biomedical ethics in medical practice. Health-care institutions provide an opportunity to put a number of ethical issues into a practical focus. They can also give the stimulus necessary to build a framework for developing the practice of biomedical ethics. Finally, they provide a sustained space for monitoring the outcome of practices developed to foster ethics in these institutions.

On August 7 and 8, 1997, the Northwestern University Medical School and Chicago Clinical Ethics Programs jointly held a conference on this subject. The discussions that took place in the course of this conference provide food for thought to countries such as India, which are developing a discourse on biomedical ethics.

The conference stressed the following four areas: addressing end-of-life issues using a multi-disciplinary approach; bioethics and legal reasoning: the matter of physician-assisted dying, before the US Supreme Court; directions in the development of bioethics; and imperatives for universasl health coverage. These subjects were the focus of the plenary sessions, each of which was followed by concurrent sessions on related themes.

The first plenary session on end-of-life issues was followed by concurrent sessions with topics such as religious voices and secular settings, improving palliative care in the acute care setting, ethical issues in surgical care; 'Do Not Resuscitate' orders in the OR; home care and ethics: relationships and boundaries, and ethical consults and ethics education in a community hospital.

The second plenary session on physician-assisted dying before the Supreme Court was followed by concurrent sessions on bioethics and death, strategies for advance directives in community hospitals, end-of-life decision making in long-term care, beyond advance directives: jump-starting advance care planning, and euthanasia: ultimate compassion.

The plenary on directions in the development of bioethics was followed by concurrent sessions which addressed pertinent issues such as the ethics consultant as mediator: techniques of dispute resolutions, minors as research subjects; genetic testing in children, integrated ethics for medical students; hospital staff and teaching clinical research ethics to medical students and house-staff, and patient participation in the health care team.

The plenary on universal health care coverage was followed by discussions on ethical perspectives on foregoing nutrition/hydration, current hospice developments, developing an organisational ethics statement, ethics as a problem solving skill; making moral philosophy practical, and lastly, ethical aspects of holistic/spiritual medicine in modern health-care system.

A mix of the four principles

This list of sessions should give a sense of the efforts being made to apply theoretical ethical concepts in the practice of clinical medicine. It also indicates the direction that health -care institutions in the US seem to be pursuing to develop an optimal mix of the four principles of biomedical ethics - beneficence, non-malficence, autonomy and justice.

Role-playing sessions put participants in these difficult situations and challenged them to work their way through the dilemma. For example,.a patient unsatisfied with her treatment, or an elderly person who is kept unaware of his health condition. An ethics consultant would have to take the views of everyone into consideration, and respond to the situation keeping ethical principles in mind.

Ethical theory and practice

Putting ethical theory into clinical practice invariably entails making quick, sometimes uncomfortable decisions in an area which can have a long-term impact on the individuals as well as society in general. This tension can be overcome only by blending ethical practices into everyday life so that it is second nature, one's gut responses are themselves ethical to the core. Towards this end, the conference evidently contributed substantially to make the relevant tools available to participants for honing skills and to institutions to formulate a framework for ushering an ethical environment.

Can we not draw some lessons from this for our healthcare institutions ?

Anil Pilgaokar

"Doctors, for example, have long allowed their patients to die of pneumonia when, if they were allowed to recover after treatment, they would lead a life only of suffering and further misery; and such doctors have been applauded for their humanity and wisdom. Yet those same doctors throw up their hands in horror at the very thought of actively intervening to procure the death of their patients, their happy release from useless suffering They cite the very same sanctity of life as the cause of their horror at the very idea of killing which they had entirely forgotten in the case of the old hemiplegic or dement that they let die of pneumonia. It isn t life, therefore, which is sacrosanct, but life which partakes of certain qualities, the lack of which renders such life at best meaningless, at worst harmful to self and others."

Theodore Dalrymple in *So little done*

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