A Virtual Training Course in Clinical Ethics

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Using Checklists in Clinical Treatment, Care, and Ethics

This virtual training course in personalized medicine and clinical ethics builds on a checklist, originally developed 1987 (Sass and Viefhues) at the Bochum Center for Medical Ethics. The checklist is also known as the 'Bochum Questionnaire' and available in Brazilian, Chinese, Croatian, Dutch, English, German, Italian, Spanish, Swedish, and Turkish language, also on the internet. Checklists are used routinely in many fields of life. In medicine, checklists are in use by family practitioners to collect basic medical and laboratory data of patients and to note details of prognosis, treatment and prescriptions, therapeutic or chronic improvement, by hospitals at time of admission and later to document clinical patient data, in research to document patient/subject's reaction. Checklists are useful for documentation and review; they also guarantee that a wide range of issues are known and considered rather than only a few with most intriguing and acute details. Checklists must be short, must allow for precise documentation, and eventually need to be complemented by special additional checklists such as lists documenting laboratory tests or sonograms or special ethical issues in different fields. The checklist used in this training course is based on the original 1987 model, but colleagues have modified this list and students have been encouraged to critically review this and other checklist.

Traditionally, checklists for patient's values and wishes were not necessary as the family doctor [a] knew his/her patients and their families very well, [b] medical knowledge was only basic and options for different treatments were not available, and [c] physicians could assume that patients were representatives of a consistent moral and cultural environment having quite similar moral, religious, and cultural views and expectations from medicine and their doctors. When used in the global settings of clinical treatment and care checklists have to be open and may not predetermine the outcome of deliberations and decisions. Open checklist such as this one are helpful, when patients of different personal and cultural background are treated in Bangkok, Berlin, Buenos Aires, Bagdad and elsewhere, where no unswerving and robust value system can be assumed equally for all, as it was in the old days. Teaching

of medical ethics to students and training in clinical ethics to teams and individuals will need to use cases to be as close to reality as possible [Blake], so does this training course.

Case: Medical Status: Mrs. A., 38 years old, overweight, employed as an office clerk, complains to her doctor about dizziness during the day and some sleeplessness at night. He diagnoses high blood pressure and recommends that she lose weight and start physical exercise. He does not take a careful medical history, including family history; otherwise he would have found that all four of her grandparents died in their 40s and 50s, probably of high blood pressure or a stroke or heart attack related to genetically inherited high blood pressure. If he had known the family history, he might have prescribed medicine in addition to physical exercise and a change in eating habits.

Questions: Do you use checklist forms to document first visits and routine checkups? Are you happy with the anamnesis forms you use? Did you or your colleagues experience similar omissions, and/or too quick recommendations, as in the case of Mrs. A.? Provide a few cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the first section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification of this list; do you already have your own list?

The Medical Status

Medical-Scientific Diagnosis of the Medical Status
The evaluation of the medical-scientific diagnosis follows traditional patterns.
General considerations:
What is the patient's diagnosis and prognosis?
What type of treatment is recommended regarding the diagnosis and prognosis? What alternative treatments could be offered? What are the anticipated outcomes of these various treatment options?
If the recommended treatment is neither offered to, nor accepted by, the patient, what is the prognosis?
Special considerations:
Will the preferred medical treatment be helpful to the patient?
Will the treatment selected lead to a positive prognosis in the particular case? If it does, to what degree?
Could the selected treatment harm or injure the patient? To what degree?
How can benefits, harms, and risks be evaluated?

Medical practice:
Are any other medical treatments equally adequate?
What consideration should be given to (1) the most recent medical advances due to biomedical research as well as (2) the physician's extensive clinical experience? What relevant facts are unknown or unavailable? Are the terms employed correctly, are they precise?
Summary:
What is the optimal treatment after considering all the available scientific-medical knowledge?

The Value Status

Medical-ethical checklists use the same method as traditional medical checklists in collecting information, but this time it is information on the wish-and-value history and the value-and-wish status of the patient, her or his fears and hopes in general, and expectations from visiting a doctor or hospital or entering a nursing home specifically. Medical-ethical checklists have to be as short and precise as medical checklists.
To recognize individual preferences, wishes, and values has always been and still is essential for good clinical practice and physician ethics. But as modern medicine quite often offers [a] different options of treatment but has [b] standardized quality norms set by WHO and/or national Chambers of Physicians and/or professional organizations, and [c] standardized payment schemes, it is even more important to provide patient-oriented treatment. Also, given the pressure of time, physicians rarely find the opportunity for extended communication with patients, and patients are still reluctant to voice their wishes, values, fears and expectations. Thus, the 'value status' of the patient is as important as the 'medical status'; both have to be integrated and complete each other in good clinical treatment and care.

Case in Family Practice: Ms. B, a 24 year-old unmarried woman, pregnant in her 2d month, asks for a genetic test for Polycystic Kidney Disease. Her mother had recently died after 10 years of dialysis and she has seen her grandmother suffering from the same genetic disorder and dying prematurely. She wants to give birth to the child, but only if she is not a carrier of ADPKD; she argues that she does not want her child to suffer like she had seen her mother and grandmother suffer; also she want to know her own status and make lifestyle decisions based thereon.

Questions: What role do patient's values and wishes play in medical practice and medical decision making? What role should they play? How would you have reacted in such a case? Which aspects of this case bother you the most and how would have handled them? Do you think that the wish-and-value status of a patient should play a role in medical decision-making? Should the patient be allowed to make her/his own decisions? Should the doctor follow the patient's wishes, to what degree? Would you treat a patient differently based on her/his value-and-wish status even though quality norms and reimbursement schemes suggest otherwise? Provide one or two of your own medical cases in which value-and wish status of the patient played a prominent role! – Describe and discuss some cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the second section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already?

Case in Hospital Care: Mrs. M, 38 years-old, had her left breast removed 5 years ago because she had breast cancer. Now she has increasing pain in her lower back, and her physicians have determined that the cancer has metastasized to her bones. They recommend chemotherapy to reduce pain and to prevent or slow down the spread of cancer. Mrs. M. undergoes chemotherapy with uncomfortable side effects. Her pain increases and is not treated adequately. The physicians do not tell the 'full truth', that chemotherapy will not kill the cancer but might prolong her life. Mrs. M. dies in the hospital 8 months later, not as she had wished, at home. Without chemotherapy she might have died a few months earlier.

Questions: What did the physicians know about Mrs. M.'s wishes and values when making treatment decisions? How would you have incorporated your medical-ethical diagnosis in treatment decisions? Does the doctor have to treat the disease or the patient as a person? Is full and professional palliative care a basic right of each and every patient? Would you follow patients' Advance Directives or wishes based on their value-and-wish profile, even when that differs from your own?- Describe and discuss some cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the second section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already?

Case in a Multicultural Care Setting: Mr. T., 28 years-old, married Turkish patient of a German doctor in Germany suffers from low sperm count. The couple wants to have children. The doctor prescribes a mild prescription drug based on pig pancreas and explains to the patient that stronger medicines would be available if this one does not work. A week later the young Turk storms into the doctor's office, throwing the pills at the doctor and shouting 'You are a pig. Who does give a man pills from pig to make son. Doctor, you are a pig!'

Questions: Is it always responsible to start with the least invasive therapy even when non-medical factors such as culture or religion or even unacceptable and crazy ideas would suggest otherwise? Would you have explained to the patient that eating pork and using medicine based on pig tissue by many Muslim (and Jewish) scholars has been defined as to be different and that in Muslim ethics and medical ethics the protection of life supersedes other religious laws such as fasting? In which cases would you compromise on the principle of full truth-telling and full and informed consent; in which rare situations would you use one of the supplementary lists of the Bochum checklist? Would you follow the patient's wishes and values, which you might not share, such as prescribing contraceptives or antinidatives? When would you not follow patient's wishes? Would you in such a situation direct her/him to see another doctor or not? - Give a few cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the second section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already?

Medical-Ethical Diagnosis of the Value-and-Wish Status

The diagnosis of the value-and wish status of the patient follows three principles:
Health and well-being of the patient:
What harm or injury may arise as a result of selecting a specific method of treatment?
How might the treatment compromise the patient's well-being, cause extensive pain, or even shorten his/her life?
Might it cause physical or mental deterioration?
Might it produce fear or grave anxiety in the patient?
Self-determination and the patient's autonomy:
What is known about the patient's values, wishes, fears and expectations?

What is the patient's understanding of intensive or palliative treatment, as well as resuscitation criteria?
Is the patient well-informed about diagnosis, prognosis, and the various treatment options available for him/her?
How is it possible to satisfy the patient's preferences in formulating the treatment plan?
To what degree should the physician permit this patient to determine the treatment plan?
Who else, if anyone, could or should make decisions on behalf of a patient and his/her best interests? Must the patient agree with the chosen therapy?
Medical responsibility:
Have any conflicts surfaced between the physician, the patient, the staff, or the patient's family?
Is it possible to eliminate or resolve such conflicts by selecting a particular treatment option or plan?
How can one work to assure that the following values will be re-affirmed?
(1) Establishing mutual trust between patient and physician;
(2) Honouring the principle of truth-telling in all discussions; and
(3) Respecting the patient's privacy and protecting his/her confidentiality?
What relevant facts are unknown or unavailable?
Have the salient ethical issues been adequately formulated, clarified, and addressed within the physician-patient relationship?
Summary:
What kind of treatment is optimal given thorough attention to the salient and relevant clinical [medical]-ethical issues?

Supplementary List regarding 'Informed Consent', i.e. patient's willingness or competence to voice preferences and to make decisions based on good criteria for Informed Consent [Beauchamp, Childress]:
1. Does the patient want treatment based on paternalistic or autonomous decision-making, or on partnership?
2. Does the patient want to include the spouse or family members or someone else in making decisions or consenting?
3. What are the special challenges for physician's practice and ethics to include others in decision making?
4. What can/should be done to guarantee that each and every patient is treated according to her/his system of belief, independently, whether Christian or secular humanist, Taoist, Hindu, Confucian, Jewish or Muslim, and according to her/his value-and-wish profile

Professional Quality Assurance

Quality medical care traditionally included more than treating a particular disease; professional medical care treats the patient as a fellow person [Ramsey]. In clinical practice one size does not fit all; clinical quality standards and reimbursement schemes are general, but patients are different. The 'best for the patient'– aegroti salus suprema lex – depends on the medical status as well as the value status of the patient, integrating differential ethics into differential diagnosis, prognosis, and treatment. In pluralistic societies in particular, citizens have different preferences and understandings of qualities and goals of life, as Galen said 'non homo universalis curatur, set unus quique nostrum': 'it is not the universal person we are to treat; it is an individual, a unique, our patient'. Providing quality patient-oriented care is particularly challenging in times, when financial schemes are inflexible and objective and do not leave much room for individualized care.

A Case for Interactive Communication and Cooperation: Mr. C., 79 years-old and dependent on others. He seems to have lost all interest in life. At times he is confused and does not recognize others, even close family members or nurses. He has pain in his legs and can only walk short distances because of poor blood supply to his legs, which is caused by previous smoking. Blood vessel surgery might improve his mobility and reduce pain, also make nursing care easier, thus improving his quality of life. Mr. C. does not understand the issue and cannot make his preferences clear; he had not executed an Advance Directive when he was better off in earlier days. One of his sons and a daughter and the nurses favor surgery while his daughter is opposed.

Questions: Which of the 5 virtues/principles of communication, cooperation, competence, compassion, cultivation need to be applied in this case and in what mixture? Please, develop your own checklist for this and similar cases? How would you want to be treated in this case? Rewrite this narrative o that it would fit your personal wish-and-value profile.

A Case of a Patient Refusing Treatment: Mr. D., a 44 years-old diabetes patient, has been blind for 4 years now. Two years ago, he became a patient in the neighborhood dialysis center. After first refusing dialysis treatment, he finally accepted it. A year ago, his right leg had to be amputated; he consented because he wanted to live long enough to witness the wedding of his daughter and the birth and baptism of his first grandchild, both of which he enjoyed very much. Now, lifesaving amputation of his left arm is mandated. He refuses the

surgery and also dialysis treatment, stays at home, glides into a coma and dies, as he had wished, 10 days after his last dialysis treatment.

Questions: What would you do as a physician having the final word in the case of a patient with compromised competence to understand and/or to make decisions or to consent to treatment? How would you react in a complex situation to a patient refusing life-saving treatment? On what arguments – medical and/or non-medical – would you base your decision? How far would you take arguments from family members and/or from the nurses caring for him/her into account? Would you recognize an Advance Directive as authoritative if there had been one? Would you recognize someone, having a durable Health Care Power of Attorney as a partner in decision making or as the prime decision maker? Would you include other advisors such as priests or pastors of his/her religious belief, or friends of the patient into final treatment decisions, and how far? Under which circumstances would you refuse to treat the patient and rather refer the patient to a colleague or another institution?- Describe and discuss your own cases in which complex medical and moral decision making and complex institutional settings made it difficult to find a good patient-oriented solution! Review the decision-making section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification of this list; do you have your own list already?

Treating the Patient as a Person, integrating Medical Status and Value Status

Which options (alternative possible solutions) are available in the face of potential conflict between the medical-scientific and the medical-ethical aspects?
Which of the aforementioned scientific and ethical criteria are most affected by these alternative options?
Which options are most appropriate given the particular value profile of this patient?
Who, if anyone, should be consulted to serve as an advisor to the physician? Is referral of the patient necessary for either medical or ethical reasons?
What are the moral (in contrast to the legal) obligations of the physician with regard to the chosen treatment?
What are the moral obligations of the patient, staff, family, health care institution and system?
What, if any, are the arguments for rejecting the selected treatment?
How would or should the physician respond to these arguments?
Does the treatment decision require achieving an ethical consensus?

Consensus by whom and with whom, and to which degree?
Why?
Was/Is the treatment decision adequately discussed with the patient?
Did he/she agree?
Should the decision process be reassessed and the decision actually revised?
Summary:
What decision was made after assessing the scientific and ethical aspects of the case?
How can the physician most accurately represent the medical-ethical issues and the process of evaluating the medical and ethical benefits, risks, and harms?

Alternative Checklists using different religious or cultural references

The Bochum Checklist was developed more than 25 years ago to be used in 20th century European family medicine and hospital treatment and then has found a place in medical-ethical teaching and in clinical medicine review and consultation elsewhere around the globe. The basic principles of competent and compassionate care, of communication and cooperation, and of on-going efforts to cultivate professional and personal lives, are similar in all cultures independent of religious or philosophical traditions and customs. But different cultures have their own values and principles which are more easily referred to than to imported principles. Tai, a leading Chinese bioethicist has referred to the five classical virtues in Asian culture: Compassion as a basic human virtue in all situations, Righteousness in doing things right and doing the right things, Respect for fellow humans in all social interactions, Responsibility in personal and professional actions, and Ahimsa as respect and reverence for life and non-violence. He recommends using the three classical Confucian parameters for applying values and virtues to concrete situations: Cheng, Li, and Fa. Cheng means that the action needs to be according to the situation, i.e. each and every instance of applied ethics needs to be situational ethics. Li means reasonableness and propriety and asks whether or not an action, to be considered to be taken or to be reviewed, was or is reasonable and appropriate and does not violate stabled norms and expectation in society. Fa, lawfulness, in all situations of decision-making or reviewing is a principle of last resort, against which actions - past, present or future - need to be checked, as in morally extreme situations, lawyers might have the final word. Tai has developed a Basic Checklist which could be used in Asian cultures in mixed committees of health care professionals; it represents an open checklist similar

to the Bochum Questionnaire and calls for patient-oriented treatment and care:

Basic Checklist for Clinical Consultation in Asian Cultures: 1. Identify the issue. - 2. Speak with nurse and family if request comes from physician or vice versa. - 3. See the patient and allow the patient to speak without interruption. - 4. Ask open-ended question. - 5. Talk with the physician. - 6. Prepare an ethical analysis. - 7. Provide recommendations.

Questions: Do you think that this checklist can or should only be used in Asian countries? Use this checklist in your own institution or in clinical ethics consultation, whether in Asia or elsewhere, as an exercise in clinical practice. Apply this checklist to cases you have encountered in your professional life or have dealt with in consultation; will the outcome be different to using other questionnaires? Review other cases of cross-cultural conflict, including your own and those already discussed!

Supplementary Checklists in Special Health Care Situations

Medical and nursing care does not just address the treatment of diseases. Most Professional Codes of Conduct of physicians cover different obligations, depending on the situation and the patient, such as the Code of Conduct of the German Chamber of Physicians defines five core obligations of physicians: 'It is the obligation of the physician, in respecting the right of patient self-determination, to preserve life, to protect health and to restitute it, also to alleviate suffering and to accompany the dying up to the death.' Any one of these five obligations or a combination thereof will have to guide medical decision-making in individual cases, - and all medical cases are individual cases. Confucian physician Yang Chuan, 1700 years ago, recommended to lay people to only trust those doctors 'who have a heart of humaneness and compassion, who are clever and wise, sincere and honest'. Today, we have similar requirements for nurses, hospital administrators, and different specialists in medicine and nursing and in their teams in general and in special situations. Most issues, which I have encountered in different clinical settings, were related to carelessness (absence of professional competence and pride) and lack of compassion; both virtues and principles have been an essential part of physician's ethics since millennia and unfortunately do not play that prime role anymore in contemporary clinical ethics teaching and training.

Here are a few special situations, for which the Bochum checklist has developed and tested a small number of special questions. These special checklists include situations of long-term care and chronic disease, situations in which health care and medical treatment is confronted with issues of considerable social impact, special subject-oriented and patient-oriented issues on clinical research, intervention and care in psychiatry, hospice ethics and care for the dying.

Other special situations for which it would be important to have either special checklists or supplementary lists have been developed or need to be developed include neonatology, pediatrics, geriatrics with supplementary lists of special old-age diseases and burdens, genetic counseling, lifestyle advice and consulting, dependency care, infectious disease prevention, just to bring the special fields of integrating differential ethics into differential diagnosis and treatment up to a dozen. I encourage, as part of this virtual training course, students and teachers to develop, test, and improve, based on their own expertise and experience, supplementary or independent special lists for these and other situations. A few examples:

Supplementary Checklist for Long-term Treatment and Chronic Disease

Will the chosen medical treatment and its ethical acceptability periodically be reconsidered? - Is the treatment in line with quality standards in medical treatment and care and medical ethics [capable of being brought into line with the appearance of newly-derived] medical-scientific and/or medical-ethical information]? - What clinical or ethical factors must be reviewed [re-thought given the unforeseen appearance of new medical-scientific knowledge or medical-ethical insight] during on-going treatment? - How do patients react to modifications [alterations] in treatment strategy? - In cases where the prognosis is dim, how should the physician decide whether the patient should receive intensive or palliative treatment? - It is possible to appropriately satisfy the patient's explicit wishes, demands, as well as his/her tacit intentions, and to be reassured that they have been seriously considered?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision-making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Questions and Review of Checklist: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own modified list!

Supplementary Checklist for Medical Care and Considerable Social Impact

What are the anticipated costs, personal and material, to the patient, the family, the health care institution, and society? - Are the patient, relatives, and community able to bear these costs? - Will the costs of the social [re]integration of the patient, his/her life style, personal development, and recuperation be adequately met? - How do the answers to these questions of cost bear on the medical-scientific and medical-ethical considerations?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues!

Questions and Review of Checklist: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own list!

Supplementary Checklist for Therapeutic and Non-therapeutic Research

Has the research protocol and design taken the medical-ethical aspects under full consideration? - Is the research necessary? - Did the patient provide a truly informed consent in order to be entered into the protocol? - Who is responsible for providing adequate and thorough information to the patient subject and to assure that it is adequately understood? - What reasons might explain why a patient-subject did not give a fully informed, competent, and voluntary consent? - What procedures were initiated to avoid discriminating against a patient [subject] when requesting his/her participation in a research protocol? - What mechanisms are in place to respect and act on a patient's right to withdraw from participating in a research protocol at any time? Was the experiment fully explained to the patient [subject] in clear and fully comprehensive language?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision-making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Questions and Review of Checklist: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own modified list!
Special additional issues in Cytostatica Research:
1. Is the scientific definition of efficacy as expressed in terms of remission or no-change in conflict with the patient's definitions of quality of life? 2. Is the patient aware of a possibly scanty prognosis for full recovery? What does the patient expect from the trial? What does the researcher expect? 3. Can and will quality of life issues be dealt with separately from medical research issues? - 4. Has the patient been offered the best available palliative care? Has he/she been made aware that best palliative and quality-of-life support will continue even if she/he withdraws from the trial?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Interactive Communication, Review of Checklist: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Discuss in this seminar and present your own list! Develop and discuss special additional lists for other areas of specialized clinical research involving other specific scientific, medical, and ethical issues

Supplementary Checklist for Intervention and Care in Psychiatry

1. Is intervention indicated, given this disease and its risks? Who decides? 2. Are concepts of quality of life of this patient known? Why are they not used in deciding about treatment? - 3. Has the personal profile of this patient been modified by medication or intervention? Can it be reconstructed or supported? - 4. What are the risk, disadvantages and advantages of institutionalization? How can institutionalization be avoided? - 5. Is paternalistic treatment mandated at all? Why? How long? Who makes those decisions? - 6. Use or

develop a specific ethics checklist for this disease! - 7. How can be secured that decisions on intervention will be periodically and ad hoc reviewed?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision-making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Interactive Communication, Review of Checklist: Review these and other supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification for this particular list; do you have your own list already? Present and discuss your own modified list!

Supplementary Checklist for Intervention in Neonatology and Pediatric Care

1. Who defines the 'interest' of the child and how? - 2. Can this child be involved in the decision-making process? - 3. What are the parents' values, wishes, and fears? - 4. Are there any special actual and/or future care-giving issues? - 5. Will they be able to care for a severely handicapped child? - 6. What financial organizational or consulting services are available?

Case: A 4 years-old girl remained in a coma three weeks after brain surgery for a very severe traumatic hemorrhage. Since she was refused treatment by a well-equipped Taipei City Municipal Hospital she was transferred to a smaller hospital 100 miles south of Taipei where she was operated upon; public opinion was most sympathetic to her and supportive to apply all efforts to rescue her. When a brain death was declared, her parents refused to give up and demanded continuous treatment. Because of the pressure from the public, the health team continued treating her and promised that they would try their best to keep her alive hoping for a miracle.

Questions related to this case: What is autonomy in pediatric care? Who should the prime decision maker be? Should the decision be based only on individual or family wishes? How far should family wishes be taken into account with medical and nursing decisions? When health professionals know that the patient is still treatable, yet the family or the patient decides to forgo treatment, should health professionals go along and respect family's or patient's autonomy? When treatment is futile according to physician's knowledge and experience yet the patient or his surrogate insists upon

continuing treatment, should patient's autonomy be respected? What role do cultural differences play in caring for others, such as young children or demented adults?

Other Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision making and providing support for your solution in the best interest of your patient! How can young children, even toddlers be involved in decision making? Discuss your own cases, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Interactive Communication, Review of Checklist: Review the supplementary questions of the Bochum Checklist and the Cologne Checklist [Anderweit 2004] based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own modified list!

Supplementary Checklist for Hospice Ethics and the Care for the Dying

1. Does this patient request palliative care even at the expense of prolonging life? - 2. Does this patient request medical treatment of symptoms associated with the process of dying? - 3. Are the wishes of the patient clear? How does he/she express their wishes? - 4. Can the physician justify not following the wishes of the patient? What are the medical and nursing care options?

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision-making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Interactive Communication, Review of checklist: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own modified list!

Supplementary Checklist to develop Health Literacy among Citizens and Patients

Health is not just, as defined by WHO ' a status of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity',

rather health depends heavily on individual health competence and literacy, it is result of health-literate and health-competent care of one's own physical, emotional, and social well-being and well-feeling, achieved in competent understanding, modification, and enhancement of individual genetic, social and environmental properties, with the support of health care professionals and through equal access to health care services, including information and prediction [Sass 2011]. Mencius, the famous disciple of Lao Zi, over 2000 years ago, said 'a person with good virtue will surely have longevity'.

1. How can you improve health care competence and literacy in your particular patient? - 2. Are there any e-health websites which you can recommend? – 3. Would you or your institution like to develop a website, brochures or other written material for the promotion of your patient's health care competence? – 4. Is there a conflict between 'quality of life', as defined by the patient, and 'length of life', as defined by medical statistics and experience? - Why and how would you provide professional services in such a conflict?

Cases: Mr. X. is overweight, has cardiological problems and is developing diabetes. His doctor recommends changes in lifestyle, nutrition, and above all physical exercise. Mr. X. follows the physician's advice and becomes a much younger, happier and healthier person. - Anita, 21 years old, learns by genetic test that she is a carrier of ADPKD, which eventually will make her dialysis-dependent because of kidney failure due to growing kidney cysts. One uncle and her grandmother have already died in dialysis; her mother got a kidney transplant. Reading the website www.zystennieren.de she finds out details about her status and the prediction that her offspring's will have a high change of being carriers as well. Fortunately, in her country pre-implantation services are legal and available. She and her fiancé Freddy decide to marry and to use these services for family planning including selective abortion if the pre-implantation test would fail.

Interactive Communication: Which internet sites and printed materials do you find to be reliable and in popular language? Would you recommend those or woulf your institution put those on its website or promotional material? Would your institution or your team provide general or specific health care education for issues such as lifestyle modification, nutrition, exercise, anger management, pregnancy, diabetes, STD's etc.?

Supplementary Checklist for Cases of Considerable Moral, Cultural or Religious Differences

1. Is the intended treatment and care acceptable to the values of the patient? - 2. Is the treatment or care asked for by the patient (or her/his family or guardian) acceptable to health care providers, teams and to the institution? – 3. What are the differences and who could be brought in to reduce or solve controversies? – 4. Is it acceptable to experts, teams and institutions to recommend other experts or institutions to the patient? – 5. In which situations should potential patients not be informed about services of other providers? Summarize major points of your decision; review those after treatment of the case or your definite refusal to treat.

Cases: In a Singapore hospital a Hindu woman of 35 weeks pregnancy requests an elective Caesarian section so that birth will occur on a good auspicious and lucky day in the Hindu calendar. There were no medical complications with this pregnancy and the hospital had great experience with premature babies born at 35 weeks gestation; so they followed the woman's autonomous request. Unfortunately, the child developed severe respiratory distress which resulted in costly and distressful intensive respiratory care. Both, the parents and the pediatric team, regretted the decision later.[Joseph] – An 80-year old man suffered from cerebral hemorrhage and his Glasgow Coma Scale was down to 3. Previously he had clearly stated that in such cases without full recovery he would wish to pass on peacefully. The family in this case and his 73-year old widow nevertheless requested medical treatment and the old man was kept alive for the 'sake of his family' [Tai]. - A Taiwanese medical scientist had collected tissue from volunteers in an aboriginal village with consent of those involved. But the leaders of the community requested that the samples be destroyed because any research benefiting the community must be approved by the community and not only by individual volunteers [Tai].

Interactive Communication: What are your experiences with personal, religious or cultural disagreements in the hospital setting? How were they resolved? Where you happy with the solution found? What would be major issues in your local setting? Discuss the interactive relation between universal values an specific cultural traditions [Zhai 2011]; test and develop other checklists such as those proposed by Tai [2008:122-135] using 'compassion, righteousness, respect, responsibility, do not harm (ahimsa)' as landmark principles.

Supplementary Checklist for Clinical Training and for the Development and Promotion of the Corporate Profile

Modern medicine and health care is provided in institutional settings, in cooperation with physicians, nurses, laboratory experts and other technicians, and also with administrators. Thus, treatment decisions have to take the roles and obligations of other stakeholders into account. Physicians should provide leadership in advising other stakeholders, including patients and their families, and in training medical and nursing teams to provide individualized care. Hospital, nursing homes, and other health care facilities are corporate neighbors and their corporate profile will decide about their reputation and acceptability; to have special corporate checklists for developing internal training programs and to establish outside visibility might be the optimal management tool [Sass 2011].

1. What are the most essential virtues/principles in your particular professional fields; list in order of importance for special situations (situational ethics) 'communication, cooperation, competence, compassion, cultivation'? – 2. Is there a difference or tension between personal or collective virtues as character traits on one side and as legal, moral or cultural principles on the other? – 3. How would such a list of virtues/principles be different in other wards of your institution? – 4. Which of these principles/virtues need more training? – 5. Which principles/virtues should be used in public relations to demonstrate that your ward/institution is a good and reliable corporate neighbor? – 6. How can it be assured that always and in circumstances professional competence and personal compassion will be essential in all services?

Cases: Collect successful and unsuccessful cases from your own experience and use those for training purposes. Use good exemplary cases for internal training and for the promotion of your department in the public.

Interactive Communication: Discuss and write promotional flyers for your special field of treatment and care. Use those materials for internal training and for the promotion of your and your team's specific service. Discuss with corporate and individuals persons in your neighborhood their evaluation of your corporate profile. Learn from those discussions and improve your profile by visibly improving your service.

Other Special or Supplementary Lists for Good Patient-oriented Care

For your own training and practice, for communication with colleagues and for the education of your staff, begin to develop your own checklist model for

daily use. You may also develop your own supplementary list for special situations or special groups of patients. Reflect your own recent cases in the light of quality norms and regulations or recommendations of your professional medical association, reimbursement schemes, patient's wishes and expectations and describe and discuss those cases. Then, in using the model of the Bochum Checklist approach, develop your own model, discuss and review it and make it available for public and professional discourse.

Cases: Describe and discuss your own cases in this specific field of medical care and your method of decision making and providing support for your solution in the best interest of your patient! Discuss the case, your reasoning and decision with your team and/or colleagues! Discuss as well in this seminar!

Interactive Communication and Checklist Review: Review the supplementary questions of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? Present and discuss your own list!

REFERENCES

Anderweit S, Licht C, Kribs A, Roth B, Woopen C, Bergdolt K. (2004) Cologene Framework for Ethical Decision Making in Neonatology. Ethik Medizin 16:37-47

Anderweit S, Feliciano S, Ilkilic I, Meier-Almendinger D, Ribas-Ribas S, Sass HM, Tai MC, Zhai XM (2006) Checklisten in der klinischen Ethikberatung. Bochum: ZME

Beauchamp TL, Childress J (2001) Principles of Biomedical Ethics, New York: Oxford U Press, 5th ed

Blake DC (1992) The Hospital Ethics Committee. The Hastings Center Report 1992:6-11

Borovecki A, Sass HM (2008) The Use of Checklists in Clinical Ethics. Recklinghausen: Institute for Practical Ethics [Croatian / English edition]

Joseph R (2011) A Clinical View of Western and Eastern Principles in Global Bioethics. Asian Bioethics Review 3(1)3-13

Macklin R (1998) Ethical Relativism in a Multicultural Society Kennedy Institute of Ethics Journal 8:1-22

May AT (2012) Clinical ethics committees as living beings, in: Fritz Jahr and the foundations of global bioethics, ed. A Muzur, HM Sass, Muenster: Lit, 311-318

May AT (2013) Strukturinstrumente zur Klinischen Ethikberatung - Entwicklung und Perspektiven, in: Klinische Ethikberatung: Grundlagen, Herausforderungen und Erfahrungen, ed. F. Steger F, Muenster: Mentis

Pellegrino ED, Thomasma DC (1988) For the Patient's Good, New York: Oxford U Press

Ramsey Paul (1973) The Patient as Person, The Patient as Person. Explorations in medical ethics. New Haven CO

Sass HM (2007) Bioethics and Biopolitics. Xian: press.fmmu.su.cn [Chinese/English edition]

Sass HM (2011) Cultivating and Harmonizing Virtues and Principles. Asian Review of Bioethics 3(1)36-47

Sass HM, Viefhues H (1987) Bochumer Arbeitsbogen zur medizinethischen Praxis, Bochum: ZME

Sass HM, Viefhues H (1992) Differentialethische Methodik in der biomedizinischen Ethik, München: GSF-Forschungszentrum für Umwelt und Gesundheit

Tai MC (2008) The Way of Asian Bioethics. Princeton International Publishing Co., Ltd [ISBN 978-986-7097-86-6]

Zhai XM (2011) Diversified and in Harmony, but not Identical. Harmonizing International Guidelines with Cultural Values and National Traditions. Asian Bioethics Review 3(1)31-35

The Bochum Checklist can be downloaded from www.ethik-in-der-praxis.de in different languages.

This Virtual Training Course in Clinical Ethics is also available in www.ethik-in-der-praxis.de.