Marshall Medical Center
Bioethics Committee Orientation Information
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These materials can be printed in the order listed to be kept in a binder.

MARSHALL
MEDICAL CENTER
It's about you.

BIOETHICS COMMITTEE ORIENTATION MANUAL

MISSION STATEMENT

Marshall Medical Center proudly serves the Western slope of El Dorado County. Our mission is to promote health improvement and provide health services of extraordinary value and quality to our community.

VALUES AND PRINCIPLES

We at Marshall have dedicated our lives to healing. To that end, we are a community within the larger whole. The Marshall community -- employees, medical staff, volunteers, and directors -- embrace the following values and principles:

Our patients come First. All other values are overshadowed by the proper care of those who entrust their lives to us. It is our duty and privilege to care for our patients, and we care for them with dignity, respect and compassion.

Medicine is a Science. Therapeutics at Marshall are based on the Medical Staff's oversight of the application of the best medical science. We strive for continued improvement in all aspects of patient care, pursuing growth in our collective expertise. Excellence in prevention, diagnosis and treatment of disease are defined by documented clinical outcomes.

Healing is an Art. Scientific medicine flourishes best in a healing environment. In a healing environment, our patients and their families are an essential part of the health care team. We empower them through our support, our example and our teaching. To enrich our healing environment, members of the Marshall community treat each other with the same respect we hold for our patients.

Our hospital is not defined by walls. Our hospital is defined by the doors we open. The community is best served by a continuum of care, wherever those services are needed. We must reach out to emphasize primary care, prevention, education and collaboration with other organizations when their missions complement our own.

We bequeath this hospital to future generations. Our community is best served by institutions that are locally owned and managed. To maintain our independence and meet the present and future needs of the hospital and the community, we manage Marshall's finances prudently. We compete on the basis of value; striving to maintain the lowest costs and prices in our market. We view it as sound financial strategy to strive for uncompromising excellence in health care.

Adopted by the Marshall Board of Directors, July 7, 1995
Revised and adopted July, 1999

WELCOME TO MARSHALL MEDICAL CENTER'S BIOETHICS COMMITTEE

The Bioethics Committee of Marshall Medical Center, under the aegis of the Medical Staff, serves the patients of El Dorado County. As such, our committee has one purpose: the resolution of health care dilemmas that may face a patient, his/her family, or a health care professional. While our focus is on the resolution of an ethical dilemma, the means by which we arrive there may be through education, collaboration, or mediation.

Whatever the mode, discussion is central to our process. Underlying each discussion is a thoughtful and systematic deliberation guided by ethical principles. We endeavor to clarify objective and subjective perceptions that may confuse and complicate the path to clear communication. Within this context, meetings may focus on case presentations, current health care news items, and/or issues that may be problematic for our constituents.

A critical aspect of our commitment is to ensure the patient's point of view is treated with dignity and compassion and given a voice. Cultural values and beliefs are respected, and each case is discussed on its own merits. Although we do not establish policy, our committee may make a recommendation.

The Committee is comprised of health care professionals of Marshall Medical Center, other professionals associated with various agencies in our county, and community members at large. As a member of this committee, you are now part of a mechanism advocating for the patient and his/her family as well as providing support to our health care professionals.

We welcome you to the Bioethics Committee. Your participation will enrich discussion, enhance our perspective, and support the mission of Marshall Medical Center to promote health improvement and provide health services of extraordinary value and quality.

MARSHALL MEDICAL CENTER
BIOETHICS COMMITTEE GUIDELINES

PURPOSE

The purpose of the Bioethics Committee is to impact positively upon the quality of health care provided to our community by:

a. Creating awareness and understanding of bioethical issues and dilemmas by educating members within the healthcare community.
b. Assisting individuals or groups to understand bioethical issues and facilitate resolution of bioethical dilemmas.
c. Recommending policies related to bioethical issues.

STRUCTURE

1. This shall be a committee of the Medical Staff.

2. This committee shall consist of a minimum of the following:
   - Four physicians
   - Four nurses (2 of them Registered Nurses)
   - One Marshall Medical Center Administrator
   - One Marshall Medical Center Board Member
   - One Social Worker
   - One clergy
   - A Public Health Representative
   - Member of Community at Large

Note: The following members will also participate in the Institutional Review Board (IRB): The Chair, a physician member, a hospital administrator, legal representative, the pharmacy manager, and representatives as needed. Chair of Bioethics will also serve in capacity of Chair of the Marshall Medical IRB Committee. IRB committee conduct and membership is outlined in the Medical Staff Bylaws.

Officers: Appointment to the Chair and Co-Chair will be at the discretion of the current Chief of Medical Staff and the terms of these offices shall be two years. These terms may be extended with a quorum vote from the Bioethics Committee and approval of the Chief of Staff, for a total of four years. After four years Officers must relinquish their appointment but may remain as active committee members.

4. Quorum: A quorum shall consist of 50% of the active committee members, including at least one physician (other than the committee Chair) and two nurses. For voting purposes, excused members will be included as part of the quorum. If a quorum is not present the committee can proceed with other business but not action items.

5. New members will be given an orientation packet and will be oriented by a committee member.

6. Strict confidentiality shall be observed regarding actual case deliberation or discussion of specific sensitive issues. Each committee member will sign a confidentiality agreement, as well as any consultants or guests in attendance.

FUNCTION

7. The Bioethics Committee shall meet at least ten times/year and shall develop a standard agenda to include:
   a. development of educational presentations to the healthcare community and the community at large.

b. review and recommendations of policies with bioethical implications.
c. reports of ad hoc groups and special meetings.

8. Special meetings may be called as necessary to provide urgent consultation or to address urgent policy matters.
   a. Consultation may be requested by any physician, staff member, patient, family or other concerned person.
   b. Requests for consultation shall be made to any committee member.
   c. Time and place of the meeting shall be set by the Chair or Vice Chair who shall assure appropriate representation for the issue to be addressed.
   d. Reasonable notice of special meetings shall be given to each committee member.

9. Minutes shall be kept of all Bioethics Committee meetings. Minutes must be reviewed and approved.

Marshall Medical Center
Bioethics Committee Members
2005

Sherellen Gerhart, MD, Chair Internal Medicine
Mike Dorso, MD, Co-Chair Emergency Services
Ken Nelson, MD MCPC OB/GYN
Keith Boston, MD Family Practice
Lin Soe, MD Oncology
Kay Courter, RN Educational Services
Marlene Hensley, LCSW El Dorado County PHF
Jeanne Hinds, RN Palliative Care Specialist
Kathy Krejci, RN Director of Patient Care Services
Joan McCullough, ART Health Information Services
Mary Muse Marshall Board of Directors
Celia Orona, Ph. D. Community Member
Joel Porter, RT Cardiopulmonary Services
Cheryl Purgett, MSW Social Services
Ellen Richards, MS Community Health Library
Susan Dorsey, RN Snowline Hospice
Barbara Smiley Community Volunteer Program
Tim Thompson, D. Min. Chaplain
Shannon Truesdell, RN Assistant Administrator
Katherine Tuttle, Ph. D. Community Member
Michael Ungeheuer, PHN El Dorado County Public Health
Diane Walsh Chaplain
Carla Yorba, FNP Divide Wellness Center
Janet Buchanan Medical Staff Services
Carole Stewart Recorder

Marshall Medical Center Bioethics Committee

- Medical Staff Committee
- Regulatory Mandate
- Medical Staff or Hospital Staff Referral

Considerations – Order of Priority

1. Patient Preference
2. Medical Indication
3. Quality of Life
4. Socioeconomic

1. Patient Preference

- Autonomy
- Capacity to choose
- Informed Consent
- Refusal
- Proxy/Advanced Directives

2. Medical Indications

- Diagnosis and Prognosis
- Goals of Therapy
- Efficacy/Inefficacy
- Futility/Utility

3. Quality of Life

- Subjective Evaluation
- Bias
- Justification for DC of Life Support

4. Socioeconomic

- Family
- Costs
- Allocation of resources
- Research
- Confidentiality
- Protection of others

Bioethical Principles:

1. **Autonomy**: A person has the right to make his/her own decision.

2. **Beneficence**: Taking positive steps to do good for others.

3. **Non-Maleficence**: Avoiding inflicting harm.

4. **Justice**: Giving a person what they deserve or can legitimately claim.

5. **Veracity**: Requires that we tell the truth and not intentionally deceive or mislead anyone.

6. **Confidentiality**

7. **Utility**: Produce the greatest possible value over disvalue for person affected – the greatest good for the greatest number.

Ethical Decision Making in Committee

The Role of Review Boards and Ethics Committees in Health Care, Health Policy and Medical Research

Hans-Martm Sass
Kennedy Institute of Ethics
Georgetown University, Washington DC

Committees and Responsibilities

From the crib to the grave: committees, committees, committees. Committees have become a part of our life; some of us are members of committees; all of us depend on decisions made or recommended by committees, we don't know and by members we don't know, - anonymous bodies, making decisions for others by majority vote. Our generation has seen the mushrooming of committees all over the world and for all possible issues, including committees flees for patient: care in the hospital, for setting health care policy on the local, provincial or national level, for supervising the ethical practice of research on humans, for health education, and committees within professional groups and organizations in the nursing, medical, and researching professions.

What is the morale or the reason behind the culture of decision-making by committees? Is there a higher authority of moral judgment if made by a group of people rather than by one individual? And, if committees make moral judgments and ethical decisions, will those committees also be morally or legally liable for decisions the same way a competent individual has to be hold liable morally and legally for her or his actions? And what is the personal moral or legal liability of individual members of committees; to whom to they owe responsibility; to nobody except to their individual conscience, or to those who elected them to be a member of that committee, or to the constituency they are expected to represent whether elected by that group or not? Personal experiences and empirical research suggest that the answer to these questions might rather be NO than YES. Each of these questions is full of philosophical, cultural and political complexities which we cannot address in detail today; but it is important to keep these questions in mind in order to be aware that decision by committee is only one of many other model of deciding, accepting responsibility, setting rules, policy or strategy, drafting regulations or recommendations, distributing public or private funds, or making recommendations for policy options to other bodies. Two arguments have been voiced to support the mushrooming of commissions and committees: (a) the need for expert advice in complex political, social, and interdisciplinary Issues, and (b) the need for participatory representation of the stakeholders involved. Keeping the fragile nature of decision making and recommendation making in committee in mind, I will discuss three different types of committees in the area of health care: (a) commissions on the state or national or transnational level, (b) research review boards, required for human experimentation and innovative therapy, and (c) hospital ethics committees setting rules for hospitals or wards and focussing on individual patient's care.

Policy Setting Committees on the Provincial or State Level

For commissions on the state level it is very important that they focus (a) on identifying different views of the world and (b) on options for societal consent or on means to live with dissent, if consent cannot be achieved. Sometimes a commission has to deal with issues such as abortion for which the arguments pro and contra have been voiced for centuries, sometimes the analytical framework has not been constructed, such as in the case of genetic screening or xenotransplantation. In both oases the commission has to provide analytical justification from

first principles either for consensus formation or for policy options on how to live with dissent. The US National Commission's Belmont Report, for example, broke new intellectual grounds by identifying for a postmodern, pluralistic society the principles of autonomy, nonmaleficence, beneficence and justice as the leading first principles for establishing either consensus or reasoning in favor of acceptance of individually different positions in the respect of the dignity of the individual religious or moral conscience. More fundamental, philosophical bioethical analysis – such as writing books on general theories of justice – is best done by those whose job is to think and write, not a group of commissioners selected because of their national prominence, professional background, political connections, and ideological affiliations. An international, national or state committee can articulate others' positions, filter information, and facilitate communication among policy makers. Legally nonbonding declarations of high moral binding such as UNESCO's declaration for the protection of the human genome are easier to be achieved and to become valid than regulations or international conventions such as the EU Bioethics Convention which still needs to jump the parliamentary hurdles of some countries and need transfonnation into national law. Given the fact that declarations and regulations in bioethics all are targeted at protecting the individual fellow human as a person and as persons happen to and have every right to disagree, there are certain limits as to what can be declared and regulated. Among the number of goals and means of policy oriented ethics committees, let us briefly discuss the following nine [see also R Cook-Deegan, in: Sass 1988]:

(1) Searching for a compromise: Some public issues arise so quickly that controversy surfaces as a symptom of incomplete analysis by different factions. In such cases, there is an opportunity to articulate a position that could: be widely accepted. In political tenns, this is extremely useful because democratic government is erected on consensus, although constrained by unalienable individual rights, as the philosophers of the Age of Reason have stressed. Human gene therapy is an example: consensus that somatic cell gene therapy is little different from other medical technologies was voiced first by the US President's Commission and then by the US Congress Office of Technology. This was sufficient to prevent legislation to prohibit or limit it. The US President's Commission report on defining death, and many of the US National Commission's reports on human research subjects also exemplify this function of forming the point of condensation for consensus. Consensus fonnation is ideally suited to national commissions or ad hoc commissions. The fundamentals of religions and worldviews might be quite different and exclusive to each other, but as Jesus has demonstrated in the parable of the Good Samaritan, there are certain mid-level ethical principles, such as solidarity, reciprocity, 'neighbor's love', that can be shared by many different ideational commitments.

(2) Clarification of values and understanding of disagreements: Consensus does not always form around issues, even when a technology is the main new feature. Nuclear power and arms control have not been notable for their rational public discourse or clean and highly analytical policy process. In bioethics l commissions, the objective may be consensus but the result may be incompatible views, as we have seen in the debates on abortion and most recently on stem-cell research. The process of articulating dissent is nonetheless valuable. Seeking consensus may also contribute to public debate with no expectation that concrete recommendations are possible. Thus consensus-seeking need not be considered a failure if it yields progress but no end. There is ample value in ventilating disparate moral positions publicly. An illusory or forced consensus can result in policy change only to breed later backlash as the policy encounters resistance. The classical ethical principle to govern a procedural proposal rather than a content solution is the principle of subsidiarity, the rule, that at the lowest possible societal level and by those most directly involved decision should be made, and that larger societal or political bodies should only take action when individuals and groups most directly involved demonstrate that they are unable to

solve conflicts or provide help and support to those in need. In socialethics, this principle has proven to be of great value; elsewhere I have recommended that its use should be tested in bioethics also.

(3) Identifying emerging issues: National commissions can identify future issues. This can be quite helpful to policy makers even if no conclusions are reached about options for dealing with the issues. "Early warning" functions constitute specific, narrow, example of consensus formation. The focus is on identifying issues likely to matter in the future rather than on solutions to current policy concerns. If a set of issues is agreed to be important in the future, then a politician, can begin to formulate his or her position on those issues, and to commit resources to finding out about them. In Germany, we basically had not much public debate or a national ethics committee studying the impact of nuclear energy on attitudes and individual and group risk assessment; unfortunately only later we had those debates, when billions of Deutsche Mark: had already been employed and when nuclear energy facilities were already in use.

(4) Mitigating a societal debate and Dropable consensus: If an issue very new to the public and to experts and politicians, public policy as well as public discourse may very well benefit from a debate that pits the best minds of various camps against one another in a mutually respecting forum. More often, however, little value will be added by the commission's deliberations. Fetal research is an example of ~ issue that has been addressed by the US National Commission, then an Ethics Advisory Board, and was to be addressed by BEAC (US Bioethics Advisory Council). No action to break up the ideological logjam has been effective.

Even if consensus is not possible, a softening of positions at the extreme edges may be. If this occurs, the environment for making tough policy choices may be less threatening, and incremental policy adjustments may become possible. Some issues bound to elude consensus are relatively easy to identify. They usually have been hotly debated for years (e.g., human rights, fetal research, abortion, access to health care, surrogate motherhood, homosexuality, cloning, organs for sale). Changes on such issues require either extended careful thought, followed by changes in public attitudes, or classical political maneuvering to which ethical analysis contributes little. If continuing a controversial debate is the objective, there is generally little to be gained by having a national commission. Successful as a means and as a moderator for public discourse were two national commissions in Denmark, one addressing the issue of brain-death, the other acceptance and validation of Advance Medical Directives. Both initiatives went over a few years and funds were disbursed for supporting a debate in the academia, in neighborhoods, in churches and organizations; only after such an extended debate initiated, but not moderated or controlled by the commission, the Danish parliament was ready to pass legislation on both issues.

(5) Camouflaging governmental disinterest or inaction resulting in postponement of issues: It is quite common for politicians to be evasive or cowardice in regard to making hard choices in the public's best interest, such as in , health care finance reform or in social security and old-age pension issues. The choices to be made are mostly unpopular and to not win immediate support; but immediate support and success is important for politicians depending on the electorate's vote. To install a blue-ribbon committee or an expert group for further studies is a widely used tool to postpone or to neglect decisions. Members of those committees are in quite difficult professional and ethical position: on one side they are allowed and asked to contribute their visions, ideas and expertise, and on the other side they very clearly recognize that roost likely nothing will come out of their work, that they are actually contributing to increasing problems by putting them on the back-burner. Politicians often hope that controversies will go away. They may seek to use a 'study' or a 'committee' as a delaying tactic, judging that the intensity of conflict will dissipate over the course of a mandated study. A closely related tactic is for politicians to call for a study, while politically maneuvering to distance themselves from its

results. When the results are produced, they can accept the results they agree with, and blame the commission for those they reject.

(6) Proposing Regulations or Drafting Legislation: A committee can, having identified an existing consensus, devise a way to incorporate it into practice. In the US, the President's Commission served this role in a multitude of issues. Its report on 'Defining Death' served this function, as the template for statutes passed in the States. The US National Commission reports on children, prisoners, and other vulnerable populations were readily translated into federal regulations governing research. In Congress, this function is usually performed by committees, which have access to outside expertise and focus it on legislation. Executive agencies also have policy-making groups that perform analogous functions. From time to time, however, policy makers may wish to attend explicitly to the ethical dimensions of a policy choice. In such cases, a national committee or ad hoc panel is the logical choice. In Germany, we have so-called Enquete -Commissions for genetic technologies, instituted by and reporting to the national parliament.

(7) Creating and Providing: a Critical Mass of Ethical Experts: Ethics Committees serve as educational means in interdisciplinary, academia-public, and theory-practice interaction and experience of members of different professional and social background, it is not easy to find philosophers who despite their expertise in one or the other field of philosophy are capable of finding the common language and method of working in a team of physicians, regulators, lawyers and scientists. The same is true of the other professions. Interdisciplinary committees are the best breeding ground for crossdisciplinary understanding and evaluating.

A societal effort to incorporate ethical analysis into public policy rests on an academic reservoir of technical experts, legal scholars, and humanists, if no critical mass of people in these fields exists, then the first step in any program must be to develop one. Grants and training programs are the direct means to this end. If there is sufficient expertise in the various fields, then ad hoc committees, state committees, or permanent review boards are all possibilities. Choosing among these options will depend on the number of issues at hand, the resources available, and the objectives of seeking advice.

If consensus is a likely outcome, and publicity is desirable, then an independent blue ribbon committee is the logical choice. Care must be taken, however, to provide sufficient budget and time. Funds and schedules must, in particular, allow for the extensive network formation necessary for a proper job. If there are many issues and the decision making apparatus is complex, then a permanent analytical agency is the option of choice. In this case, the extra investment in a management structure is necessary in addition, to the report-writing team or teams.

(8) Debating and Confronting: Special Interest Group Lobbying: The modern world of public policy and public discourse is not only influenced by committees of various kind, even more so by lobby groups and special interest groups, actually dominating those issues of their specific interest -- interest groups have become much more sophisticated in their use of national direct mail fund-raising, organization of national letter-writing campaigns, boycotts, and other tactics. They have introduced a new dynamic into the political process. They are organized around specific issues, and establish a staff, newsletters, policy analysis mechanisms, and capacities for political strategy that once formed can be applied to new issues as they arise. The great strength of interest groups is their narrow focus, which permits them to concentrate on a specific agenda. But this can also be a weakness, as it tends to result in fixed policy positions that once taken are extremely difficult to modify. A narrow focus can lead to parochial policy formulations; consequences of policy recommendations may not take account of their broader impact outside the sphere of interest and thus are not in the interest of the public and most likely will not last. The abortion debate definitely is overdominated by special interest groups in all countries in Europe and the

Americas; new areas for special interest groups are environment, genetic modification of cultured animals and plants, animal research, euthanasia, in vitro fertilization, cloning, and fetal and stem cell research.

(9) Special Roles for Provincial or other Ethics Committees on the Grass-root Level: As far as I see, not enough consideration has been given to the role of ethics committees initiating public moral discourse and debate and developing public policy options on the provincial level. In a politically coordinated Europe, the role of nation states will diminish, and so will the role and authority of national ethics committees. The role of European harmonization will be increased and as a counterpart to this, new roles and responsibilities should be developed, for the provincial level. In Germany, we have quite a difference of priorities in public culture and moral concern in more religiously oriented states such as Bavaria and more secular cultures such as in the northern part of Germany. Other nation states have similar differences based on tradition and attitude in different provinces and areas of the country. As we have seen, e.g. the availability of organ-sharing has increased, since information, education and promotion of organ donation has been concentrated on the provincial level.

This is a list of issues, where societal ethics committees on a provincial level close to the individuals and institutions they serve can have an impact on consensus formation and the improvement of ethical quality in political, professional and institutional decision making: (1) access to long-term care; (b) financing health care; (3) providing moral and medical quality control on various levels: (4) setting priorities; (5) setting guidelines for governing use of human research subjects in hospital, nursing homes, home care, and ambulatory settings; (6) getting guidelines in organ-sharing for transplantation in actively promoting organ-sharing on the grass-root level; (7) setting guidelines for confidentiality of results from tests for AIDS, drug dependency, and genetic properties; finally (8) assessing the prime values, virtues and principles which might this province or community apart from neighboring others.

Research Review Committees

Clinical research is a noble enterprise in itself. socially not only acceptable but ethically required on moral, cultural, religious, and humanitarian grounds. There is no philosophical or religious tradition, in the world, that does not support and require mutual aid among fellow-humans, solidarity with the weak and needy, and research for the improvement of support, help and care for those who are sick, suffering, or in pain in modem times, strong European humanist and Christian traditions have stewarded and encouraged, clinical research for the benefit of the patient: and pioneered in the establishment of morally acceptable forms of human experimentation, developing rational and responsible procedures in clinical trials for the protection of research subjects.

Ethically unacceptable forms and goals in research design, such as concentration camp experiments by the Nazis and the Japanese or the Tuskegee syphilis studies in the United States, were the exemption rather than rule and have given rise to heightened ethical awareness and the development and improvement 1 of procedures for good clinical practice in Europe and in most civilized countries. Ethics Committees for clinical research and new therapy have been in force in Prussia since the end of the last century, requiring a responsible balance of harm, risk, and benefit and introducing the principle of informed consent, without which no human experimentation should be allowed and accepted. Since the first introduction of the Helsinki-Tokyo Guidelines for Human Experimentation review ~ have become a legal requirement for clinical trials all over Europe and in most civilized countries. Principles of 'nonmaleficence' and 'benefit over harm', 'respect for autonomy' and 'informed consent' have become essential features in Good Clinical Practice (GCP). The mandate of the clinical ethics

committees always is to primarily see into the risk-benefit balance, the informed-consent issue. Clinical ethics committees do not accept responsibility for the actual research which stays with the research teams. Clinical ethical committees in general have are required to include at least one ethicist, one legal expert, one lay person representing the neighborhood, one pharmacologist, and a minimal number of physicians of different subpecialization. But size and membership vary widely. Only a very few clinical ethics committees in Germany have actually philosophers or theologians as members, while their absence in those committees would be unthinkable of in the us. The clinical center at the us National Institute of Health has a rather large number of nine or more members, given the highly specialized research areas; all ethics committee protocols are to be reviewed by the head of the clinical ethics division and signed by the director of the clinical center. Georgetown University Hospital follows another model, having a rather small ethics committee, but decisions are prepared for the ethics committee by expert committees beforehand; the director of the hospital will have to sign the decisions of the ethics committee, and there are cases where he has refused to do .so and given the protocol back to the committee and the applicant, mostly because of issues related to informed consent and the language in informed consent forms. As the parameters and duties of clinical ethics committees are already well established, let me focus on three crucial issues which will overshadow the debate in the future: (1) can ethics be taught and can an expertise in clinical ethics deliberation be developed; {2} are there special requirements for cross-cultural and multinational multicenter studies; (3) has the informed consent principle come to the end of its usefulness and should it be replaced by a more appropriate model such as the ‘ informed request' model or a 'contract model'?

(1) Can ethics be taught? Here is my thesis: Ethical Principles and bioethical assessment can be taught the same way logic, rational modes of analysis, assessment, and cognitive knowledge can be taught. But ethical behavior is an attitude which is as much independent from conceptual analysis as irrational behavior of those who have very well been trained in logic, rational strategy, and assessment of risk. It is well known that knowing the rules and laws does not prevent individuals from violating rules and breaking laws: the better rules are understood, the more sophisticatedly can they be broken, circumvented or bend. Nevertheless, teaching bioethics in the medical and the clinical research setting intends to improve ethical knowledge, assessment skills, and the embodiment of moral attitudes into the day-to-day work of research and clinical care. If we would live in ideologically closed societies, there would be no need for professional ethical teaching as the role of the professions would be determined by the forces of ideological and political power and ethics would be replaced by exercises in dominance and subordinance. Teaching ethics in a multicultural environment therefore is the superior way to assess and to confirm values, virtues, principles, human and civil rights, and to support consensus formation, and coordinated action on various levels of private and professional activity. Bioethics, along with. other ethics in highly advanced areas of decision making, production, and research, additionally has to face the fact that there are certain ethical challenges, for which traditional moral authorities such as Moses or Jesus. Aristotle or Kant never gave direct guidance, such as for how to deal clinically with human experimentation or genetic predictions, endstage chronic diseases, artificial modes of making babies, or how to treat fellow-humans with irreversible and full brain damage in the presence of highly advanced medical capabilities.

While cognitive knowledge can be taught and learned, attitudinal affirmation or change is more complex and cannot be guaranteed even by the best teaching methods. This is confirmed by a US survey among young physicians who had attended bioethical classes as part of the required clinical curriculum demonstrated that only 3% them actually changed their system of belief and concept of ethics as a result of those teachings while 94% declared that their attitudes in general have been formed prior to attending professional schools. Their understanding of clinical ethics was strongly influenced by clinical experience (68%), role model behavior of their clinical teachers (63%), by peer discussion (53%) and by family tradition (58%). As far as specific awareness of

issues in clinical ethics were concerned, physicians thought that classes in bioethics improved communication skills with patients (83%), sensitivity in palliative care (52%), partnership with patients in clinical decision making (68%), protecting patient's privacy (56%); but in issues of public controversy bioethics teaching did not change understanding and attitudes; abortion (12%), definition of death (16%) withholding of treatment from severely handicapped newborns (7%) or organ donation (5%) . While we have no such empirical data yet from Europe, experiences with mandatory courses in bioethics within medical curricula suggest that results might not be much different. As the majority of medical curricula in the European Community does not have required courses in bioethics yet, it is important to introduce medical humanities into the core curriculum, and also into continuing medical education. Bioethics education for clinical research has to be an essential part of bioethics teaching in general, but additionally there should be specific and highly targeted bioethics training for researchers and research teams, also for members of research ethics committees.

Teaching bioethics in medical education does net intend to compete with teaching philosophy in philosophy departments, but adds skills of moral and cultural analysis and assessment to quality education in medical practice and medical research. Bioethics teaching has two goals: (1) It helps physicians and researchers in quality control and quality assurance of care and of research by integrating 'blood status' and 'value status' of the patient in individualized differential diagnosis and to treat the patient according to her or his individual understanding of quality of life, risk profile, expectations, fears and hopes. Clinical data, ethical principles, and personal data. Of the individual patient together will form the basis for individualized prognosis, goals of therapy and therapeutic intervention. (2) The protection of human and civil rights of probands and patients has to be based on a commonly shared strong bioethical and legal platform, which does not compromise with local customs or cultural attitudes who do not live up to these standards. The European and WHO regulations for GCP define such quality standards, which must not be allowed to be violated even if not protected by national laws or safeguarded by cultural attitudes.

Because of the practical relevance of bioethics teaching, the methods of teaching must primarily be based on case studies, scenario assessment, evaluation of principles, virtues and vices, points-to-consider lists and regulations. It is more important that physicians learn to apply bioethical principles in real-life situations of clinical conflict than mastering the arcane walks in ivory-tower theories of ambiguous authority.

Here is a seven point list of concepts which have to be entertained in bioethics teaching specific to researchers, regulators, and members of ethics committees: {1} It is not acceptable that investigators or ethics committees force their particular view on values or weltanschauung on others, the least on those vulnerable fellow humans whose life or well-being depends on their actions. {2} Basic philosophical or religious have to be left to the individual while basic human and civil right issues, including those regulating clinical research, have to be left to the respective regulatory or legislative authorities. (3) No research can ever be done without appropriate approval by the research subject, and the form and content of consent, request, or approval has to be checked carefully, in particular regarding those whose capacity to approve is or might be impaired. (4) Clinical research is a process the biomedical, biometrical, and bioethical parameters of which might change during the course of the trial; therefore a one-time punctual review prior to the begin of the trial does not guarantee highest levels of subject protection and quality of the trial. (5) To review the outcome of trials not only on biomedical and biometrical grounds but on bioethical grounds as well, is very educational and will improve future trial design and trial procedures. (6) While the four-phase randomized controlled clinical trial (RCT) has become the research model of choice and is supported by a multitude of rules and expectations among researchers, ethicists. regulators, and politicians, other avenues of research such investigational new drug trials (IMD). participatory models of risk-

and-benefit-sharing with patients and probands, and biometrical or biomedical alternatives to human experimentation, including computer simulation, use of historical data, cell-, tissue-, and animal-research, has to become a routine part of the evaluation and education process. (7) Of particular educational and strategic importance is the evaluation of morally controversial features such as randomization, double-blind-studies, placebo control versus available alternative drug control, termination of the trial, breaking the code etc.; these challenges occur again in clinical research and therefore should belong to the core topics in bioethics education.

(2) Ethical challenges in multicenter clinical trials: As most clinical trials are conducted in multi-center studies, often including centers in different countries regulated by different legal and regulatory parameters and cultural and professional attitudes, the harmonization and quality assurance of bioethical standards is of prime importance and rightly has become the focus of the European Commission. It is self-evident, that good ethical practice in multicenter clinical trials can only be assured by coordinated and integrated bioethics education across the centers and nations involved and by harmonization in the ethical design and quality control of the trial.

Of particular importance is the fair and equal treatment of subjects in multicenter trials across the borders of states and cultures. In biometrical issues we already enjoy a high degree of coherent and fully integrated statistical quality. We should strive for similar degrees of bioethical quality control and clinical research design. The following six features should be considered to implement, to improve, and to harmonize the biometrical as well as bioethical quality and equality of trials; (1) A bioethics coordinator or coordinating team, comparable to the coordinator recommended by GCP rules would be charged with coordinating bioethical review and assessment prior, during and after the trial; the coordinator also would be available for acute or routine consultation on bioethical issues at each of the centers for investigators and local review committees. {2} Prior to initiating the trial the development of a specific bioethical 'Points to consider' list and specific case studies -would sensitize those involved, speed up the process, and help in creating and improving a common bioethical language and modes of analysis, assessment, and judgment. A bioethics training and harmonization workshop including the heads of local research teams and review boards, the sponsor, insurers and regulators discussing historic cases of comparable moral and medical risk and prospective cases which might occur in the intended trial would improve the strength and design of any large-scale trial. Such a workshop would be imperative if complex cross-national legal and cross-cultural ethical issues are involved. {3} A concerted action of centers involved, and including sponsors and whenever possible regulators and insurers, should prior to the beginning of the trials decide on crucial bioethical issues such as (a) placebo control, (b) bioethical and biometrical selection of subjects, (c) language and content of informed consent forms, (d) modification of routine procedures in RCT's and GCP, and (e) define moral and clinical uncertainties regarding risk or harm. (4) While the regulations for GCP require a bioethics review for discontinued trials, it would be extremely educative and would contribute to quality assurance of trials if at the end of all trials final bioethics review and result report, together with the biomedical and biometrical results and reports, would routinely be put together. (5) it would also improve design duality and bioethics standards if informed consent forms would be developed and. tested prior to the beginning of the trial. (6) The input from research subjects during and after the trial will be one of the best tools in. continuing research ethics training and in improving the bioethical setup of the trial during its course. Also it would be very important to learn from patient's input for future trials of similar bioethical risk; the bioethics literature on clinical research ethics focusses increasingly on issues of patient's input ad response.

The Bochum Center for Medical Ethics has developed a generic points-to-consider list of ten questions, which then will have to lead into the development of more specific lists regarding specific ethical and medical risk of the trial. Here are the ten specific questions: (I) is the trial design optimal from a medical-ethical perspective?

{2} Is this particular trial necessary? (3) Did the patient give his or her informed consent? (4) Was the information completely or incomplete given or understood? (5) Could there be reasons that consent was not fully voluntary? (6) What principles of justice/fairness were used in selecting patients? (7) Does the patient know about his/her right to terminate participation at any time? Is such termination technically possible? {8} Will there be an ongoing communication with the patient during the trial? Mho s personally responsible for continued communication with the patient? (9) Define conflicts between the interest of research, the presumed interest of the patient and interest of the patient as expressed by himself/herself. (9) How do you handle these conflicts of interest? Discuss these conflicts with your patient.

An even more specific list for phase I cytostatioca trials has the following four questions: (1) Is your definition of efficiency as expressed in terms of remission or no change in conflict with the patient's definition of quality of life? (2) Which health index profiles or checklists did you use in communicating with the patient? Do you have your own standardized point-to-consider list, especially designed for this particular trial? (3) Is the patient aware of a possible scanty prognosis for full recovery? What does the patient expect form the trial? What does the researcher expect? {4} Has the patient been offered best available palliative care? Has he/she been made aware that best palliative care will continue even if he/she withdraws from the participating in the trial?

(3) informed request or a contract model replacing the informed consent principle?: The discussion of specific ethical issues in multicenter trials raises the question whether or not the traditional informed consent model still is good enough to set the highest possible ethical quality standard. Elsewhere I have proposed to replace the consent model with a contract model. Let me briefly sketch the concept of the contract model. It has become a routine in GCP and in clinical trial regulation, to require informed consent of research subjects prior their inclusion in. the trial and to inform about their right to withdraw from the trial anytime. The 'informed, consent' principle is an essential feature in all clinical trials and required by governmental regulations from the beginning of this century. But just asking for consent is a soft paternalistic principle and not the appropriate expression of the subject's autonomy. Other risky scenarios in the professional and personal setting are handled by principles more appropriate to shared risk and partnership in communication and cooperation: models of 'participatory contract' or informed request. Times and challenges in clinical trials have changed since A B Hill's successfully demonstrated the four-phase model of randomized controlled trials in his 1948 streptomycin research. Today, after decades of successful clinical trials and progress in bioethical reasoning and experience many research issues such as randomization, placebo control, high risk evaluation, uncertainty assessment and acceptance, data protection, and patient's or proband's benefit cannot be comfortable and ethically handled -within such a model of soft paternalism.

Areas of clinical where the traditional model of soft paternalism becomes particularly troublesome include at least the following three: (1) very high medical or moral risk such as adventures in phase I oncological trials in infertility research; (2) issues of data protection and probable benefit or harm which go well beyond the realms of traditional trials involving only the research subject proper and nobody else, such as in predictive genotyping for early health risk recognition and for drug delivery based on individual properties in drug metabolism; (3) issues surrounding the storage of human cells, tissue or other properties for which new avenues of data protection, research subject's benefit, as well as pedigree harm-and-benefit features have to be identified, assessed, and managed in and ethically responsible fashion. Host of these areas will need new forms of risk sharing and new models of communication-in-trust and cooperation-in-trust between sponsors, regulators, insurers, investigators, patients and their families and friends.

Participatory models such as a more formal contractual relationship between subjects and researchers or principles of a more active' informed request' by the patient rather than the more passive principle of 'informed consent' should be introduced and tested by sponsors, investigators, insurers, and patients, and evaluated by ethics committees and multicenter trial workshops. Therefore, as research ethics committees will have to guarantee, harmonize, and improve the good ethical practice of well established procedures in GCP, bioethics education and training also has to look into new avenues of meeting the bioethical challenges in more recent areas of clinical investigations which warrant new features of participatory responsibility and risk-and-benefit sharing among, sponsors, researchers, regulators, patients and their families.

Hospital Ethics Committees

Hospital ethics committees are the least known and least widely used instruments to improve the medical and moral quality of patient care on the grass-root level, in the ward, on the bedside. The US journal HEC (for: Hospital Ethics Committees) provides the beat insight into the discussions and developments in this field.

In the hospital, we clearly have to differentiate between two types of committees, (1) the decision making and Rolicv setting committee, defining the moral character of a hospital or a ward and (2) the consulting committee in individual patient care.

{ 1 } The decision making committee does not address individual cases, rather sets policy and determines the ethical profile of a hospital or a ward. A catholic Hospital, e.g. most likely will set the ethical rule, that abortion, are not performed at all or only in the most rare situations of immediate threat of death to the pregnant woman; at the same time a municipal hospital funded by taxpayer's money and being responsible to and serving a wider constituency probably should, have at its moral priority to respect the pregnant woman's reproductive choices. It must be normal, that in pluralistic societies rich in different world views, beliefs and attitudes different providers of health care offer different sets of values and virtues. The corporate identity and the corporate profile and corporate ethics will be different from institution to institution, thereby serving as a corporate profile to the potential client and patient and as a guidance in educating and training staff, nurses and physicians.

(2) Totally different from the decision making model is the bedside ethics committee evaluating ethical conflicts and ethical requirements in actual individual cases. There seems to be a common understanding that bedside ethics committees should not take away responsibility from attending physicians and their team as this would be counter-productive for good patient care and against the tradition of physician's ethics to accept final responsibility for the individual patient. But bedside ethics committees may serve as a sounding board and discourse medium to analyze issues and conflicts and to evaluate options for individual patient care, thus helping the physician to form and to defend her or his own course of action. Many model of hospital ethics committees have been experimented with and it would lead too far to discuss them all. Also, some hospitals have one or two individual clinical ethics specialists, often a retired senior-physician or a priest, performing similar duties as a bedside ethics committee would do.

Instead of a Conclusion

In a 1975 review of US Presidential Advisory Commissions from Truman to Nixon Wolanin writes: 'Commissions are uniquely capable of analyzing problems because they are temporary systems; they can recruit well-qualified members and staff; they have unusually good access to expertise and data; and they serve as an integrative framework for an interdisciplinary and multi-interest consideration, of problems. Commissions are also

particularly capable of persuading others to accept as authoritative the findings and recommendations because they can command a wide audience for their findings , they have a decision-making process that conforms to the public's ideal of how decisions should be made; and they enjoy the benefits of being both inside and outside the government. [p.41] These are quiet positive remarks on public advisory committees; but there are less favorable experiences as well with ethics committees.

From a European perspective, I should balance this positive account with recalling Jean Jaques Rousseau's proposal to differentiate between, the volontee generale [expressing and formulating human rights and human obligations] and a volontee de tous [a majority vote which by its sheer majority or unanimity may call for the most inhuman actions out of mass-hysteria or fundamental ideologies shared by all as the dark days of the inquisition or the holocaust demonstrate quite clearly], reminding us that even unanimous votes by this or that ethics committee does not guarantee good ethical quality nor protection of citizens or patients from exploitation or discrimination. Common sense teaches that a too easy consensus within a group or committee might not be in the interest of those depending on these anonymous committees. Therefore, a prime ethical and analytical rule for ethics committees in the presence of societal or religious dissent should be to strive for the protection of the individual patient's or citizen's own personal decision in health care matters based on very personal beliefs, goals and values As a golden rule for all sorts of ethics committees one could formulate: as long as and whenever philosophers, theologians, physicians, scientist, lawyers, and politicians of different background disagree, then they have an obligation to form a consensus on the protection of the individual conscience, values and wishes as the true and essential expression of human dignity.

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COUNCIL OF EUROPE CONSEIL DE L'EUROPE

European Treaty Series - No. 5

Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11

Rome, 4.XI.1950

The text of the Convention had been amended according to the provisions of Protocol No. 3 (ETS No. 45), which entered into force on 21 September 1970, of Protocol No. 5 (ETS No. 55), which entered into force on 20 December 1971 and of Protocol No. 8 (ETS No. 118), which entered into force on 1 January 1990, and comprised also the text of Protocol No. 2 (ETS No. 44) which, in accordance with Article 5, paragraph 3 thereof, had been an integral part of the Convention since its entry into force on 21 September 1970. All provisions which had been amended or added by these Protocols are replaced by Protocol No. 11 (ETS No. 155), as from the date of its entry into force on 1 November 1998. As from that date, Protocol No. 9 (ETS No. 140), which entered into force on 1 October 1994, is repealed and Protocol No. 10 (ETS no. 146) has lost its purpose.

The governments signatory hereto, being members of the Council of Europe,

Considering the Universal Declaration of Human Rights proclaimed by the General Assembly of the United Nations on 10th December 1948;

Considering that this Declaration aims at securing the universal and effective recognition and observance of the Rights therein declared;

Considering that the aim of the Council of Europe is the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms;

Reaffirming their profound belief in those fundamental freedoms which are the foundation of justice and peace in the world and are best maintained on the one hand by an effective political democracy and on the other by a common understanding and observance of the human rights upon which they depend;

Being resolved, as the governments of European countries which are like-minded and have a common heritage of political traditions, ideals, freedom and the rule of law, to take the first steps for the collective enforcement of certain of the rights stated in the Universal Declaration,

Have agreed as follows:

Article 1[1] – Obligation to respect human rights

The High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of this Convention.

Section I[1] – Rights and freedoms

Article 2[1] – Right to life

1 Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2 Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

a in defence of any person from unlawful violence;

b in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

c in action lawfully taken for the purpose of quelling a riot or insurrection.

1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

Article 3[1] – Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 4[1] – Prohibition of slavery and forced labour

1 No one shall be held in slavery or servitude.

2 No one shall be required to perform forced or compulsory labour.

3 For the purpose of this article the term "forced or compulsory labour" shall not include:

a any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention;

b any service of a military character or, in case of conscientious objectors in countries where they are recognised, service exacted instead of compulsory military service;

c any service exacted in case of an emergency or calamity threatening the life or well-being of the community;

d any work or service which forms part of normal civic obligations.

Article 5[1] – Right to liberty and security

1 Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

a the lawful detention of a person after conviction by a competent court;

b the lawful arrest or detention of a person for non- compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

c the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;

d the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;

e the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

f the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

2 Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3 Everyone arrested or detained in accordance with the provisions of paragraph 1.c of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5 Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.

Article 6[1] – Right to a fair trial

1 In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2 Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3 Everyone charged with a criminal offence has the following minimum rights:

a to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;

b to have adequate time and facilities for the preparation of his defence;

c to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

d to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

e to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

Article 7[1] – No punishment without law

1 No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed.

2 This article shall not prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognised by civilised nations.

Article 8[1] – Right to respect for private and family life

1 Everyone has the right to respect for his private and family life, his home and his correspondence.

2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Article 9[1] – Freedom of thought, conscience and religion

1 Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2 Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Article 10[1] – Freedom of expression

1 Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

2 The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

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1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

Article 11[1] – Freedom of assembly and association

1 Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests.

2 No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.

Article 12[1] – Right to marry

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

Article 13[1] – Right to an effective remedy

Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

Article 14[1] – Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Article 15[1] – Derogation in time of emergency

1 In time of war or other public emergency threatening the life of the nation any High Contracting Party may take measures derogating from its obligations under this Convention to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with its other obligations under international law.

2 No derogation from Article 2, except in respect of deaths resulting from lawful acts of war, or from Articles 3, 4 (paragraph 1) and 7 shall be made under this provision.

3 Any High Contracting Party availing itself of this right of derogation shall keep the Secretary General of the Council of Europe fully informed of the measures which it has taken and the reasons therefor. It shall also inform the Secretary General of the Council of Europe when such measures have ceased to operate and the provisions of the Convention are again being fully executed.

Article 16[1] – Restrictions on political activity of aliens

Nothing in Articles 10, 11 and 14 shall be regarded as preventing the High Contracting Parties from imposing restrictions on the political activity of aliens.

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1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

Article 17[1] – Prohibition of abuse of rights

Nothing in this Convention may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms set forth herein or at their limitation to a greater extent than is provided for in the Convention.

Article 18[1] – Limitation on use of restrictions on rights

The restrictions permitted under this Convention to the said rights and freedoms shall not be applied for any purpose other than those for which they have been prescribed.

Section II[2] – European Court of Human Rights

Article 19 – Establishment of the Court

To ensure the observance of the engagements undertaken by the High Contracting Parties in the Convention and the Protocols thereto, there shall be set up a European Court of Human Rights, hereinafter referred to as "the Court". It shall function on a permanent basis.

Article 20 – Number of judges

The Court shall consist of a number of judges equal to that of the High Contracting Parties.

Article 21 – Criteria for office

1 The judges shall be of high moral character and must either possess the qualifications required for appointment to high judicial office or be jurisconsults of recognised competence.

2 The judges shall sit on the Court in their individual capacity.

3 During their term of office the judges shall not engage in any activity which is incompatible with their independence, impartiality or with the demands of a full-time office; all questions arising from the application of this paragraph shall be decided by the Court.

Article 22 – Election of judges

1 The judges shall be elected by the Parliamentary Assembly with respect to each High Contracting Party by a majority of votes cast from a list of three candidates nominated by the High Contracting Party.

2 The same procedure shall be followed to complete the Court in the event of the accession of new High Contracting Parties and in filling casual vacancies.

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1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

2 New Section II according to the provisions of Protocol No. 11 (ETS No. 155).

Article 23 – Terms of office

1 The judges shall be elected for a period of six years. They may be re-elected. However, the terms of office of one-half of the judges elected at the first election shall expire at the end of three years.

2 The judges whose terms of office are to expire at the end of the initial period of three years shall be chosen by lot by the Secretary General of the Council of Europe immediately after their election.

3 In order to ensure that, as far as possible, the terms of office of one-half of the judges are renewed every three years, the Parliamentary Assembly may decide, before proceeding to any subsequent election, that the term or terms of office of one or more judges to be elected shall be for a period other than six years but not more than nine and not less than three years.

4 In cases where more than one term of office is involved and where the Parliamentary Assembly applies the preceding paragraph, the allocation of the terms of office shall be effected by a drawing of lots by the Secretary General of the Council of Europe immediately after the election.

5 A judge elected to replace a judge whose term of office has not expired shall hold office for the remainder of his predecessor's term.

6 The terms of office of judges shall expire when they reach the age of 70.

7 The judges shall hold office until replaced. They shall, however, continue to deal with such cases as they already have under consideration.

Article 24 – Dismissal

No judge may be dismissed from his office unless the other judges decide by a majority of two-thirds that he has ceased to fulfil the required conditions.

Article 25 – Registry and legal secretaries

The Court shall have a registry, the functions and organisation of which shall be laid down in the rules of the Court. The Court shall be assisted by legal secretaries.

Article 26 – Plenary Court

The plenary Court shall

a elect its President and one or two Vice-Presidents for a period of three years; they may be re-elected;

b set up Chambers, constituted for a fixed period of time;

c elect the Presidents of the Chambers of the Court; they may be re-elected;

d adopt the rules of the Court, and

e elect the Registrar and one or more Deputy Registrars.

Article 27 – Committees, Chambers and Grand Chamber

1 To consider cases brought before it, the Court shall sit in committees of three judges, in Chambers of seven judges and in a Grand Chamber of seventeen judges. The Court's Chambers shall set up committees for a fixed period of time.

2 There shall sit as an *ex officio* member of the Chamber and the Grand Chamber the judge elected in respect of the State Party concerned or, if there is none or if he is unable to sit, a person of its choice who shall sit in the capacity of judge.

3 The Grand Chamber shall also include the President of the Court, the Vice-Presidents, the Presidents of the Chambers and other judges chosen in accordance with the rules of the Court. When a case is referred to the Grand Chamber under Article 43, no judge from the Chamber which rendered the judgment shall sit in the Grand Chamber, with the exception of the President of the Chamber and the judge who sat in respect of the State Party concerned.

Article 28 – Declarations of inadmissibility by committees

A committee may, by a unanimous vote, declare inadmissible or strike out of its list of cases an application submitted under Article 34 where such a decision can be taken without further examination. The decision shall be final.

Article 29 – Decisions by Chambers on admissibility and merits

1 If no decision is taken under Article 28, a Chamber shall decide on the admissibility and merits of individual applications submitted under Article 34.

2 A Chamber shall decide on the admissibility and merits of inter-State applications submitted under Article 33.

3 The decision on admissibility shall be taken separately unless the Court, in exceptional cases, decides otherwise.

Article 30 – Relinquishment of jurisdiction to the Grand Chamber

Where a case pending before a Chamber raises a serious question affecting the interpretation of the Convention or the protocols thereto, or where the resolution of a question before the Chamber might have a result inconsistent with a judgment previously delivered by the Court, the Chamber may, at any time before it has rendered its judgment, relinquish jurisdiction in favour of the Grand Chamber, unless one of the parties to the case objects.

Article 31 – Powers of the Grand Chamber

The Grand Chamber shall

1 a determine applications submitted either under Article 33 or Article 34 when a Chamber has relinquished jurisdiction under Article 30 or when the case has been referred to it under Article 43; and

b consider requests for advisory opinions submitted under Article 47.

Article 32 – Jurisdiction of the Court

1 The jurisdiction of the Court shall extend to all matters concerning the interpretation and application of the Convention and the protocols thereto which are referred to it as provided in Articles 33, 34 and 47.

2 In the event of dispute as to whether the Court has jurisdiction, the Court shall decide.

Article 33 – Inter-State cases

Any High Contracting Party may refer to the Court any alleged breach of the provisions of the Convention and the protocols thereto by another High Contracting Party.

Article 34 – Individual applications

The Court may receive applications from any person, non-governmental organisation or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in the Convention or the protocols thereto. The High Contracting Parties undertake not to hinder in any way the effective exercise of this right.

Article 35 – Admissibility criteria

1 The Court may only deal with the matter after all domestic remedies have been exhausted, according to the generally recognised rules of international law, and within a period of six months from the date on which the final decision was taken.

2 The Court shall not deal with any application submitted under Article 34 that

a is anonymous; or

b is substantially the same as a matter that has already been examined by the Court or has already been submitted to another procedure of international investigation or settlement and contains no relevant new information.

3 The Court shall declare inadmissible any individual application submitted under Article 34 which it considers incompatible with the provisions of the Convention or the protocols thereto, manifestly ill-founded, or an abuse of the right of application.

4 The Court shall reject any application which it considers inadmissible under this Article. It may do so at any stage of the proceedings.

Article 36 – Third party intervention

1 In all cases before a Chamber or the Grand Chamber, a High Contracting Party one of whose nationals is an applicant shall have the right to submit written comments and to take part in hearings.

2 The President of the Court may, in the interest of the proper administration of justice, invite any High Contracting Party which is not a party to the proceedings or any person concerned who is not the applicant to submit written comments or take part in hearings.

Article 37 – Striking out applications

1 The Court may at any stage of the proceedings decide to strike an application out of its list of cases where the circumstances lead to the conclusion that

a the applicant does not intend to pursue his application; or

b the matter has been resolved; or

c for any other reason established by the Court, it is no longer justified to continue the examination of the application.

However, the Court shall continue the examination of the application if respect for human rights as defined in the Convention and the protocols thereto so requires.

2 The Court may decide to restore an application to its list of cases if it considers that the circumstances justify such a course.

Article 38 – Examination of the case and friendly settlement proceedings

1 If the Court declares the application admissible, it shall

a pursue the examination of the case, together with the representatives of the parties, and if need be, undertake an investigation, for the effective conduct of which the States concerned shall furnish all necessary facilities;

b place itself at the disposal of the parties concerned with a view to securing a friendly settlement of the matter on the basis of respect for human rights as defined in the Convention and the protocols thereto.

2 Proceedings conducted under paragraph 1.b shall be confidential.

Article 39 – Finding of a friendly settlement

If a friendly settlement is effected, the Court shall strike the case out of its list by means of a decision which shall be confined to a brief statement of the facts and of the solution reached.

Article 40 – Public hearings and access to documents

1 Hearings shall be in public unless the Court in exceptional circumstances decides otherwise.

2 Documents deposited with the Registrar shall be accessible to the public unless the President of the Court decides otherwise.

Article 41 – Just satisfaction

If the Court finds that there has been a violation of the Convention or the protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party.

Article 42 – Judgments of Chambers

Judgments of Chambers shall become final in accordance with the provisions of Article 44, paragraph 2.

Article 43 – Referral to the Grand Chamber

1 Within a period of three months from the date of the judgment of the Chamber, any party to the case may, in exceptional cases, request that the case be referred to the Grand Chamber.

2 A panel of five judges of the Grand Chamber shall accept the request if the case raises a serious question affecting the interpretation or application of the Convention or the protocols thereto, or a serious issue of general importance.

3 If the panel accepts the request, the Grand Chamber shall decide the case by means of a judgment.

Article 44 – Final judgments

1 The judgment of the Grand Chamber shall be final.

2 The judgment of a Chamber shall become final

a when the parties declare that they will not request that the case be referred to the Grand Chamber; or

b three months after the date of the judgment, if reference of the case to the Grand Chamber has not been requested; or

c when the panel of the Grand Chamber rejects the request to refer under Article 43.

3 The final judgment shall be published.

Article 45 – Reasons for judgments and decisions

1 Reasons shall be given for judgments as well as for decisions declaring applications admissible or inadmissible.

2 If a judgment does not represent, in whole or in part, the unanimous opinion of the judges, any judge shall be entitled to deliver a separate opinion.

Article 46 – Binding force and execution of judgments

1 The High Contracting Parties undertake to abide by the final judgment of the Court in any case to which they are parties.

2 The final judgment of the Court shall be transmitted to the Committee of Ministers, which shall supervise its execution.

Article 47 – Advisory opinions

1 The Court may, at the request of the Committee of Ministers, give advisory opinions on legal questions concerning the interpretation of the Convention and the protocols thereto.

2 Such opinions shall not deal with any question relating to the content or scope of the rights or freedoms defined in Section I of the Convention and the protocols thereto, or with any other question which the Court or the Committee of Ministers might have to consider in consequence of any such proceedings as could be instituted in accordance with the

Convention.

3 Decisions of the Committee of Ministers to request an advisory opinion of the Court shall require a majority vote of the representatives entitled to sit on the Committee.

Article 48 – Advisory jurisdiction of the Court

The Court shall decide whether a request for an advisory opinion submitted by the Committee of Ministers is within its competence as defined in Article 47.

Article 49 – Reasons for advisory opinions

1 Reasons shall be given for advisory opinions of the Court.

2 If the advisory opinion does not represent, in whole or in part, the unanimous opinion of the judges, any judge shall be entitled to deliver a separate opinion.

3 Advisory opinions of the Court shall be communicated to the Committee of Ministers.

Article 50 – Expenditure on the Court

The expenditure on the Court shall be borne by the Council of Europe.

Article 51 – Privileges and immunities of judges

The judges shall be entitled, during the exercise of their functions, to the privileges and immunities provided for in Article 40 of the Statute of the Council of Europe and in the agreements made thereunder.

Section III[1,2] – Miscellaneous provisions

Article 52[1] – Inquiries by the Secretary General

On receipt of a request from the Secretary General of the Council of Europe any High Contracting Party shall furnish an explanation of the manner in which its internal law ensures the effective implementation of any of the provisions of the Convention.

Article 53[1] – Safeguard for existing human rights

Nothing in this Convention shall be construed as limiting or derogating from any of the human rights and fundamental freedoms which may be ensured under the laws of any High Contracting Party or under any other agreement to which it is a Party.

Article 54[1] – Powers of the Committee of Ministers

Nothing in this Convention shall prejudice the powers conferred on the Committee of Ministers by the Statute of the Council of Europe.

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1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

2 The articles of this Section are renumbered according to the provisions of Protocol No. 11 (ETS No. 155).

Article 55[1] – Exclusion of other means of dispute settlement

The High Contracting Parties agree that, except by special agreement, they will not avail themselves of treaties, conventions or declarations in force between them for the purpose of submitting, by way of petition, a dispute arising out of the interpretation or application of this Convention to a means of settlement other than those provided for in this Convention.

Article 56[1] – Territorial application

1[2] Any State may at the time of its ratification or at any time thereafter declare by notification addressed to the Secretary General of the Council of Europe that the present Convention shall, subject to paragraph 4 of this Article, extend to all or any of the territories for whose international relations it is responsible.

2 The Convention shall extend to the territory or territories named in the notification as from the thirtieth day after the receipt of this notification by the Secretary General of the Council of Europe.

3 The provisions of this Convention shall be applied in such territories with due regard, however, to local requirements.

4[2] Any State which has made a declaration in accordance with paragraph 1 of this article may at any time thereafter declare on behalf of one or more of the territories to which the declaration relates that it accepts the competence of the Court to receive applications from individuals, non-governmental organisations or groups of individuals as provided by Article 34 of the Convention.

Article 57[1] – Reservations

1 Any State may, when signing this Convention or when depositing its instrument of ratification, make a reservation in respect of any particular provision of the Convention to the extent that any law then in force in its territory is not in conformity with the provision. Reservations of a general character shall not be permitted under this article.

2 Any reservation made under this article shall contain a brief statement of the law concerned.

Article 58[1] – Denunciation

1 A High Contracting Party may denounce the present Convention only after the expiry of five years from the date on which it became a party to it and after six months' notice contained in a notification addressed to the Secretary General of the Council of Europe, who shall inform the other High Contracting Parties.

2 Such a denunciation shall not have the effect of releasing the High Contracting Party concerned from its obligations under this Convention in respect of any act which, being capable of constituting a violation of such obligations, may have been performed by it before the date at which the denunciation became effective.

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1 Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

2 Text amended according to the provisions of Protocol No. 11 (ETS No. 155).

3 Any High Contracting Party which shall cease to be a member of the Council of Europe shall cease to be a Party to this Convention under the same conditions.

4[1] The Convention may be denounced in accordance with the provisions of the preceding paragraphs in respect of any territory to which it has been declared to extend under the terms of Article 56.

Article 59[2] – Signature and ratification

1 This Convention shall be open to the signature of the members of the Council of Europe. It shall be ratified. Ratifications shall be deposited with the Secretary General of the Council of Europe.

2 The present Convention shall come into force after the deposit of ten instruments of ratification.

3 As regards any signatory ratifying subsequently, the Convention shall come into force at the date of the deposit of its instrument of ratification.

4 The Secretary General of the Council of Europe shall notify all the members of the Council of Europe of the entry into force of the Convention, the names of the High Contracting Parties who have ratified it, and the deposit of all instruments of ratification which may be effected subsequently.

Done at Rome this 4th day of November 1950, in English and French, both texts being equally authentic, in a single copy which shall remain deposited in the archives of the Council of Europe. The Secretary General shall transmit certified copies to each of the signatories.

[1] Text amended according to the provisions of Protocol No. 11 (ETS No. 155).

[2] Heading added according to the provisions of Protocol No. 11 (ETS No. 155).

Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11

Paris, 20.III.1952

Headings of articles added and text amended according to the provisions of Protocol No. 11 (ETS No. 155), as of its entry into force, on 1 November 1998.

The governments signatory hereto, being members of the Council of Europe,

Being resolved to take steps to ensure the collective enforcement of certain rights and freedoms other than those already included in Section I of the Convention for the Protection of Human Rights and Fundamental Freedoms signed at Rome on 4 November 1950 (hereinafter referred to as "the Convention"),

Have agreed as follows:

Article 1 – Protection of property

Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

The preceding provisions shall not, however, in any way impair the right of a State to enforce such laws as it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions or penalties.

Article 2 – Right to education

No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.

Article 3 – Right to free elections

The High Contracting Parties undertake to hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature.

Article 4[1] – Territorial application

Any High Contracting Party may at the time of signature or ratification or at any time thereafter communicate to the Secretary General of the Council of Europe a declaration stating the extent to which it undertakes that the provisions of the present Protocol shall apply to such of the territories for the international relations of which it is responsible as are named therein.

Any High Contracting Party which has communicated a declaration in virtue of the preceding paragraph may from time to time communicate a further declaration modifying the terms of any former declaration or terminating the application of the provisions of this Protocol in respect of any territory.

A declaration made in accordance with this article shall be deemed to have been made in accordance with paragraph 1 of Article 56 of the Convention.

1 Text amended according to the provisions of Protocol No. 11 (ETS No. 155).

Article 5 – Relationship to the Convention

As between the High Contracting Parties the provisions of Articles 1, 2, 3 and 4 of this Protocol shall be regarded as additional articles to the Convention and all the provisions of the Convention shall apply accordingly.

Article 6 – Signature and ratification

This Protocol shall be open for signature by the members of the Council of Europe, who are the signatories of the Convention; it shall be ratified at the same time as or after the ratification of the Convention. It shall enter into force after the deposit of ten instruments of ratification. As regards any signatory ratifying subsequently, the Protocol shall enter into force at the date of the deposit of its instrument of ratification.

The instruments of ratification shall be deposited with the Secretary General of the Council of Europe, who will notify all members of the names of those who have ratified.

Done at Paris on the 20th day of March 1952, in English and French, both texts being equally authentic, in a single copy which shall remain deposited in the archives of the Council of Europe. The Secretary General shall transmit certified copies to each of the signatory governments.

History of Marshall Medical Center
As taken from the Marshall Medical Patient & Visitor Information Brochure

In the late 1950's, a group of local citizens saw a great need for improved healthcare services in El Dorado County. The citizens formed a committee to petition the State of California for a nonprofit charger under which a hospital could be built and operated. As a result of this, plans were drawn, funds were solicited, Michigan-California Lumber Company donated ground for a hospital site, and Marshall Hospital opened its doors in 1959. Marshall Medical Center derives its name from the pioneer James Marshall, who discovered gold at Sutter's Mill a few miles north of Placerville.

We are an independent healthcare organization serving the western slope of El Dorado County. We have a local board of directors who volunteer their time to represent the needs and interests of a growing community. We are wonderfully supported by over one hundred auxiliary members who volunteer year-round to provide assistance to patients and their families.

We have 105 licensed beds at the main site in Placerville which includes an intensive care/cardiac unit, 24-hour emergency department, general medical and surgical units, telemetry monitoring units, pediatric rooms, birthing rooms, and a transitional care center. Throughout the western slope of El Dorado County, we also provide a wide variety of services such as lab, x-ray, primary care and home care. The Divide Wellness Center in Georgetown provides primary and urgent care services and counseling. More than 100 physicians representing most medical specialties have staff privileges at Marshall Medical Center. Nurses, technicians and other healthcare specialists support them. The entire healthcare team, while valuing the current medical technology available at Marshall Medical Center, places equal value on the importance of personalized care. We support many community programs and services, such as the Community Health Library, health screenings and vaccinations.

We offer a year-round menu of classes for everything from childbirth education and babysitting to cardiac rehabilitation and basic life support/CPR. We are a leader in coordinating end-of-life care with other healthcare professionals for patients in our hospital or in their homes. Our home care service provides ongoing comprehensive medical care in your home. We host a number of self-help or support groups, including the American Cancer Society, Mothers Network, and the Loss Support Group.

All of us at Marshall Medical Center will make every effort to extend the utmost care and courtesy to you. If there is anything we can do to make your stay more comfortable, please let us know.

Ethics Committee Core Curriculum

Glossary: Bioethics Terms

Tim Madigan

Abortion

The termination of a pregnancy prior to birth.

Altruism

Derived from the Greek words meaning "self-ruled." A concern primarily with the well-being of others rather than one's own self-interest.

Autonomy

The view that one's actions are independent from the will of others. Moral autonomy is the freedom to reach one's own values about what is right and wrong.

Benificence

Performing an act which is good or which brings about good effects.

Bioethics

Literally "life ethics." An exploration of ethical dilemmas arising in the health care field, as well as relating to medical aspects of human beings. The term was coined by oncologist Van Rensselaer Potter.

Categorical Imperative

A term used by Immanuel Kant to refer to an unconditional duty one is required to perform. An act is immoral if the rule that would authorize it cannot be universalized. Consequences should not be taken into consideration. For example, "physicians have a duty not to lie to their patients". This is a secularized version of "The Golden Rule."

Cognitive

That aspect of human beings that involves rationality and reason.

Competence

A patient's capacity to make decisions about the provision of medical care for him or herself (see also Decision Making Capacity). Competence is also considered to be the *legal* capacity to make decisions in contrast to capacity/decision making capacity).

Conscience

The view that one has an inner sense of right and wrong, by which one perceives one's possibilities and responsibilities.

Confidentiality

Not divulging information which another has revealed on condition of secrecy.

Consent

A voluntary act by which one person agrees to allow another to do something.

Consequentialism

Ethical theories that are concerned with the consequences that follow from specific actions. Often referred to be the Greek term "teleology", the study of goals. Examples include ethical relativism and utilitarianism.

Cost-Benefit Analysis

Also called "end-justifies-the-means" approach. The idea that one should strive for the greatest benefits deriving from the least cost expended.

Decision Making Capacity

A patient's ability to make decisions about the provision of medical care for him or herself. This is a clinical determination which is specific to the decision at hand. As such, it may vary from time to time, or from decision to decision (see also Competence).

Deontology

Literally "the study of rules." An ethical theory concerned with following the proper duties pertaining to one's given role. Examples include Kant's Categorical Imperative and Divine Command theories. Contrasted with consequentialism.

Descriptive ethics

Describing how people act in given situations or societies. No evaluation is placed on whether such acts are right or wrong.

Duty ethics

The name sometimes attributed to Immanuel Kant's system of ethics because of his stress on performing a moral act out of sense of duty, not inclination.

Emotivism

The theory that morality is primarily based not on reason but rather on human emotions.

Empiricism

Reasoning from experience and sense observation.

Ethical Absolutism

The theory that morality is absolute rather than relative: there are moral truths that must be obeyed at all times, in all situations.

Ethical Egoism

A consequential system of ethics in which one is primarily concerned with one's own self-interest.

Ethical Relativism

The theory that acts are determined to be right or wrong depending upon the society in which one lives. "When in Rome, do as the Romans do."

Ethics

The systematic study of how we ought to act toward ourselves and others.

Euthanasia

A Greek word meaning "happy death". It has come to mean the deliberate ending of a human life. "Active" euthanasia refers to the direct killing of a patient. "Passive" euthanasia involves the withdrawal of medical technologies in order to allow the underl ying disease to take its natural course. "Voluntary" euthanasia means that the act is undertaken at the behest of the patient, and should be distinguished from "nonvoluntary" euthanasia, where the patient has made no such request, and "involunary" euthana sia, where the action is performed against the patient's wishes.

Extraordinary Measures

Any means used to treat a sick or dying person that is out of the ordinary, or heroic.

Human Being

A member of the species homo sapiens.

Inclinations

Actions which humans are inclined to perform out of habit or emotions rather than through reasoning.

Informed Consent

Usually a formal written consent that patients give to health care professionals allowing them to conduct tests, procedures, or experimentation on patients with their complete understanding and agreement.

Morality

From the Latin moralis, meaning "customs or manners." How people act. Ethics is the study of morality.

Nonmaleficence

Not performing an action that would cause harm to a patient. "Above all, first do no harm."

Normative ethics

Theories which prescribe how people should act. Valuation is placed on right or wrong. Contrasted with descriptive ethics.

Obligations

Responsibilities human beings have toward one another by law, morality, custom or tradition.

Ordinary Measures

Distinguished from extraordinary or heroic means of medical treatment of patients: refers to the appropriate treatment that would not be unusual or beyond what should be done in routine situations.

Paternalism

A type of human relationship in which one person acts as a father figure and another acts as a child. In medicine, the view that the physician knows best and should be obeyed.

Person, Personhood

The point at which a human being can be considered to have a personality and is a member of the human moral community.

Prima Facie Duty

Literally a duty "at first glance" or "at face value." Accepting a duty unless there is good reason to question it or examine it further.

Proposition

A statement that asserts a particular view or position.

Proxy Consent

Voluntary informed consent given on behalf of another who is unable for some reason to give it himself or herself.

Rights

Justified claims upon others for actions or nonactions.

Situation ethics

The theory invented by Joseph Fletcher that says there are no moral absolutes except for love - what is moral in any situation is the loving thing to do in that situation.

Slippery Slope Argument

If X is allowed, Y will follow, and Y is ethical unacceptable.

Supererogatory Act

In deontology, an act that goes above and beyond what one is required to perform. Acts of charity are examples of this.

Triage

From the French word for "sorting," in emergency situations where medical care must be rationed, individuals are classified into three categories:

1. those who will survive even without immediate treatment.
2. those who won't survive even with immediate treatment.
3. those who will only survive with immediate treatment.

Utilitarianism

A normative ethical theory that advocates bringing about the greatest good for the greatest number of people. A consequential ethics advocated by John Stuart Mill.

Value

Any object or quality that is found to be desirable or worthwhile.

Virtue ethics

A moral theory that can be traced to the writings of Aristotle, which holds that ethics is concerned with developing a virtuous character.

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ACRONYMS

ACRONYM	NAME
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
ALFE	Assisted Living Facility for Elderly
APS	Adult Protective Services
B&C	Board and Care
CAT or CT	computed (axial) tomography
CBC	complete blood count
CHD	Coronary Heart Disease
CHF	Congestive Heart Failure
CMMS	Centers for Medicare and Medicaid Services (formerly HCFA)
CNA/NA	Certified Nurses Aide/Nurses Aide
COPD	chronic obstructive pulmonary disease
CPT	Current Procedural Terminology (physician coding)
DHS	Department of Health Services
DRG	Diagnosis Related Groups (hospital coding)
Dx	diagnosis
ECG/EKG	electrocardiogram
EEG	electroencephalogram
EMG	electromyogram
EMI	electric and musical induction (brain scanner)
ER	Emergency Room
FUO	Fever of Unknown Origin

q-daily	once a day
BID	twice a day
TID	three times a day
ad lib	as desired
PRN	as the occasion arises
PO	by mouth
NPO	nothing by mouth
AC	before meals
PC	after meals

GI	gastrointestinal
HIPPA	Health Insurance Portability and Accountability Act
HS	at bedtime (hours of sleep)
ICF	Intermediate Care Facility
ICU/CCU	Intensive Care/Critical Care Units
I&O	intake and output
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LCD	Licensing and Certification Division
LPN	licensed practical nurse
LPS CON	Lanterman-Petris-Short Conservatorship
LVN	licensed vocational nurse
MBCA	Medical Board of California (formerly BMQA)
MI	myocardial infarction (heart attack)
MMPS	Multipurpose Senior Service Program
MMR	measles, mumps, rubellla
MRI	magnetic resonance imaging
MS	multiple sclerosis
MT	monitor tech (heart monitors)
OB	obstetrics
OPS	outpatient service
OR	operating room
OT	occupational therapy
OTC	over the counter (drug that can be obtained without a prescription)

PEDS	pediatrics
PEP-C	Patient Experience of Performance – CA
PET scan	positron emission tomography
PG	Public Guardian
~~QID~~ (do not use abbreviation)	four times a day
RCF	Residential Care Facility
RA	rheumatoid arthritis
RF	rheumatoid factor
Rh	rhesus factor in blood
RN	Registered Nurse
Rx	prescription
SNF	Skilled Nursing Facility
SOB	shortness of breath
SOC	Share of Cost
S/P	Status Post
stat	immediately
SSA	Social Security Administration
SSI	Supplemental Security Income
TB	tuberculosis
TCC	Transitional Care Center
U/A	urinalysis
USA	Universal Support Associate
UTI	urinary tract infection

URI	upper respiratory infection
VO	verbal order
WBC	white blood cells
WNL	within normal limits

PREFIXES

-ectomy	Removal of, e.g. hyster-ectomy, tonsill-ectomy
-otomy	opening, exploration of, e.g. lapar-otomy

TERMS

Nosocomial	hospital acquired
Prophylactic	preventative

OTHER ACRONYMS

TERMS GLOSSARY

AHA	American Hospital Association
AMA	American Medical Association
BMQA	Board Medical Quality Assurance
CAHHS	California Association of Hospital and Health Systems
CHFC	California Hospital Facilities Commission
CHA	California Healthcare Association
CMA	California Medical Association
CON	Certificate of Need
CQIC	Clinical Quality Improvement Committee
CT	"Cat Scan" (Computerized Tomography)
DHS	Department of Health Services
EBP	Employee Benefit Plan
ECF	Extended Care Facility
ER	Emergency Room
ED	Emergency Department
EPMG	Emergency Physicians Medical Group
ESC	Emergency Services Committee

GEA	General Economic Adjustment
GSPSRO	Greater Sacramento Professional Standards Review Organization
HCFA	Health Care Financing Administration
HCNC	Hospital Council of Northern California
HFS	Health Facility Systems
HHS	Health and Human Services
HMO	Health Maintenance Organization
HSA	Health Systems Agency
ICU/CCU	Intensive Care Unit/Cardiac Care Unit
IP	Inpatient
IPA	Independent Practice Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MCF	Medical Care Foundation
MCPC	Marshall Center for Primary Care
MEC	Medical Executive Committee
MHHH	Marshall Hospital Home Health
MRC	Medical Review Committee
MRI	Magnetic Resonance Imaging
OB	Obstetrics
OP	Outpatient
OR	Operating Room
OSHPD	Office of Statewide Health Planning and Development
PARAGON	Patient management software program
PC/AM	Primary Care/Adult Medicine Committee
PI	Performance Improvement
PIC	Performance Improvement Committee
PPO	Preferred Provider Organization
PSRO	Professional Standards Review Organization
QIC	Quality Improvement Committee
QMS	Quality Management Services
SNF	Skilled Nursing Facility
SRC	Surgery Review Committee
SSHA	Sacramento Sierra Hospital Association
SSMI	Sacramento Society Medical Improvement – Sacramento El Dorado Medical Society
TCC	Transitional Care Center
TDA	Tax Deferred Annuity
Title 18	Regulations re Medicare
Title 19	Regulations re Medicaid (Medi-Cal)
Title 22	Regulations re Licensing and Certification of Hospitals
Title 24	Regulations re Building Requirements for Hospitals
UCD	University of California, Davis

MARSHALL MEDICAL CENTER
1100 MARSHALL WAY
Placerville, CA 95667

DECLARATION OF COMPLIANCE WITH CONFIDENTIALITY POLICIES

As a member of a committee of the Medical Staff of Marshall Medical Center, or as a person who attends such a committee, I recognize that I may occasionally gain access to confidential information which may include, for example, medical information on individual patients or the patient population, peer review material, or proprietary business information related to the institution. I recognize that the disclosure of such material may be a violation of the rights of others and inconsistent with the provision of quality medical care. By accepting the position on the committee, I agree that I will hold this information in confidence, and will not engage in discussions regarding such information with outside persons or family members, nor make any unauthorized disclosures of such information.

Date: _____

Printed Name: _____

Signature: _____

Committee: Bioethics Committee