Ministry of Public Health of Ukraine
"Ukrainian Medical Stomatological Academy"

"APPROVED"
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METHODICAL INSTRUCTIONS
FOR INDEPENDENT WORK OF STUDENTS DURING PREPARATION
TO PRACTICAL (SEMINAR) CLASSES AND IN CLASS

Academic subject	Safety of Vital Functions. Bioethics
Module No 1	Safety of Vital Functions. Bioethics
Topic	Bioethical foundations of doctor's practice
Year of study	I
Faculty	Dental, Medical
Number of academic hours	2

Poltava – 2020

1. Relevance of the topic

There is considerable healing power in the physician-patient alliance. Working together offers the opportunity to significantly improve the patient's quality of life and health status. This therapeutic alliance involves specific and important physician obligations.

2. The specific aims:

1. To obtain a general view of medicinal forms and peculiarities of prescribing them:
   - To learn the basic knowledge in types of relationship
   - To learn basic knowledge in physician-patient communication
   - To learn what to do in difficult situations
2. To know the additional inscriptions and prescriptions

3. Basic knowledge and skills necessary to study the topic (inter-disciplinary integration)

The preceding subjects	The acquired knowledge
History of medicine, Philosophy, Clinical subjects	Historical aspects of the formation of the medical profession, Bioethics and deontology as components of a successful doctor's work

4. The task for students individual work

4.1. The list of basic terms, parameters, characteristics which the student should master while preparing for the class.

Term	Definition
Informed consent	is a process for getting permission before conducting a healthcare intervention on a person.
Shared decision-making (SDM)	is an approach in which clinicians and patients communicate together using the best available evidence when faced with the task of making decisions.

4.2. Theoretical questions for the class (to the topic):

1. Bioethical background of professional doctor's activity.
2. Models of relation s between the doctor and patient.
3. Biomedical ethics communication with the deontology and medical psychology.
4. Truthful and informative of consent between the doctor and patient.
5. Models of doctor—patient relationship by Robert Witch.
6. Deontology as a component of prevention and treatment of psychosomatic pathology in the practice of the physician.
7. Privacy policy — moral, ethical and legal aspects

4.3. Practical tasks pertaining to the topic and to be completed during the class:

1. To be able to engage in trusting contact with the patient.
2. To be able to assess the emotional and psyciological state of the patient.
3. To be able to practice the rules and principles of biomedical ethics and ethics when working with patients in the clinic.
4. To be able to give medical and ethical and legal assessment of the specific cases of the position of privacy and confidentiality in solving situational problems.

The content of the topic:

What is a fiduciary relationship?

Fiduciary derives from the Latin word for "confidence" or "trust". The bond of trust between the patient and the physician is vital to the diagnostic and therapeutic process. It forms the basis for the physician-patient relationship. In order for the physician to make accurate diagnoses and provide optimal treatment recommendations, the patient must be able to communicate all relevant information about an illness or injury. Physicians are obliged to refrain from divulging confidential information. This duty is based on accepted codes of professional ethics, which recognize the special nature of physician-patient relationships.

How has the physician-patient relationship evolved?

The historical model for the physician-patient relationship involved patient dependence on the physician's professional authority. Believing that the patient would benefit from the physician's actions, a paternalistic model of care developed. Patient's preferences were generally not elicited, and were over-ridden if they conflicted with the physician's convictions about appropriate care.

During the second half of the twentieth century, the physician-patient relationship has evolved towards shared decision making. This model respects the patient as an autonomous agent with a right to hold views, to make choices, and to take actions based on personal values and beliefs. Patients are acknowledged to be entitled to weigh the benefits and risks of alternative treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values

Will the patient trust me if I am a student?

Students may feel uncertain about their role in patient care. Building trust requires honesty: students must be honest about their role, letting the patient know s/he is a physician-in-training. In some settings, an attending physician or resident can introduce the student to initiate a trusting relationship. In other settings, students may need to introduce themselves. One form of introduction would be "Hello, I am Mary Jones. I'm a third year medical student who is part of the team that will be caring for you during your hospitalization. I'd like to hear about what brought you into the hospital."

Many patients appreciate the opportunity to work with the student on the team. Students usually have more time to spend with a patient, listening to the patient's history and health concerns, and may become more aware of personal concerns than other team members. Patients notice and appreciate this extra attention.

How much of herself should the physician bring to the physician-patient relationship?

Many patients may feel more connected to a physician when they know something of the physician's life, and it may sometimes be appropriate to share information about family or personal matters. However, it is essential that the patient, and the patient's concerns, be the focus of every visit.

What role should the physician's personal feelings and beliefs play in the physician-patient relationship?

Occasionally, a physician may face requests for services, such as contraception or abortion, which raise a conflict for the physician. Physicians do not have to provide medical services in opposition to their personal beliefs. In addition, a nonjudgmental discussion with a patient regarding her need for the service and alternative forms of therapy is acceptable. However, it is never appropriate to proselytize. While the physician may decline to provide the requested service, the patient must be treated as a respected, autonomous individual. Where appropriate, the patient should be provided with information about how to obtain the desired service.

What can hinder physician-patient communication?

There may be many barriers to effective physician-patient communication. Patients may feel that they are wasting the physician's valuable time; omit details of their history which they deem unimportant; be embarrassed to mention things they think will place them in an unfavorable light; not understand medical terminology; or believe the physician has not really listened and, therefore, does not have the information needed to make good treatment decisions.

Several approaches can be used to facilitate open communication with a patient. Physicians should:

- sit down
- attend to patient comfort
- establish eye contact
- listen without interrupting
- show attention with nonverbal cues, such as nodding
- allow silences while patients search for words
- acknowledge and legitimize feelings
- explain and reassure during examinations
- ask explicitly if there are other areas of concern

What happens when physicians and patients disagree?

One third to one half of patients will fail to follow a physician's treatment recommendations. Labeling such patients "noncompliant" implicitly supports an attitude of paternalism, in which the physician knows best. Patients filter physician instructions through their existing belief system and competing demands; they decide whether the recommended actions are possible or desirable in the context of their everyday lives.

Compliance can be improved by using shared decision making. For example, physicians can say, "I know it will be hard to stay in bed for the remainder of your pregnancy. Let's talk about what problems it will create and try to solve them together." Or, "I can give you a medication to help with your symptoms, but I also suspect the symptoms will go away if you wait a little longer. Would you prefer to try the medication, or to wait?" Or, "I understand that you are not ready to consider counseling yet. Would you be willing to take this information and find out when the next support group meets?" Or, "Sometimes it's difficult to take medications, even though you know they are important. What will make it easier for you to take this medication?"

Competent patients have a right to refuse medical intervention. Dilemmas may arise when a patient refuses medical intervention but does not withdraw from the role of being a patient. For instance, an intrapartum patient, with a complete placenta previa, who refuses to undergo a cesarean delivery, often does not present the option for the physician to withdraw from participation in her care. In most cases, choices of competent patients must be respected when the patient cannot be persuaded to change them.

What can a physician do with a particularly frustrating patient?

Physicians will sometimes encounter a patient whose needs, or demands, strain the therapeutic alliance. Many times, an honest discussion with the patient about the boundaries of the relationship will resolve such misunderstandings. The physician can initiate a discussion by saying, "I see that you have a long list of health concerns. Unfortunately, our appointment today is only for fifteen minutes. Let's discuss your most urgent problem today and reschedule you for a longer appointment. That way, we can be sure to address everything on your list." Or, "I know that it has been hard to schedule this appointment with me, but using abusive language with the staff is not acceptable. What do you think we could do to meet everybody's needs?"

There may be occasions when no agreeable compromise can be reached between the physician and the patient. And yet, physicians may not abandon patients. When the physician-patient relationship must be severed, the physician is obliged to provide the patient with resources to locate ongoing medical care.

When is it appropriate for a physician to recommend a specific course of action or override patient preferences?

Under certain conditions, a physician should strongly encourage specific actions. When there is a high likelihood of harm without therapy, and treatment carries little risk, the physician should attempt, without coercion or manipulation, to persuade the patient of the harmful nature of choosing to avoid treatment.

Court orders may be invoked to override a patient's preferences. However, such disregard for the patient's right to noninterference is rarely indicated. Court orders may have a role in the case of a minor; during pregnancy; if harm is threatened towards oneself or others; in the context of cognitive or psychological impairment; or when the patient is a sole surviving parent of dependent children. However, the use of such compulsory powers is inherently time-limited, and often alienates the patient, making him less likely to comply once he is no longer subject to the sanctions.

What is the role of confidentiality?

Confidentiality provides the foundation for the physician-patient relationship. In order to make accurate diagnoses and provide optimal treatment recommendations, the physician must have relevant information about the patient's illness or injury. This may require the discussion of sensitive information, which would be embarrassing or harmful if it were known to other persons. The promise of confidentiality permits the patient to trust that information revealed to the physician will not be further disseminated. The expectation of confidentiality derives from the public oath which the physician has taken, and from the accepted code of professional ethics. The physician's duty to maintain confidentiality extends from respect for the patient's autonomy.

Would a physician ever be justified in breaking a law requiring mandatory reporting?

In general, mandatory reporting requirements supersede the obligation to protect confidentiality. While the physician has a moral obligation to obey the law, she must balance this against her responsibility to the patient. Reporting should be done in a manner that minimizes invasion of privacy, and with notification to the patient. If these conditions cannot be met, or present an intolerable burden to the patient, the physician may benefit from the counsel of peers or legal advisors in determining how best to proceed.

What happens when the physician has a relationship with multiple members of a family?

Physicians with relationships with multiple family members must honor each individual's confidentiality. Difficult issues, such as domestic violence, sometimes challenge physicians to maintain impartiality. In many instances, physicians can help conflicted families towards healing. At times, physicians work with individual family members; other times, they may serve as a facilitator for a larger group. As always, when a risk for imminent harm is identified, the physician must break confidentiality.

Physicians can be proactive about addressing the needs of changing family relationships. For example, a physician might tell a preteen and her family, "Soon you'll be a teenager. Sometimes teens have questions they would like to discuss with me. If that happens to you, it's okay to tell your parents that you'd like an appointment. You and I won't have to tell your parents what we talk about if you don't want to, but sometimes I might encourage you to talk things over with them."

The physician-family relationship also holds considerable healing power. The potential exists to pursue options that can improve the quality of life and health for the entire family.

Tasks for self-check:

Choose the correct answer:
What are not related to models of relationships between medical professionals and ordinary people?
The model of the traditional type
Model sacral type.
Model technical type.
Collegiate model type
Model contract type

Cooperation between doctor and patient has four main components. Name them.
Support, understanding, respect, compassion.
Telling the truth, fulfill promises to benefit, restore justice.
Benefits, dignity, justice, personal freedom.
Empathy, qualification, experience and responsibility.
Justice, usefulness, self, empathy.

Name the patients with whom the treatment is difficult to establish relationships.
Not inclined to cooperate with the doctor; with purposes other than treatment; which is difficult to establish rapport; trust which impede the healing process.
Prevents determine the cause of the disease; lack of patient desire to establish cooperation with the doctor; enter a doctor in the conflict; using the relationship with the doctor in unauthorized purposes.
Distrust doctor; consult many doctors; not fulfilling doctor's recommendations; arguing with doctors.
Inert, suspicious, conflict, obsessive
Persistent, demanding, controversial suspicious.

What set of moral standards apply to models sacral type?
The benefit, protection of human dignity, adhere to justice, protection of personal liberty, speak the truth and fulfill the promises made to adhere to justice.

Telling the truth only in certain circumstances, to fulfill the promises of the law, benefit, restore fairness when examining patients.
Support, understanding, respect, compassion.
Empathy, qualification, experience and responsibility.
Justice, usefulness, self, empathy.

Who a physician in the model of technical type?
The physician-scientist.
Doctor soothsayer.
PC-Doctor.
Medical services supervisor.
The doctor-priest.

References:

Basic.

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The methodical guidance has been compiled by Lienkova O.O.