

Interactive Health Care Principles in the Clinical Setting : Competence, Compassion, Communication, Cooperation, Cultivation

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ABSTRACT

Health is not just a status, rather a balanced result of health-literate and risk-competent care of one's own physical, emotional, and social well-being and well-feeling with the support of health care professional. To care for my health primarily is my own responsibility and benefit. Principles in health care ethics are the five C's - COMPETENCE, COMPASSION, COMMUNICATION, COOPERATION, CULTIVATION - for all partners involved. Principles of respect for autonomy and justice are civil rights; the no-harm and do-good principles always had been essential in expert ethics, in medicine and elsewhere; these are common sense principles already integrated in the four C's. The interactive model of the five C's will be exemplified by presenting interactive principles and virtues, eight each for the expert and for the lay person, based on traditional interactive rules by 15th century Confucian doctor Gong Tingxian.

BALANCING HEALTH IN CULTIVATING HEALTH CARE

Caring for health is a balancing act. As far as we all want to live a happy life, it is primarily our own responsibility to care for health by means of lifestyle modification, sometimes making hard choices between fun in life and length of life. As far as individual health is concerned, health is the essential basis for a good, happy and long life. WHO wrongly defines health as 'a state of complete physical, mental and social

wellbeing and not merely the absence of disease and infirmity' [cf 10:280]. Such a definition is too small, too static, quite misleading as a maxim for medical intervention, health care policy and health care ethics. Health is not a status, health is a challenge, a gift to take care of; health is balance, health care is a balancing act. We better define **'Health is not just a status, rather a balanced result of health-literate and risk-competent care of one's own physical, emotional, and social well-being and well-feeling, achieved in competent understanding, modification and enhancement of individual genetic, social and environmental properties, with the support of health care professionals and through equal access to health care services, including information, prediction and prevention'**. The prime responsibility in caring for health lies with the individual person and her or his competence to understand the foundations of health and to care for health, - only indirectly with others as competent and compassionate experts in diagnosis, treatment and advise and therefore all health care service models need to be modified in order to set priorities and support in the care for health right and correct; the health care system should not be a repair shop, rather a well defined expert complex to serve health, individual health and public health; both are human and civil rights of highest priority. Such a modern understanding of health actually comes close to the traditional Asian understanding of health and health care; I quote Tai and Lin: 'Confucius said that our body is a gift from our parents; therefore we must take good care of it rather than abuse it. Whoever fails in this duty is unrighteous because he does not comply with the mandate of heaven' [cf. 5:280]. Mencius in the 'Doctrine of the Mean' defines: 'a person with great virtue will surely have longevity' [cf. 10:362]. Thus, health competence is essential for a good life, for quality of life, for happy and healthy social interaction. I also can quote Fritz Jahr, a German protestant pastor who recognized three levels of protecting and promoting life in his interpretation of the biblical 5th commandment 'Thou shall not kill': [a] the Golden Rule of not hurting, i.e. of helping and supporting, [b] the obligation to self-preservation 'by not taking one's life, by not shortening it, hurting or endangering in weakening it with unchastity, extremes in eating and drinking, rage, foolhardiness etc.', and [c] the 'bio-ethics imperative 'Respect each living being as an end in itself and treat it if possible as such' [7:appendix]. The arguments of Confucius, Mencius, Jahr and others make sense to many cultural traditions and moral attitudes in the modern world of caring for health. Basic health care competence by the lay person and professional competence in

compassionate communication, cooperation, and care by the experts are the two basic elements of successfully caring for, protecting, and restoring health. Thus health care ethics is partnership ethics.

HEALTH CARE ETHICS IS PARTNERSHIP ETHICS

Partnership ethics are interactive. Mencius once said: 'Between father and son, there should be affection, between ruler and minister, there should be righteousness, between husband and wife, there should be attention to their separate functions, between young and old, there should be a proper order, and between friends, there should be faithfulness' [cf 10:201]. I add to Mencius: '**Between experts, lay persons, and corporate persons there should be competence and compassion, fairness and trust, communication and cooperation**'. A view at a 500 years old interactive list of virtues of physicians and lay people demonstrates such a superiority over more simple modern sets of principles very clearly. Confucian doctor Gong Tingxian in the 15th century was the first who presented an interactive list of health care ethics for both, doctor and patient, the expert and the lay: 'First Rule for Physicians: In the first place they should adopt a disposition of humaneness: this is a justified demand. They should make a very special effort to assist the people and to perform far reaching good deeds. – First Rule for Patients: In the first place they are to choose 'enlightened physicians [ming-i]' and thereby receive help in their ailment. They have to be careful, because life and death follow each other closely'. [cf 10:234]. Doctor Gong Tingxian made it mandatory that medical students study humanities first, i.e. what we would call 'philosophicum', and only thereafter physical and medical sciences, i.e. the 'physicum'. For the patient, he requires strict adherence to the regimen advised by the expert including changes in lifestyle. It is also interesting, that Gong Tingxian does not mention the traditionally strong cultural influence of the family; rather, he holds the quite modern view, that the lay individual is directly responsible for good and successful communication and cooperation with the expert. In the modern world, we have to include corporate persons such as hospitals, nursing homes, health insurers, politicians, and regulators into the partnership model; if the institutional framework for providing and financing health care is not competent and compassionate as well; physicians and patients will not be able to successfully

interact in the care for health. Codes of conduct and virtues and principles have to be obeyed by lay persons, experts, and corporate persons in partnership of communication and cooperation.

Compassion and competence belong together. Without compassion, competence is blind and dangerous; without competence, compassion is helpless and fruitless. For specialized tasks and complex issues throughout history we always were depending on professional and expert services. This is even more true in the modern worlds everywhere. Thus, trust-based communication and cooperation with the expert is important for the lay person. What would be the type of medical expert, I should trust? The answer comes from famous Confucian doctor Yang Chuan, who 1700 years ago advised **'to trust and rely only on such physicians who have the heart of humanness and compassion, are clever and wise, sincere and honest'** [cf 10: 200]. This is a much more detailed and wider list of virtues and principles requested from the expert than modern models of clinical ethics based on the four principles –autonomy, nonmaleficence, beneficence, justice – would suggest. But as we know so much more about risks to health and causes for diseases in modern health care, we also can have and must have more health competence in citizens as lay persons. According to Aristotle, a competent master in his craft knows how to do things and does things right, knows why it is done the way it is done, and knows how to talk about it and teach and train disciples. There are and will be different and highly specialized professional competencies in health care such as family medicine, oncology, neurology, nursing, hospice care, but we also can have and must have basic lay health competency in health care matters, competency by mothers and couples, children, seniors, the sick and the healthy. Without a certain level of health literacy and health care competency, there cannot be a successful communication and cooperation between the expert and the lay, no so-called 'autonomy' of patients in decision making or consenting.

Deficiencies of the 'autonomy, nonmaleficence, beneficence, justice' model. It is remarkable that neither 'competence' nor 'compassion' are mentioned in modern lists of virtues and principles for health care professionals based on the Belmont Report and the four principles of 'autonomy, nonmaleficence, beneficence, justice' which since have had a global influence on shaping medical and clinical ethics

and clinical ethics teaching and consulting [1]. Those four principles were originally developed in 1978 as a basic and common moral principles which could be agreed upon in a pluralistic society with diverse religious and cultural views to guide human experimentation and only later introduced into the treatment setting of family and clinical medicine. The bottom line of the Belmont Report requires 'informed consent' from probands and patients; but such a maxim was already introduced 1900 in Prussian regulations and again 1934 in German regulations together with the principle that the highest officer in the research or treatment institution be personally responsible for research and treatment [10:355]. Given the strong reference to competence and compassion in physician's ethics in all cultures, it is significant, that the requirements for professional competence and personal and professional compassion unfortunately are missing in the Belmont Report and subsequently in all other modern sets of medical ethics principles.

Also, the Belmont Report and its subsequent modifications only contain a list of professional ethics principles with no reference to interactive principles with health care partners and to virtues and principles on the side of the probands and patients. The principle 'informed consent' as a subsequent soft-paternalistic requirement for allowing medical research to start and to continue actually is a principle essential for all interactions among free people in free societies everywhere and not only in medical research and clinical care. Similarly, the principle 'justice' as the right to equal treatment and equal opportunity is a basic element of human and civil rights and should be self-understanding in the hospital setting. Whenever societies, cultures, or political systems are not strong enough to 'respect persons' and to guide 'just and equal treatment', then those principles will fail in the subsystems of caring for health in a competent and compassionate manner. Thus, the lack of detailed reference to - actually not even mentioning - the principles of competence and compassion is an essential deficiency in modern medical ethics; so is the lack of understanding that principles of respect for individual self-determination and justice are primarily social and political principles in general and not just for the health care setting. Lack of medical and nursing competence is widespread everywhere; unfortunately non-compassion actually is taught in many teaching settings of Western medicine arguing that compassion should not interfere with 'scientific' diagnosis and therapy.

Whenever respect for persons and justice are trampled and missing in a society or culture, the health care field will have a hard time to implement those within unfriendly and inhospitable cultural, legal, and political environments. Respect for persons, nonmaleficence, beneficence, and justice, however, are important principles for situationally defining and fine-tuning the principles of competence and compassion, of communication and cooperation in the health care setting, not at least in the clinic. Principles of 'non harm' and 'doing good' have to be implemented in balance with each other, depending on the medical and ethical situation of each and every case. Consulting and treating medically rarely is without risk, potential harm or harmful side-effects; they cannot be treated separately as is suggested by separating the two principles and taught in modern biomedical ethics.

Networking partners. Ethics is an interactive enterprise among partners and rarely a one-sided activity towards objects; thus presenting and teaching physician's ethics only is not enough. Acting virtuously or viciously is acting based on moral and cultural principles, traditions, and attitudes of different parties involved, i.e. experts of various kind and different services, customers, consumers, patients, their families and friends and neighborhoods and institutions. Institutions belong as acting corporate persons directly into the **network of acting partners** morally or immorally, of being selfish, arrogant, non-caring, or supportive, person-oriented, compassionate, competent. Even though attitudes and principles are different in different cultures and times, the most common principle and virtue is the so-called golden rule 'do not do to others what you want not be done to you' or 'respect human dignity in all of your fellow humans as you want to be treated by others'.

Thus, ethics is reciprocal and all interactions among humans are based on interacting principles and virtues. For the expert-lay interaction I could formulate as an advice for experts in the field of health care as a counterpart to the advice given by Dr. Yang Chuan, **to be fair and compassionate with such patients who are compliant, clever and wise, sincere and honest in caring for health and being aware of limitations in medical services for health, life and the quality of life**'. Michael Tai has presented a list of Confucian principles for bioethics in general which can very well be integrated into clinical ethics: '**compassion, righteousness, respect, responsibility, ahimsa**' [11:122-127]. I have suggested balancing principles and

virtues: for the patient self-determination versus compliance, for the expert professional responsibility versus respect for the patient's visions and wishes, balancing the good of the intervention with potential harm, - both partners interacting with competence and compassion and in communication-in-trust and cooperation-in-trust within a competent and compassionate institutional and organizational framework [10:204f]. Depending on cultural and professional traditions and expectations, also depending on situational challenges, the balance of responsibility between partners is different.

One of the central questions in international medical ethics is the balance of decision making between the expert and the lay person, the physician and the patient, or the physician, nurse, patient, family. It has been argued that Asian medical ethics is more paternalistic and US-American medical ethics is more oriented towards autonomy of the patient, while European models are in-between. Veatch correctly has observed that contemporary European models seem to be between traditional Asian models supporting the authority and responsibility of the doctor, while US-American medical ethics puts emphasis on the authority and competence of the patient to make decisions, - 'more paternalistic and authoritarian than the American, but less willing to hide reality from the patient than the Japanese' [12:38]. He calls it a 'dilemma that is becoming critical in international comparative medical ethics. Humans simultaneously affirm a belief in a universal foundation for morality – that there is a single moral standard for all people – and that there are obvious cultural differences on matters such as what to tell a dying patient'. These cultural differences will be more prevalent in some countries than in others, but they inform and form individual differences among expert providers and lay receivers of medical and nursing care. So, what roughly can be described as cultural different cultures, in each and any case is a different individual attitude, expectation, vision and wish in regard to health care treatment.

Fan [6] and Nie and Campbell [8] have correctly argued that modern medical ethics and clinical attitudes are quite different even within Asian institutions and among Asian providers and recipients of health care. Thus, to confront Asian and European and US clinical ethics is misleading. We find Buddhists and Moslems in German hospitals and nursing homes, but we also find Christians, Non-believers and

all sort of different world views in Asian hospitals as well, expressing not just a standard Christian or Taoist or Jewish attitude towards health, quality of life and end of life, but the very personal interpretation of a specific cultural or religious tradition or a mix thereof. Also, we find patients who do not 'want to be told' and leave decisions to the physician or the team in Europe and the Americas, and we find Asian patients who want to take part or even direct and control clinical decision making. Then, there are patients who were used to be independent and used to make decisions on their own for all of their life, but due to senility or pain or other factors are not willing or capable to be involved in clinical decision making whatsoever. So, the prime emphasis of US-American biomedical ethics on 'patient's autonomy' is a valuable philosophical and human-right concept, but not working well in the clinical setting in Europe, Asia, or North America. Better would be to use the 'respect for persons' as an overarching principle to remind the network of partners in caring for health and patients of the principles of 'compassion' and 'communication'. We rarely find a clinical situation where the full authority of the 'autonomy' of the patient as the prime principle can be implemented given the influence of pain, drugs, dependency, extraordinary environment on the hospital patient or nursing home occupant.

There is the twofold challenge of intercultural medical ethics: to recognize the differences between cultures and the differences of interpretation within any given culture. Thus, **all ethics, including medical and clinical ethics, has to be 'intercultural' given [a] differences between cultures, [b] personal interpretation within one culture, [c] balancing decision making among and between partners. COMPETENCE, COMPASSION, COMMUNICATION, COOPERATION, CULTIVATION**

Competence, compassion, communication, cooperation are not separate principles, but they are intertwined and they and their implementation have in any given case be put to work to form the framework for best possible individualized treatment and review in clinical care.

Competence has been a requirement in most classical schools of physicians and well protected against quackery, charlatans and professionally inferior people; competence is the backbone of professional modern health care; it is required to

practice medicine and to be kept up-to-date in continuing education. Basic forms of health care competence for lay people as well have been part of most cultures. Modern medicine and lifestyle research knows much more about the influence of genetic heritage, workplace and private social environments, eating and physical exercise habits than previous generations; this richness of knowledge has not yet been made available broadly enough to citizens in general or specialized education to promote health literacy, health care competence and health responsibility. Only lay health care competence and literacy will allow citizens to be self-determined and 'autonomous' decision makers as good partners to their doctors. Competence is also required by institutions of health care as corporate persons, presenting to the public and to their employees and customers a professional attitude of reliability, responsibility, and trustworthiness, which integrates organizational, financial and leadership competence with competence that there needs to be free space for competent and compassionate communication and cooperation between experts and their patients, also the competence to recognize that institutions of caring for health have to be solid in organization and financing but the patient and the mission has to come first.

Compassion has been an integral part of health care professional's ethos, reputation, recognition, and authority; today it is not widely taught in biomedical and clinical teaching, not even in specialized training courses in clinical ethics consultation. Compassion goes beyond the scientific capabilities of modern medicine and the technical training of doctors, nurses, and other health care professionals; it is the golden rule for respecting life and caring for life in a human, i.e. compassionate way. The compassion principle must inform regulations and guidelines for each and every treatment situation; it is an indispensable tool for educating clinical ethics committee members and for guiding their consulting and decision. Compassion as a virtue of corporate persons in the health care field includes the understanding that strict treatment schemes and financial success need to be measured along the overreaching goal of serving in the care for health. Fritz Jahr, the father of bioethics, once defined compassion as 'universal moral law' (universales Sittengesetz [7]).

Communication is the most important principle for both, patient and health care expert, also among health care experts and with corporate health care persons. Only

communication can evaluate the health status and health care needs of a patient, integrating the value-and-wish status with the medical status into a complete health care and health care need status and associated diagnosis, prognosis and therapy. Communication among different groups of health care experts and individuals needs to be learned and trained in the development of a common language and the development of trust into arguments independently whether they come from a nurse or chief doctor. Communicating with patients and their families is even more complicated; the health care expert has an obligation to initiate and to lead the communication, to choose in individual cases the most appropriate method of communication from narratives to the inclusion of family or friends. Communication is time consuming, therefore costly, but indispensable for good professional and compassionate health care. Training courses in particular for those who are members of clinical ethics committees are essential, but institution leaders and leading physicians and nurses also need to have excellent communication training and competence.

Cooperation is a two-way street, and there are often crossroads where three or more partners meet and exchange expertise and responsibility. Cooperation among health care providers quite often is deficient; patients sometimes do not comply. Cooperation in the clinic is important, but even more so in the every-day life setting when lay persons have to stay in close contact with experts in prevention and prediction, to protect and to improve their health. Modern medicine allows lay persons to become health literate and health responsible; our modern understanding of human dignity and civil right, i.e. the 'respect for person' requires more than informed consent; it requires 'informed contracts' between experts as advisers and lay persons as advise seekers. Much needs to be done to develop a truly cooperative framework in the care for health. Not at least are government and educational institutions responsible for developing such a comprehensive system of health care cooperation far beyond the clinical setting.

Cultivation is a principle of highest goals and aspiration in many cultures, in particular in Asian cultures primarily for the self-development and the higher autonomy of the individual, but secondly as well for building cultivated communities of persons of culture, compassion and competence in life matters and health matters. Tai [11] and

others in the attempt to present a truly Asian perspective in bioethics have made cultivation a prime principle. Cultivation primarily is self-cultivation with indirect influence on the cultivation of neighbors and others as a role model and in encouraging reciprocal ethics, thus creating harmonious and cultivated communities and societies. For experts and lay persons in health care facilities and for those facilities themselves, cultivation as self-cultivation needs to be an overreaching goal in pursuing and implementing competence with compassion, compassionate and competent communication and cooperation. When leaders and their associates of clinics and other health care institutions just look at the basics of medical science, financial survival, and organizational flows, then the goal of cultivation together with better and sustained competence, compassion, communication and cooperation will not succeed. Thus, cultivation, even though a goal primarily for cultivating individual persons, nevertheless becomes a goal in corporate development and life, - an impulse for continuously improving and cultivating institutional structures and developments; clinical ethics committees can and need to play an essential role in the overall cultivation of their facility. Cultivation as a personal, professional and corporate goal cannot be achieved without competence in professional and personal life, not without compassion, and definitely not without communication and cooperation among compassionate and competent partners. Thus, cultivation is the final goal in all civilized forms of working together, personally, professionally, institutionally, socially, - it is the way of cultivation, rarely ever a final end and complete achievement.

INTERACTIVE VIRTUES FOR HEALTH CARE EXPERTS, LAY PEOPLE, AND CORPORATE HEALTH CARE PERSONS

There are at least three reasons that health care ethics in the future should follow Gong Tingxian's interactive model of partnership: progress (a) in predictive and preventive medicine, (b) in intensive care and in methods of prolonging life as well as suffering, and (c) the emotional, ethical, and economic limits in providing all and every possible medical intervention, they all make the development and the support of an ethos of individualized health care a prime challenge in global bioethics. Patient ethics and lay risk competence in health care matters and the development of virtues and principles for taking care of one's own health should be given priority over secondary

issues in physician's ethics. **Physician's ethics** will have to change from paternalism to partnership. Also, most interactive models of applied ethics have to include Institutional ethics as particularly in the clinical setting experts of various kind and patients and their families and communities have to work in an institutional setting with its own principles in corporate structure, goal, and ethics. A recent Code of Conduct for German Physicians names five core obligations: 'respect the right of patient's self-determination, save life, protect health and retribute it, alleviate suffering, accompany the dying' [cf.4:19]; only the second one, 'safe life', seems to be in the forefront of clinical daily routine with not enough emphasis on the other four obligations. Situational expertise and ethics based on compassion, communication and cooperation with the patient will tell the expert the most adequate mix of the five obligations following a rule given by famous doctor Galen, private physician of Roman Emperor Marc Aurel ,**Non homo universalis curatur, set unus, quique, nostrum, - we do not treat a universal person, but a unique one, a special one, one of us**'. In the institutional setting of universal norms for WHO and professional organization recommended quality norm insurance company set universal norms for reimbursement, such individualized treatment of each and every patient in the clinical setting is the greatest challenge to the experts, the consulting bodies and the institution.

The global richness in individual, familial, and communal cultures calls for differentiated health care services according to the values and wishes of the individual client or patient, not those of the 'doctor' nor those of the 'system' which provides health care. Following is a set of interactive maxims, virtues and principles in expert-lay partnership care for health: Eight for the lay person and eight for the health care expert, built on the interactive format of Dr. Gong Tingxian. Lay risk competence in health care matters and the development of virtues and principles for taking care of one's own health should be given priority over secondary issues in physician's ethics. Physician's ethics will have to change from paternalism to partnership. The global richness in individual, familial, and communal cultures calls for differentiated health care services according to values and wishes of the individual client or patient, not those of the 'doctor' nor those of the 'system' which provides health care. Future bioethics research and teaching has to shift emphasis from physician's ethics to lay ethics and patient's ethics and the ethics of cooperation-in-trust. [10: 12-13;212-213]

1. Building Cooperation and Trust: The First Rules stress the lay person's obligation to actively search for and to find the right expert and the expert's obligation to serve her or his patient as a fellow human and not just as a technician of medicine.

1. Find truly educated and trustworthy health experts. - 1. Treat your patient as a person, not just his or her symptoms. - No educated person will leave important issues such as health care solely to the discretion of an expert. From the true health care professional we rightly request not just best technical service but personal attention, compassion, patience, helpfulness and even sacrifice. At times difficult balances between patient autonomy and expert responsibility, between beneficence (bonum facere, do good) and non-maleficence (primum nil nocere, do no harm) need to be established; this will not be possible without trust as the underlying virtue and principle of all parties involved. In the clinical setting, the first rule for the institution would be 'Provide and improve efficient health care settings for providers and customers'.

2. Develop Health Risk Competence: The Second Rules call on the educated lay person to educate herself or himself in matters of health and to develop individual competence in the care of health, while the health care expert is called to teach and to educate the lay person and to assist her or him in accepting health care responsibility.

2. Develop competence and responsibility in health risk management. - 2. Assist you patient in developing health risk competence. - Health care primarily has to be understood as a human and civil obligation, rather than a right which can be claimed from others. Professionals should be partners rather than elitists and not withhold information necessary to the educated citizen for her or his self-determination in health care matters. In the clinical setting we require the institution: '2. Protect and support competent and compassionate professional health care'.

3. Total Health Care: The Third Rules emphasize the particular importance of mutual responsibility and interaction of the lay and the expert in predictive and preventive health care. The simple principle of informed consent to medical treatment does not meet the challenges of preventive and acute health care. *3. Make extended use of predictive and preventive medicine. - 3. Integrate the 'clinical status' and the 'value status' of your patient into differential ethics, diagnosis and prognosis.* Patient oriented treatment will also depend on cultural traditions and the critique of modern cultures treating medicine as a repair system and tool, rather than the science and art of

balancing health risk and challenges. In the clinical setting we have to ask: '*3. Set institutional frameworks for the whole range of health care services*'.

4. Risks and Results of Intervention: The Fourth Rules remind both groups that acute medicine has its limits and risks and calls for trust-based cooperation and risk partnership. *4. Expect healing or relief from acute medicine, but be aware of the limits and risks of any medical intervention. - 4. Be aware of the benefits, limits and risks of acute intervention and discuss those with your patient.* Expert-lay partnership ethics has to communicate risks and benefits in an adequate way and also look into alternatives to purely medical and clinical interventions. Trust-based communication and cooperation will go beyond 'informed consent' and best be transformed into a model of 'informed contract' determining rights and responsibilities for both sides. The clinic as a corporate person has to allow for and to protect free space for complex individualized decision making among and between providers and customers; so we just need to require: '*3. Support and protect providers and customers of health care service.*'

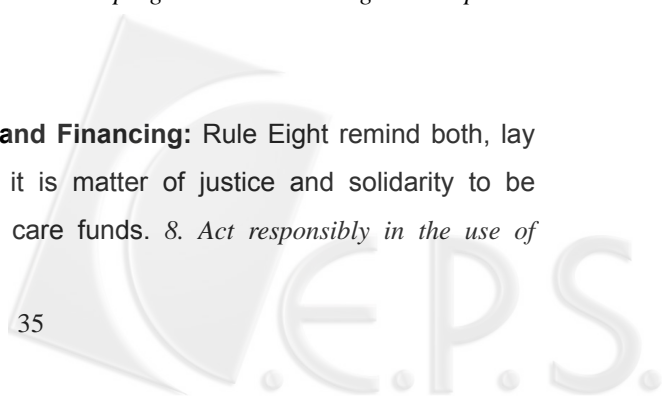
5. Expert-Lay Partnership: The Fifth Rules underline that it is the lay person first who carries prime responsibility in preventive care for health, while the expert's role is reduced to understanding and compassionate information, advice and support. *5. Expect information and advice from medical experts and be a fair partner with them. - 5. Be an expert partner with your patient and respect her or his wishes and values. -* The obligation to care for one's own health is the precondition for rights one might claim that others should care for one's health. Expert advice as well as treatment has to be individualized; individual risk parameters, values, goals and wishes, and the difference between well-being and well-feeling mark the limits of 'objective' health care as defined by WHO and executed by modern repair type medical and clinical systems and disease description and payment schemes. The health care institution needs to establish itself as an active and creative facilitator of a variety of health care services.

6. Great Health Care Learning: The Sixth Rules stress, that qualities of life can only be defined individually, never objectively and not easily by others. *6. Define and implement your sense of qualities of life, from childhood to old age, in sickness and in health; seek information from experts, the media and internet .- 6. Continuously educate yourself and provide the best possible clinical and personal service.*

Health care professionals have to strive to continuously educate themselves in best possible technical service. Educated citizens have to recognize that qualities of life do transform and modify themselves – they do not reduce - over the years and that they have to redefine or adjust goals and preferences accordingly. Professional health care advice therefore must respect individual preferences and choices in the delivery of technically best but individualized service. Patient-oriented support and compassion is of particular importance in the care for the incompetent, the terminally ill and the dying. The clinic, thus, has the obligation to request highest possible professional standards in medicine, nursing, and management: *'6. Provide for support of continuing professional education'*.

7. Health and Care Communication: Therefore Rule Seven calls on the professional to help the patient to develop health literacy and to discuss health and care related issues within the family and with friends and to assist the lay person in understanding suffering, weakness, and dying, also to help her or him to recognize those values and wishes and to establish those directives in advance which should govern trusted surrogates and health care experts to make adequate decisions in circumstances of incompetence. *7. Discuss health and care issues and goals with family and friends; prepare advance directives and name proxy decision makers for circumstances of incompetence. - 7. Help your patient to become health literate and to discuss health and care with family and friend; assist your patient in preparing advance directives and in working with proxies for the benefit of your patient.* Advanced Directives are just one tool to protect patient's personal values and visions and the cultural environment of her or his particular family and value community. It is here, where personal and cultural differences have to be recognized in the clinical setting probably more than in primary health care and advice. Thus, health care communication is a prime principle for the clinic as well, for leadership internally and for outreach into the neighborhood as a good and trusted neighbor: *'7. Offer outreach programs and be a good corporate neighbor'*.

8. Responsible Organization and Financing: Rule Eight remind both, lay citizens and health care experts, that it is matter of justice and solidarity to be responsible in the allocation of health care funds. *8. Act responsibly in the use of*



communal health care funds. - Modern health care depends on a complex system of prevention and intervention, basic and supplementary care, distribution of labor, cooperation and specialization, also on effective and just administration and allocation of funds. Therefore it is mandatory that all players in the field of caring for health, for the suffering and the dying, are responsible for the protection and improvement of existing health care delivery and follow the same Rule: '8. *Act responsibly in the use of communal and other health care funds and resources*'.

CLINICAL ETHICS DECISION MAKING

Tai and Tsai once described three models of clinical decision making in Asia 'physician making paternal decisions, physician given the power to make decision, physician consulting with family to make decision' [cf 10:235]. We find these three models not only in Asia; we find them as well in the praxis of clinical ethics in Europe and the Americas.

1. The paternalistic decision making model as a general rule does fit into the partnership model and also not into the civilized understanding of human dignity and civil rights and responsibilities. It may however be the model of last resort in cases of emergency when the patient cannot give an input into health care or treatment decisions. If patient's wishes and values or those of the family or community cannot be evaluated and if time permits, a special consultation body would be helpful to serve as a sounding board and/or partner-in-communication.

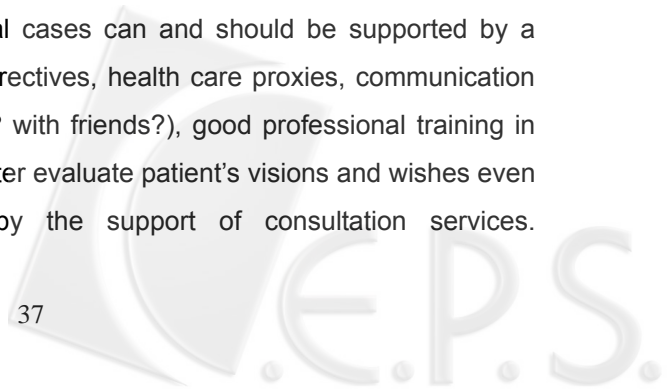
2. Allowing the expert to make decisions in a trust-based expert-lay relationship seems to be a special form of cultivated communication and cooperation to leave decisions to the expert. This is in particular true for all detailed technical issues. But also if there is a stark difference between health care competence of the patient and the family on one side and technical or even life-and-death decisions to be made by the expert. For centuries, this was the model preferred by in most cultures. It is a model which sets particular trust into the individual expert, not necessarily into the institution or the system; it needs to be seen and be taken care of that the trust given to the individual expert is honored by the system and the institution as well, eventually

opening new avenues of communication and cooperation via ethics consultation bodies or experts.

3. Experts making decisions based on communication with family or friends might be in the best interest of the patient is a model which suits the clinical setting much more than expert-lay interaction in primary care. Many patients might be too sick or too ill or too incompetent to make reasonable contributions to decision making based on their values and wishes; therefore others –primarily and traditionally the family – has to be a partner in making decisions in the ‘best interest’ of the patient. But there is a professional obligation of the expert to find out about potential unethical motives of family decision makers or about the family’s competence to evaluate the situation and the issues at stake in the patient’s ‘best interest’.

4. Therefore, we need to add as a golden standard a fourth decision making model: **competent and compassionate expert-lay partnership in communication and cooperation**, assisted or supported by family, friends, institutions, and society. Such a communication-and-cooperation model of partnership is particularly difficult to work in the clinical setting as patients and experts regularly have no long-term established history and experience of building trust and mutual understanding. The expert-patient partnership model is superior to the other model for two reasons: (1) patient oriented medicine treats the entire person, not just this or that disease or illness and different people have different visions and wishes in regard to medical treatment and its options, (2) in a more and more intercultural world even the hospital setting, it cannot be assumed that the patient shares similar visions and values to those of the medical system, the hospital, the doctor, the teams, and the family and neighborhood.

Complicated as it is for the integration into clinical decision making, this golden-standard model for most clinical cases can and should be supported by a number of supportive tools: advance directives, health care proxies, communication with family (who speaks for the family? with friends?), good professional training in medical ethics and nursing ethics to better evaluate patient’s visions and wishes even in compromising situations, finally by the support of consultation services.



Consultation groups or individuals serve a multiple purpose of supporting communication-and-cooperation between different individuals and groups of health care experts, with patients and their families and with the wider community. Of particular importance therefore is the research in and the development of development of communication-consultation-cooperation education.

TRAINING IN CLINICAL ETHICS CONSULTATION

To demonstrate how expert-patient partnership needs to work, I briefly introduce a checklist, which I have developed and tested over the last 30 years at the Bochum Center of Medical Ethics in Germany [4;9;10:45-45;248-254]. It is a tool for clinical-ethics decision making and consultation services, which is time-efficient, poor in deep philosophical and moral argumentation and rich in narratives and other material which allows to put actual cases into the perspective of similar scenarios and professional and cultural values and standards.

Methodically we follow in ethics the checklist model which is well known and the golden standard in technical clinical status evaluation, prognosis and therapy review. We assume that the few issues we address – values and wishes of the patient, her or his intention or competence to be involved in specific clinical decisions, the good balance of professional obligations with patient's wishes – are existing in most cultures and traditions, including cultures and traditions in health care. For special cultures and situations, however, we use a small number of additional questions to be answered. The checklist has three parts: part 1 evaluates medical, information, facts, uncertainties and risks, part 2 evaluates ethical and cultural information, facts, uncertainties and risk associated with this particular patient, part 3 combines information and judgment from parts 1 and 2.

In part 3 we ask: 'What options are available in the face of potential conflicts between medical-scientific and medical-ethical aspects? Which options are the most appropriate given the value-and-wish profile of the patient? Who, if anyone should be consulted as an advisor? Is referral necessary for medical or ethical reasons? What are the moral (in contrast to scientific or legal) obligations of the physician/team to the

patient? What are the obligations to of the patient, the family, the society and state, health care institution and financing authorities? – What, if any, are the arguments against the treatment decision? Does the treatment decision need consensus? How does the physician in charge respond to these questions? Was the treatment decision adequately discussed with the patient and/or family? Does he / do they agree? Summarize in writing the decision and medical and ethical reasons!

In part 2 we ask: What is known about the patient's values, wishes, fears and expectations? What is the patient's understanding of intensive or palliative treatment as well as resuscitation criteria? Is the patient well informed about diagnosis, prognosis, and the various treatment options available for him/her? How is it possible to satisfy the patient's preferences in formulating the treatment plan? To what degree should the physician permit this patient to determine the treatment plan? Who else, if anyone, could or should make decisions on behalf of a patient and his/her best interests? Must the patient agree with the chosen therapy? Here are 2 cases which we use in clinical ethics training using the checklist approach. The first case is a case of paternalistic decision making without 'trust and good communication' with the patient and no concern for patient-oriented treatment. The other case is of cross-cultural relevance and addresses as well individual understandings of 'trust and good medicine'.

Case in Hospital Care: Mrs. M, 38 years-old, had her left breast removed 5 years ago because she had breast cancer. Now she has increasing pain in her lower back, and her physicians have determined that the cancer has metastasized to her bones. They recommend chemotherapy to reduce pain and to prevent or slow down the spread of cancer. Mrs. M. undergoes chemotherapy with uncomfortable side effects. Her pain increases and is not treated adequately. The physicians to not tell the 'full truth', that chemotherapy will not kill the cancer, but might prolong her life. Mrs. M. dies in the hospital 8 months later, not as she had wishes at home. Without chemotherapy she might have died a few months earlier. - And here are the questions which we pose in the training course, if they are not voiced by the participants themselves: What did the physicians know about Mrs. M.'s wishes and values when making treatment decisions? How would you have incorporated your medical-ethical diagnosis in treatment decisions? Does the doctor have to treat the disease or the

patient as a person? Is full and professional palliative care a basic right of each and every patient? Would you follow patients' Advance Directives or wishes based on their value-and-wish profile, even so when that differs from your own?- Describe and discuss some cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the second section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already? [9]

Case in Multicultural Care Setting: Mr. T., a 28 years-old married Turkish patient of a German Doctor in Germany suffers from low sperm count. The couple wants to have children. The doctor prescribes a mild prescription drug based on pig pancreas and explains to the patient stronger medicines would be available if this one does not work. A week later the young Turk storms into the doctor's office, throwing the pills at the doctor and shouting 'You are a pig. Who does give a man pills from pig to make son. Doctor, you are a pig!' – And here are questions we pose, some of them relate to potential cultural conflicts, others to a patient's individual understanding of 'good medicine' others to the physician's understanding of 'good therapy': Is it always responsible to start with the least invasive therapy even when non-medical factors such as culture or religion or even unacceptable and crazy ideas would suggest otherwise? Would you have explained to the patient that eating pork and using medicine based on pig tissue by many Moslem scholars has been defined as to be different and that in Muslim ethics and medical ethics the protection of life supersedes other religious laws such as fasting? In which cases would you compromise on the principle of full truth-telling and full and informed consent; in which rare situations would you use one of the supplementary lists of the Bochum checklist? Would you follow patient's wishes and values, which you might not share, such as prescribing contraceptives or antinidatives? When would you do not follow patient's wishes? Would you in such a situation direct her/him to see another doctor or not? - Give a few cases which demonstrate that careful information on the patient's medical status and history is essential for good treatment! Review the second section of the Bochum Checklist based on your experience! Do you have recommendations for improvement or modification to this list; do you have your own list already?

The **short list of questions** in the checklist allows to concentrate on essential issues, but for special situations we have **additional sub-lists**, such as a sub-list to evaluate a patient's willingness or competence to take part in clinical decision making and to implement the principle of 'informed consent' into clinical reality: 1. Does the patient wants treatment based on paternalistic or autonomous decision making or on partnership? - 2. Does the patient want to include the spouse or family members or someone else in making decisions or consenting? - 3. What are the special challenges for physician's practice and ethics to include others in decision making? - 4. What can/should be done to guarantee that each and every patient is treated according to her/his system of belief, independently whether Christian or secular humanist, Jewish or Muslim, and according to her/his value-and-wish profile? We have other supplementary lists for special situations such as long-term treatment, cases of considerable social impact, therapeutic research with even more detailed –sub-sub-lists such as one for cytostatica research, intervention in psychiatry, dementia, paediatrics with sub-sub-list in neonatology, and for hospice care. When introducing these lists in workshops, we do so with cases and associated questions if those are not raised by the participants. Also, we ask participants to add one or two questions of their own and not treat our own small list as inflexible and modify it as necessary.

FINAL REMARK

I have discussed only one side of the ethics of health partnership in communication and cooperation between the experts and the lay. And I have tried to exemplify my approach by limiting details of methods and principles to the clinical treatment, which is only one field – unfortunately the one which is primarily in focus of health care politics and health care financing. It is the obligation of the community of health care experts to help the lay people individually and as a community, and to help experts in health policy and insurance to modify the system **towards a more healthy model of health care partnership in competence, compassion, communication, and cooperation, finally in the cultivation of all persons involved, experts, lay persons and their families, institutions and their partners, by a cultivating society and cultivating global cultures of care, competence and compassion.**

Famous doctor Sun Si Miao put it this way: 'Superior doctors treat the state, better doctors treat a patient as a person, common doctors treat the illness' [cf 10:356]. Cultivation can be understood as the highest goal for the treatment of the overall culture of the state and society, which will guide and improve competence, compassion, communication and cooperation the clinical setting as well. Classical concepts of good health care in public and professional cultures of the East and the West will help to modernize medicine, which has deteriorated towards an intervention based system of disease management. In this regard, **there is no basic difference between Eastern and Western bioethics, medical ethics, and clinical ethics, just different characteristics and emphases based on cultural traditions, attitudes and expectations.**

Thus, clinical medicine and care and clinical medical ethics need to be seen in the wider context of individual and collective health care as a partnership enterprise requiring **competence, compassion, communication, cooperation** from all partners. These C-principles –competence, compassion, communication, cooperation, and cultivation – are formal principles which translate into personal and professional virtues independent of different worldviews and cultures, including cultures in health care ethics and clinical ethics. Competence, compassion, communication, and cooperation need to form the base in clinical ethics teaching and consulting, also in defining special situation strategies and in devising clinical ethics checklists. The four C's express a common morality, not commonly shared moral beliefs, but as such they qualify for a clinical culture which follows the old maxim 'aegroti salus suprema lex - **the good of the patient is the highest order**'. The 'salus' - the good, the sake, the interest, the goal, the vision and wish of those who are in our care - will need to be found out competently and compassionately, in communication and cooperation with the patient, within the team, with consultants and with family and friends. Such an approach to and practice of clinical service and clinical ethics will lead to professional and personal cultivation of all involved; clinical ethics committees have to play an essential role in this never-ending cultivation processes of individuals, families, institutions, societies and global humankind.

APPENDIX

EIGHT HEALTH CARE RULES FOR THE LAY PERSON

1. Find truly competent and compassionate health experts.
2. Develop competence and responsibility in your health risk management.
3. Make extended use of predictive and preventive medicine.
4. Expect healing or relief from acute medicine, but be aware of the limits and risks of any medical intervention.
5. Expect information and advice from medical experts and be a fair partner with them.
6. Define and implement your sense of qualities of life, from childhood to old age, in sickness and in health.
7. Prepare a health plan, also advance directives and name proxy decision makers for circumstances of incompetence.
8. Act responsibly in the use of communal health care funds.

EIGHT HEALTH CARE RULES FOR THE HEALTH PROFESSIONAL

1. Treat your patient as a person competently and compassionately,, not just his or her symptoms.
2. Assist you patient in developing health risk competence.
3. Integrate the 'clinical status' and the 'value status' of your patient into differential ethics, diagnosis and prognosis.
4. Be aware of benefits, limits, and risks of acute intervention and discuss those with your patient.
5. Be an expert partner with your patient and respect her or his wishes and values.
6. Continuously educate yourself and provide the best possible clinical and personal service.
7. Assist your patient in preparing a health plan including advance directive; work with proxies for the benefit of your patient.
8. Act responsibly in the use of communal health care funds.

EIGHT HEALTH CARE RULES FOR THE CORPORATE HEALTH CARE PERSON

1. Provide and improve efficient health care settings for providers and customers
2. Protect and support competent and compassionate professional health care.



3. Set institutional frameworks for the whole range of health care services.
4. Support providers and customers of health care service.
5. Establish yourself as a health care center for prevention, education and treatment
6. Provide for support of continuing professional education.
7. Offer outreach programs and be a good corporate neighbor.
8. Act responsibly in the use of all health care funds and resources.

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