

CHAPTER 18

- Reading 18.1 **Maehle, A-H. and Geyer-Kordesch, J. (2000)** Introduction, pps 1–9, in *Historical and Philosophical Perspectives on Biomedical Ethics: from Paternalism to Autonomy?* (Maehle, A-H. and Geyer-Kordesch, J., eds.) Aldershot, England: Ashgate Publishing Ltd.
- Reading 18.2 **Dorland's American Illustrated Medical Dictionary.** (25th edn). (1974). Philadelphia, PA: Saunders
- Reading 18.3 **Fulford, K.W.M. and Hope, R.A. (1994).** Psychiatric ethics: a bioethical ugly duckling? Chapter 58 in *Principles of Health-care ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons. (Extract pps 684–685*.)
- Reading 18.4 **Fulford, K.W.M. and Hope, R.A. (1994).** Psychiatric ethics: a bioethical ugly duckling? Chapter 58 in *Principles of Health-care ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons. (Extract pps 688–689.)
- Reading 18.5 **Kopelman, L.M. (1994).** Case method and casuistry: the problem of bias. *Theoretical Medicine* 15: 21–37. (Extract pps 25–27.)
- Reading 18.6 **Crisp, R. (1994).** Quality of life and health care. Chapter 13 in *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press. (Extract p 181.)
- Reading 18.7 **Hare, R.M. (1993).** The philosophical basis of psychiatric ethics. Pages 15–30 in *Essays on Bioethics*. Oxford: Clarendon Press. (Extract pages 28–29.)
- Reading 18.8 **Fulford, K.W.M., Smirnov, A.Y.U., and Snow, E. (1993).** Concepts of disease and the abuse of psychiatry in the USSR. *British Journal of Psychiatry*, 162: 802–803. (Extract pp. 802–803.)
- Reading 18.9 **Sackett, D.L. Straus, S.E., Scott Richardson, W., Rosenberg, W., and Haynes, R.B. (2000).** *Evidence-Based Medicine: how to practice and teach EBM*, (2nd edn). Edinburgh and London: Churchill Livingstone (Extract page 1.)

Reading 18.1**EXERCISE 1**

3 Extracts from: Maehle, A-H. and Geyer-Kordesch, J. (2000) Introduction, pps 1–9, in *Historical and Philosophical Perspectives on Biomedical Ethics: from Paternalism to Autonomy?* (Maehle, A-H. and Geyer-Kordesch, J., eds.) Aldershot, England: Ashgate Publishing Ltd.

Extract 1: Page 1**Introduction****Andreas-Holger Maehle and Johanna Geyer-Kordesch**

New technologies create new ethical dilemmas. This is true not only of today, but of the past. What may not keep pace with the rapid quest for medical advance is the debate about it. This debate we cannot avoid, nor can it be left to the experts. Health and how we attain it implies choice and it also implies that we know what the implications of whatever choices made will be, for us and for others.

This idea is at the core of modern medical ethics.

Extract 2: Page 1–2

Reflections on the past, particularly the analysis of how experimentation in medicine (on humans and animals) shaped debate, is fundamental to our examining our position today. The chapters of this book show different patterns emerging and a slow uptake in public discussion. Many of the contentious issues have been reserved to internal debates within the profession. Medicine has always been jealous of its expertise, perhaps rightly so, in view of the oft cited view that lay men or women cannot understand the science. They may well not. But as the history of medicine demonstrates, few patients were informed that they were material for trials. This was before Nuremberg, and it took repugnant atrocities, in which medicine was implicated, to set in motion the large number of codes that sought to define the balance between potential harm and the inevitable risk research on humans incurs. Yet these codes are not definitive. They seem, in their very multitude, to produce vagueness, a condition ideal for exploiting the unwary with platitudes.

Extract 3: Page 3

Modern bioethics has a history in itself and the specific problems it contends with are the ones contemporary society must confront in detail. Since the 1970s Western countries have experienced a surge in bioethics. The institutionalization of bioethics at universities, the integration of ethicists in hospitals, the important role of ethics committees in the review of

biomedical research and health policy-making, and an exploding bioethics literature testify to this remarkable development. This raises the question of the distinctive features of modern bioethics, especially in comparison with traditional medical ethics. One defining influence has been identified in the rapid growth of medical technologies since the 1960s, e.g. chronic haemodialysis, transplantation surgery, modern methods of reanimation, the life-sustaining techniques of intensive care, and in vitro fertilization.

These and other new technologies have led to ethical problems without direct precedence in the professional medical ethics of the past and thus to a new kind of medical ethics (Jonsen, 1998; Jonsen, 2000). Another interpretation of the move from medical professional ethics to bioethics has highlighted the opening of the hitherto privileged doctor-patient relationship, in its ethical dimensions, by other professional groups, in particular lawyers, moral philosophers, theologians, and sociologists (Rothman, 1991). Finally, the specific social background to the birth of bioethics in the USA in the 1960s has received special attention as a force shaping the current emphasis on rights. The movements for civic rights, equality of ethnic minorities, and women's liberation paved the way for patients' rights and a new approach to ethics in medicine (Reich, 1995; Cooter, 2000; Whong-Barr, 2001).

Tom Beauchamp's and James Childress' four principles of biomedical ethics—beneficence, nonmaleficence, justice, and respect for autonomy—were a landmark in the emerging bioethical discourse (Beauchamp and Childress, 1979, 5th edition 2001). Although all four principles have traditional roots (beneficence and nonmaleficence are already stipulated as proper behaviour for doctors in the Hippocratic Oath), patient autonomy emerged as a new, profound orientation for medical ethics. Thus Ruth Faden, Tom Beauchamp and Nancy King distinguished an old 'beneficence model' of patient information and consent from a modern 'autonomy model' (Faden, Beauchamp and King, 1986). It has since become customary to view modern biomedical ethics as being guided by the principle of patient autonomy. The older medical ethics, by contrast, are usually seen as an expression of the beneficent paternalism of doctors (Jonsen, 2000:116f). But is it really justified to assume a historical shift from medical paternalism to patient autonomy? Were patients, a hundred years ago, entirely subject to the paternalistic judgments of their doctors? Are patients now, at the start of the twenty first century, fully autonomous in their decisions on matters of their medical treatment?

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Reading 18.2**EXERCISE 4**

From: *Dorland's American Illustrated Medical Dictionary*. (25th edn). (1974). Philadelphia, PA: Saunders

Hippocratic Oath. Various versions of the *Oath* exist, but the following text can be taken as representative:

'I swear by Apollo the physician, by Aesculapius, Hygeia and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement the following Oath:

'To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the

precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practise my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.'

Reading 18.3**EXERCISE 7**

Extract from: Fulford, K.W.M. and Hope, R.A. (1994). *Psychiatric ethics: a bioethical ugly duckling?* Chapter 58 in *Principles of Health-care ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons. (Extract pps 684–685*.)

Involuntary Treatment and the Four Principles

Among other possible approaches, the four principles provide a helpful framework for exploring the difficulties involved in involuntary treatment. What is at issue is a balance of the patient's autonomy against the obligations of the doctor to act beneficently, or at any rate non-maleficently. This is no less than a statement of the *prima facie* dilemma posed by cases 1 and 3 in our study.

Within the framework provided by the principles, moreover, other philosophical insights help to sharpen our understanding. Thus, Beauchamp and Childress draw on Joel Feinberg's concept of 'weak paternalism' to help specify the intuitive basis of compulsory treatment. Strong paternalism involves overriding a patient's express wishes in their best interests even though they are capable of autonomous decision-making. But it is weak

paternalism that is involved in the psychiatric case. Compulsory psychiatric treatment is justified only where the patient is *not* capable of autonomous decision-making. This in turn leads to an account of autonomy. Again, Beauchamp and Childress, drawing on various philosophical sources, supply this. Autonomy requires understanding, intention, and freedom from external controlling influences. Competence, in turn, is a threshold condition for autonomy. People are competent to make an autonomous decision if they are capable not only of understanding what is involved but also of deliberating on the decision in a coherent way.

All in all, then, there is a useful package of ideas here, useful as a framework both for setting out and for clarifying the issues raised by involuntary psychiatric treatment. Sometimes, indeed, this package is sufficient to resolve questions of involuntary treatment, or at any rate to justify decisions made about such treatment, in actual practice—as in case 9 described by Beauchamp and Childress. This case describes an elderly lady with periods of confusion caused by arteriosclerosis. She was confined against her express wishes in a mental hospital on the grounds, first, that it was in her best interests (she was at risk of serious injury during periods of confusion), and, second, that her impaired cognitive functioning, although intermittent, rendered her incompetent to make a genuinely autonomous decision about confinement in hospital. We may disagree with the decision made in this case, but even disagreement would have to be framed within the package of ideas outlined in Beauchamp and Childress's *Principles*.

* [Page 685 is a table, not relevant to this reading]

Reading 18.4**EXERCISE 8**

A second extract from: Fulford, K.W.M. and Hope, R.A. (1994). *Psychiatric ethics: a bioethical ugly duckling?* Chapter 58 in *Principles of Health-care ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons, (Extract pps 688–689.)

. . . there are clear indications that a scientific model of the medical concepts is implicit in Beauchamp and Childress's *Principles*. There are hints of this in repeated references to the pre-eminence of the doctor's specialist knowledge: autonomy can mean acceptance of authority (p. 69); the authority of the doctor is modeled on that of a parent (pp. 212–213); a patient's (autonomous) wishes may be overridden where these amount to 'poor choices

about courses of action recommended by their physicians' (pp. 211–212). The most explicit indication, however, comes in the discussion of rationality as a component of competence. Beauchamp and Childress argue that judgements of rationality, like other elements of competence, often involve references to (highly contestable) value judgements about what a rational person would do (p. 84). But they then go on to contrast the evaluative nature of judgements of rationality with medical judgements. Balancing autonomy with beneficence is said to be a 'moral *not a medical* problem' (p. 84, our emphasis). Moreover, 'if precise, nonevaluative criteria were available for making such determinations of competence, the [problem of deciding whether someone's choices are rational] would vanish'; as it is 'moral judgements and policy choices . . . cannot be avoided' (p. 84, our bracket).

All this suggests, then, that Beauchamp and Childress assume a standard 'medical' model of the medical concepts in which they are, at root, value-free.

Reading 18.5**EXERCISE 9**

Extract from: Kopelman, L.M. (1994). Case method and casuistry: the problem of bias. *Theoretical Medicine* 15: 21–37. (Extract pps 25–27.)

To illustrate that our biases affect how we pick out cases, their relevant features and what problems we think they exemplify, imagine people presenting three accounts of the same events to an institutional ethics committee meeting:

Case A. Baby W's parents want her to continue to have maximal treatment in the neonatal intensive care unit, where she has spent her entire four months of life. The doctors and nurses object because they view such treatment as futile and inhumane. The baby, they believe, is dying and these painful interventions will needlessly, and without benefit, prolong her suffering. Moreover, the neonatal intensive care unit is crowded, care is costly, and others are being denied admission. The parents threaten to sue if treatments are stopped.

When the case is presented in this way, most of us would agree that the case's relevant features concern devising fair procedures to overrule surrogates who demand futile, costly and painful procedures for patients. This case might lead us to consider getting a court order to stop inhumane treatment, or to reexamine some of our policies about surrogate consent, malpractice, physicians' right to refuse to provide care they believe harmful, or the differences between rights to refuse and to demand medical treatments.

Case B. Our agreement about the nature of the problems exemplified in Case A and what to do, however, presupposes we have framed the case in a way that captures the relevant features. Let us suppose that the doctors, nurses, and ethics committee members have ignored certain information that Baby W's family considers important. They argue that the reason they want her treated is because their extended family is coming from other parts of the world to be together for Baby W's death. This gathering has great symbolic meaning to them and so they beg that the treatments be briefly continued. The treatment is futile to prolong Baby W's life beyond a few weeks or months, but not futile for the different goal of having the family gather and grieve.

Deliberately omitting this information seems to show bias, because this material could transform our view of the situation, what is relevant for discussion, and the problems exemplified. We might now see the problems differently: as whether a treatment that is futile for prolonging life more than a few weeks or months could be provided for a short time as long as it did not cause unnecessary suffering or risk other's well-being; or as what constitutes compassionate treatment of a family in such distress; or as why the doctor, nurses, and committee members were biased in their original presentation and unsympathetic in deciding what was relevant to the discussion.

Case C. Now suppose that the family confronts the members of the ethics committee, doctors, and nurses charging them with bias because they ignored the information that the family wants the treatments continued until their relatives gather for the death of Baby W. The doctors, nurses and committee members respond that they are not biased because Baby W's parents have been saying this for two of the four months that Baby W has been in the hospital. The parents, they believe, are using this as an excuse to get the high technology treatments they refuse to believe are futile and inhumane.

In an actual consultation, these various points of view described as Cases A, B, and C would quickly emerge. Informed and impartial persons of good will would probably come to a shared understanding of what the case is and the problems it exemplifies. In an actual consultation, however, other biases might arise from activities or procedures that are harder to identify, including: who has access to the committee, how committee members are appointed, what procedures are followed, when the meeting is held, the order of business, who collects the information and presents it, who decides whether the results are recorded in the chart, who is introduced by first names and by "doctor," and so on.

Making sound moral judgments about actual cases presuppose accurate and pertinent information. Yet, real cases have ragged edges and what we pick out as "the case" can unintentionally introduce bias. In framing a case, we have to sift material, assign it importance, and decide what further information we need. Whether intentionally or not, we bring a variety of goals and values to our encounters with people and this is reflected in how or in what way we use cases.

Reading 18.6

EXERCISE 11

From: Crisp, R. (1994). Quality of life and health care. Chapter 13 in *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press. (Extract p 181.)

The Second Unacceptable Conclusion. Other things being equal (i.e. there being no bad side-effects), we should remove all but very basic funding from support for the severely mentally defective, and use it to decrease risks of death for non-defective people.

Again, as long as the probability numbers on the right-hand side of the equation are above zero, the conclusion follows. Therefore, however great the loss in quality of life of severely mentally defective people, and however little the risk of death avoided, we should channel funding away from the severely mentally defective. Let us assume that there is a one in a hundred million chance that a person will be killed by an adder each year. Then however devastating the consequences might be, Q*[a QALY them] implies that we should use resources now employed to help the severely mentally defective for adder-extermination. For, faced in imagination with the choice of living the lives in question in random serial order, I will point to the lost life in the UK every two years and judge that *no* number of severely mentally defective lives at whatever level would counterbalance the value of that non-defective lifetime.¹

¹ The notion of comparing in imagination lives lived in random serial order as a method of interpersonal comparison is taken from C. I. Lewis (1946) *An Analysis of Knowledge and Valuation*. La Salle, IL: Open Court, pp. 546–7.

This time, in the moral sphere, the Q*-Theorist cannot urge me to adopt the Global Conception in assessing the value of the lives in question. For I am already doing so. I am considering the life of the adder-victim *and* the lives of the mentally-defective persons in a global manner.

What seems to be happening is that I am totting up at the moral level the value of lives assessed globally at the prudential level. To avoid the Unacceptable Conclusions, it appears that we must adopt a certain *Meta-global* outlook at the moral level. Here, Q* runs into its final, and, as far as I can see, insurmountable, problem. It cannot offer us an outlook which avoids Unacceptable Conclusions. For such conclusions rest on Q*'s Meta-global outlook—that we should maximize QALYs. To avoid those conclusions, the Meta-global outlook has to differ structurally from a mere extension of the Totting-up Conception into the moral sphere. Moral positions based on fairness, perhaps, can offer a more plausible Meta-global outlook than that of Q*.² At the moral level, seeing things Meta-globally, a society in which mentally defective people receive substantial support appears fairer than one in which they are ignored for the sake of eliminating small risks of death for non-defective people.

If the above argument is correct, the maximizing assumptions on which Q* is based make that theory morally unacceptable as it stands. Account should be taken of considerations of fairness.³

² I use the term 'fairness' for lack of a better alternative. Admittedly, like much of what I say in this paragraph, the notion of fairness is vague. I am leaving a great deal of unfinished business. My aim, however, is to show that there is work to be done.

³ Considerations of justice and fairness in relation to the QALY are discussed in J. Harris (1987) 'QALYfying the value of life', *Journal of Medical Ethics* 13; and M. Lockwood (1988) 'Quality of life and resource allocation', in J. M. Bell and S. Mendus (eds.) *Philosophy and Medical Welfare*. Cambridge: Cambridge University Press.

Reading 18.7**EXERCISE 13**

Extract from: Hare, R.M. (1993). The philosophical basis of psychiatric ethics. Pages 15–30 in *Essays on Bioethics*. Oxford: Clarendon Press. (Extract pages 28–29.)

Lastly, we may consider a related problem: How are we to decide which conditions are mental diseases and which are merely deviations from the currently accepted social or political norms (3.6 f., 4.5)? This is the problem raised by the political abuse of psychiatry in the Soviet Union. For example, is homosexuality a disease; and if it is, is 'revisionism'? Where do we draw the line? The term 'disease' is above all a ticket giving entry to what has been called 'the sick role'. It is an evaluative term, implying that the person with the disease ought, other things being equal, to be treated in order to remove it. If we classify homosexuality, or 'revisionism', as a disease, what we are doing is subscribing to such an evaluation. So it is no use hoping by mere conceptual analysis to settle the question of whether homosexuality is a disease. We shall call it one if we approve of the treatment of homosexuals to remove their homosexuality (if this is possible); and the same with 'revisionism'. The crucial decision, then, is whether to approve of this. And it should depend on whether the approval, and therefore practice, of treatment to remove homosexuality will on the whole be for the best for the homosexuals and others. Confining ourselves for

the moment to voluntary treatment, it would seem that sound critical thinking might arrive at the following principle: if the patient wants not to be a homosexual and asks for treatment because he wants to have sexual relations with the opposite sex, he should be given what he wants; on the other hand, if he wants not to be a homosexual only because of the social stigmas and legal penalties attached to homosexuality, it might be better, if we could, to remove the stigmas and penalties. The reason why critical thinking would arrive at this conclusion is that in the first case the interests of the patient and others are advanced by 'cure', whereas in the second they would be better advanced by the removal of the need for it. If the situation is thus clarified, it becomes less important whether we call the condition a disease or something else.

But if *compulsory* treatment for homosexuality or 'revisionism' comes into question, the right to liberty again becomes of the first importance. Since having things done to one against one's will is something that nobody wants (this is a tautology), it is in itself an evil; it can only be justified by large countervailing gains (e.g. as above, the protection of the public from dangerous mental patients). It is hard to see what these gains could be in the two cases we are now considering. In both of them the general good would be much better advanced by removing the political institutions which make 'revisionism' something that the authorities feel impelled to suppress, or by removing the habits of thought which make people want to persecute homosexuals. It will be better all round for everybody if this comes about.

Reading 18.8**EXERCISE 14**

Two extracts from: Fulford, K.W.M., Smirnov, A.Y.U., and Snow, E. (1993). Concepts of disease and the abuse of psychiatry in the USSR. *British Journal of Psychiatry*, 162: 802–803. (Extract pp. 802–803.)

Extract 1: page 802**Findings**

We examined the Soviet literature from two main aspects: firstly, from an aspect of simple publication statistics—that is the number of publications and their locations—these being taken to be measures respectively of the level and distribution of interest in the subject; secondly, from an aspect of content—the actual ideas expressed. Our principal finding was that in both respects the Soviet literature was similar to the corresponding literature in the West.

The overall pattern of publications on the concepts of illness and disease in the USSR was found to have run broadly parallel with that in the West. The most influential author was the pathologist, Davydovskii, whose ideas on the concept of disease appeared first in 1962, corresponding approximately with a period of growing interest in these concepts in the West, as well as in the USSR.

Extract 2: pages 802–803

There were considerably fewer publications overall in the Soviet literature. However, this is a reflection of the smaller volume of publications in the USSR generally.

Davydovskii's views were published in his influential textbook *Problems of Causality in Medicine* (1962) and in the *Archives of Pathology* (Davydovskii & Silvestrov, 1966). This was during the Khrushchev era, a period of partial liberalization following the fall of Stalin. It was at this time that psychiatric repression of dissidents first became widespread (Koryagin, 1989). Vasilenko's papers, and the literature he provoked, although not directly concerned with abuse, coincided with growing concern among many Soviet psychiatrists, as well as in the West, about the political manipulation of psychiatry in the USSR.

The Samizdat literature was concerned largely with political protest. Psychiatry is widely criticized: there are many accounts of false diagnosis, and calls for reform, but little discussion of conceptual issues. This, of course, stands in contrast to the corresponding anti-psychiatric and anti-medical literature in the West, much of which, as we noted earlier, actually turned on the validity of concept of mental illness.

Davidovskii was an anatomist and his views on disease, which became the basis of the dominant Soviet school of thought, were strongly biological. Arguing against the view of certain Marxist-Leninist philosophers that disease is essentially a social

phenomenon, he noted that there are no external agents (not even infections) which cause disease in all cases (e.g. Davidovskii, 1962, p. 12). It is rather the internal condition of the organism which determines whether or not disease develops when it comes into contact with a pathogen (e.g. Davidovskii, 1962, p. 32). Disease is thus a reaction of the organism to a pathogen, the form of which is governed by such factors as inherited predisposition, age, sex, and previous exposure. Social factors are among the agents which may provoke certain diseases. Similarly, social adaptation may be impaired by disease. But disease is primarily a biological phenomenon, the criteria for which are predominantly anatomical and functional in nature.

The literature in the early 1970s takes up the issue of the criteria of disease in more detail, and this theme continues through to the 1980s. In Vasilenko's 1972 paper, for example, a specifically pathological 'reaction' of the organism is identified with disturbance of functioning. This is in turn defined partly by reference to the normal operation of particular functional systems (e.g. Sarkisov, 1973), partly by reference to the goals of the organism as a whole (e.g. Kagermazov, 1973). Again, social criteria of disturbance of functioning are discussed (e.g. Akhmedzhanov, 1973; Petlenko *et al*, 1984), but the overall emphasis is still on the essentially biological nature of disease. The disease reaction is, at root, a disturbance of bodily structure and functioning (Vasilenko, 1976; Vlasov, 1988; Petrov & Petrov, 1989).

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Reading 18.9**EXERCISE 21**

From: Sackett, D.L. Straus, S.E., Scott Richardson, W., Rosenberg, W., and Haynes, R.B. (2000). *Evidence-Based Medicine: how to practice and teach EBM*, (2nd edn). Edinburgh and London: Churchill Livingstone (Extract page 1.)

WHAT IS EBM?

Evidence-based medicine (EBM) is the integration of best research evidence with clinical expertise and patient values.

- By *best research evidence* we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic,

rehabilitative, and preventive regimens. New evidence from clinical research both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

- By *clinical expertise* we mean the ability to use our clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations.
- By *patient values* we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

When these three elements are integrated, clinicians and patients form a diagnostic and therapeutic alliance which optimizes clinical outcomes and quality of life.