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Editorial: Ethics Around the Globe

EJAIB has always received a number of papers over the past 24 years from Latin America, and this issue includes a further two on medical ethics from Brazil. Lins explores the influence of Albert Schweitzer in the healthcare system, and Oliveira dos Santos et al. present results of a study of anesthesiologists' practices in delivery of palliative care. The original purpose to develop broad international dialogue was the reason for the words "and International" abbreviated by the "I" in EJAIB. This cross-cultural reflection on bioethics has been one of the rich aspects of the discourse, to have a vision beyond "EJAB", and one which can be expected to grow as the editorial office has moved with me to AUSN, which will enable broader dialogue.

This issue of *EJAIB* is delayed due to this move to USA, as I have been organizing a number of conferences around the world in my new capacity at AUSN, mainly jointly with Eubios Ethics Institute. I hope to be able to do more writing and editing now that a busy 2013 is coming to an end, and please explore the AUSN website for News from the Provost that provides updates on my activities.

The first paper in this issue is by one of my mentors from my time at Tsukuba, Professor Humitake Seki, who explores ethics in martial art with intercultural comparisons. The linkages between cultures and ideologies run deep, and the common cosmologies that people have is also explored in the paper from Kyrgyzstan by Tamara and Diethelm. May and Sass propose a check-list approach to help make ethical decisions in personalized medicine. The issues of justice in systems of healthcare in Japan, gender equality in Bangladesh, also link to the paper from Brazil.

EJAIB welcomes papers from a variety of perspectives to encourage dialogue. I hope readers will support that dialogue, send in commentaries or articles, and continue to support us.

– Darryl Macer

The strategy at an initial stage of this martiality is based on the same philosophy and morality as the "rule of virtue" of Taoism (Lao Tzu [6 c. BC]: Tao Te Ching, LXI); that is,

"A great nation flows down to be the world's pool, as the female to be under heaven.

In stillness, the female constantly overcomes the male, as in stillness she takes the low place.

Therefore, in stillness, a great nation lowers itself and wins over a small one."

In striking contrast to the divine martiality, the combat arts of all other non-spiritual traditions without reliable backgrounds of historical and religious evidence are in linear motion; both the kinetic and ethical constructions of this motion are based solely in joy of "the felling an enemy and destroying evil" during limited time of fighting to spare for the "refuting error to reveal righteousness", the ethical embodiment of divine martiality of "the struggle for existence" is technically impossible for any great master of martial art.

As the divine martiality is of the Will of Heaven, its manifestation exists neither in attack nor in defense but must operate of itself based on the paradigm that reveals the great moral law of "Acceptance and Resorption" by exorcising the attitudes of "Ten Evils ": 1) endurance, 2) overconfidence, 3) greed, 4) anger, 5) fear, 6) doubt, 7) distrust, 8) hesitation, 9) contempt, and 10) conceit. Therewith the divine martiality, a warrior is able to approach combat from a great position of "absolute impartiality of the physical and moral rectitude" with the delight naught in unavailing joy of "felling an enemy and destroying evil".

Such the great moral law of "Acceptance and Resorption" cherished by the "warrior of virtue" represents an approach not only to "Life" but also to "Social Interaction of All Forms".

The universe has continuously evolved from the time of its creation until the present day. Since human appearance, the "divine intent" of the Lord God described in "The First Sin and Its Punishment" in Genesis must be the ethical guide for this evolution: Whereby "divine dynamics" that propel this evolution places humankind for keeping desirable the Biosphere, and Cherubim with the revolving sword could be a symbolized "ethical strategy of social interaction of all forms " above an evolutional principle of "survival of the fittest upon the struggle for existence".

References

1) Campbell, G. (2010): Oxford King James Bible: 400th anniversary edition. Oxford University Press. 1520 pp
2) Chamberlain, B. H. (Translation)(1982): The Kojiki, Records of Ancient Matters. Tuttle Publishing. 489 pp
3) Seki, H. (2009): Martial Art of the Kashima Spiritual Transmission. Kyorin-shoin Co. 123 pp.

The Check-list Approach in Personalized Medicine

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Abstract

Modern medicine, based on enormous progress in science and its applications, has lost dimensions of individualized treatment and compassion which traditionally were an essential part of physician's service over the millennia in Eastern and Western cultures. Today diseases and symptoms, rather than persons, are treated, based on objective quality norms and inflexible payment schemes rather than the rather than persons. We present a checklist model for personalized health care, which has been successful in teaching and practice to reclaim lost territory in treating patients as persons.

The Quest for Personalized Treatment and Care

Quality medical care traditionally included more than treating a particular disease; professional medical care treats the patient as a fellow person. In clinical practice one size does not fit all; clinical quality standards and reimbursement schemes are general, but patients are different. The 'best for the patient as the prime rule'– aegroti salus suprema lex – needs to take both, the medical status and well as the value status of the patient, into account by integrating differential ethics into differential diagnosis, prognosis, and treatment. Not only citizens in modern pluralistic societies have different preferences and understandings of the quality of life and its goals of life; Galen, personal physician of Roman Emperor Augustus 2000 years ago, reminded his fellow professionals 'non homo universalis curatur, set unus quique nostrum': it is not the universal person we are to treat, it is an individual, unique, our patient! Providing this type of quality and patient-oriented care is particularly difficult in times when financial schemes are inflexible and objective, and do not leave much room for individualized care.

Confucian physician Yang Chuan, 1700 years ago requested that the prospective patient must be smart to choose her or his physician carefully based on virtues which include more than technical expertise: 'Trust only those physicians who have the heart of humanness and compassion, who are clever and wise, sincere and honest' [Sass 2007]. Paul Ramsey, theologian and ethicist in the early days of medical ethics facing great successes of scientific medicine, published his influential book 'The Patient as Person' (Boston 1973). 40 years later the European Association of Centers for Medical Ethics (EACME) held a conference *"Personalized Medicine"* in Bochum, Germany (September 2013).

Modern health care settings carry additional

challenges: the institutionalization of medicine and the increased diversification of worldviews and personal values and wishes among providers and recipients. In the new century of globalization, we find Buddhists in Berlin, Muslims in Paris and Bochum, Christians in China, and non-believers in Beijing, Basel, Rome or New York. Physicians are not experts in worldviews. Among religiously affiliated people some are fundamentalists, some very liberal, some just loosely affiliated. Also, quite a number of patients are not used or ever had an opportunity to make independent decisions in their everyday lives. We have both, globalization of previously geographically based cultures and attitudes, and individualization in personal cultures towards traditional and modern worldviews. – Today, medicine and health care is widely provided in institutional settings, in cooperation with physicians, nurses, technicians, and administrators. Thus, treatment and care are provided by quite a number of stakeholders. Hospitals, Nursing Homes, Health Care Insurers, and Research Institutions are corporate persons with a distinct corporate profile and in need of a corporate ethics profile as good neighbors.

The Checklist Approach

In 1987, the founders of the Bochum Center for Medical Ethics (ZME) Hans-Martin Sass, an ethicist, and Herbert Viefhues, a physician, developed an open checklist for good medical and moral personalized treatment, based on an instrument which was very well known to physicians in exploratory diagnosis: a checklist, short and based on previous experience and an obligation for best possible treatment. Checklists are used elsewhere in technical procedures such as car maintenance, quality control of products and services of different kind, in assessing customer satisfaction, and in many other fields of personal and professional life. In medicine, medical checklists are routinely used by family practitioners and clinicians to collect basic medical and laboratory data of patients and to note details of prognosis, treatment and prescriptions, therapeutic or chronic improvement; they are used by hospitals at time of admission and later to document clinical patient data, also in research to document patient/subject's reaction. Health care experts and teams are well experienced and comfortable with using all kinds of checklists, so the introduction of a checklist for personalized care was the logical choice. In applied ethics, such as in clinical ethics and hospital care, one cannot distinguish clearly between theory and practice; both are intertwined and 'one cannot competently engage in education or policy development without a competency for case review' [Blake]. Checklists also are not only useful for documentation and review; they also guarantee that a wide range of issues is recognized rather than only the few with most intriguing details of a particular case. Checklists need to be short, allow for precise documentation, and eventually be complemented by special additional checklists such as checklists documenting laboratory blood tests or sonograms.

The Bochum checklist integrates information about the 'medical status' and the 'value status' of the patient and subsequent decision making into one instrument. A good medical-ethical checklist needs to be open to different visions of the world and of individual wishes held by patients; and physicians and other health care experts also need to evaluate their medical and moral options as well. Ethics without expertise is ineffective; expertise without ethics is blind. Traditionally, checklists for patient's values and wishes were not necessary traditionally as the family doctor (a) knew his/her patients and their families very well, (b) limited medical knowledge did not allow for a wide range of different treatments, and (c) physicians could assume that patients were representatives of a consistent moral and cultural environment having quite similar moral, religious, and cultural views and expectations from medicine and their doctors.

Checklists have to be clear-cut, short and precise. The Bochum checklist in its basic form presents three sets of questions: (1) medical status; (2) value status; (3) treatment decisions. Physicians are well trained and experienced with diagnosing the medical status of a patient, often in complex forms of differential diagnosis; this checklist asks them to use the same precision and well-defined terms in diagnosing the wish-and-value status. In order to find a well-argued answer, we ask to present a written summary at the end of both sets of questions. Ethics terminology often is not as precise and scientific language, therefore we found it important to start with scientific issues and move thereafter to more complex value-and-wish issues. Similarly, treatment decisions and their routine reviews also have to be written down. - Additional checklists were developed and widely tested empirically using dozens of cases from Bochum hospitals; the first 3 additional checklists offered help for special situations in (1) long term treatment (2) considerable social impact, and (3) medical research. A special sub-list was developed for phase 1 cytostatica research. Thereafter other checklists were asked for (4) in psychiatric intervention, (5) in neonatology and pediatrics, (6) in the care for dying, and (7) in considerable moral, cultural and religious differences among stakeholders and (8) in team training and in the development of a corporate profile.

Learning and Training – Integrating Expertise with Ethics

The Bochum checklist was and is widely used in teaching preclinical and clinical medical students, in training multidisciplinary teams in hospital wards and in hospitals, also ethics consultation groups and corporate leadership for devising and reviewing the corporate profile and special traditional or new activities. In particular, in case discussions within care-and-treatment teams representing different professions, we found it important to develop a common language in using these checklists. In other situations we have asked medical and nursing students as well as care teams to develop their own short checklist of a particular case; this was a particular effective approach in learning and interactive training. Some department teams have used the checklist approach to write down standard answers for routine questions and issues in a particular ward or

department. In the educational setting we have encouraged the students to bring cases for evaluation and to also check the validity and practicality of checklists used. In institutional training sessions we have avoided to use cases from within the house in order to avoid potential embarrassment of persons, who had been involved, having been careless or made mistakes. There is nothing sacred about the checklists we have used and encouraging students, clinical experts and Clinical teams to develop their own specific checklists is an interactive contribution to livable and productive casuistry.

Of course, this checklist approach is a model of so called soft-paternalism and not an expression of the Georgetown model of the four principles – autonomy of the patient, non-maleficence, beneficence, justice (Beauchamp and Childress). It shares with the Georgetown model the *'primum nil nocere'* – first do no harm – principle, i.e. the requirement of balancing potential harm with potential benefit. But it puts a high emphasis on compassion as an instrument for personalized care and on professional expertise. When Sass introduced the Bochum checklist at the Kennedy Institute of Ethics, the question 'To what degree should the physician permit the patient to determine the treatment plan?' was particularly criticized. In the meantime, medical ethicists and responsible health care experts, also in the USA and not only in Europe and Asia, have a more differentiated and positive understanding of 'soft paternalism' as one of the professional virtues in treating the frail and the sick.

The original checklist for personalized healthcare was developed more than 25 years ago in Europe and has found a place in medical-ethical teaching and in clinical medicine review and consultation around the world. The basic principles of competent and compassionate care are similar in all cultures independent of their religious or philosophical or customary tradition. Translations exist in many languages and are used in clinical training and medical education, in English (Stuart Spicker), Brazilian (Juan Carlos Batistiole), Chinese (Qiu Renzong), Croatian (Ana Borovecki), Dutch (Henk ten Have), Italian (Antonio Autiero), Japanese (Akio Sakai), Spanish (Jose-Alberto Mainetti), Swedish (Erwin Bischoffsberger SJ), and Turkish (Ilhan Ilkilic). Basic principles of competent and compassionate care are similar in all cultures independent of their religious or philosophical or customary tradition and they can be dealt with in one single non-ideological and open questionnaire. However, different cultures have their own values and principles which are more easily referred to than to imported principles. Tai has referred to 5 classical virtues in Asian culture: 'Compassion' as a basic human virtue in all situations, 'Righteousness' in doing things right and doing the right things, 'Respect' for fellow humans in all social interactions, 'Responsibility' in personal and professional actions, and 'Ahimsa' as respect and reverence for life and non-violence. He recommends using the three classical Confucian parameters for applying values and virtues to concrete situations: Cheng, Li, and Fa. 'Cheng' requires situational action and ethics. 'Li' requires reasonableness and propriety, also the respect for stable norms and expectation in society. 'Fa', lawfulness in all situations, is a principle of last resort, against which actions. He successfully has used this basic checklist for mixed committees of health care professionals in Asian cultures: '1. Identify the issue. - 2. Speak with nurse and family if request comes from physician or vice versa. - 3. See the patient and allow the patient to speak without interruption. - 4. Ask open-ended question. - 5. Talk with the physician. - 6. Prepare an ethical analysis. -7. Provide recommendations.' [Tai, p. 122-128].

Discussion

Open checklists for personalized and patient-centered medical treatment and care [May, in press] have been successfully used for over 25 years as a tool in educating students in medicine and nursing, in guiding interdisciplinary teams in hospitals and nursing homes, and in supporting health care institutions and health insurances in shaping and reviewing their corporate profile and in training staff and executives in improving competence and compassion. It is recommended, that students and groups and individuals in treatment and care are encouraged to develop their own questionnaires in interactive learning, training, and reviewing, and in professional treatment and care.

Bochum Checklist For Patient-Oriented Clinical Care

Integrating medical status and value status in patient-oriented treatment and care

I. Differential diagnosis of the medical status

The evaluation of the medical-scientific diagnosis follows these traditional patterns.

General considerations: What is the patient's diagnosis and prognosis? - What type of treatment is recommended regarding the diagnosis and prognosis? What alternative treatments could be offered? What are the anticipated outcomes of these various treatment options? - If the recommended treatment is neither offered to nor accepted by the patient, what is the prognosis?

Special considerations: Will the preferred medical treatment be helpful to the patient? - Will the treatment selected lead to a positive prognosis in the particular case? If so, to what degree? Could the selected treatment harm or injure the patient? To what degree? - How can benefits, harms, and risks be evaluated?

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

Summary: What is the optimal treatment after considering all the available scientific-medical knowledge?

II. Differential ethics of the value-and-wish status

The diagnosis of the value status of the patient follows three principles:

Health and well-being of the patient: What harm or injury may arise as a result of selecting a specific [single] method of treatment? - How might the treatment compromise the patient's well-being, cause extensive pain, or even shorten his/her life? - Might it cause physical or mental deterioration? - Might it tend to produce fear or grave anxiety in the patient?

Self-determination and the patient's autonomy: What is known about the patient's values, wishes, fears and expectations? - What is the patient's understanding of intensive or palliative treatment as well as resuscitation criteria? - Is the patient well-informed about diagnosis, prognosis, and the various treatment options available for him/her? - How is it possible to serve the patient's preferences in formulating the treatment plan? - To what degree should the physician permit this patient to determine the treatment plan? - Who else, if anyone could or should make decisions on behalf of a patient and his/her best interests? Must the patient agree with the chosen therapy?

Medical responsibility: Have any conflicts surfaced between the physician, the patient, the staff, or the patient's family? - Is it possible to eliminate or resolve such conflicts by selecting a particular treatment option or plan? - How can one work to assure that the following values will be reaffirmed? - (1) the establishment of mutual trust between patient and physician; (2) the principle of truth-telling in all discussions; - (3) the respect for the patient's privacy and the protection of his/her confidentiality? - What relevant facts are unknown or unavailable?

Have the salient ethical issues been adequately formulated, clarified, and addressed within the physician-patient relationship?

Summary: What kind of treatment is optimal giving thorough attention to the salient and relevant clinical ethical issues?

III. Treatment of the Case

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

Does the treatment decision require achieving an ethical consensus? - By whom and with whom?

Why? - Was/Is the treatment decision adequately discussed with the patient? - Did he/she agree?

Should the decision process be reassessed and the decision actually revised?

Summary: What decision was made after assessing the scientific and ethical aspects of the case? How can the physician most accurately represent the medical-ethical issues and the process of evaluating the medical and ethical benefits, risks, and harms?

Selected Supplementary Checklists for Special Situations

1. Long-term Treatment

Will the chosen medical treatment and its ethical acceptability periodically be reconsidered? Is the treatment in line with quality standards in medical treatment and care and medical ethics? - What clinical or ethical factors must be reviewed during on-going treatment? - How do patients react to modifications in treatment strategy? - In case where the prognosis is dim, how should the physician decide whether the patient should receive intensive or palliative treatment? - Is it possible to appropriately satisfy the patient's explicit wishes, demands, as well as his/her tacit intentions, and to be reassured that they have been seriously considered?

2. Considerable Social Impact

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

3. Therapeutic and Non-therapeutic Research

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

3.1. Cytostatica phase-1 research as an example for an additional checklist:

1. Is the scientific definition of efficacy as expressed in terms of remission or no-change in conflict with the patient's definitions of quality of life?
2. Is the patient aware of a possibly scanty prognosis for full recovery? What does the patient expect from the trial? What does the researcher expect?
3. Can and will quality of life issues be dealt with separately from medical research issues?
4. Has the patient been offered the best available

palliative care? Has he/she been made aware that best palliative and quality-of-life support will continue even if she/he withdraws from the trial?

4. Psychiatric Intervention

1. Is intervention indicated, given this disease and its risks? Who decides?
2. Are concepts of quality of life of this patient known? Why are they not used in deciding about treatment?
3. Has the personal profile of this patient been modified by medication or intervention? Can it be reconstructed or supported? - 4. What are the risks, disadvantages and advantages of institutionalization? How can institutionalization be avoided? - 5. Is paternalistic treatment mandated at all? Why? How long? Who makes those decisions? - 6. Use or develop a specific ethics checklist for this disease! - 7. How can it be secured that decisions on intervention will be periodically and ad hoc reviewed?

5. Neonatology and Pediatric Care

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

6. Care for the Dying

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

7. Considerable Moral, Cultural or Religious Differences

1. Is the intended treatment and care acceptable to the values of the patient?
2. Is the treatment or care asked for by the patient (or her/his family or guardian) acceptable to health care providers, teams and to the institution?
3. What are the differences and who could be brought in to reduce or solve controversies?
4. Is it acceptable to experts, teams and institutions to recommend other experts or institutions to the patient? – Summarize major points of your decision; review those after treatment of the case.

8. Corporate Profile: Clinical Training and Public Profile

1. What are the most essential virtues/principles for your institution and its specific wards?
2. Which role play the following virtues/principles: communication, cooperation, competence, compassion, cultivation.
3 Are they of different importance in special fields of your service?
4. Is there a difference between personal or collective virtues as character traits and as legal, moral or cultural principles?
5. How would such a list of virtues/principles be different in special wards of your institution?
6. Which of these principles/virtues need more training?
7. Which principles/virtues should be addressed in public relations to demonstrate that your ward/institution is a good and reliable corporate neighbor?

References

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A 'Virtual Training Course in Clinical Ethics' by Hans-Martin Sass, using the checklist method, is also available in www.ethik-in-der-medizin.de in English language.