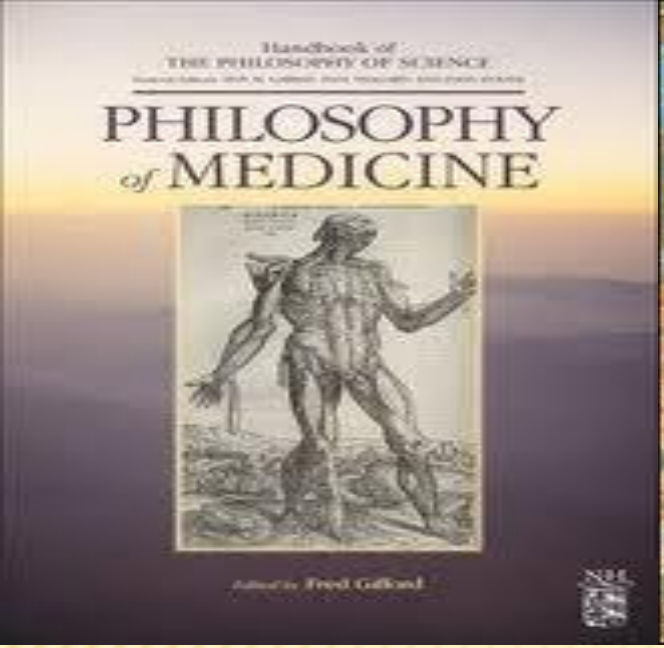
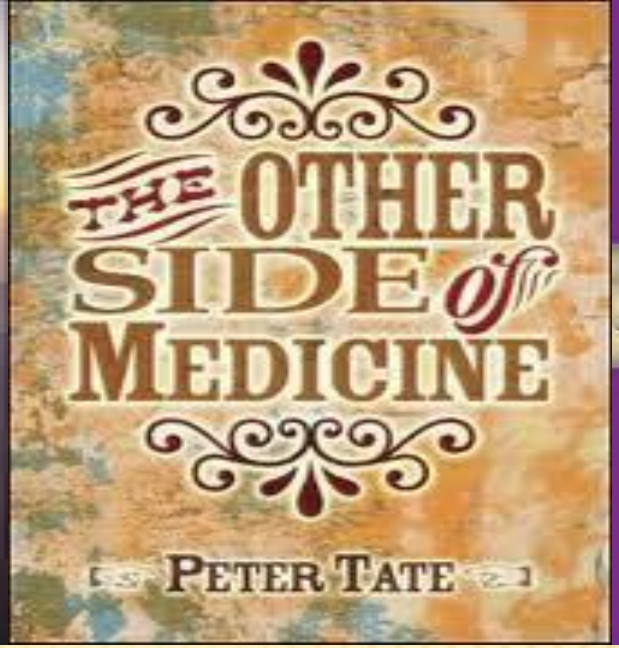
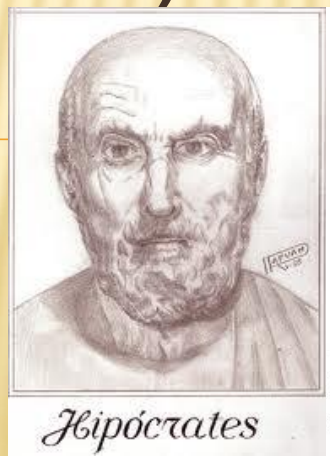


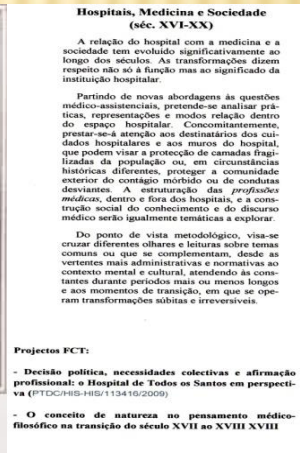


"A prática atual da Medicina: Uma dicotomia de contradições que é necessário (saber!) descodificar"

JOSÉ POÇAS

MÉDICO HOSPITALAR




Hospitais, Medicina e Sociedade
(séc. XVI-XX)

A relação do hospital com a medicina e a sociedade tem evoluido significativamente ao longo dos séculos. As transformações dizem respeito não só à função mas ao significado da instituição hospitalar.

Partindo de novas abordagens às questões médico-assistenciais, pretende-se analisar práticas, representações e modos relação dentro do espaço hospitalar. Concomitantemente, prestar-se-á atenção aos destinatários dos cuidados hospitalares e aos muros do hospital, que podem visar a protecção de camadas fragilizadas da população ou, em circunstâncias históricas diferentes, proteger a comunidade exterior do contágio mórbido ou de condutas desviantes. A estruturação das *prefixões médicas*, dentro e fora dos hospitais, e a construção social do conhecimento e do discurso médico serão igualmente temáticas a explorar.

Do ponto de vista metodológico, visa-se cruzar diferentes olhares e leituras sobre temas comuns ou que se complementam, desde as vertentes mais administrativas e normativas ao contexto mental e cultural, atendendo às constantes durante períodos mais ou menos longos e aos momentos de transição, em que se operam transformações súbitas e irreversíveis.

Projectos FCT:

- **Decisão política, necessidades colectivas e afirmação profissional: o Hospital de Todos os Santos em perspectiva** (PTDC/HIS-HIS/113416/2009)

- **O conceito de natureza no pensamento médico-filosófico na transição do século XVII ao XVIII XVIII**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UNIVERSIDADE NOVA DE LISBOA

Seminário Internacional
"Hospital, Medicina e Sociedade"

Lisboa, 6 e 7 de Julho de 2012
2011

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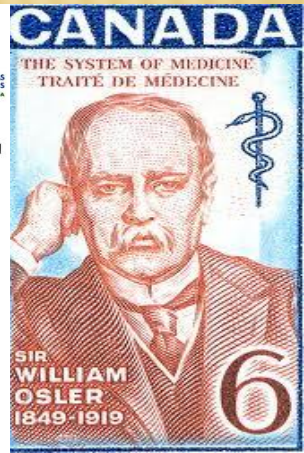

Summary

- I)- INTRODUÇÃO
- II)- QUESTÕES INTEMPORAIS de ÉTICA CIVILIZACIONAL
- *III)- A MISSÃO dos MÉDICOS, a NECESSIDADE dos DOENTES, e o INTERESSE da SOCIEDADE*
- IV)- SERÁ o RECURSO à TECNOLOGIA A (ÚNICA) RESPOSTA POSSÍVEL?
- V)- SERÃO os PROBLEMAS da SAÚDE (SOBRETUDO) ECONÓMICO-FINANCEIROS?
- VI)- E o que FAZER ENTÃO?
- VII)- CONCLUSÃO

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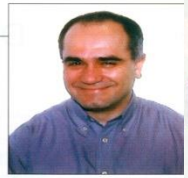
A Saúde em Portugal, ou a eterna dicotomia entre o Ser e o Parecer



José Poças
Director de Serviço de um Hospital SA

OPINIÃO

MEDICAMENTOS

LIGAÇÕES PERIGOSAS ?

Responda quem souber

Os médicos não podem continuar a ser os "bodes expiatórios" do mau funcionamento do sistema

José M. D. Poças*

OPINIÃO

A equação dos impossíveis e a eterna atracção pelo abismo

"... aqueles que tornam impossível a revolução pacífica, tornam inevitável a revolução violenta..." (sic.) John F. Kennedy (1917 – 1963)

OPINIÃO

"Segunda parte de uma trilogia: Reformar, sim. Rentabilizar, também. Mas com diálogo e a participação empenhada e esclarecida dos profissionais"

OPINIÃO

"A Saga do Rei Nu"

OPINIÃO

Carta Aberta aos Colegas Directores de Serviço dos Hospitais Públicos Nacionais

OPINIÃO

"Terceira parte de uma trilogia: reflexões acerca de três aspectos fundamentais da saúde no nosso país"

OPINIÃO
Mensagem

«Mensagem de despedida ou Carta aberta às consciências conscientes»

cultura medicina

"Dos fracos não rezará a história, ou Ode em memória do insigne Ricardo Jorge"

OPINIÃO

«DORAVANTE»

«... a mudança é uma questão de vontade ... a cooperação gera mais valor do que a competição, ao contrário do que se tem suposto nos últimos 20 anos ...» (sic.) *Guilherme de Oliveira Martins (in «JL», Fevereiro/2010)*

OPINIÃO

"Primeira parte de uma trilogia: De 4 para 5%, ou a triste história em como com INSENSATEZ e INABILIDADE se consegue transformar uma pequena numa ENORME DIFERENÇA"

OPINIÃO

José M. D. Poças
Presidente do Distrito Médico de Setúbal da OM

Quem nunca ouviu falar nesta pequena e velha história, mas porventura alguns dos mais distraídos não terão a verdadeira consciência que a sua principal ilação se aplica ...à vida dos cidadãos portugueses, e designadamente à dos próprios médicos

Algumas considerações acerca de uma (mera) questão de Confiança, a propósito de duas Efemérides (exemplares) e de duas Histórias (verídicas)

OPINIÃO

"Morreu o Poeta, não morreu a poesia"

José Poças, Mário Parreira

O futuro da Medicina em Portugal: considerações a propósito da parábola do burro e da cenoura

Velhos Problemas e Novos Contextos: Uma Realidade Inversa?

("... hoje assistimos a um regresso ao séc. XVIII: ao despojar o Estado das suas responsabilidades e prerrogativas, minámos a sua reputação..." sic. Tony Judt, in Jornal The Guardian; "... uma das características do Liberalismo Social foi a renúncia a políticas redistributivas e a políticas fiscais progressistas..." sic. Vivevç Navarro in Revista Sistema)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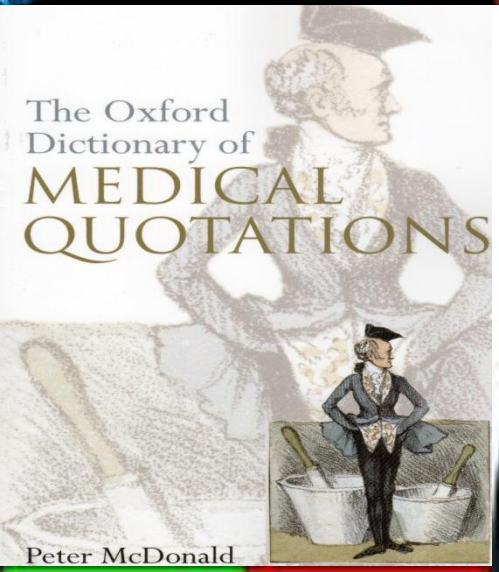
The Oxford Dictionary of
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Peter McDonald


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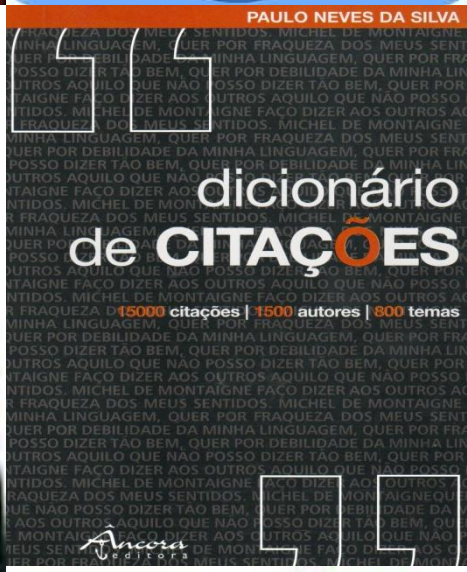
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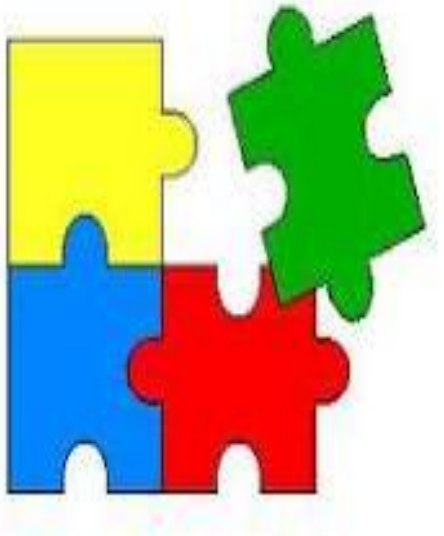
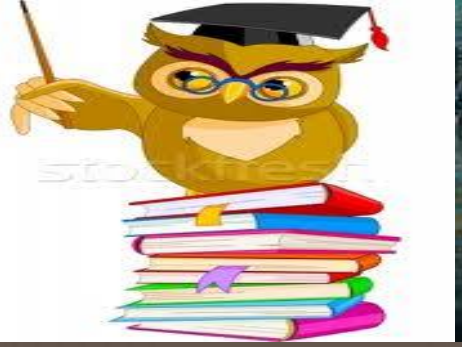
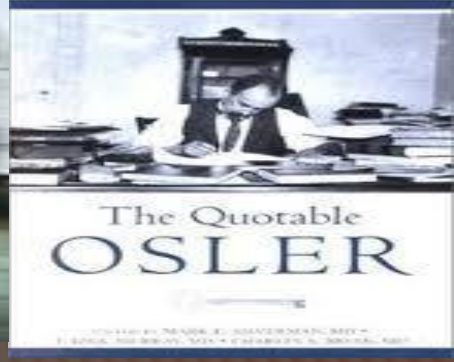
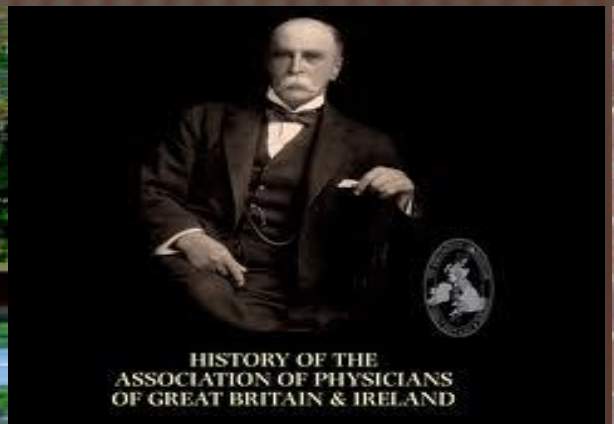






I)- INTRODUÇÃO

"... O VERDADEIRO VALOR DA EXPERIÊNCIA NÃO ESTÁ EM VER MAIS, MAS ANTES EM VER COM A DEVIDA CLARIVIDÊNCIA ..." (SIC.) *(SIR WILLIAM OSLER, 1849—1919)*

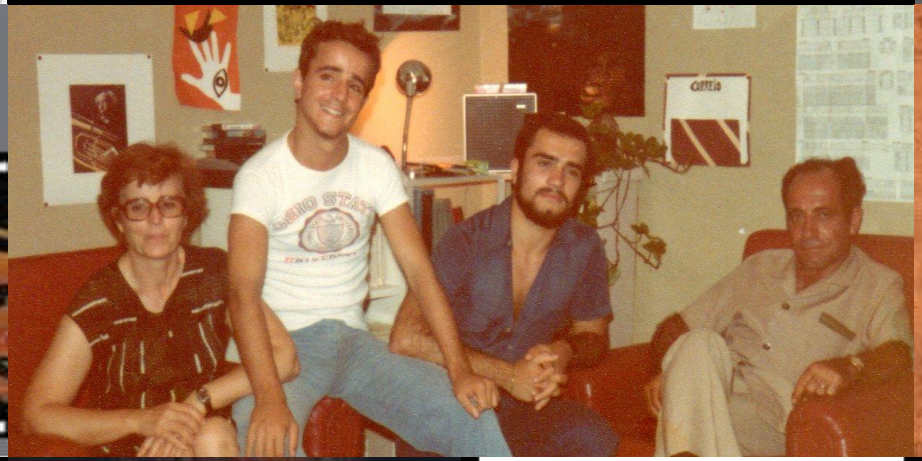


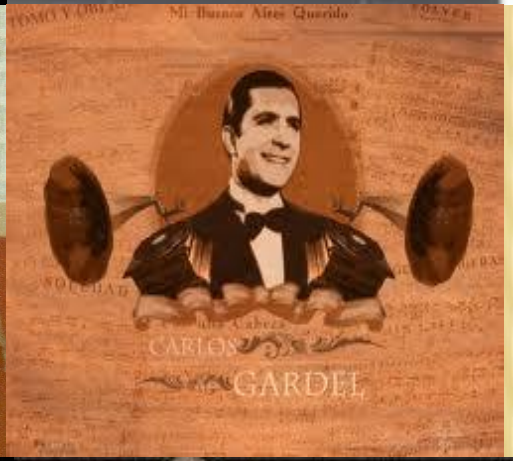

29
USA
BILL HALEY
ROCK & ROLL SINGER, 1925 - 1981


Rock & Roll
Tango


60
+30
FÜR DIE JUGEND
DEUTSCHE
BUNDESPOST


Los Exitos de sus Películas
CARLOS
GARDEL




Mi Buenos Aires Querido
CARLOS
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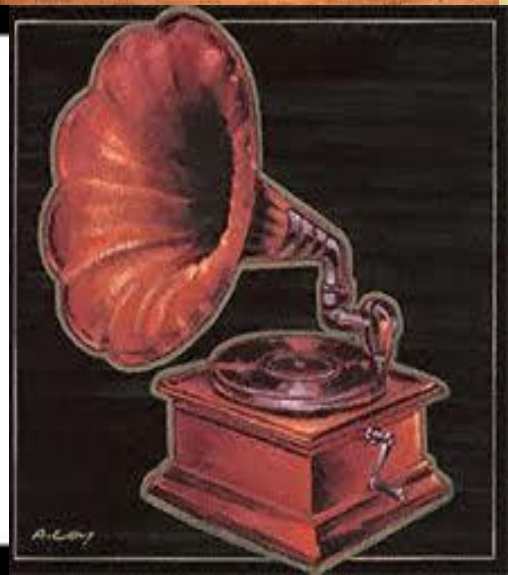
MUSIC
TITAN
JUKEBOX

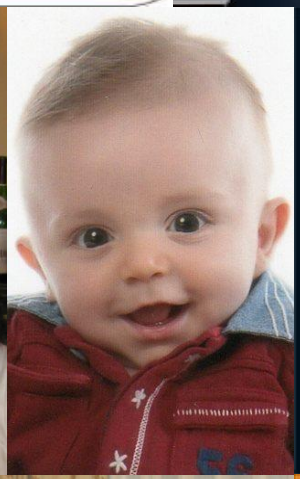



The FUTURE of...


FUTURE

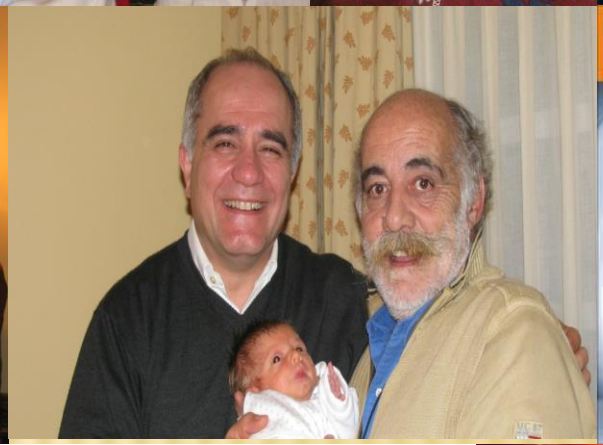

Future of Learning

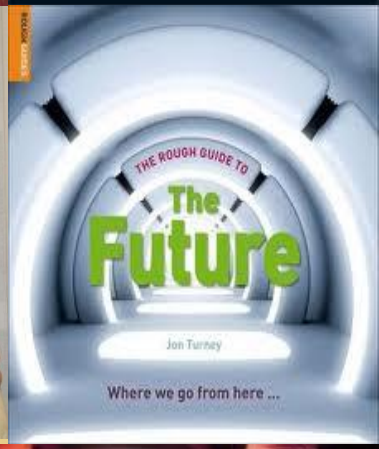

THE LOST
FUTURE




THE
FUTURE IS
COMING
Transform Now
LIMKOKWING


DISPATCH
FROM THE
FUTURE
POEMS BY LEIGH STEIN



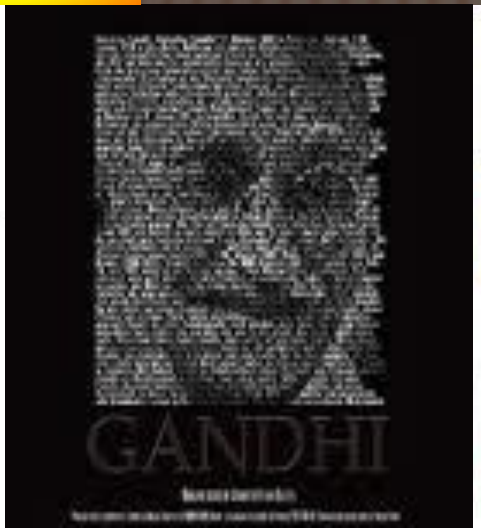

THE ROUGH GUIDE TO
The
Future
Jon Turney
Where we go from here ...

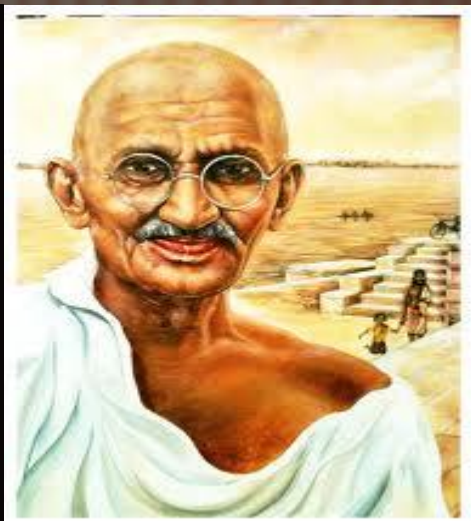

LOST
PAST PRESENT & FUTURE


The Future

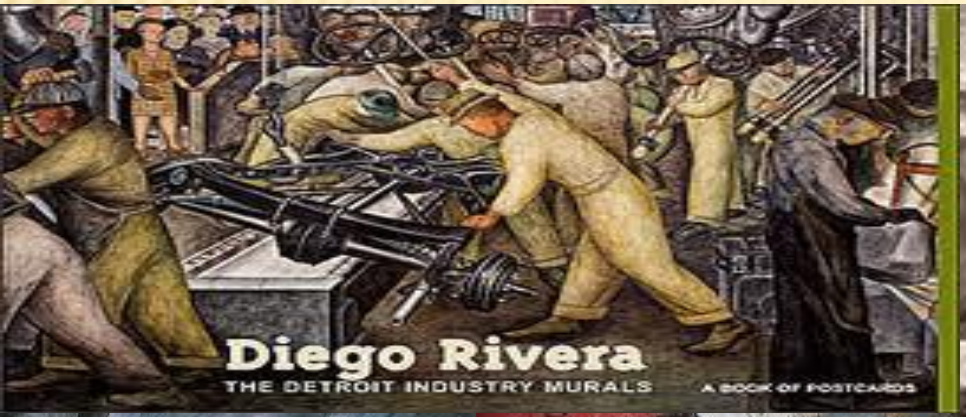

Future jobs that don't exist today

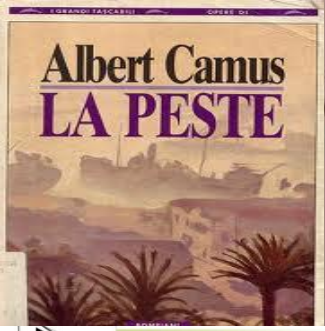
" ... NO MUNDO HÁ RIQUEZA SUFICIENTE PARA SATISFAZER AS NECESSIDADES DE TODOS, MAS NÃO PARA ALIMENTAR A GANÂNCIA DE CADA UM ..." (*SIC.*) (MAHATMA GANDHI, 1869-1948)

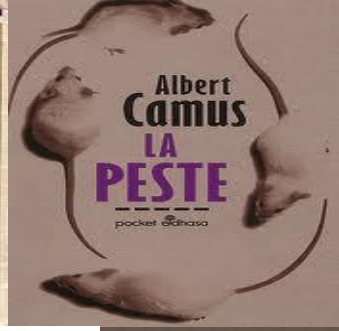


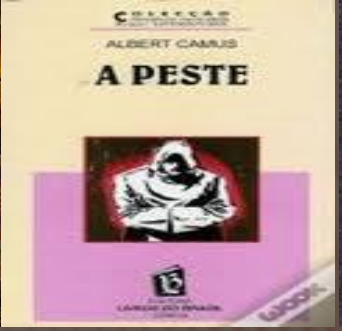


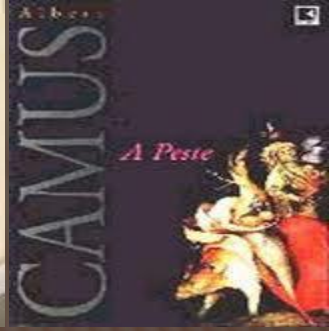
- *" ... o melhor do nosso progresso não se mede pelo incremento da abundância daqueles que já de si têm muito, mas sim pela capacidade de disponibilizar o suficiente para os que têm demasiado pouco ..."* *(sic.) (Franklin Roosevelt, 1882-1945)*

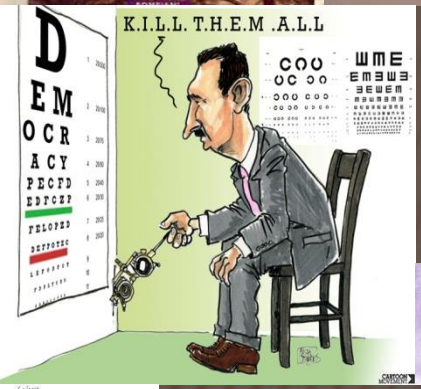




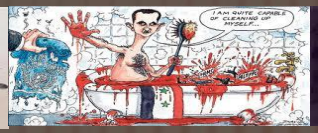


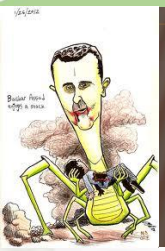




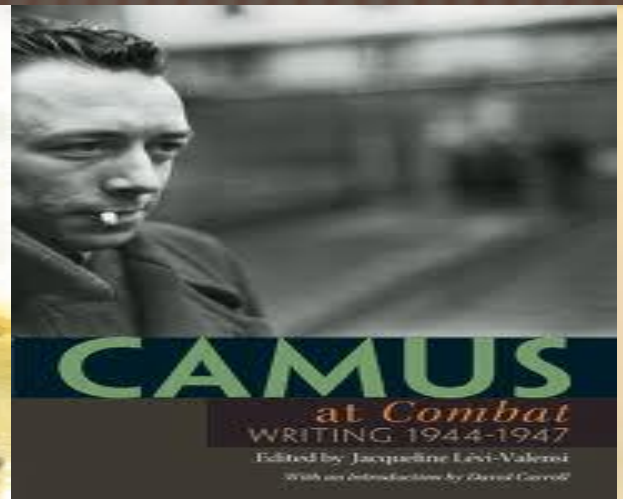


II)- QUESTÕES INTEMPORAIS de ÉTICA CIVILIZACIONAL





" ... UM HOMEM SEM ÉTICA É UMA BESTA SELVAGEM PERDIDA SOBRE A TERRA ..." *(SIC.) (ALBERT CAMUS, 1913-1960)*




DIALOGO
NEL CVAL SE
DIALOGO
ENEL CVAL SE



LIBRI VARY MAIORIS FORMÆ


Curationum Medicinalium
AMATI LVSITANI
MEDICI PHYSICI
CENTVRIAE QVATVOR.
Quibus præmittitur
Commentatio de introitu medici ad ægrotantem,
De Crisi, & diebus Decretorijs:
VENETIIS,
M D L V I I


AMATI LVSITANI
Medici ac Philosophi Celeberrimi
IN
DIOSCORIDIS ANAZARBEI
de medica materia libros quinque
ENARRATIONES ERVDITISSIMAE.
Quibus etiam tum Simplicium medicamentorum nomenclaturæ Græcæ, Latinæ, Italicæ, Hispanicæ, Germanicæ, & Gallicæ proponuntur: tum errores aliorum omnium, qui ad hanc usque diem de hac materia scripserunt, improbantur.
Cum priuilegio Illustrissimi Senatus Veneti.

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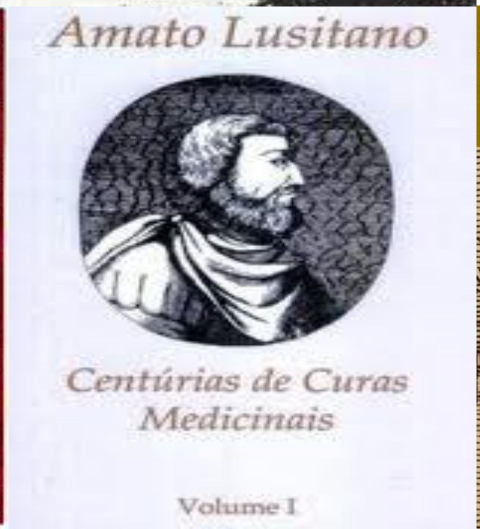
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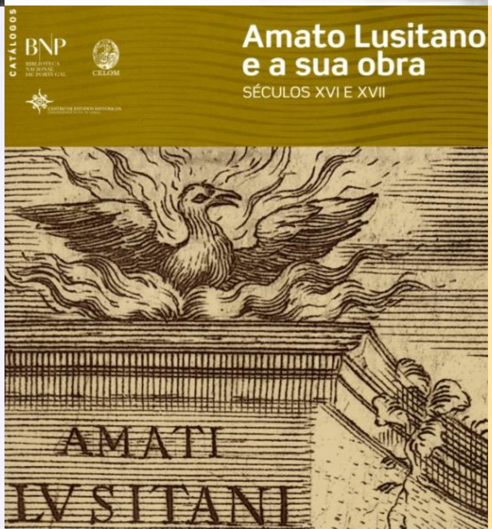
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e a sua obra
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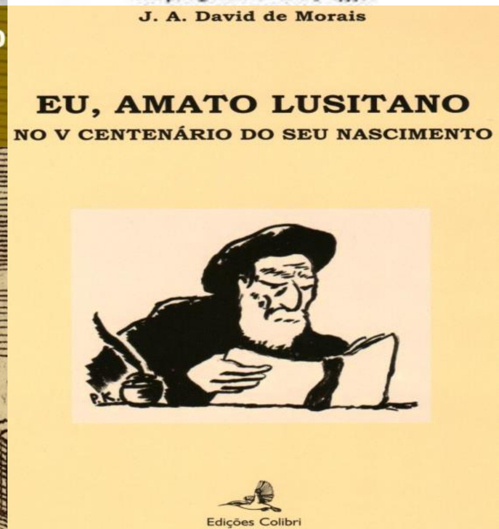
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A Perspective for the New Millennium

Mary Jane Kagarise, RN, BSN, MSPH; George F. Sheldon, MD

The Historical, Ethical, and Legal Background of Human-Subjects Research

Todd W Rice MD MSc

THE HISTORICAL, ETHICAL, AND LEGAL BACKGROUND OF HUMAN-SUBJECTS RESEARCH

HUMAN RIGHTS WATCH

CRIMES AGAINST HUMANITY

INTERNATIONAL CRIMINAL COURT ALLIANCE — PEACE THROUGH JUSTICE

1932-1972, Tuskegee Syphilis Study

Late 1950's, NIH CRC policy required Review of all research by Ethics Committee

1974, Congress passes National Research Act; Start of Modern IRBs

1950's, Willowbrook Hepatitis Studies

Early 1970's, San Antonio Contraception Study

Late 1950's-1962, Thalidomide Use In Pregnant Women

1945-1949, Nuremberg Trials

1978, Belmont Report

1945 1955 1965 1975 1985

1955, Wichita, KS Jury Deliberation Taping

1966, Dr. Beecher's N Engl J Med article

1975-1978, National Commission Meetings

1964, NIH requires Ethics Review Of all PHS-funded Research and World Med Assoc Declaration of Helskinki

1981, Secretary of DHHS signs 45 CFR 46

1960's, Jewish Chronic Disease Hospital Study

Fig. 1. Timeline in the development of regulations on human-subjects research protections and institutional review boards (IRBs). NIH = National Institutes of Health. CRC = Clinical Research Center. PHS = Public Health Service. DHHS = Department of Health and Human Services. CFR = Code of Federal Regulations.


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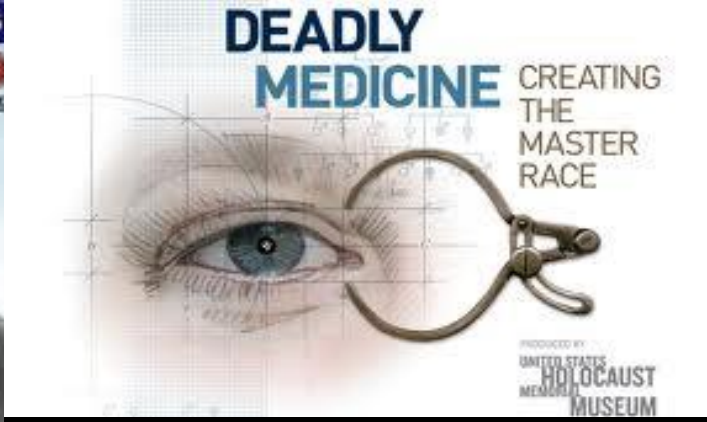
THE CROSS & THE STAR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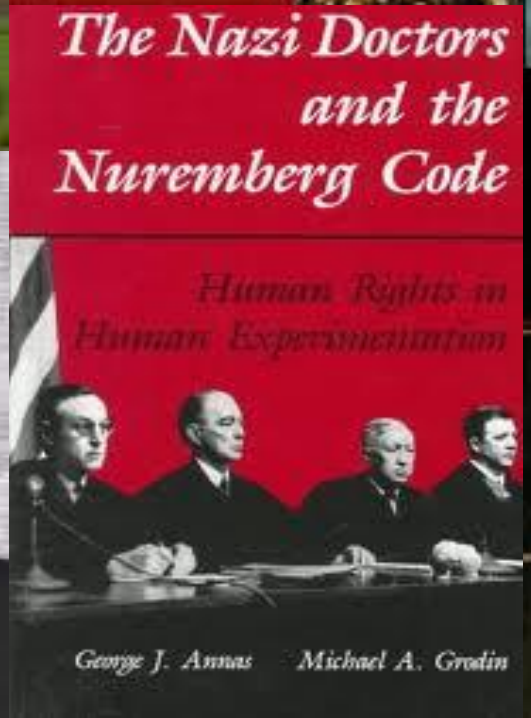
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Human Rights in Human Experimentation
George J. Annas
Michael A. Grodin


hatfling von auschwitz
Josef Mengele
o anjo da morte
SEXTA
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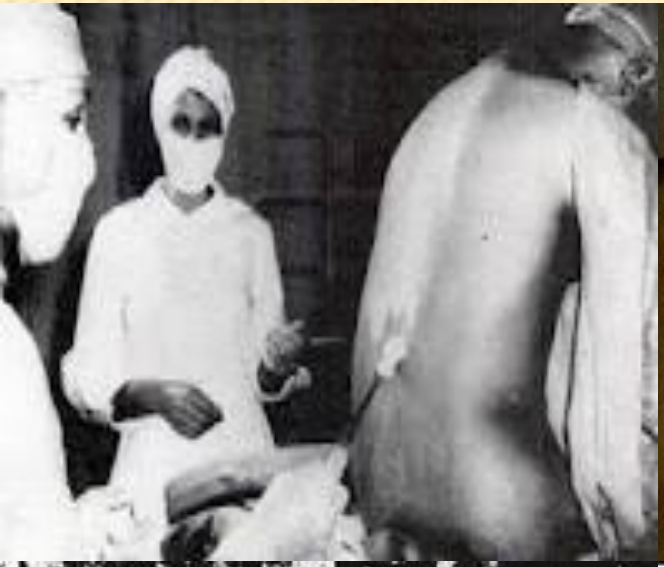
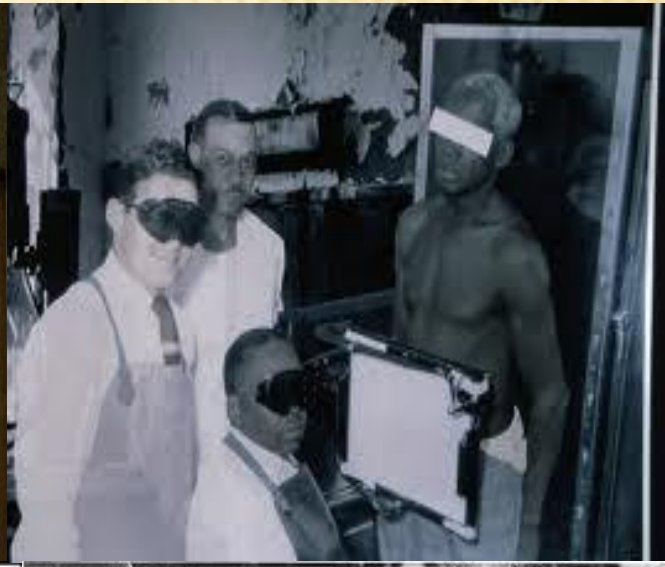
TUSKEGEE SYPHILIS DISEASE STUDY (1932-1972)





The New York Times

Syphilis Victims in U.S. Study Went Untreated for 40 Years

By JEAN HELLER
The Associated Press

WASHINGTON, July 25—For 40 years the United States Public Health Service has conducted a study in which human beings with syphilis, who were induced to serve as guinea pigs, have gone without medical treatment for the disease and a few have died of its late effects, even though an effective therapy was eventually discovered.

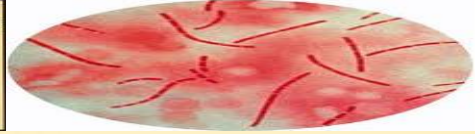
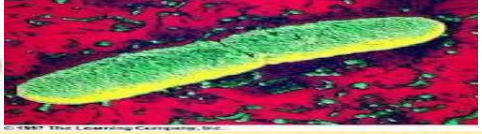
The study was conducted to determine from autopsies what the disease does to the human body.

Officials of the health service who initiated the experiment have long since retired. Current officials, who say they have serious doubts about the morality of the study, also say that it is too late to treat the syphilis in any surviving participants.

Doctors in the service say they are now rendering whatever other medical services they can give to the survivors while the study of the disease's effects continues.

Dr. Merlin K. DuVal, Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs, expressed shock on learning of the study. He said that he was making an immediate investigation.

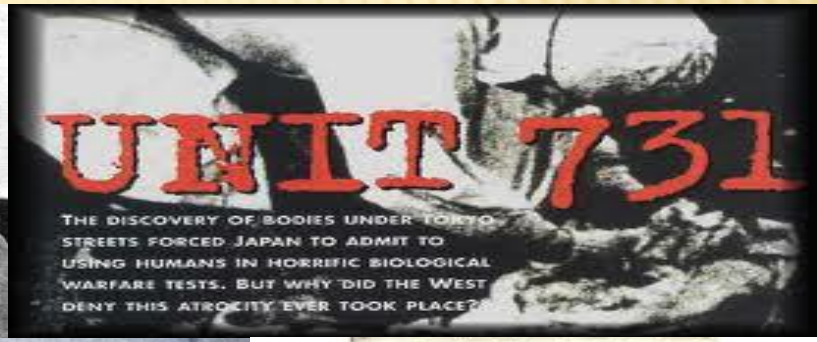
The experiment, called the Tuskegee Study, began in 1932 with about 600 black men,

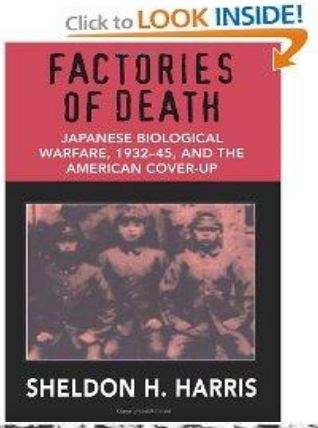



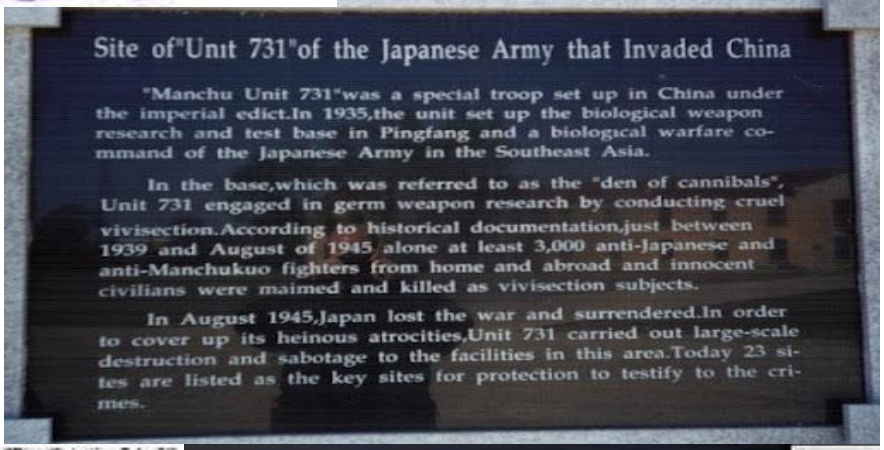

GUERRA SINO-JAPONESA (1937-1945)

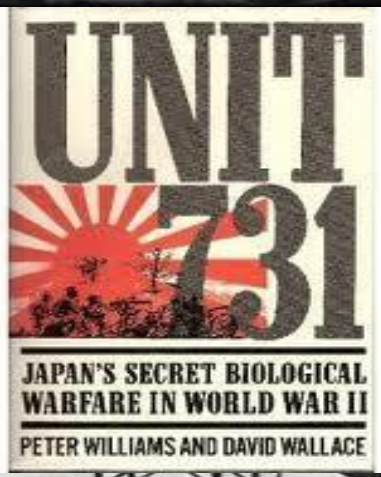
Japan accidentally killed 1,700 of its own soldiers with biological weapons

1941

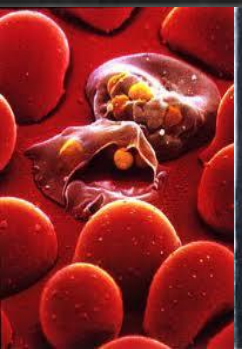


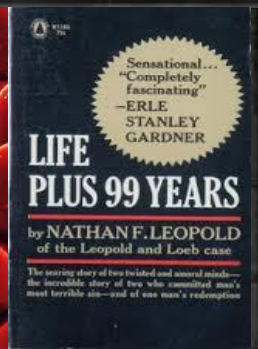


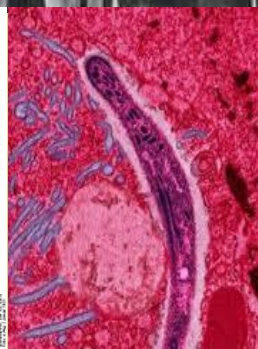




ILLIONOIS STATEVILLE PRISON (USA WWII)







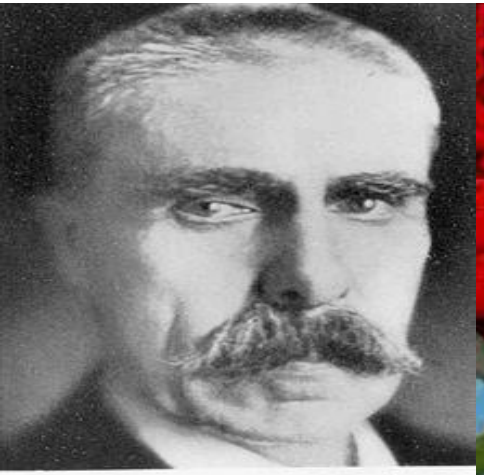
The Nobel Prize in Physiology or Medicine 1927

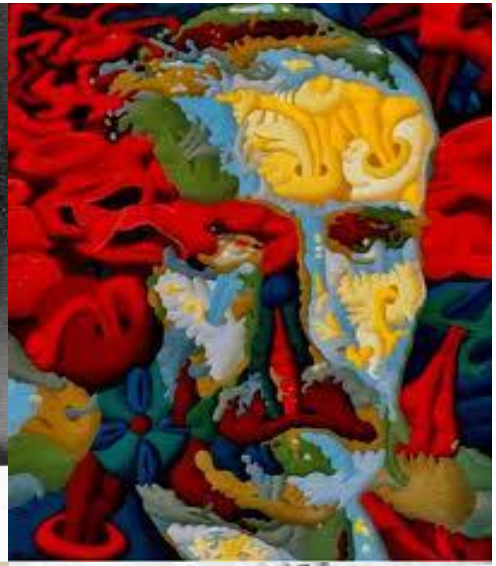
Julius Wagner-Jauregg

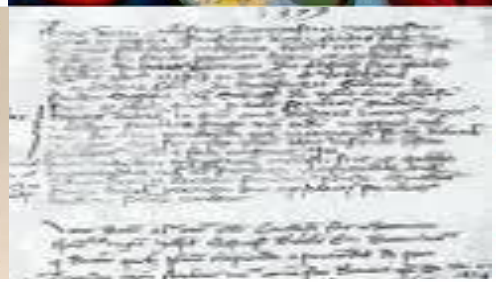
The Nobel Prize in Physiology or Medicine 1927

Julius Wagner-Jauregg

Biography







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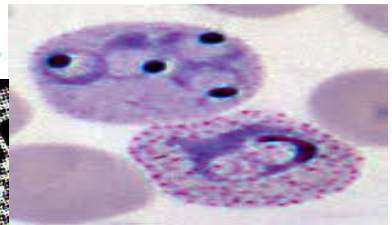
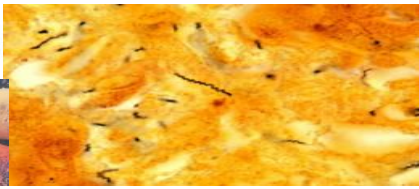


The History of Malariotherapy for Neurosyphilis

Modern Parallels



Stephanie C. Austin; Paul D. Stolley, MD, MPH; Tamar Lasky, PhD

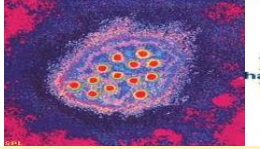
Table 2.—Results of Malariotherapy for Neurosyphilis*

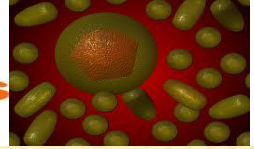
Name of Author	Year Published	No. of Cases	% Remission	% Improved	% Unimproved	% Died
Gertsmann (Austria)	1925	400	33.0	14.0	...	...
Von Raven (Germany)	1926	30	50.0	25.0	...	...
Askgaard (Finland)	1927	197	40.0	10.0	19.0	25.0
Bunker and Kirby (United States)	1928	156		50.0		12.5
Matz (United States)	1928	346	24.0	41.0	31.5	3.5
Meyer (Germany)	1929	270	17.7	15.5	36.6	30.3
Bouman (Holland)	1929	126	...	53.0	37.5	9.5
Holmes (United States)	1930	58	5.0	57.0	36.3	1.7
Van Meter (United States)	1930	234	29.0	25.0	17.0	28.0
Gugenheim (Germany)	1931	50	60.0	28.0	12.0	0.0
Walther (Switzerland)	1931	33	42.0	40.0	9.0	9.0
Stanley (United States)	1932	181	28.7	8.3	...	...
Paulain (France)	1935	1070	37.5	42.0	14.5	6.0
Cheney (United States)	1935	410	18.3	32.5	19.8	29.5
Buduis (Russia)	1936	353	53.0	19.5	17.3	10.2
Bohls (United States)	1937	62	30.6	37.9	24.2	8.7
Kupper (United States)	1938	190	31.5	23.1	19.5	25.7

Table 1.—Wagner-Jauregg's Results of Comparative Treatment With Malaria and Malaria Combined With Neosalvarsan*

	Malaria, %	Malaria and Neosalvarsan, %
Full remission	25.0	48.5
Rapid deterioration	22.0	6.7
Death	18.7	12.0

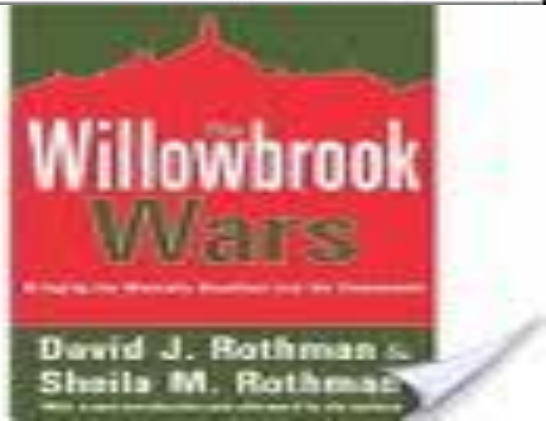
*Source of data is reference 5. He does not report on all of the cases, so percentages do not add to 100%




WILLOWBROOK STATE HOSPITAL (1950 - 1970)

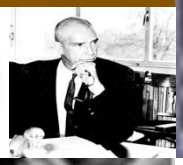
Dr. Saul Krugman believes he is serving mankind by producing hepatitis in mentally retarded children in New York state institution.

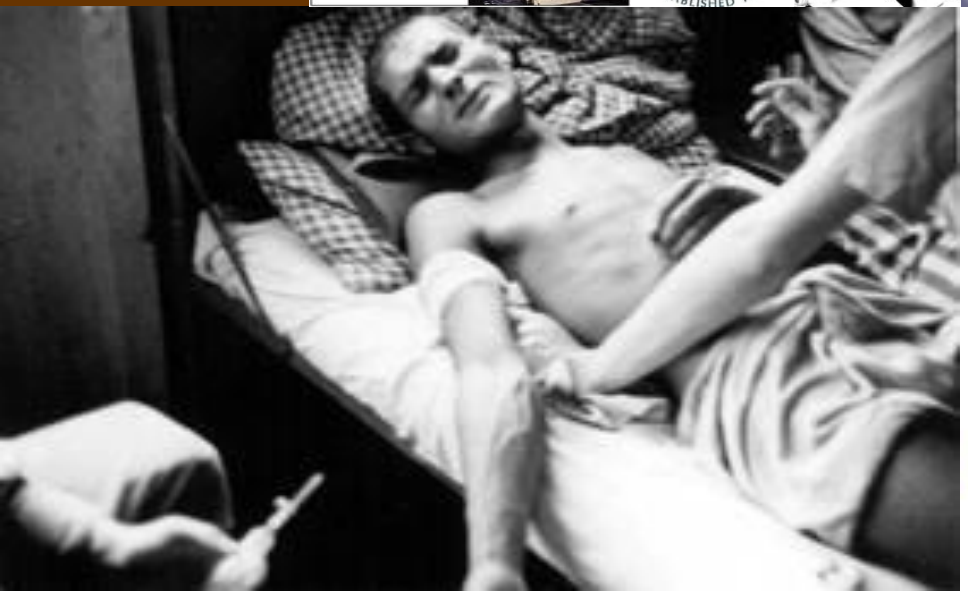


JEWISH CHRONIC DISEASE HOSPITAL STUDY (1960)

The Study

- In 1963, studies were undertaken at New York City's Jewish Chronic Disease Hospital to develop information on the nature of the human transplant rejection process. These studies involved the injection of live cancer cells into patients who were hospitalized with various chronic debilitating diseases
- Patients were not told that they would receive cancer cells because, in the view of the investigators, this would frighten the patients unnecessarily





Journal of Medicine

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Reprinted from pages 1354-1360.

SPECIAL ARTICLE

ETHICS AND CLINICAL RESEARCH*

HENRY K. BEECHER, M.D.†

BOSTON

A National Survey of U.S. Internists' Experiences with Ethical Dilemmas and Ethics Consultation

Gordon DuVal, SJD, Brian Clarridge, PhD, Gary Gensler, MS, Marion Danis, MD

Table 2. Physicians' Ethical Dilemmas

	Most Recent Ethical Dilemmas			Ethical Dilemmas Leading to Ethics Consultation		
	General Internists	Hematologist-Oncologists	Critical Care/Pulmonologists	General Internists	Hematologist-Oncologists	Critical Care/Pulmonologists
N	82	119	113	48	65	95
End of life, %*	51†	55	78	69	71	79
Patient autonomy, %	35†	36	61	54	51	63
Justice, %	23†	13	6	0	0	2
Conflicts between parties, %	35	34	38	38	43	38
Professional conduct, %	11	8	4	6	5	2
Truth telling, %	6‡	12	4	0	5	3
Religious or cultural issues, %	6	4	4	10	5	3
Other, %	10	12	6	8	7	7

* The percentage of responses that were assigned to each code from the scheme outlined in the Appendix. Results add up to more than 100% because up to 3 codes were assigned to each response. Responses of "don't know," "no," and uninterpretable responses were omitted.

† Percentages differ among subspecialties; P < .01.

‡ Percentages differ among specialties; P < .05.

§ Other dilemmas involved abortion, genetic testing, substance abuse, research participation, and beneficence.

OBJECTIVE: To identify the ethical dilemmas that internists encounter, the strategies they use to address them, and the usefulness of ethics consultation.

DESIGN: National telephone survey.

SETTING: Doctors' offices.

PARTICIPANTS: General internists, oncologists, and critical care/pulmonologists (*N* = 344, 64% response rate).

MEASUREMENTS: Types of ethical dilemmas recently encountered and likelihood of requesting ethics consultation; satisfaction with resolution of ethical dilemmas with and without ethics consultation.

RESULTS: Internists most commonly reported dilemmas regarding end-of-life decision making, patient autonomy, justice, and conflict resolution. General internists, oncologists, and critical care specialists reported participating in an average of 1.4, 1.3, and 4.1 consultations in the preceding 2 years, respectively (P < .0001). Physicians with the least ethics training had the least access to and participated in the fewest ethics consultations; 19% reported consultation was unavailable at their predominant practice site. Dilemmas about end-of-life decisions and patient autonomy were often referred for consultation, while dilemmas about justice, such as lack of insurance or limited resources, were rarely referred. While most physicians thought consultations yielded information that would be useful in dealing with future ethical dilemmas (72%), some hesitated to seek ethics consultation because they believed it was too time consuming (29%), might make the situation worse (15%), or that consultants were unqualified (11%).

CONCLUSIONS: While most internists recall recent ethical dilemmas in their practices, those with the least preparation and experience have the least access to ethics consultation. Health care organizations should emphasize ethics educational activities to prepare physicians for handling ethical dilemmas on their own and should improve the accessibility and responsiveness of ethics consultation when needed.

KEY WORDS: questionnaires; internal medicine; ethics, clinical; ethicists; referral and consultation.
J GEN INTERN MED 2004;19:251–258.

Assessing the Legal and Ethical Preparedness of Master of Public Health Graduates

Brian Agee, MD, and Ronald W. Gimbel, PhD

TABLE 3–Relationships Between Scenario Responses of Master of Public Health Graduates (n=84) and Completion of Formal Graduate Courses in Law and Ethics: Uniformed Services University of the Health Sciences, 2000–2006

Measure	Quarantine	Vaccine	Food Code	Sexually Transmitted Infection	Prison	Institutional Review Board	Town Hall	Red Cross	Teaching
Students completing formal course in ethics									
Mann-Whitney *U*	554.0	592.5	571.5	587.5	591.5	493.5	578.0	491.5	575.0
z score	-0.68	-0.22	-0.45	-0.28	-0.22	-1.38	-0.38	-1.44	-0.41
Asymptotic significance (2-tailed)	.49	.82	.65	.78	.83	.17	.71	.15	.69
Students completing formal course in law									
Mann-Whitney *U*	725.0	597.0	544.0	643.5	510.5	587.0	564.0	592.5	688.5
z score	-0.05	-1.54	-1.99	-0.96	-2.35	-1.54	-1.79	-1.52	-0.66
Asymptotic significance (2-tailed)	.96	.13	.05	.34	.02	.12	.07	.13	.51

Ethical Challenges in Preparing for Bioterrorism: Barriers Within the Health Care System

Matthew K. Wynia, MD, MPH, Lawrence O. Gostin, JD

TABLE 2—Master of Public Health Graduates (n = 84) Responses to Survey Scenarios: Uniformed Services University of the Health Sciences, 2000–2006

Scenario	Prepared or Very Prepared, %	Scale Rating,[a] Mean (SD)
Quarantine	61	3.51 (0.91)
Vaccine	65	3.57 (0.84)
Food code	76	4.00 (0.99)
Sexually transmitted infection	76	3.88 (0.93)
Prison	63	3.62 (0.98)
Institutional review board	70	3.84 (0.92)
Town hall	54	3.42 (0.92)
Red Cross	67	3.73 (0.83)
Teaching	55	3.49 (0.96)

[a] 1 = very unprepared, 5 = very prepared.

Objectives. We explored the relationship between the preparedness of master of public health (MPH) graduates in public health law and ethics and their completion of courses in these areas.

Methods. We reviewed accredited public health schools and programs to assess the supply of required and elective courses in law and ethics. In addition, we conducted an Internet-based scenario survey of MPH graduates. Survey results were analyzed, and relationships between scenario responses and completion of law and ethics courses were assessed.

Results. Of the 93 programs and schools reviewed, 14% required a course in ethics and 16% required a course in law. The majority (range = 55%–76%) of the survey respondents indicated being "prepared" or "very prepared" for each of the 9 public health scenarios. There were no significant relationships between scenario responses and completion of an ethics course. Responses to 2 scenarios (one involving food code violations and one involving a prison population) were significantly related to participants' completion of a course in law.

Conclusions. Few public health schools and programs require graduate courses in ethics and law. Most MPH graduates report being prepared to address public health challenges. Additional research is necessary to improve techniques for measuring preparedness. (*Am J Public Health.* 2009;99:1505–1509. doi:10.2105/AJPH.2007.133173)

Resident Physicians' Preparedness to Provide Cross-Cultural Care

Cultural Competence in the Era of Evidence-Based Practice

JOAN ENGEBRETSON, DrPH,* JANE MAHONEY, DSN,† AND ELIZABETH D. CARLSON, DSN, MPH, APRN, BC‡

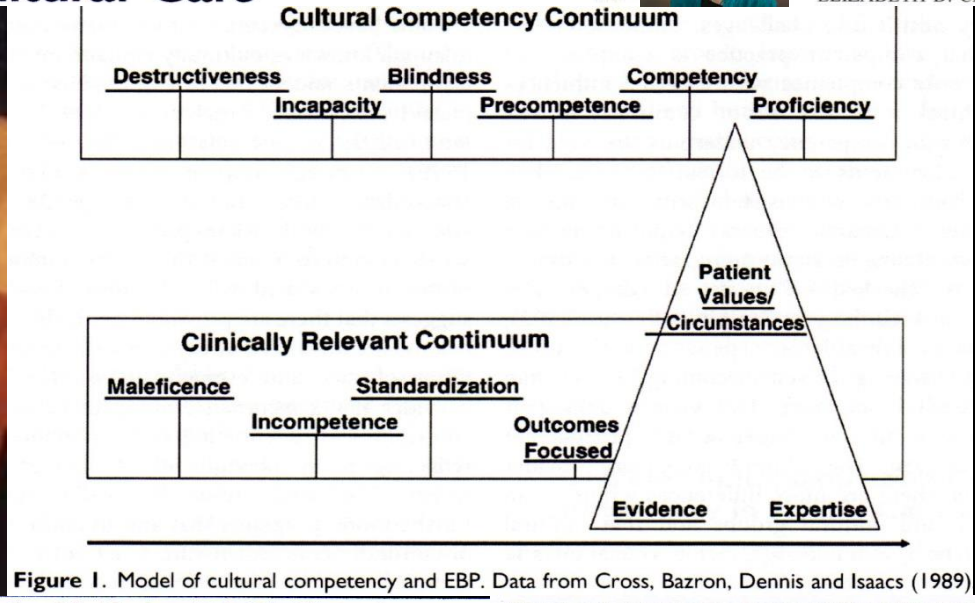


Figure 1. Model of cultural competency and EBP. Data from Cross, Bazron, Dennis and Isaacs (1989)

Table 4. Residents Who Reported Receiving Little or No Instruction in Cross-Cultural Care Beyond Medical School,* by Specialty

		Specialty, %						
	All (N = 2047)†	Emergency Medicine (n = 299)	Family Medicine (n = 308)	Internal Medicine (n = 271)	General Surgery (n = 278)	Obstetrics/ Gynecology (n = 276)	Pediatrics (n = 291)‡	Psychiatry (n = 312)
How patient wants to be addressed	50.4	68.9	28.8	49.9	75.2	62.7	46.8	29.3
Assess understanding of illness	35.6	49.5	16.1	37.3	56.7	42.8	31.0	16.6
Negotiate about treatment plan	33.0	46.3	17.1	30.3	55.2	43.8	30.8	20.8
Identify mistrust	56.3	73.2	42.6	52.8	78.7	69.9	58.8	32.4
Identify relevant religious beliefs	49.7	64.9	37.5	51.8	66.0	47.8	48.5	26.8
Identify relevant cultural customs	47.9	62.5	31.3	54.4	66.6	50.7	35.8	22.6
Identify decision-making structure	52.2	72.9	33.8	48.2	72.2	61.2	54.2	38.2
Work with interpreter	34.7	37.1	23.5	38.2	45.1	31.8	23.6	40.6

*Response was 1 "none" or 2 "very little" on a scale of 1 to 5 "a lot." $P<.001$ for all comparisons; χ^2 test of equality of all proportions used.
†Data in this column adjusted for the differential probability of selection across specialties and the probability of response within each specialty.
‡Each question allowed respondent to answer for the patient or for a pediatric patient's family.

Context Two recent reports from the Institute of Medicine cited cross-cultural training as a mechanism to address racial and ethnic disparities in health care, but little is known about residents' educational experience in this area.

Objective To assess residents' attitudes about cross-cultural care, perceptions of their preparedness to deliver quality care to diverse patient populations, and educational experiences and educational climate regarding cross-cultural training.

Design, Setting, and Participants A survey was mailed in the winter of 2003 to a stratified random sample of 3435 resident physicians in their final year of training in emergency medicine, family practice, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, or general surgery at US academic health centers.

Results Responses were obtained from 2047 (60%) of the sample. Virtually all (96%) of the residents indicated that it was moderately or very important to address cultural issues when providing care. The number of respondents who indicated that they believed they were not prepared to care for diverse cultures in a general sense was only 8%. However, a larger percentage of respondents believed they were not prepared to provide specific components of cross-cultural care, including caring for patients with health beliefs at odds with Western medicine (25%), new immigrants (25%), and patients whose religious beliefs affect treatment (20%). In addition, 24% indicated that they lacked the skills to identify relevant cultural customs that impact medical care. In contrast, only a small percentage of respondents (1%-2%) indicated that they were not prepared to treat clinical conditions or perform procedures common in their specialty. Approximately one third to half of the respondents reported receiving little or no instruction in specific areas of cross-cultural care beyond what was learned in medical school. Forty-one percent (family medicine) to 83% (surgery and obstetrics/gynecology) of respondents reported receiving little or no evaluation in cross-cultural care during their residencies. Barriers to delivering cross-cultural care included lack of time (58%) and lack of role models (31%).

Conclusions Resident physicians' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Although cross-cultural care was perceived to be important, there was little clinical time allotted during residency to address cultural issues, and there was little training, formal evaluation, or role modeling. These mixed educational messages indicate the need for significant improvement in cross-cultural education to help eliminate racial and ethnic disparities in health care.

JAMA. 2005;294:1058-1067

Esther Mucznik

PORTUGUESES NO HOLOCAUSTO

Histórias das vítimas dos campos de concentração, dos cônsules que salvaram vidas e dos resistentes que lutaram contra o nazismo

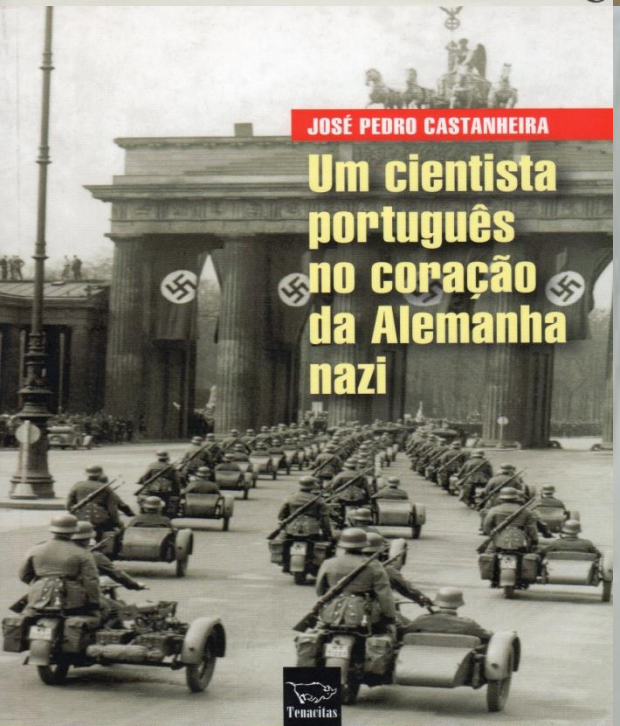
JUDEUS

EM PORTUGAL DURANTE A II GUERRA MUNDIAL

Em Fuga de Hitler e do Holocausto

Irene Flunser Pimentel

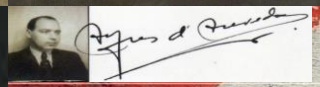
Prémio Pessoa 2007



JOSÉ PEDRO CASTANHEIRA

Um cientista português no coração da Alemanha nazi

Tenacitas



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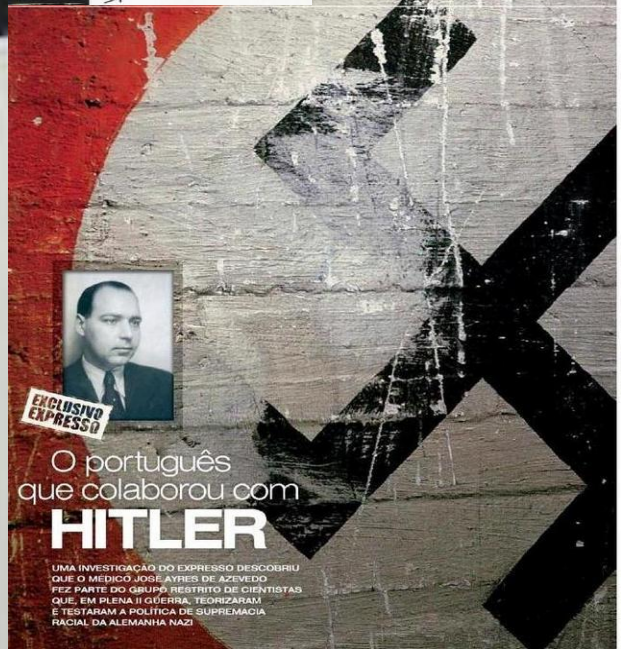

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UMA INVESTIGAÇÃO DO EXPRESSO DESCOBRIU QUE O MÉDICO JOSÉ AYRES DE AZEVEDO FEZ PARTE DO GRUPO RESTRITO DE CIENTISTAS QUE, EM PLENA II GUERRA, TEORIZARAM E TESTARAM A POLÍTICA DE SUPREMACIA RACIAL DA ALEMANHA NAZI


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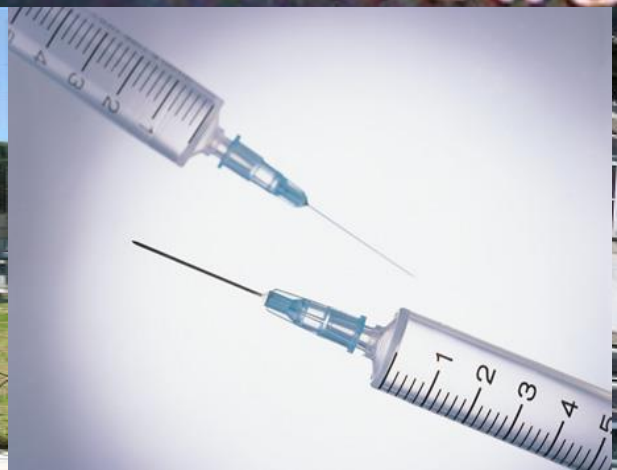
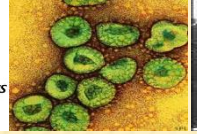
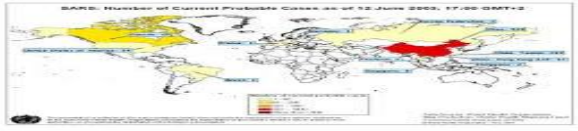
CRIANÇAS DA CASA PIA SÃO "COBAIAS" EM ESTUDO DE SAÚDE NORTE-AMERICANO

Investigação sobre os efeitos do uso de amálgamas de mercúrio nos dentes

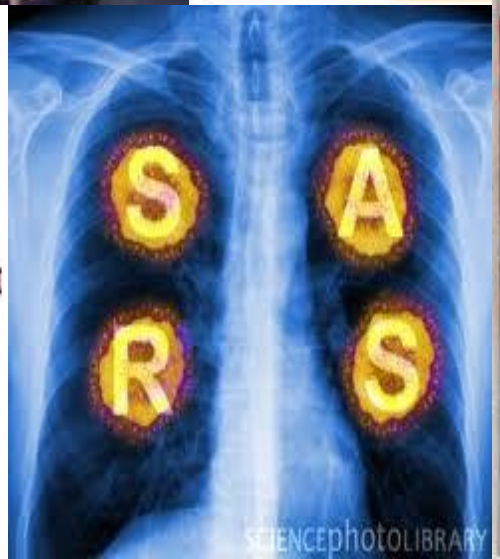


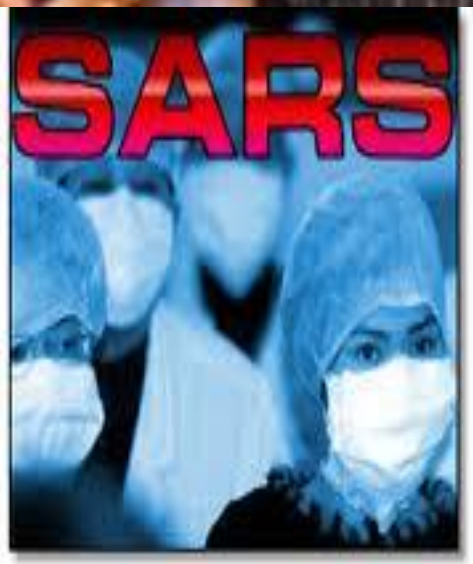




"... ISTO PODE BEM VIR A SER O MEU PRÓPRIO FIM..."

(SIC) (CARLO URBANI, HANOI, 2003)





III)- A MISSÃO dos MÉDICOS, a NECESSIDADE dos DOENTES, e o INTERESSE da SOCIEDADE

"... NÓS DEVEMOS TRABALHAR NO INTERESSE ESTRITO DOS DOENTES E DOS CIDADÃOS, E NÃO NO DOS ADMINISTRADORES OU DOS ADVOGADOS ..."

(SIC.) (SH VERMUND, H FAWAI AJIC, 1999, 27, 497-499)

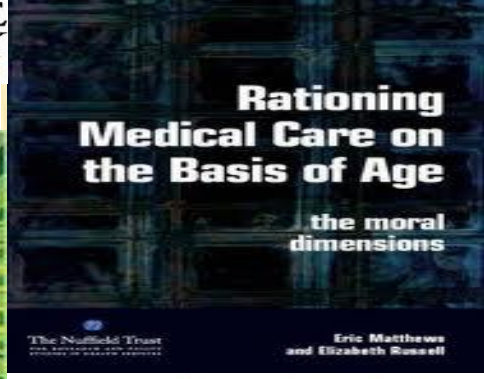
Health Care Anal (2006) 14:25–36
DOI 10.1007/s10728-006-0008-6
ORIGINAL ARTICLE

DALHOUSIE UNIVERSITY
Inspiring Minds

Is Health Inequality Across Individuals of Moral Concern?

Yukiko Asada

Published online: 20 September 2006



CHEST

Medical Ethics

The Ethics and Reality of Rationing in Medicine

Leslie P. Scheunemann, MD, MPH; and Douglas B. White, MD

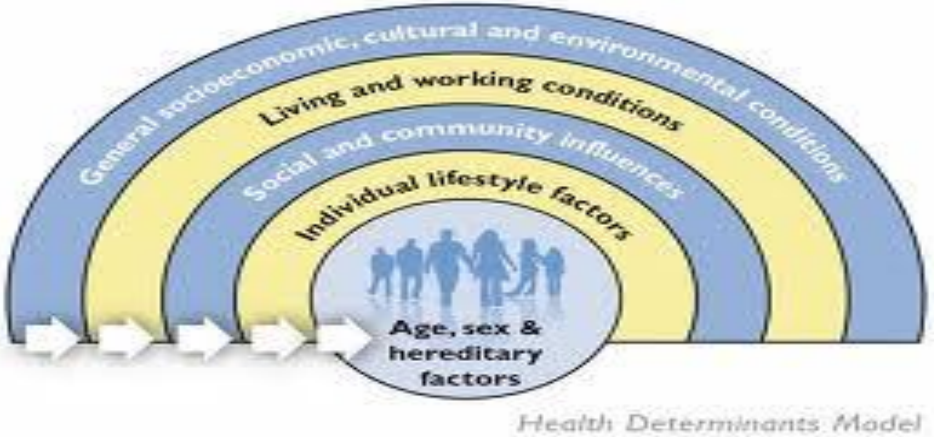
UPMC
University of Pittsburgh Medical Center

Rationing is the allocation of scarce resources, which in health care necessarily entails withholding potentially beneficial treatments from some individuals. Rationing is unavoidable because need is limitless and resources are not. How rationing occurs is important because it not only affects individual lives but also expresses society's most important values. This article discusses the following topics: (1) the inevitability of rationing of social goods, including medical care; (2) types of rationing; (3) ethical principles and procedures for fair allocation; and (4) whether rationing ICU care to those near the end of life would result in substantial cost savings.

CHEST 2011; 140(6):1625–1632

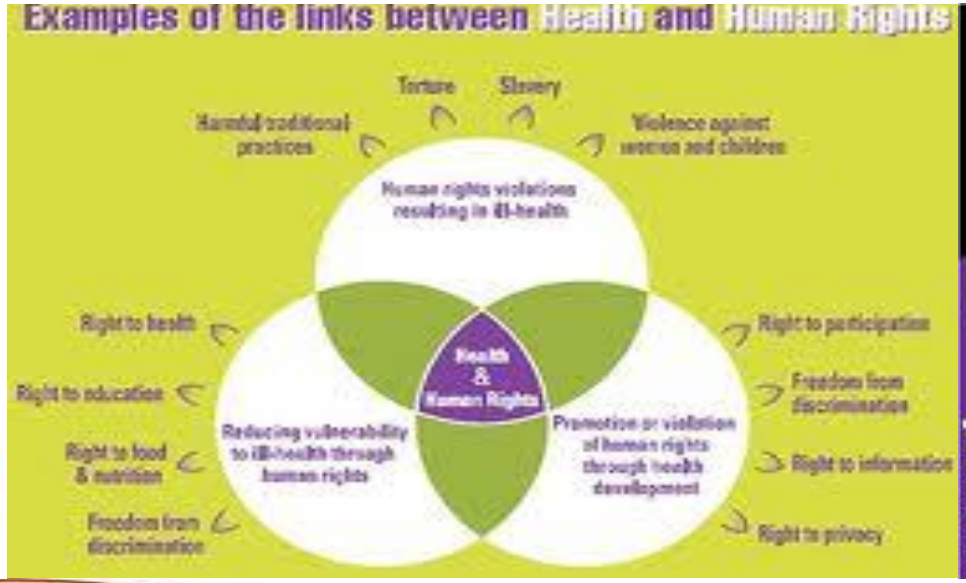
Abbreviations: QALY = quality-adjusted life year; UNOS = United Network for Organ Sharing

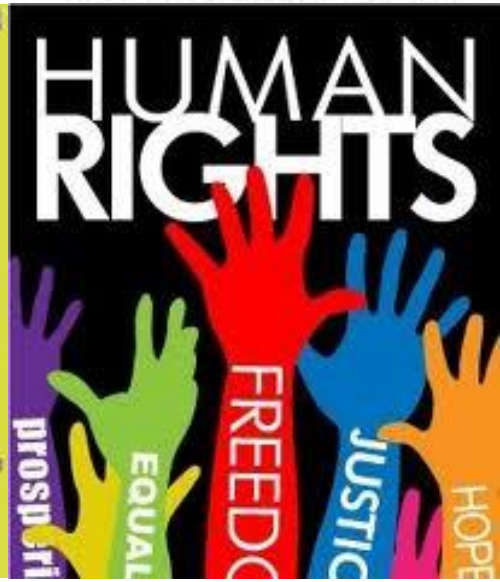
Source: Dahlgren and Whitehead, 1991



Health Determinants Model

my life
my health





American Board of Internal Medicine®

PERSPECTIVE

ACP ASIM

Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine*

TABLE 1 THE PHYSICIAN CHARTER

THREE FUNDAMENTAL PRINCIPLES

- Primacy of patient welfare
- Patient autonomy
- Social justice

TEN PROFESSIONAL RESPONSIBILITIES (COMMITMENTS)

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

Source: Medical Professionalism Project 2002.

Medical Professionalism: Conflicting Values for Tomorrow's Doctors

Erica Borgstrom, MA, Simon Cohn, PhD, and Stephen Barclay, FRCGP, MD

General Practice and Primary Care Research Unit, University of Cambridge, Cambridge, UK.

Old Professionalism:

Detachment
Paternalism
Restricted communication with patients
Medical beneficence most prominent ethical principle

New Professionalism:

Empathy
Emotional Engagement
Open Communication
Patient-centered
Patient autonomy as most prominent ethical principle

Box 1. Examples of attributes associated with 'old' and 'new' professionalism

A VISÃO DO PRIMADO DO INDIVÍDUO

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redefine THE POSSIBLE.

Soc Sci Med Vol 22, No 11, pp 1175–1179 1986
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SECTION I

CODES OF MEDICAL ETHICS: TRADITIONAL FOUNDATIONS AND CONTEMPORARY PRACTICE*

P SOHL[1] and H A BASSFORD[2]
[1]Institute of Social Medicine, University of Copenhagen, 32 Juliane Mariesvej, DK-2100 Copenhagen Ø, Denmark and [2]Atkinson College, York University, 4700 Keele Street, North York, Ontario, Canada, M3J 2R7

- "... torna-se portanto evidente que os diferentes sistemas socio-económicos existentes acarretam um significativo impacto na maneira em como os médicos tratam os seus doentes. Se estes não tiverem isso em consideração, e não pugnarem pela alteração possível das condicionantes que obstam ao seu melhor desempenho profissional, poderão então cair num relativismo cultural, segundo o qual a salvaguarda da saúde do seu paciente deixaria de ser a sua principal preocupação, deixando assim que as circunstâncias políticas da conjuntura se sobreponham o seu superior dever ético de tratar o doente o melhor possível..." *(sic)*

(Sohl, P, Bassford, HA, Soc. Sci. Med. 1986, 22, 11, 1175-1179)

ORIGINAL COMMUNICATIONS

Hastings Center Report, March-April 1994

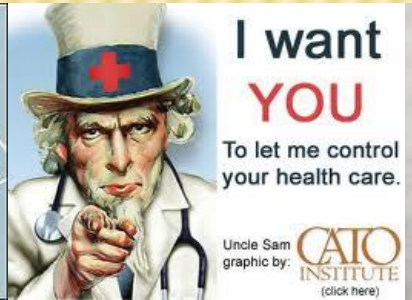
THE MEDICAL ETHOS AND SOCIAL RESPONSIBILITY IN CLINICAL MEDICINE

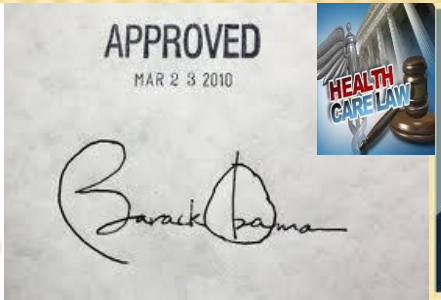
Charles K. Francis, MD
Los Angeles, California

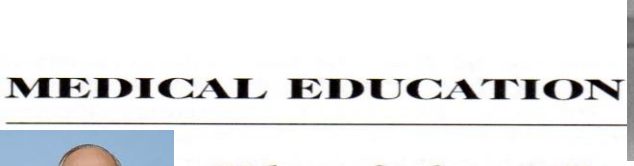
Health Care Reform and the Future of Physician Ethics

by Susan M. Wolf

- "... apesar de uma crescente prosperidade económica, os custos com a saúde estão em crescendo, os empregadores estão a diminuir as suas comparticipações, o número dos cidadãos não cobertos por seguros de saúde não deixa de crescer, e os direitos dos doentes estão cada vez mais comprometidos. A instituição de benefícios de caráter pecuniário aos médicos decorrentes da adoção de determinadas atitudes de racionalização quanto à utilização de certos meios de investigação clínica, está a minar irreversivelmente a confiança dos doentes ... a instituição de cuidados de saúde com cobertura universal é pouco credível que venha a ocorrer, pelo "nossa" profunda desconfiança no poder regulatório do Governo e do Estado, bem como pela nossa "fé cega" na capacidade "moralizadora" dos mercados e da nossa autonomia profissional ..." *(sic.) (Francis, CK, J. Nat. Med. Assoc,2001, 93, 5, 157-169)*







Physician Professionalism for a New Century

JAMES W. HOLSINGER JR.,[1,2]* AND BENJAMIN BEATON[2]

[1]Departments of Medicine, Surgery and Anatomy, College of Medicine, University of Kentucky, Lexington, Kentucky
[2]Cabinet for Health and Family Services, Commonwealth of Kentucky, Frankfort, Kentucky

- "... por alturas do final do século passado, a contrariedade dos médicos para com a sua prática profissional era já uma realidade incontornável e generalizada. Esta tinha-se transformado progressivamente num mar de burocracia, num decréscimo de autonomia, numa perda de prestígio, que fez emergir pois um profundo sentimento de frustração ..." *(sic.) (Zuger, A, NEJM, 2004, 350, 69-75)*

EDITORIALS

Doctors in society: medical professionalism in a changing world

Raymond C Tallis, member of the Working Party on Medical Professionalism

Volume 5 Number 6 November/December 2005 SUPPLEMENT No 1

CLINICAL MEDICINE

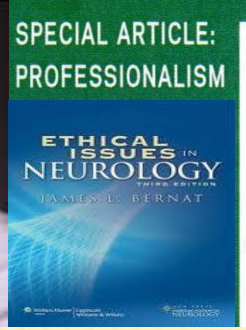
Journal of the Royal College of Physicians of London

Doctors in society

Medical professionalism in a changing world

Report of a Working Party of the Royal College of Physicians, December 2005

- "... o futuro do profissionalismo médico dependerá pois, sobretudo, da criação de um ambiente favorável ao desenvolvimento dos seus profissionais... É igualmente necessário motivar os decisores políticos ... no sentido destes os valorizarem adequadamente, como forma decisiva de promover a qualidade dos serviços prestados aos doentes. Os médicos devem assim liderar este debate, exibindo as suas convicções neste tipo de postura, que jamais poderá ser imposta pelos governantes, mas ser antes a genuína emanação da própria classe. Não se trata então de uma mera questão de opção individual, mas antes a afirmação de uma consciência profunda dos próprios na sua real missão, contra quaisquer contrariedades que possam vir a desvirtuar estes princípios ..." *(sic) (Working Party RCPL, Clin. Med., 2005, 5, 6, Sup.1, S1-S40)*

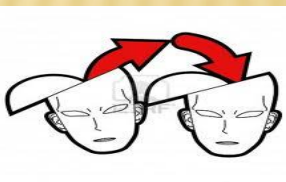


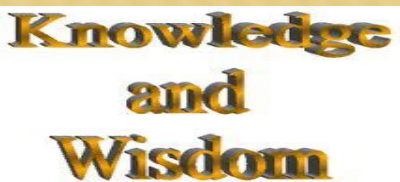
Invited Article:

AMERICAN ACADEMY OF NEUROLOGY Foundation

Threats to physician autonomy in a performance-based reimbursement system

- "... a autonomia do médico ... deve ser definida como a capacidade em melhor saber utilizar os conhecimentos científicos na sua prática clínica ao serviço dos cuidados que presta aos seus doentes ... enquanto as sociedades científicas das respetivas especialidades tiverem a capacidade de liderar a conceção, a aplicação, e a atualização periódica de normas consensuais de orientação clínica, as ameaças àquela autonomia poderá ser mitigada ... contudo, se forem utilizadas predominantemente com o objetivo de servirem como meio de controlo dos custos, entrarão então em contradição com o espírito da medicina baseada na evidência ... as decisões clínicas especificamente dirigidas aos doentes devem pois refletir a ponderação de todos os fatores individuais envolvidos ... dado que, em muitas circunstâncias da prática clínica diária, têm apenas que ser suportadas na sua experiência e conhecimento , dado não existirem de todo. Por tudo isto, é pois suposto que os médicos devam aplicar todas as suas capacidades no prioritário benefício dos doentes, colocando-o inclusive acima dos dividendos pelo que possam vir a ser recompensados e decorrentes da adoção de práticas que contrariem estes mesmos pressupostos enunciados ... " *(sic.) (Larriviere, DG, Bernat, JL, Neurology, 2008, 70, 2338-2342)*





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- Norma nº 068/2011 de 30/12/2011 - Terapêutica Biológica da Doença Inflamatória do Intestino do Adulto
- Norma nº 067/2011 de 30/12/2011 - Prescrição de Agentes Biológicos nas Doenças Reumáticas
- Norma nº 066/2011 de 30/12/2011 - Prescrição de Exames Laboratoriais para Avaliação de Dislipidemias
- Norma nº 065/2011 de 30/12/2011 - Tratamento da Psoríase com Agentes Biológicos em Idade não Pediátrica
- Norma nº 064/2011 de 30/12/2011 - Prescrição de Antibióticos em Patologia Dentária
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- Norma nº 057/2011 de 28/12/2011 - Imagiologia do Abdómen e Pélvis: Ecografia Ginecológica
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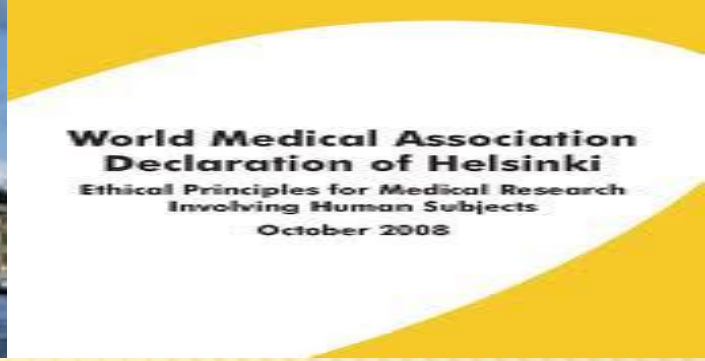
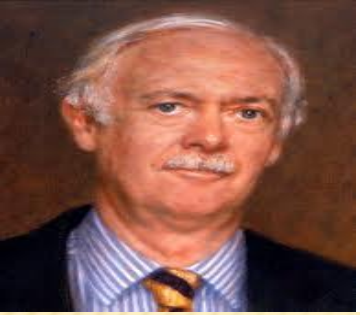


- Adenda de 1989
  - "... o interesse do sujeito deve sempre prevalecer acima dos interesses da sociedade ..."
  - "... todo e cada um dos doentes deve beneficiar do melhor tratamento conhecido possível..."

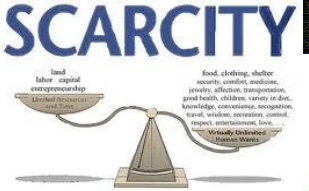
A VISÃO DO PRIMADO DA SOCIEDADE



Ethonomics

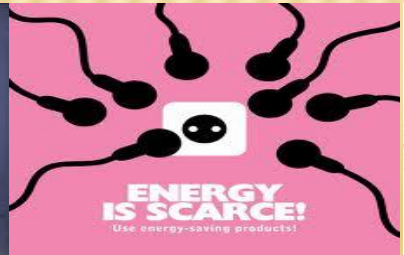
The Ethics of the Unaffordable

Miles Little, MD, MS, FRACS



SPECIAL ARTICLE

- "... nós, médicos, vemo-nos frequentemente na posição de advogados dos doentes, embora nos esqueçamos infelizmente que muitas vezes também estes mesmos profissionais têm também que comunicar e dar conselhos que vão contra o que, em princípio, aqueles esperariam ouvir, tão só porque , afinal, na realidade, não existe outra possibilidade. No conhecimento deste tipo de constrangimento ... a nova ética médica que emergirá, indexará também as preocupações para com a comunidade e não só para com o indivíduo, incluindo pois também os contributos de diversa proveniência (políticos, economistas, administradores, e de outros profissionais da saúde), Neste momento, parece prevalecer um ambiente adverso, com um acentuado antagonismo de posições entre os que prestam diretamente os cuidados de saúde, os que têm a responsabilidade de administração dos recursos e ainda os que os financiam. Um planeamento adequado deverá conduzir à conclusão que deixou de ser possível assegurar uma proliferação indefinida dos serviços ... e que os avanços científicos que se vão sucedendo poderão nunca chegar a beneficiar muitos dos que deles poderiam vir a necessitar... Enquanto formos apenas confiando em meras promessas inatingíveis, iremos semear a animosidade e a insatisfação na nossa prática clínica, ao ponto de muitos de nós já desejarmos que os nossos próprios filhos sigam outras profissões ..." *(sic) (Little,M, Arch. Surg., 2000, 135, 17-21)*



Annals of IM

CHEST

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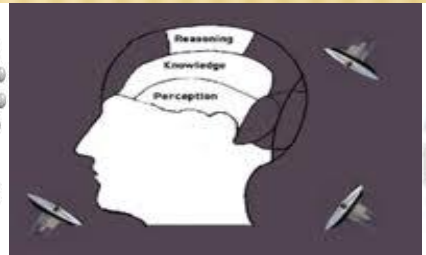
The Ethical Foundations of Professionalism* : A Sociologic History

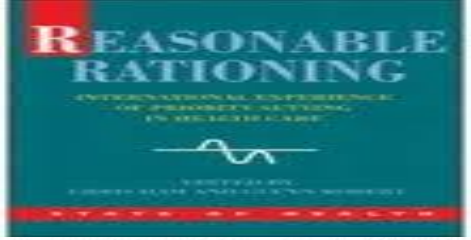
Harold C. Sox

Chest 2007;131;1532-1540
DOI 10.1378/chest.07-0464

WHAT IS THE ANSWER?

- "... presentemente, os médicos estão cada vez mais a entrar em conflito, quer com as administrações das unidades de saúde, quer mesmo com os governantes, dado que as suas decisões clínicas acerca dos problemas dos doentes individualmente considerados estão na base de um aumento da despesa inerente que assume cada vez mais cifras insuportáveis. Como os recursos das sociedades são finitos por natureza, os códigos de conduta profissional deverão adaptar-se no sentido de abranger, não só a obrigação do médico para com o seu doente, mas também para com a sociedade onde ambos se inserem. Por isto mesmo, os decisores políticos estão cada vez mais a tentar condicionar aquilo que representa, por um lado, o que o doente deseja para si mesmo, bem como o que este entende que o seu médico lhe deve proporcionar. Esta pressão está a afrontar a autonomia profissional dos médicos, ao ponto de a reduzir apenas a uma mera caricatura daquilo que historicamente foi habitualmente contemplado nos códigos de ética da sua profissão. Será que esta trajetória se poderá alguma vez inverter de acordo com a tradição histórica ?" *(sic) (Sox, HC, Chest, 2007, 131, 5, 1532-1540)*



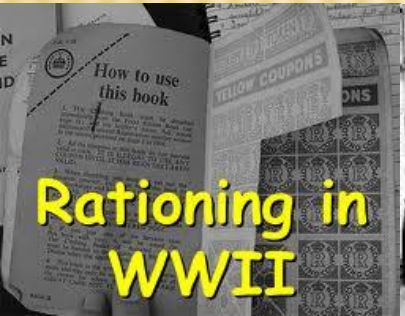


Perspective
MAY 24, 2012

From an Ethics of Rationing to an Ethics of Waste Avoidance

Howard Brody, M.D., Ph.D.

- " ... a ética do "racionamento" começa por duas considerações. Primeiramente, esta necessidade ocorre simplesmente porque os recursos são finitos, e alguém tem que decidir quando e onde deverão ser aplicados. Depois, porque, como consequência, ele torna-se assim tão inevitável, quanto se o evitarmos de todo de uma forma explícita, ele terá que ser implicitamente assumido com o eventual recurso a métodos injustos. O maior drama ocorrerá então quando deixarmos que os recursos se esgotem, e provocarmos assim que os doentes, que são muito mais do que simples estatísticas, venham a sofrer as suas nefastas consequências. Os especialistas de ética contra-argumentam então que o problema poderia ser resolvido se eliminássemos o desperdício, a fraude e o abuso. No fundo, a ética do racionamento e do desperdício deverão ser verdadeiramente complementares e não exclusivas. Talvez que assim possamos continuar a propiciar uma cobertura universal dos cuidados e uma efetiva contenção dos custos ..." *(sic.) (Brody,H, NEJM, 2012, 366, 21, 1949-1951)*



RESEARCH ETHICS

Medical decision making in scarcity situations

J J M van Delden, A M Vrakking, A van der Heide, P J van der Maas

J Med Ethics 2004;30:207–211. doi: 10.1136/jme.2003.003681

Table 2 Percentage of agreement with statements concerning the use of selection criteria

Statement	Agreement with statement (%) Oncology (n = 30)	Nursing home (n = 29)	Cardiology (n = 21)	Physicians total (n = 80)	Policy makers (n = 29)
In older patients under treatment occurs more often than in younger patients (p = 0.03*)	73	62	75	70	45
Older patients shouldn't be victims of scarcity in health care more often than younger patients	93	86	76	86	83
In case of scarcity of beds as a consequence of a shortage of staff, it is acceptable that patients are selected by their age upon admission	3	7	10	6	7
Expensive life prolonging treatments should be used primarily to prevent the death of people younger than 75 years of age (p = 0.02*, p = 0.002†)	63	35	52	50	28
In case of scarcity of organs for transplantation it is acceptable that patients are selected on their age	73	62	67	68	48
A good physician takes the functions that a patient fulfils in family and society into account in important medical decisions. (p = 0.009*)	53	59	76	61	39

*Significant difference with Mann-Whitney test ($p \leq 0.05$) between all physicians and policy makers.
†Significant difference with Mann-Whitney test ($p \leq 0.05$) between oncologists and nursing home physicians.

Table 3 Percentage of agreement with statements concerning the locus of decision making

Statement	Agreement with statement (%) Oncology (n = 30)	Nursing home (n = 29)	Cardiology (n = 21)	Physicians total (n = 80)	Policy makers (n = 29)
A good doctor's prime concern is for the interests of patients, who are committed to his or her care, even if this leads to a less efficient allocation of the scarce resources (p = 0.05)*	83	93	100	91	83
Not the doctor but the government should make choices concerning the allocation of scarce resources on other than medical grounds	67	62	76	68	76
Physicians also have to consider the justifiability of their decisions when these influence the allocation of scarce medical resources	90	93	86	90	93
Clear government policy concerning health care for the elderly can provide guidance when justifying medical decisions in individual cases	63	45	62	56	66
Restrictions enforced by the government disturb good medical decision making for individual patients	37	41	60	44	52

*Significant difference with Mann-Whitney test ($p \leq 0.05$) between oncologists and cardiologists.

Table 4 Percentage of agreement with statements concerning the ethical justification of age selection

Statement	Agreement with statement (%) Oncology (n = 30)	Nursing home (n = 29)	Cardiology (n = 21)	Physicians total (n = 80)	Policy makers (n = 29)
In the care for older people improvement of quality of life should be more important than prolonging life (p = 0.04)*	87	100	100	95	93
Because elderly patients have lived the greatest part of their life, younger patients should have more rights to life prolonging treatment than older patients	13	24	33	23	17
Scarce life prolonging treatments should be allocated in such a way that as many people as possible reach the mean life expectancy.	23	24	21	23	21

*Significant difference with Mann-Whitney test ($p \leq 0.05$) between oncologists and nursing home physicians

The issue of the allocation of resources in health care is here to stay. The goal of this study was to explore the views of physicians on several topics that have arisen in the debate on the allocation of scarce resources and to compare these with the views of policy makers. We asked physicians (oncologists, cardiologists, and nursing home physicians) and policy makers to participate in an interview about their practices and opinions concerning factors playing a role in decision making for patients in different age groups. Both physicians and policy makers recognised allocation decisions as part of their reality. One of the strong general opinions of both physicians and policy makers was the rejection of age discrimination. Making allocation decisions as such seemed to be regarded as a foreign entity to the practice of medicine. In spite of the reluctance to make allocation decisions, physicians sometimes do. This would seem to be only acceptable if it is justified in terms of the best interests of the patient from whom treatment is withheld.

Department of Ethics

Principles for allocation of scarce medical interventions

Govind Persad, Alan Wertheimer, Ezekiel J Emanuel

	Advantages	Disadvantages	Examples of use	Recommendation
Treating people equally				
Lottery	Hard to corrupt; little information about recipients needed	Ignores other relevant principles	Military draft; schools; vaccination	Include
First-come, first-served	Protects existing doctor-patient relationships; little information about recipients needed	Favours wealthy, powerful, and well-connected; ignores other relevant principles	ICU beds; part of organ allocation	Exclude
Favouring the worst-off: prioritarianism				
Sickest first	Aids those who are suffering right now; appeals to "rule of rescue"; makes sense in temporary scarcity; proxy for being worst off overall	Surreptitious use of prognosis; ignores needs of those who will become sick in future; might falsely assume temporary scarcity; leads to people receiving interventions only after prognosis deteriorates; ignores other relevant principles	Emergency rooms; part of organ allocation	Exclude
Youngest first	Benefits those who have had least life; prudent planners have an interest in living to old age	Undesirable priority to infants over adolescents and young adults; ignores other relevant principles	New NVAC/ACIP pandemic flu vaccine proposal	Include
Maximising total benefits: utilitarianism				
Number of lives saved	Saves more lives, benefiting the greatest number; avoids need for comparative judgments about quality or other aspects of lives	Ignores other relevant principles	Past ACIP/NVAC pandemic flu vaccine policy; bioterrorism response policy; disaster triage	Include
Prognosis or life-years saved	Maximises life-years produced	Ignores other relevant principles, particularly distributive principles	Penicillin allocation; traditional military triage (prognosis) and disaster triage (life-years saved)	Include
Promoting and rewarding social usefulness				
Instrumental value	Helps promote other important values; future oriented	Vulnerable to abuse through choice of prioritised occupations or activities; can direct health resources away from health needs	Past and current NVAC/ACIP pandemic flu vaccine policy	Include but only in some public health emergencies
Reciprocity	Rewards those who implemented important values; past oriented	Vulnerable to abuse; can direct health resources away from health needs; intrusive assessment process	Some organ donation policies	Include only irreplaceable people who have suffered serious losses

Table 1: **Simple principles and their core ethical values**

	Principles included	Advantages	Objections
UNOS points systems for organ allocation in the USA	First-come, first-served; sickest-first; prognosis	Can combine all possible principles; flexible	Includes least justifiable principles: first-come, first-served and sickest-first; low priority given to prognosis; vulnerable to bias and manipulation, such as being listed on multiple transplantation lists and misrepresentation of health status; allows multiple organ transplants, thus saving fewer lives
QALY allocation	Prognosis; excludes save the most lives	Maximises future benefits; considers quality of life; used in many existing, quantitatively sophisticated frameworks	Outcome measure disadvantages disabled people; incorrect conception of equality by focusing on equality of QALYs rather than equality of persons; does not incorporate many relevant principles
DALY allocation	Prognosis; instrumental value; excludes save the most lives	Maximises future benefits; includes instrumental value, saving people whose productivity is key to a flourishing society	Outcome measure disadvantages disabled people; age considered as modifying value of individual life-years, rather than from standpoint of distributive justice; definition of instrumental value is too focused on economic worth, and could justify bias towards heads of household and other "traditional" social positions; does not incorporate many relevant principles
Complete lives system	Youngest-first; prognosis; save the most lives; lottery; instrumental value, but only in public health emergency	Matches intuition that death of adolescents is worse than that of infants or elderly; everyone has an interest in living through all life stages; incorporates the largest number of relevant principles; resistant to corruption	Reduced chances for persons who have lived many years; life-years are not a relevant health care outcome; unable to deal with international differences in life expectancy; need lexical priority rather than balancing; complete lives system is not appropriate for general distribution of health care resources

UNOS=United Network for Organ Sharing. QALY=quality-adjusted life-years. DALY=disability-adjusted life-years.

Table 2: **Four multiprinciple systems**

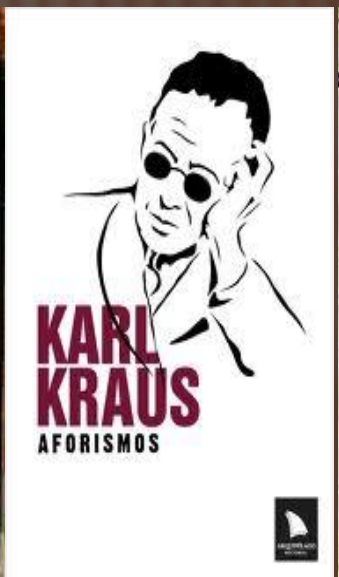
Allocation of very scarce medical interventions such as organs and vaccines is a persistent ethical challenge. We evaluate eight simple allocation principles that can be classified into four categories: treating people equally, favouring the worst-off, maximising total benefits, and promoting and rewarding social usefulness. No single principle is sufficient to incorporate all morally relevant considerations and therefore individual principles must be combined into multiprinciple allocation systems. We evaluate three systems: the United Network for Organ Sharing points systems, quality-adjusted life-years, and disability-adjusted life-years. We recommend an alternative system—the complete lives system—which prioritises younger people who have not yet lived a complete life, and also incorporates prognosis, save the most lives, lottery, and instrumental value principles.



IV)- SERÁ o RECURSO à TECNOLOGIA A (ÚNICA) RESPOSTA POSSÍVEL?

" ... O DESENVOLVIMENTO TECNOLÓGICO SÓ DEIXA UM PROBLEMA POR RESOLVER: A DEBILIDADE DA NATUREZA HUMANA..." *(SIC.) (KARL KRAUS, 1874-1936)*






ORIGINAL ARTICLES

How Do Physicians Respond to Patients' Requests for Costly, Unindicated Services?

Thomas H. Gallagher, MD, Bernard Lo, MD, Margaret Chesney, PhD, Kate Christensen, MD


OBJECTIVE: To determine how physicians respond to a request for an expensive, unindicated test.

DESIGN: Cross-sectional observational study.

SETTING: Four sites of a group-model HMO.

PARTICIPANTS: Thirty-nine internist volunteers.

INTERVENTION: A standardized patient requesting magnetic resonance imaging (MRI) of the head to rule out multiple sclerosis (MS) was inserted unannounced into physicians' regular schedules. The patient's only complaint was fatigue with no neurologic symptoms.

MEASUREMENTS AND MAIN RESULTS: Physicians and standardized patients completed assessments after each visit. Thirty-five (90%) of 39 physicians "had no idea" that the patient they saw was the standardized patient, and the remaining four participants (10%) were only "somewhat suspicious." Three (8%) of the physicians agreed to the MRI at the initial visit, and eight (22%) said they might order an MRI in the future. All doctors who refused the MRI told the patient this was based on lack of a medical indication for the test; seven (19%) also cited the test's expense. Twenty physicians (53%) of 38 agreed to a neurology referral. In response to the standardized patient's concerns, nine physicians (23%) verbalized that MS is scary, and four (10%) asked the patient about their friend's experience with MS. A few physicians appeared to dismiss the patient's concerns, such as by telling the patient they were being "paranoid."

CONCLUSIONS: Few physicians agreed to a standardized patient's request for a medically unindicated MRI, but more than half agreed to refer this patient to a specialist. As physicians practice cost-conscious medicine, they may need to focus on good communication to maintain patient satisfaction.

KEY WORDS: patients' requests; managed care; conflict of interests; doctor-patient communication.
J GEN INTERN MED 1997;12:663–668.

Table 1. Physician Response to Standardized Patient Visit

Physician Behavior	%	Number/Total
Responding to patient's concerns about MS		
Acknowledged the uncertainty involved in diagnosing MS	49	19/39
Said early diagnosis of MS is not useful because no therapy exists	41	16/39
Verbalized that MS is scary	23	9/39
Told me that even if test were positive I might not have MS	23	9/39
Told me if test were negative I could still have MS	15	6/39
Asked if I would be reassured by a negative test	13	5/39
Asked me to say more about my friend's experience with MS	10	4/39
Responding to patient's concerns about conflicts of interest		
Tried to answer my concerns about financial conflicts of interest	89	32/36
Told me it was reasonable to be concerned about financial conflicts of interest	8	3/36
Resolution of visit		
Outlined their plans for future care	59	23/39
Told me how to reach them personally before the next visit	36	14/39
Encouraged me to call back with questions or concerns	33	13/39
Solicited feedback from me on their plan for care	31	12/39

Journal of medical ethics 1994; 20: 12–18

CARDIFF UNIVERSITY

The ethics of screening: Is 'screeningitis' an incurable disease?

Darren Shickle and Ruth Chadwick *University of Wales College of Medicine and University of Cardiff, respectively*

Screening and the 'Worried Well'

STOP!

Are YOU Healthy?

ARE YOU SURE??

Did you know that there is a malignant disease called Screeningitis?

DON'T PANIC

There is a screening test available …

… and it is accurate …

… MOST of the time …

… BUT the treatment is PAINFUL !! …

… AND HAS A LOW SUCCESS RATE !!!

The principles proposed by Wilson and Junger (17) in the mid-1960s, have attracted much criticism. However, these criteria may be useful guidelines for the development of screening programmes:

1. The condition sought should be an important problem.
2. There should be an acceptable treatment for patients with recognised disease.
3. Facilities for diagnosis and treatment should be available.
4. There should be a recognised latent or early symptomatic stage.
5. The natural history of the condition, including its development from latent to declared disease, should be adequately understood.
6. There should be a suitable test or examination.
7. The test or examination should be acceptable to the population.
8. There should be agreed policy on whom to treat as patients.
9. The cost of case-finding (including diagnosis and subsequent treatment of patients) should be economically balanced in relation to the possible expenditure as a whole.
10. Case finding should be a continuous process and not a 'once and for all' project.

Clinical Medicine

Physical Diagnosis Versus Modern Technology
A Review

FAITH T. FITZGERALD, MD, *Sacramento, California*

- " ... um estudo retrospetivo realizado entre 1960 e 1989 a partir de 100 autópsias, concluiu que nessas três décadas, independentemente da enorme evolução verificada na tecnologia utilizada nos exames auxiliares de diagnóstico (sobretudo nos domínios da imagiologia), em cerca de 8 a 12% dos casos registou-se uma omissão de um diagnóstico que poderia ter tido implicações importantes no prognóstico vital, e noutros tantos casos não foi identificada uma doença que, independentemente da gravidade, não teria grande impacto no prognóstico, por falta de terapêutica eficaz disponível ... contudo, erros de diagnóstico devidos à não utilização criteriosa das tecnologia laboratoriais indicadas, ou pela pouca precisão do diagnóstico clínico, podem ser bastante dispendiosas devido a conflitos jurídicos, e terem consequências bastante funestas para os doentes ..." (sic.)

The role of physical diagnosis in an age of modern diagnostic technology has been evaluated by investigators assessing specific techniques in a number of areas, though there has been no systematic comprehensive study of the sensitivity, specificity, cost-benefit ratio, and reliability of physical diagnosis relative to technologic diagnostic tools. In a review of published studies comparing physical with nonphysical diagnostic techniques, the startling accuracy of physical diagnosticians in some areas contrasts sharply with the extremely poor correlation of physical findings with autopsy or imaging studies in others. In a time of constricting financial resources, physicians—and those who teach or judge physicians' skills—must begin to compare physical and nonphysical diagnostic techniques rigorously so that the best, safest, and least expensive diagnostic test is chosen in each clinical situation.

(Fitzgerald FT: Physical diagnosis versus modern technology—A review. West J Med 1990 Apr; 152:377-382)

J Med Ethics: Medical Humanities 2001;27:10–19

Medical Technology

Medical Technology Challenge

The technological invention of disease

Bjørn Hofmann *University of Oslo, Norway*

UNIVERSITAS OSLOENSIS MDCCCXI

- "... a Tecnologia faz hoje em dia parte intrínseca do conceito de Doença, dado que passou a ser o seu meio privilegiado de avaliação ..." *(sic.) (Hofman,B, J. Med. Ethics, 2001, 27, 10-19)*

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J Law Med Ethics. Author manuscript; available in PMC 2011 February 2.

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J Law Med Ethics!3121!449)2*;!8ê24/!epj;21/22220ir2859.831Y/3121/11571/y/

The Hippocratic Bargain and Health Information Technology

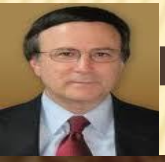
Mark A. Rothstein, J.D.
Herbert F. Boehl Chair of Law and Medicine and Director of the Institute for Bioethics, Health Policy and Law at the University of Louisville School of Medicine

From Hippocrates to facsimile

Protecting patient confidentiality is more difficult and more important than ever before

Daniel Y. Dodek, BSc; Arthur Dodek, MD

- "...a Confidencialidade é um Direito dos Doentes, nunca um Privilégio ..." *(sic) (DY Dodek, A Dodek, Can. Med. Assoc. J, 1997, 156, 6, 847-852)*



HISTORICAL PERSPECTIVE

From Hippocrates to modern medicine

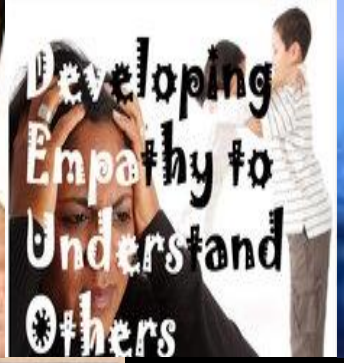
CE Orfanos*

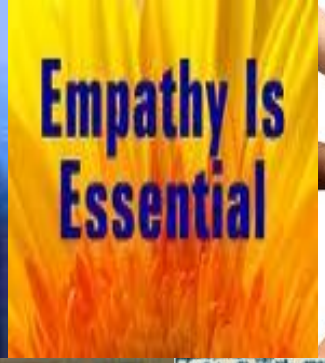
- " ... a medicina moderna perdeu as suas características originais de uma postura de compaixão para com o enfermo sofredor. Os pacientes transformaram-se em seres anónimos, as intervenções cirúrgicas deram o lugar a meros procedimentos identificados através de código de barras, as salas de reanimação e os blocos operatórios dos nossos hospitais assemelham-se cada vez mais com o "*cockpit*" de um avião, rodeados da mais sofisticada parafernália eletrónica ... contudo, os desenvolvimentos recentes nos domínios da farmacogenética e da proteínomica reforçam cada vez mais a necessidade de não prescindirmos no futuro, de mantermos uma visão holística e individualizada da prática médica ... finalmente, parece-me vital para manter a credibilidade do exercício da atividade médica, saber permanecer fiel às normas da ética profissional, e resistir aos "*lobbies*" que teimam em transformar este inolvidável mister num puro e mero negócio ..." *(sic.) (Orfanos, CE, JEADV, 2007, 21, 852-858)*

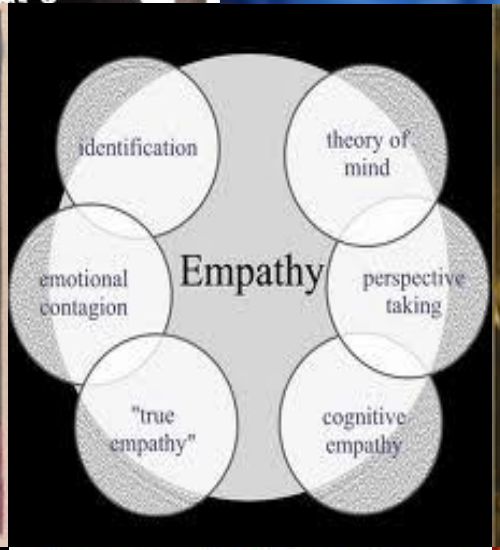


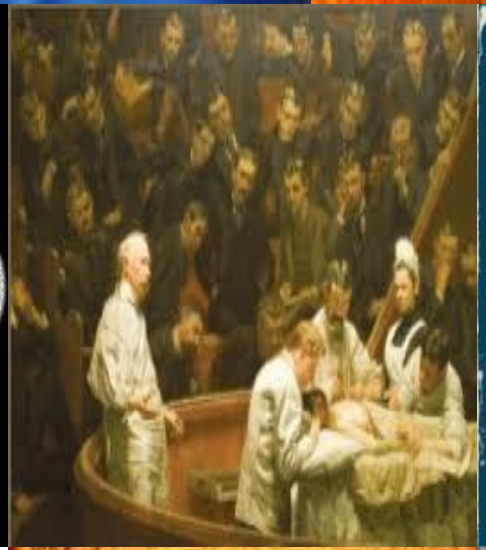


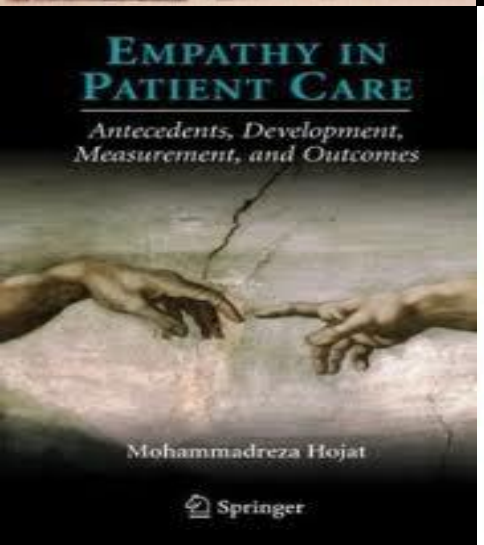


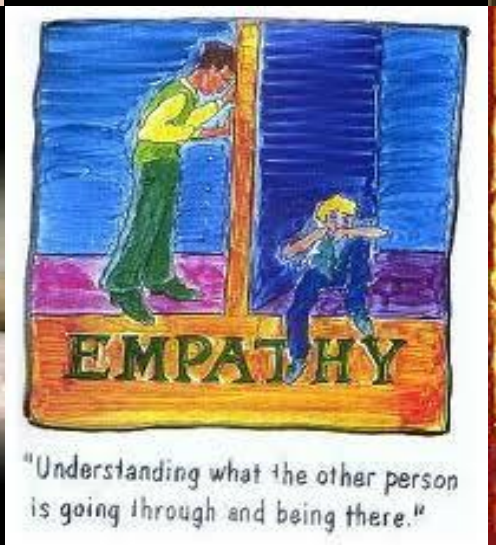


Developing
Empathy to
Understand
Others

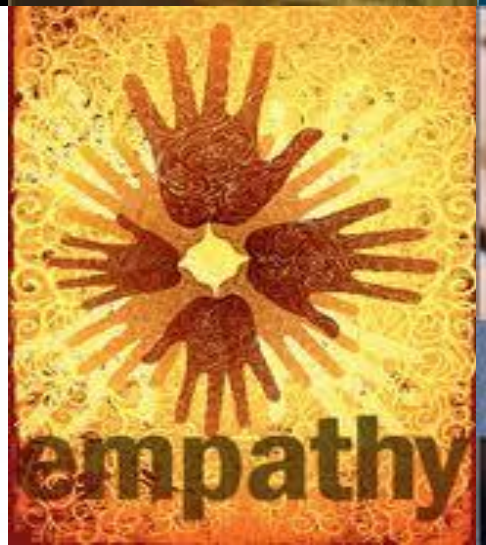

Empathy Is
Essential


identification
theory of mind
emotional contagion
Empathy
perspective taking
"true empathy"
cognitive empathy




EMPATHY IN
PATIENT CARE
Antecedents, Development,
Measurement, and Outcomes
Mohammadreza Hojat
Springer


EMPATHY
"Understanding what the other person
is going through and being there."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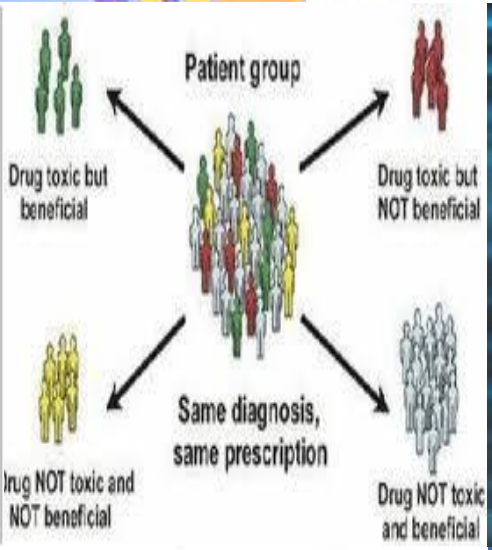
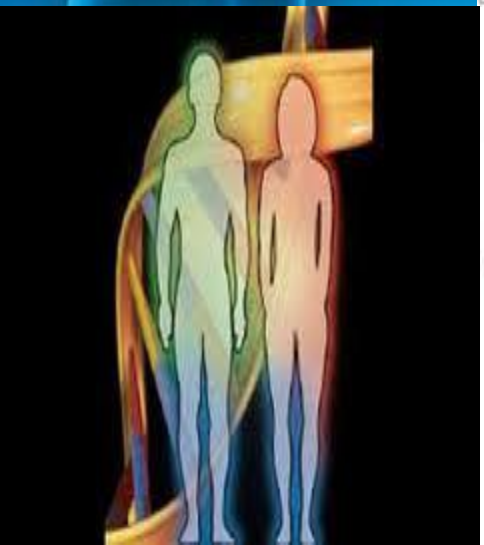
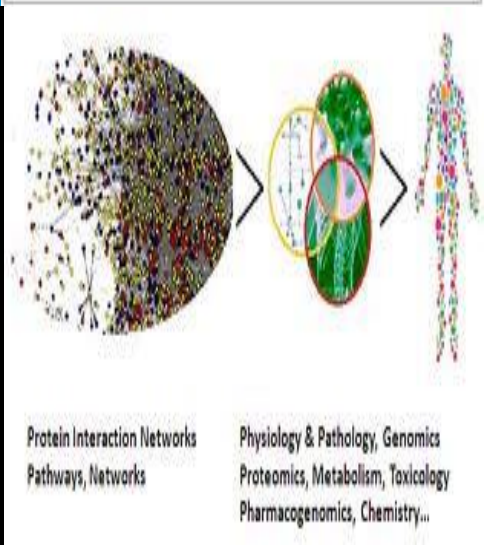
Microbiome
Xeno-metabolome


Patient group
Drug toxic but beneficial
Drug toxic but NOT beneficial
Same diagnosis, same prescription
Drug NOT toxic and NOT beneficial
Drug NOT toxic and beneficial




Protein Interaction Networks
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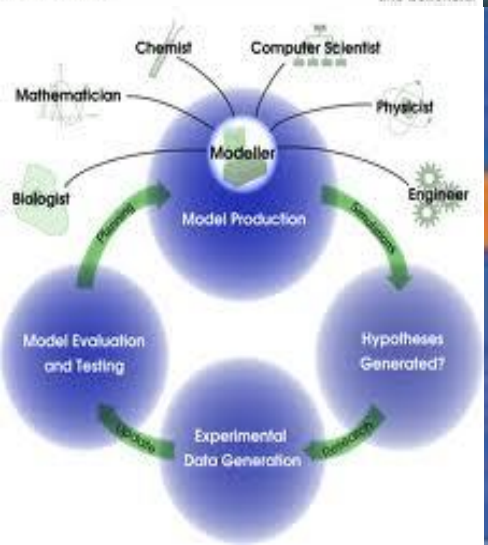
Physiology & Pathology, Genomics
Proteomics, Metabolism, Toxicology
Pharmacogenomics, Chemistry...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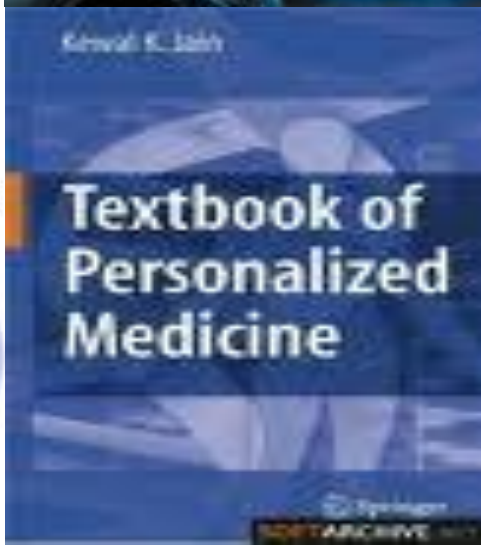
Modeller
Biologist
Engineer
Model Production
Model Evaluation and Testing
Hypotheses Generated?
Experimental Data Generation


Textbook of
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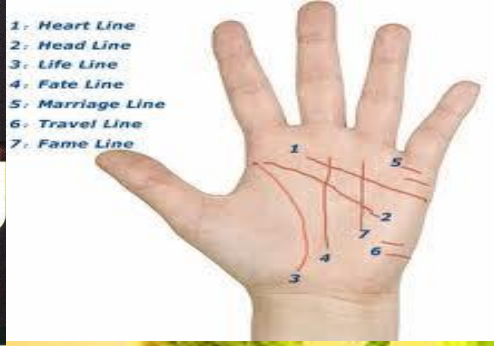
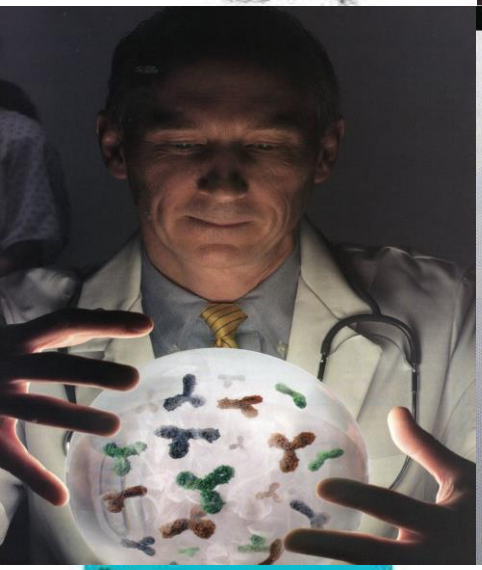
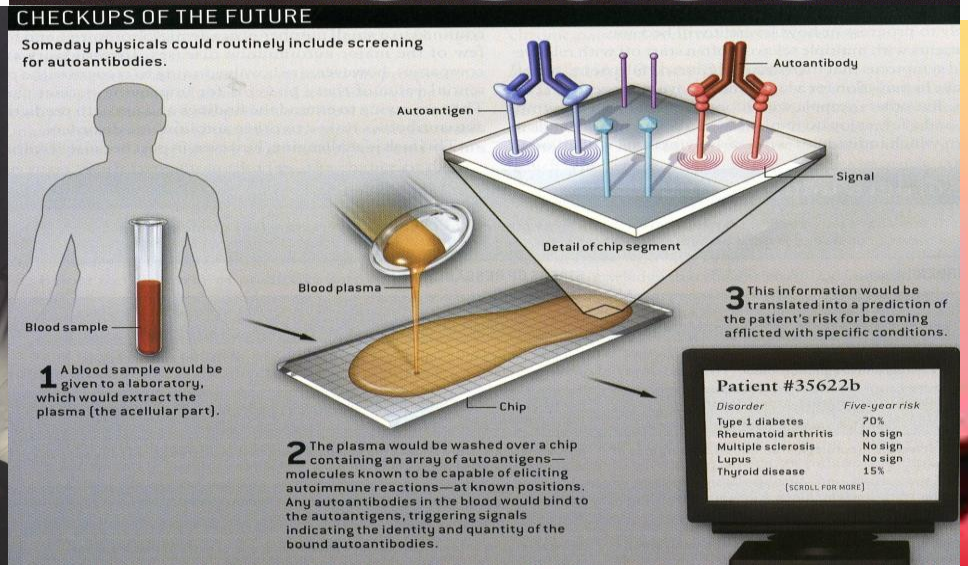
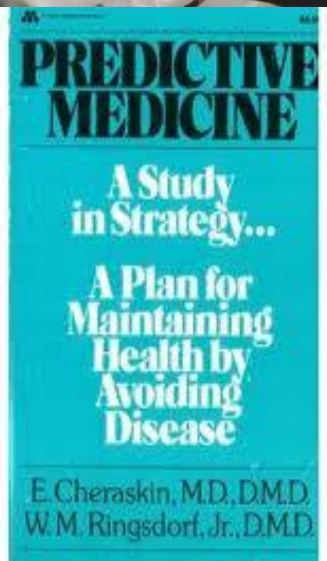
Antibodies could foretell the future of your health

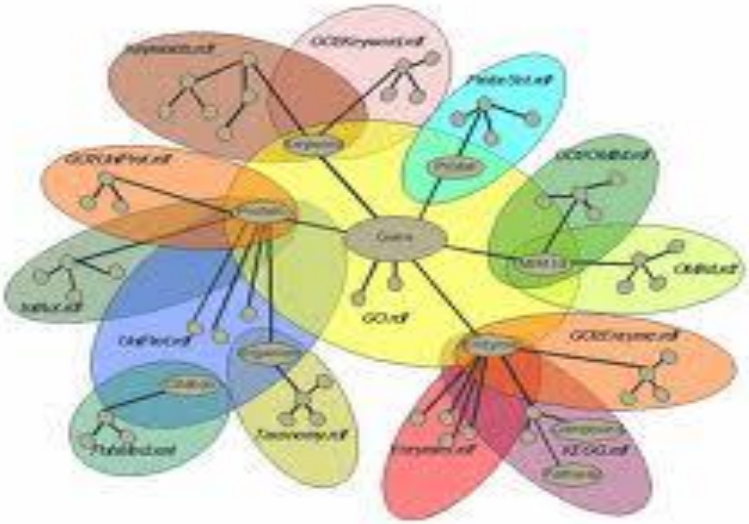
Predicting Disease

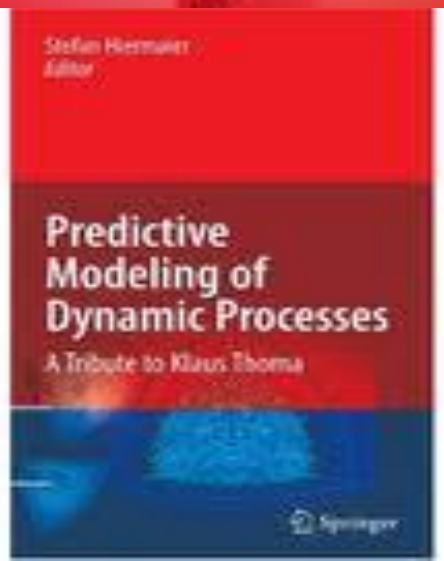












Current Drug Targets, 2006, 7, 1721-1727

Why should We Bother? Ethical and Social Issues in Individualized Medicine

Norbert W. Paul[1,*] And Heiner Fangerau[2]

[1]*Johannes Gutenberg-University of Mainz Medical School, Institute for History, Philosophy and Ethics of Medicine, Am Pulverturm 13, 55131 Mainz, Germany and* [2]*University of Düsseldorf Medical School, Box 10 10 07, 40001 Düsseldorf, Germany*

Hum Genet (2011) 130:3–14
DOI 10.1007/s00439-011-1028-3

REVIEW PAPER

Personalized medicine: new genomics, old lessons

Kenneth Offit

Received: 10 February 2011 / Accepted: 30 May 2011 / Published online: 26 June 2011

Hum Genet (2011) 130:3–14

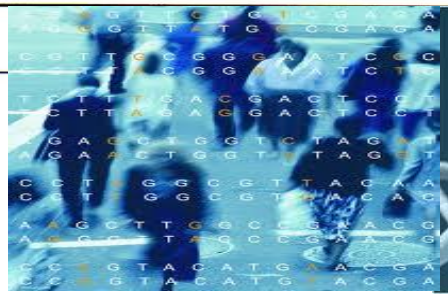
Table 1 Examples of genetic and genomic testing in personalized medicine

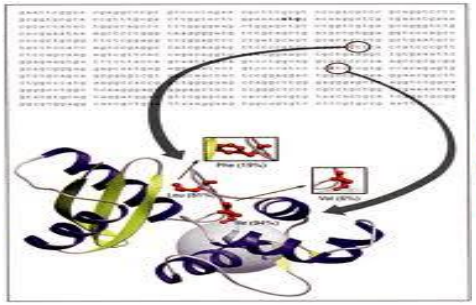
Pre-symptomatic risk assessment
- *BRCA1/2* testing for breast cancer[a]
- Lynch syndrome testing for hereditary colon cancer[b]
- Long QT interval[c,d]
- Spinal Muscular Atrophy[e]

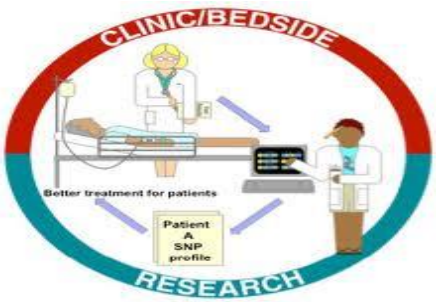
Diagnosis
- Beta thalassemia[f]
- Fusion genes and rearrangements including *BCR-ABL, E2A-PBX1, TEL-AML1*, and *MLL* in pediatric leukemia[g]
- Gene expression profiles define subtypes of breast cancer[h]
- Human Papilloma Virus detection[i]
- Hepatitis C detection[j]
- PCR detection of micro-organisms (bacteria, fungi)[k]

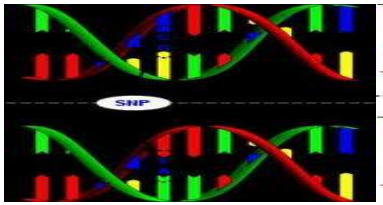
Prognosis
- Fragile X syndrome (number of trinucleotide repeats predicts severity)[l]
- Gene expression signatures and prognosis in breast cancer[m]
- Gene expression analysis and lymphoma prognosis[n]

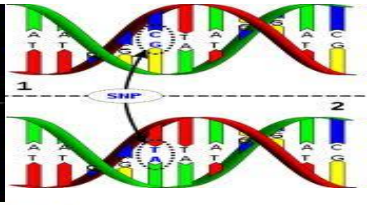
Treatment and pharmacogenomics
- Therapies for targeted gene mutations in cancer[o]
  - *EGFR* point mutations in lung cancer and glioblastoma and cetuximab, gefitinib, erlotinib, panitumumab, lapatinib treatment
  - *KIT*, *PDGFR* mutations in sarcoma, glioma, liver and renal cancer, melanoma and imatinib, nilotinib, sunitinib, sorafenib treatment
  - *BRAF* mutations in melanoma treated by RAF inhibitors
  - *BCR-ABL* translocation in chronic myelogenous leukemia treated by imatinib
  - *KRAS* wild-type status correlated with resistance to EGFR inhibition
  - PARP inhibitors in *BRCA* mutant breast, ovarian, prostate and pancreatic cancer
  - Herceptin (Trastuzumab) in HER2 + breast cancer
- Pharmacogenomic applications[p]
  - *CYP 2C19*2* variant (rs4244285) associated with diminished clopidogrel response[q]
  - Rs2395029 testing for HLA-B*5701 allele, correlated with hypersensitivity to abacavir treatment for HIV+ patients[r]



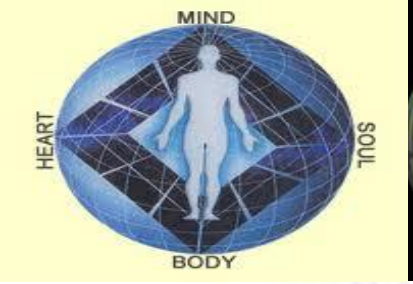








[a] Robson and Offit (2007), [b] EGAPP (2009a), [c] Napolitano et al. (2005), [d] Lehnart et al. (2007), [e] Prior et al. (2008), [f] Galanello and Origa (2010), [g] Carroll et al. (2003), [h] Sorlie et al. (2001), [i] Nicol et al. (2010), [j] Pham et al. (2010), [k] Tsalik et al. (2010), [l] Sherman et al. (2005), [m] Kim and Paik (2010), [n] Rosenwald et al. (2002), [o] Macconaill and Garraway (2010), [p] U.S. Food and Drug Administration (2011), [q] Shuldiner et al. (2009), [r] Colombo et al. (2008)



Another View of Holistic Medicine

Physical

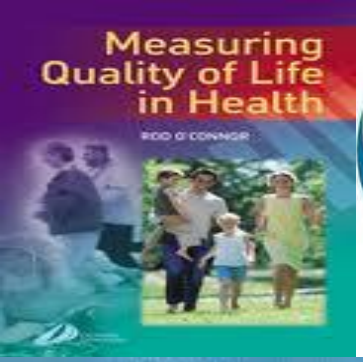
Surgeon, Physical Therapist, General Practitioner, Medication, Exercise, Meditation

Mental

Psychotherapist, Psychiatrist, Counselor, Hobby, Vacation, Meditation, Religion

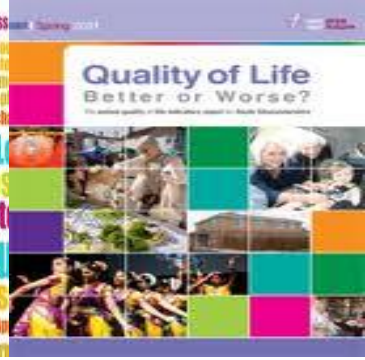
Energetic

Acupuncture, Homeopathy, Yoga, Tai Chi, Chi Gong, Meditation, Religion


Measuring
Quality of Life
in Health
ROD O'CONNOR


Quality of Life

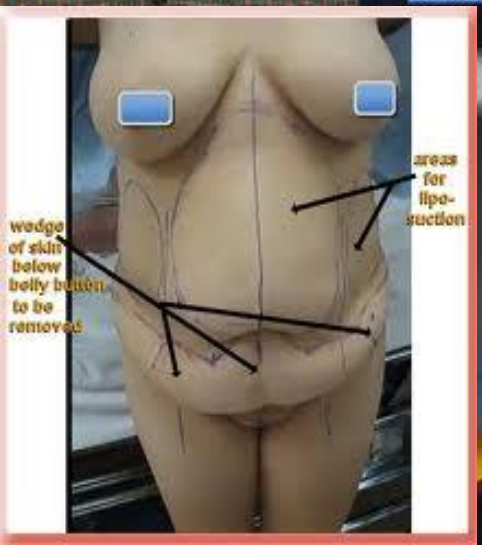

Liposuction
Medical
Anesthetic
Doctor
Devices
Many
Different
General
Make
Suction-Assisted
Sterilized
Thighs
Fat


Quality of Life
Better or Worse?


BEFORE

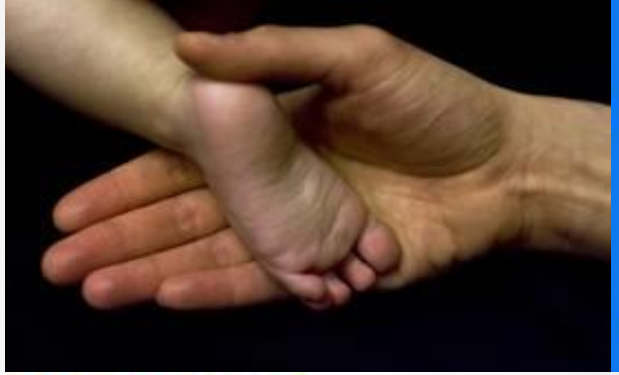

AFTER

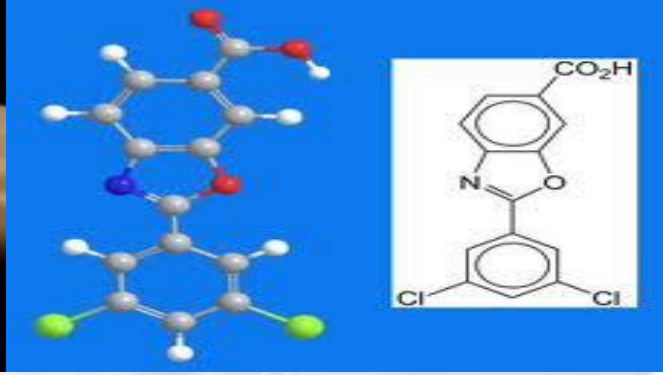

Michael Jackson
1958-2009


areas for lipo-suction
wedge of skin below belly button to be removed


before
after


Vyndaqel 20 mg
soft capsules
tafamidis
For Oral Use
30 soft capsules




CO2H
N
O
Cl
Cl


Caminhada Solidária
ESPOSENDE em MOVIMENTO
DIA 31 DE JULHO
PARTICIPAÇÃO DA ROSA MOTA
CONCENTRAÇÃO E INSCRIÇÃO
9H00 - Piscinas Foz do Cávado
5 Euros - com oferta de t-shirt e outros brindes
PROGRAMA
9H30 - Caminhada
11H00 - Aérobica e alongamentos
INFORMAÇÕES
APP - Núcleo de Esposende
Tel: 253 966 776
Inscrição no local
ASSOCIAÇÃO PORTUGUESA DE PARAMILOIDOSE
NÚCLEO DE ESPOSENDE
Juntos contra a Paramiloidose
Patrocínios:


+/- 4 KM
A DESCER
25-07-2009
ORGANIZAÇÃO
GSM
Inscrições limitadas
COM O APOIO:

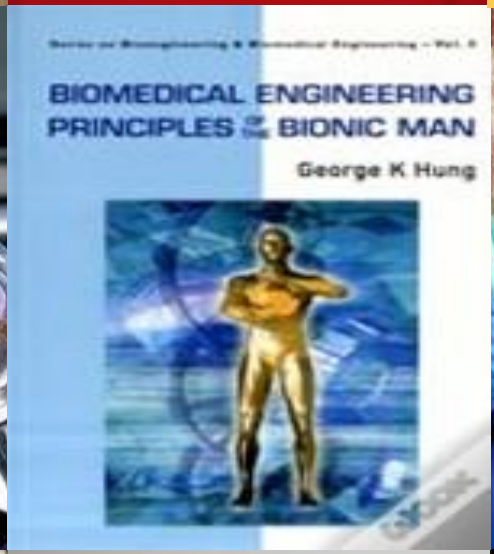

DIA NACIONAL
DE LUTA CONTRA A
PARAMILOIDOSE
ONDE ESTAMOS E PARA ONDE VAMOS?
16 JUNHO 11:00 HORAS

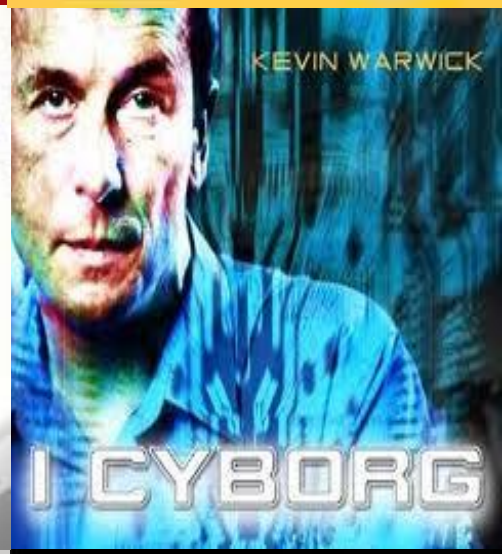

ASSOCIAÇÃO PORTUGUESA DE PARAMILOIDOSE
30 anos
1979/2009
Três décadas
ao serviço da
Paramiloidose

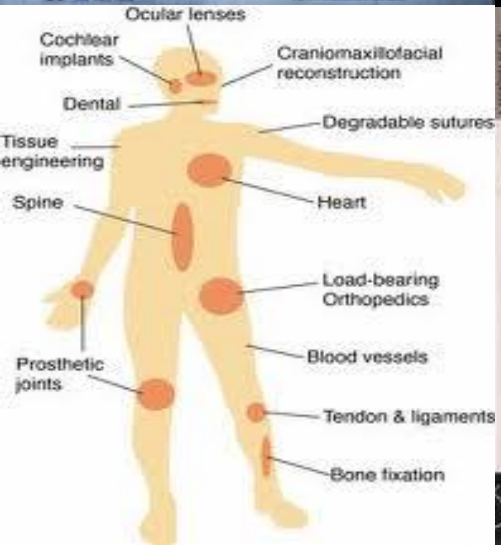

THE BIONIC MAN

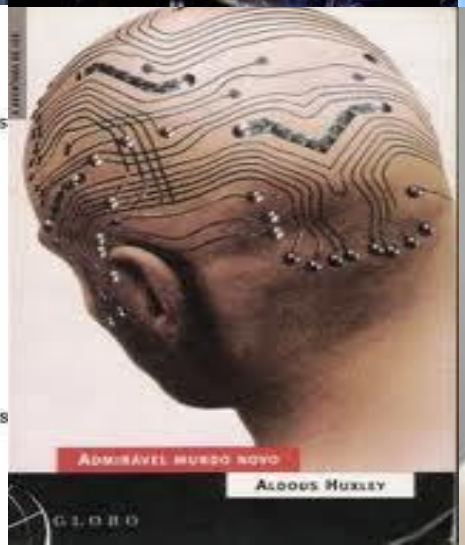

Artificial
Organs


PART MAN,
PART MACHINE,
ALL COP.
ROBOCOP


BIOMEDICAL ENGINEERING
PRINCIPLES OF THE BIONIC MAN
George K Hung


KEVIN WARWICK
I CYBORG


Ocular lenses
Cochlear implants
Craniomaxillofacial reconstruction
Dental
Degradable sutures
Tissue engineering
Heart
Spine
Load-bearing Orthopedics
Blood vessels
Prosthetic joints
Tendon & ligaments
Bone fixation


ADMIRÁVEL MUNDO NOVO
ALDOUS HUXLEY
GLOBO

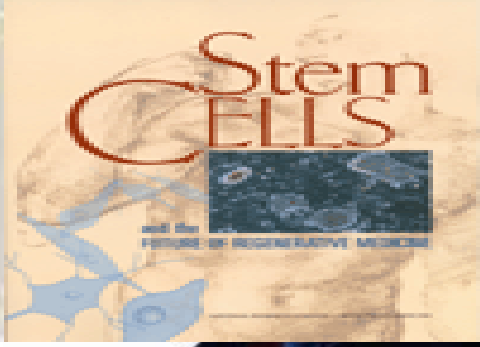
VISÃO
Newsletter
27 de Mai de 2012

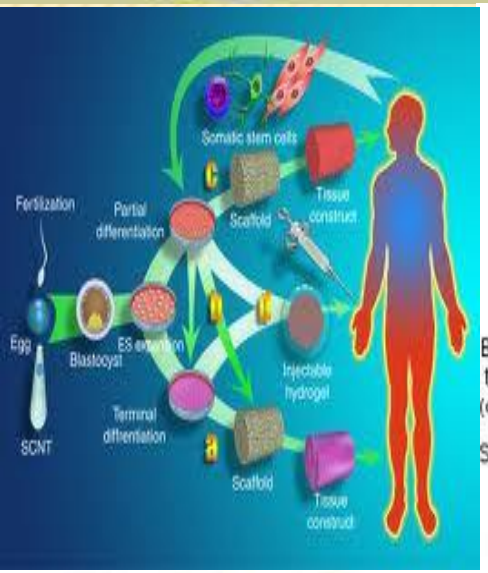
A história do primeiro 'cyborg' de carne e osso

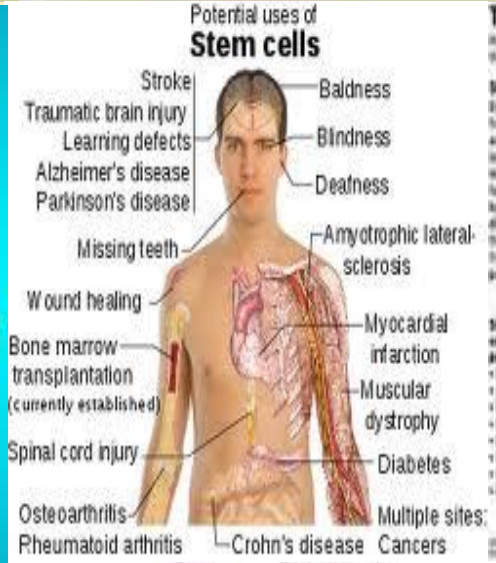
Conheça Neil Harbisson, o primeiro humano a ser oficialmente reconhecido enquanto homem/máquina. Incapaz de distinguir as cores, frequentemente troçado pela câmara sempre pendurada na cabeça, o 'cyborg' fala com paixão da correspondência entre as cores e as notas de música

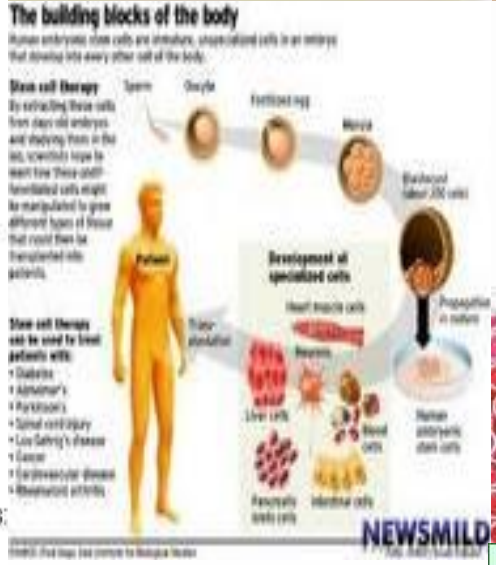

Regenerative
Medicine Today

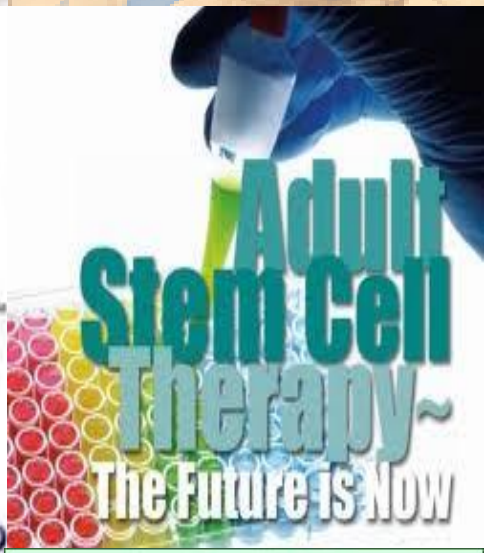

Non-Embryonic Stem Cell
Treatment, The Future is Here

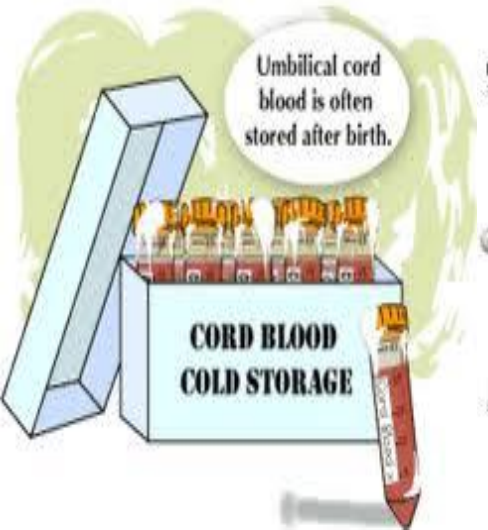

Stem
CELLS

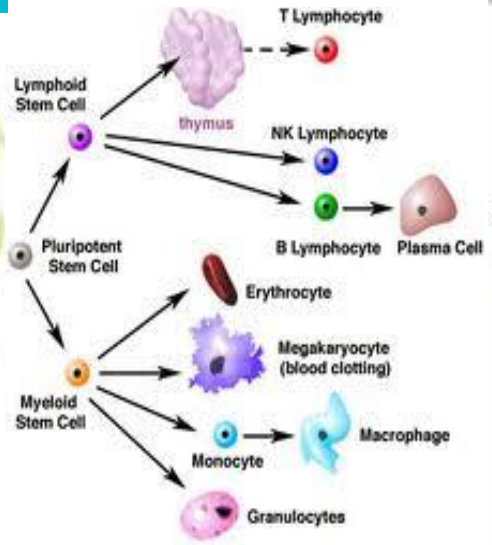

Somatic stem cells
Fertilization
Partial differentiation
Scaffold
Tissue construct
Egg
Blastocyst
ES extraction
Injectable hydrogel
Terminal differentiation
SCNT
Scaffold
Tissue construct


Potential uses of
Stem cells
Stroke
Traumatic brain injury
Learning defects
Alzheimer's disease
Parkinson's disease
Missing teeth
Wound healing
Bone marrow transplantation (currently established)
Spinal cord injury
Osteoarthritis
Rheumatoid arthritis
Baldness
Blindness
Deafness
Amyotrophic lateral-sclerosis
Myocardial infarction
Muscular dystrophy
Diabetes
Multiple sites:
Crohn's disease
Cancers

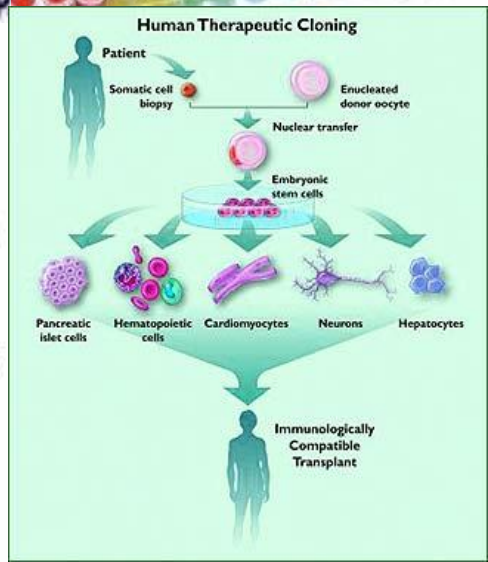

The building blocks of the body
Stem cell therapy
Development of specialized cells
NEWSMILD


Adult
Stem Cell
Therapy~
The Future is Now

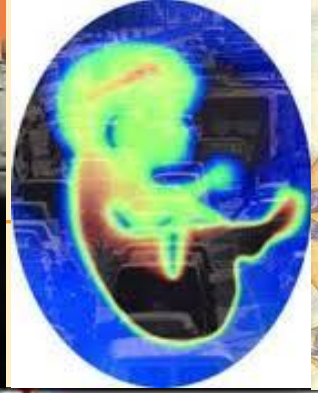

Umbilical cord blood is often stored after birth.
CORD BLOOD
COLD STORAGE

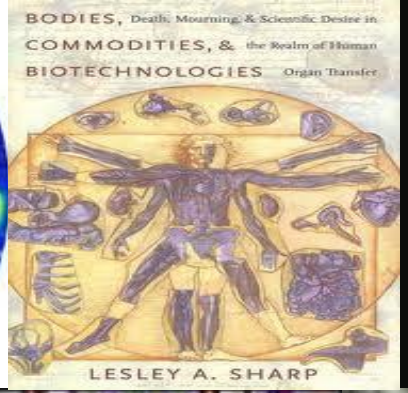

T Lymphocyte
Lymphoid Stem Cell
thymus
NK Lymphocyte
B Lymphocyte
Plasma Cell
Pluripotent Stem Cell
Erythrocyte
Megakaryocyte (blood clotting)
Myeloid Stem Cell
Macrophage
Monocyte
Granulocytes


Marrow Stroma
Gene Delivery
Bone
Cardiac Muscle
Adipose
STEM CELLS
Cartilage
Tendon & Ligament
Biopharmaceuticals

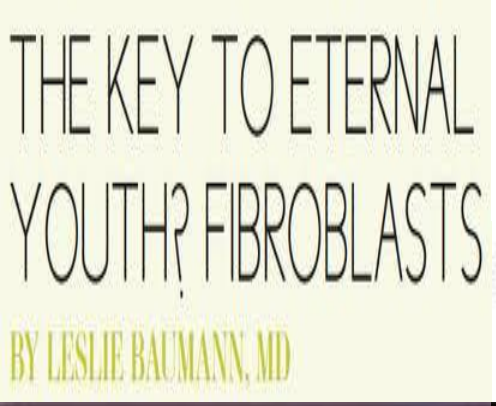

Human Therapeutic Cloning
Patient
Somatic cell biopsy
Enucleated donor oocyte
Nuclear transfer
Embryonic stem cells
Pancreatic islet cells
Hematopoietic cells
Cardiomyocytes
Neurons
Hepatocytes
Immunologically Compatible Transplant


HUMAN
CLONING
right or wrong?




BODIES, Death, Mourning, & Scientific Desire in
COMMODITIES, & the Realm of Human
BIOTECHNOLOGIES Organ Transfer
LESLEY A. SHARP


TIME
HUMAN
CLONING
IS CLOSER
THAN YOU
THINK
For couples who can't have a child—
or who have lost one—the unthinkable
may soon be possible. Here are the perils

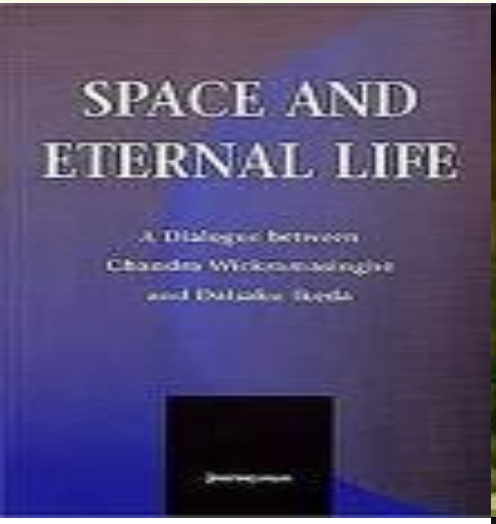

THE KEY TO ETERNAL YOUTH? FIBROBLASTS
BY LESLIE BAUMANN, MD


I WANT TO LIVE FOREVER

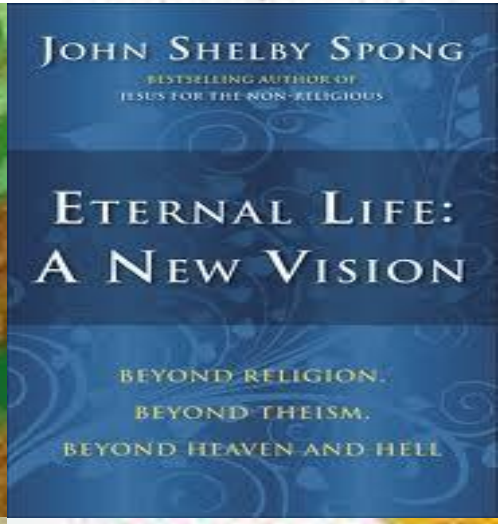

I DO NOT WANT TO DIE

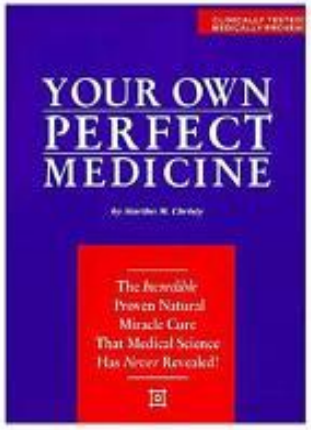

Eternal Youth
still you, just better

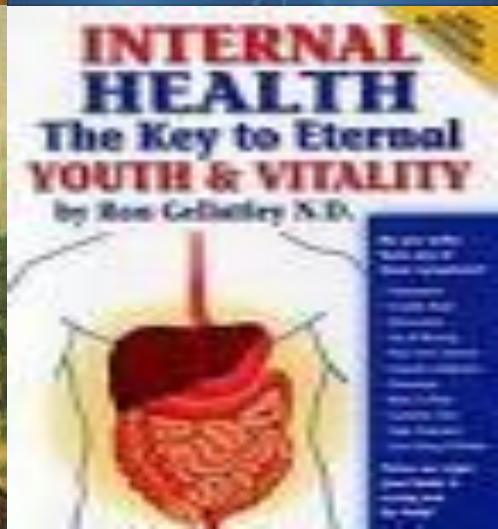

Eternal Youth
beauty salon

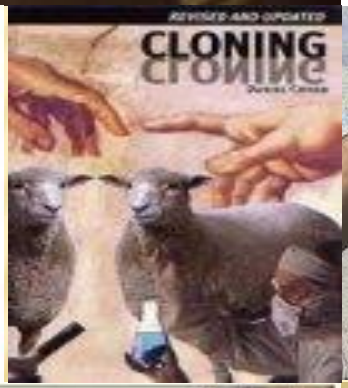

SPACE AND ETERNAL LIFE
A Dialogue between

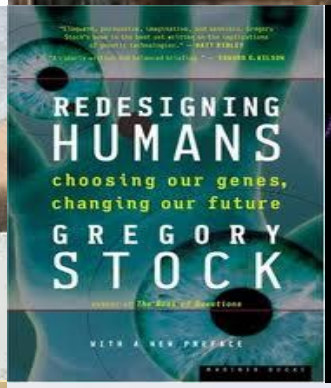

Permanent youth

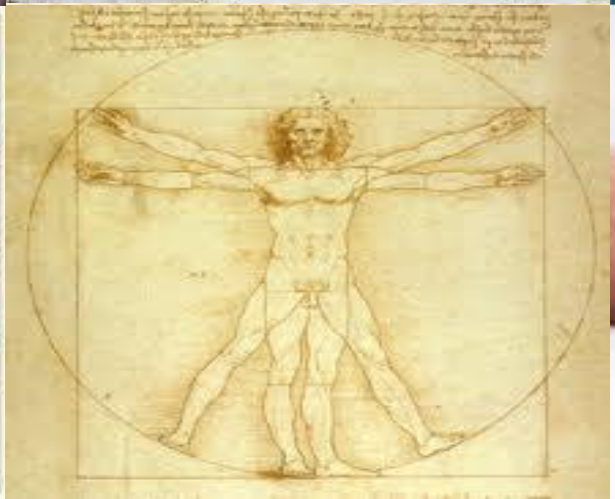

JOHN SHELBY SPONG
BESTSELLING AUTHOR OF JESUS FOR THE NON-RELIGIOUS
ETERNAL LIFE: A NEW VISION
BEYOND RELIGION,
BEYOND THEISM,
BEYOND HEAVEN AND HELL


YOUR OWN PERFECT MEDICINE
The Incredible Proven Natural Miracle Cure That Medical Science Has Never Revealed!


INTERNAL HEALTH
The Key to Eternal YOUTH & VITALITY


REVISED AND UPDATED
CLONING


REDESIGNING
HUMANS
choosing our genes,
changing our future
GREGORY
STOCK



PHILOSOPHICAL TRANSACTIONS OF THE ROYAL SOCIETY B

Phil. Trans. R. Soc. B (2011) **366**, 108–112
doi:10.1098/rstb.2010.0288

Review

Tragedy and delight: the ethics of decelerated ageing

David Gems*

Institute of Healthy Ageing, and G.E.E., Darwin Building, University College London, Gower Street, London WC1E 6BT, UK

Biogerontology is sometimes viewed as similar to other forms of biomedical research in that it seeks to understand and treat a pathological process. Yet the prospect of treating ageing is extraordinary in terms of the profound changes to the human condition that would result. Recent advances in biogerontology allow a clearer view of the ethical issues and dilemmas that confront humanity with respect to treating ageing. For example, they imply that organismal senescence is a disease process with a broad spectrum of pathological consequences in late life (causing or exascerbating cardiovascular disease, cancer, neurodegenerative disease and many others). Moreover, in laboratory animals, it is possible to decelerate ageing, extend healthy adulthood and reduce the age-incidence of a broad spectrum of ageing-related diseases. This is accompanied by an overall extension of lifespan, sometimes of a large magnitude. Discussions of the ethics of treating ageing sometimes involve hand-wringing about detrimental consequences (e.g. to society) of marked life extension which, arguably, would be a form of enhancement technology. Yet given the great improvements in health that decelerated ageing could provide, it would seem that the only possible ethical course is to pursue it energetically. Thus, decelerated ageing has an element of tragic inevitability: its benefits to health compel us to pursue it, despite the transformation of human society, and even human nature, that this could entail.

Keywords: ageing; decelerated ageing; disease; ethics; longevity




Thalidomide

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100

Talidomida
Apoio, informação e orientação


Wellcome Images





FACE TRANSPLANT
gone wrong
Bone
Nerve
Cartilage
Gland
Artery
Vein
I dream my new face will help me find love
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30 | CIÊNCIA | PÚBLICO, SEX 22 JUN 2012

Publicado último artigo sobre o vírus da gripe das aves feito em laboratório

Depois de meses de discussão e receios de bioterrorismo, o segundo trabalho sobre o vírus H5N1, modificado para ser transmissível entre mamíferos, foi revelado. Mas este tipo de investigação parou

NATURE | NEWS

Fears grow over lab-bred flu

Scientists call for stricter biosafety measures for dangerous avian-influenza variants.

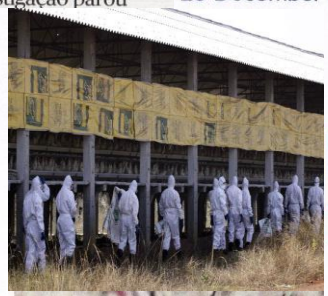
Declan Butler

20 December 2011

H5N1 Bird Flu Effects Downplayed as WHO Calls for Weaponized Strain to Go Public

Risk = Hazard + Outrage

The Peter Sandman Risk Communication Website



THE HINDU

Tim McCoy
NaturalSociety
February 24, 2012

S & T

'Lab-created H5N1 viruses removed natural barriers'

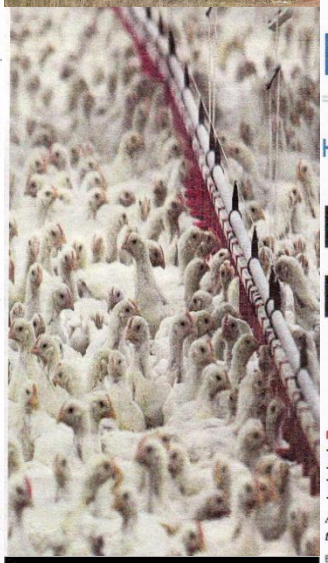
R. PRASAD

The H5N1 Debate Needs Respectful Dialogue, Not "Education" or One-Sided Advocacy

by Peter M. Sandman

(a February 17, 2012 email to Lisa Schnirring of *CIDRAP News*)

Lisa Schnirring's *CIDRAP News* article is also online.



Science News ... from universities, journals, and other research organizations

New H5N1 Viruses: How to Balance Risk of Escape With Benefits of Research?

Laboratory Mutant H5N1 Controversy

ScienceDaily
Your source for the latest research news

Science
CENSORED

As aves são o repositório natural da gripe: nelas surgiu o vírus H5N1

June 23, 2012

HUFF POST SCIENCE
THE INTERNET NEWSPAPER: NEWS BLOGS VIDEO COMMUNITY

BLOG

A New H5N1 Flu Virus? This Research Should Stop Now

Featuring fresh takes and real-time analysis from HuffPost's signature lineup of contributors
Hot on the Blog: Dr. Peggy DrexlerMarlo ThomasMuhammad Yunus

Posted: 02/19/2012 3:07 pm

Examiner.com

H5N1 | May 4, 2012 | ADD A COMMENT

Potentially deadly and highly transmissible H5N1 flu virus created in lab

TIME Healthland
A Healthy Balance of the Mind, Body and Spirit

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FLU

H5N1 Paper Published: Deadly, Transmissible Bird Flu Could Be Closer than Thought

After an epic debate over whether to release research detailing how scientists created H5N1 in the lab, Nature finally published one of the two controversial papers on Wednesday.

By BRYAN WALSH | @bryanrwalsh | May 3, 2012 | 3

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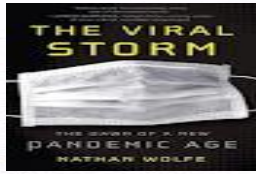


POLITICAL SCIENCE

Why is the U.S. government trying to control the contents of scientific journals?

EMORY

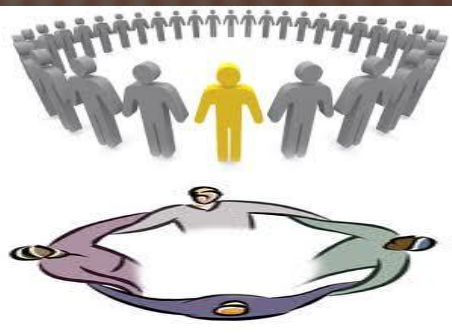
ROLLINS

SCHOOL OF

PUBLIC

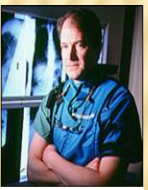
HEALTH

" ... PARECE QUE NOS HABITUAMOS A PENSAR NOS PROBLEMAS DE SAÚDE TAL COMO O FAZEMOS RELATIVAMENTE A TODOS OS OUTROS DE NATUREZA DIVERSA, EM QUE A CIÊNCIA E A TECNOLOGIA NOS HÁ-DE SALVAR, EMBORA NA REALIDADE A RESPOSTA DEVA ANTES SER ENCONTRADA SOBRETUDO NO SER HUMANO E NA SUA CAPACIDADE RELACIONAL ..." *(SIC.) (JAMES W. CURRAN)*



EM SUMA ...

- " ... a prática médica está presentemente numa posição algo vulnerável e indefinida, dado que é concebível que a própria Medicina se esteja a transformar em algo substancialmente diferente daquilo por que sempre clamou dever ser a sua verdadeira índole, ou seja, a missão de se dedicar essencialmente ao tratamento do Ser Humano enquanto Doente ... sendo por isso que acredito profundamente que o nosso maior desafio de natureza ética na situação presente é o do retorno a essa veneranda tradição ... " *(sic.) ("Medicine as a dependent tradition: Historical and Etical reflections", Richard Vance, Perspective in Biology and Medicine, 1985, 28, 2, 282 -302)*



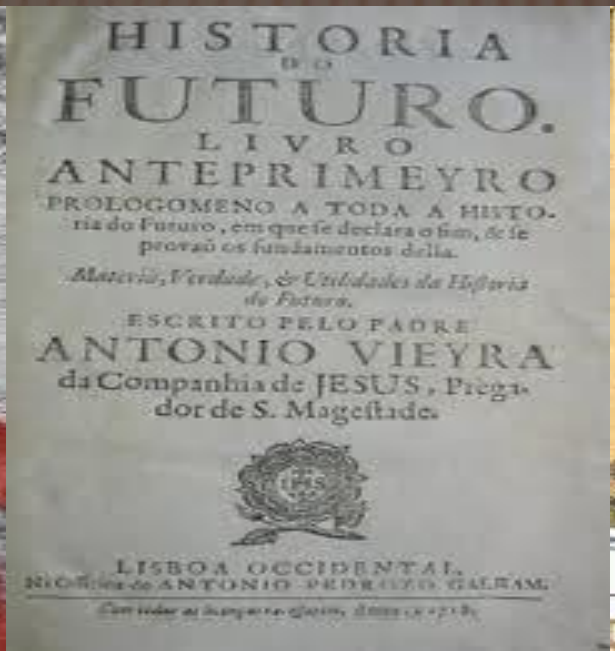
" ... o desenvolvimento das qualidades humanísticas e a compaixão pelos doentes por parte dos estudantes e dos jovens internos, constituem pilares básicos fundamentais para o exercício do nosso mister, o qual irá sempre requerer um acompanhamento permanente baseado no exemplo por parte dos respectivos professores e tutores, para os quais nunca será suficientemente apenas disponibilizarem meios tecnológicos, por mais sofisticados que possam ser ... " (sic.) (*"Is simulation based medicine training the future of clinical medicine?", JG, Murphy, et al, European Review for Medical and Pharmacological Sciences, 2007, 11, 1 -8)*

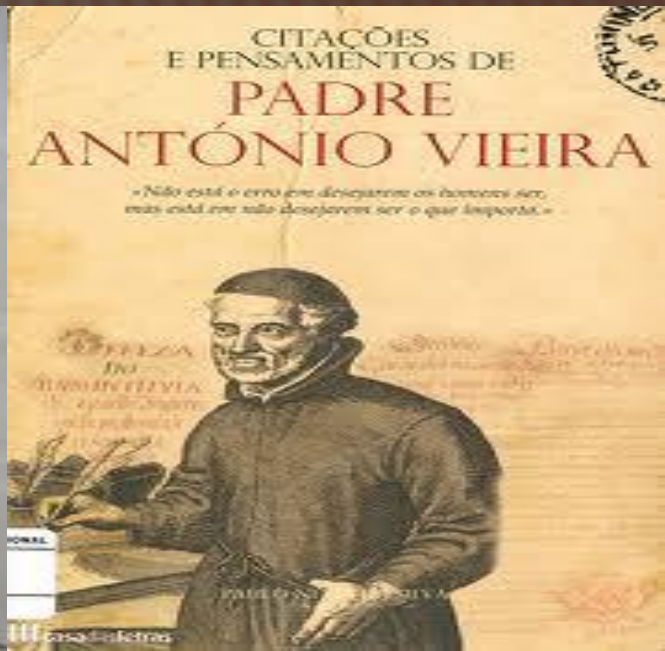
MAYO CLINIC




V)- SERÃO os PROBLEMAS da SAÚDE (SOBRETUDO) ECONÓMICO-FINANCEIROS?

" ... POUCO CONHECE A RIQUEZA DA SAÚDE QUEM CUIDA QUE POR ALGUM PREÇO PODE SER CARA, QUANTO MAIS CARÍSSIMA ..." *(SIC.) (PADRE ANTÓNIO VIEIRA 1608-1697)*

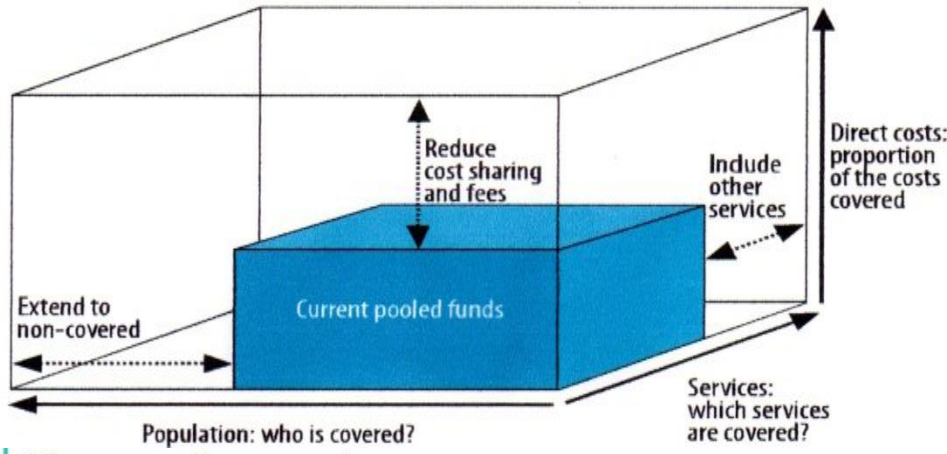




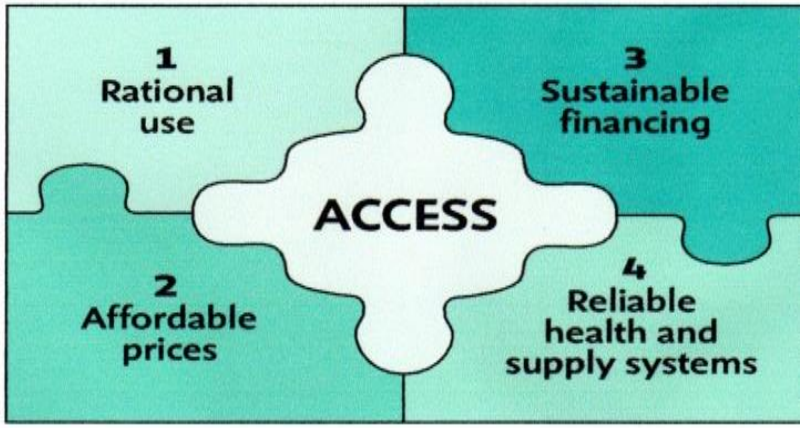
CONSTATAÇÕES DA REALIDADE

" ... existiu uma previsão supostamente realista segundo a qual no ano 2.000 nenhum país, ou sequer qualquer dos seus cidadãos, viesse a ter um nível de saúde inferior ao aceitável ... a Saúde Pública é a arte de saber aplicar a ciência num determinado contexto político para reduzir as desigualdades na prestação dos cuidados de saúde enquanto se assegura simultaneamente a melhor saúde possível a um maior número de pessoas ... a proporção do PNB alocado à Saúde deixou de crescer, e tem mesmo vindo a diminuir à escala planetária ... constatando-se que do total do dispêndio financeiro em investigação de novos fármacos, somente 10% corresponde às doenças que são responsáveis por 90% da mortalidade em todo o Mundo ... existindo cerca de 2 biliões de pessoas sem qualquer acesso aos medicamentos considerados essenciais ... calcula-se ainda que o desperdício orce entre 20 a 40 % do total daquilo que se gasta com a Saúde ... somente 20 % das pessoas têm uma cobertura social adequada, sendo calculado que para tal seriam apenas necessário cerca de 60 USD / pessoa / ano, em contraste com os actuais 20 USD, sendo certo que cerca de 50 % desta despesa é suportada directamente pelo próprio cidadão ... " *(WHO Reports, 1998, 2004 e 2010)*

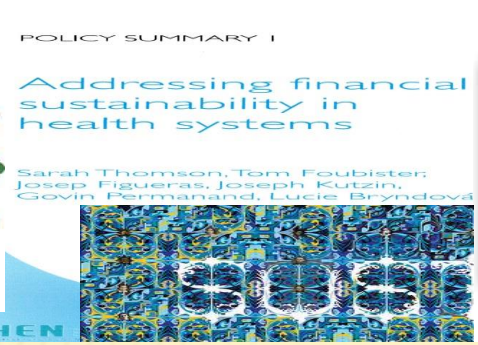
Fig. 1. **Three dimensions to consider when moving towards universal coverage**



The access framework

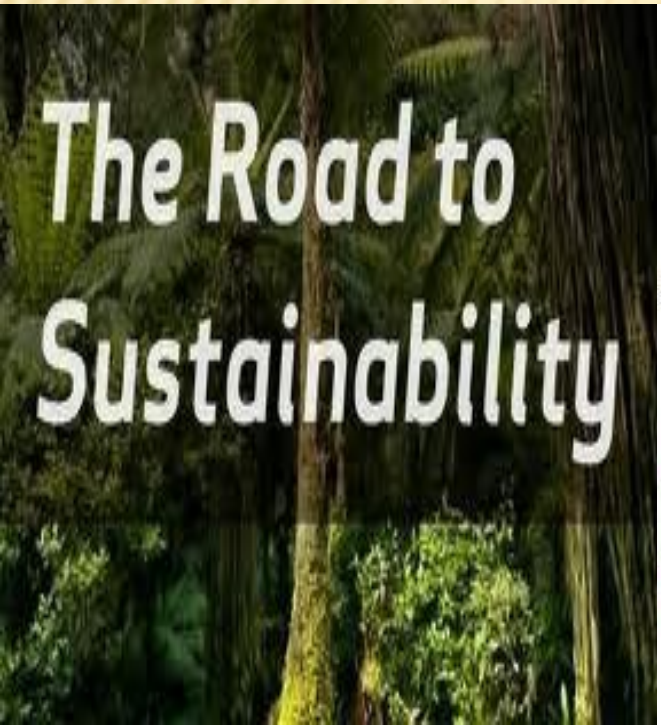


Source: WHO, 2000



- " ... a inovação tecnológica é o factor mais importante de incremento dos custos em saúde ...o envelhecimento "apenas" contribui com cerca de 10% ..." (EU Report, 2009)

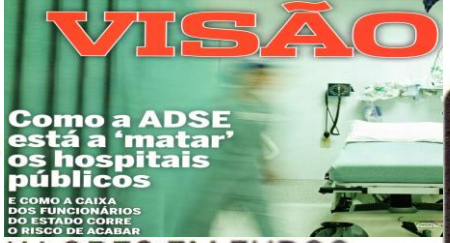
- " ... no debate acerca da sustentabilidade financeira relativa à prestação dos cuidados de saúde, talvez seja importante levantar a seguinte questão: Como é que ninguém questiona o facto de se gastar praticamente 12 % do PIB em actividades recreativas, mas simultaneamente toda a gente reclamar que se torna incomportável despender cerca de 10 % em saúde? ... " (Canada Report, 2002)



Quanto se paga

Valores a desembolsar pelos utentes são em grande parte dos casos mais vantajosos quando se está coberto pela ADSE

*Valores apurados mediante a análise dos planos propostos por quatro seguradoras



VALORES EM EUROS

	Em taxas moderadoras no SNS	Pela ADSE numa unidade privada convencionada	Através de seguro de saúde nos privados*
Consulta de clínica geral	5	3,49	12,5 a 20
Consulta de especialidade	7,50	3,99	10 a 50
Urgência	20	19,55	26 a 40
Raio-X Tórax, uma incidência	2,14	2	5 a 7,5
TAC Crânio	14	16	25 a 30

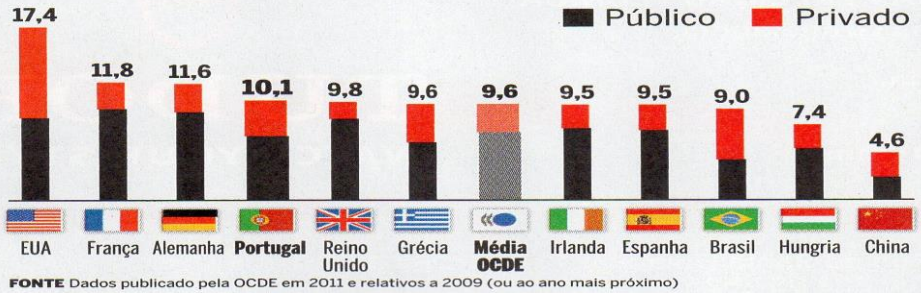
FONTE ADSE, Ministério da Saúde; Seguradoras INFOGRAFIA VISÃO

Contexto

Estamos realmente a gastar de mais?

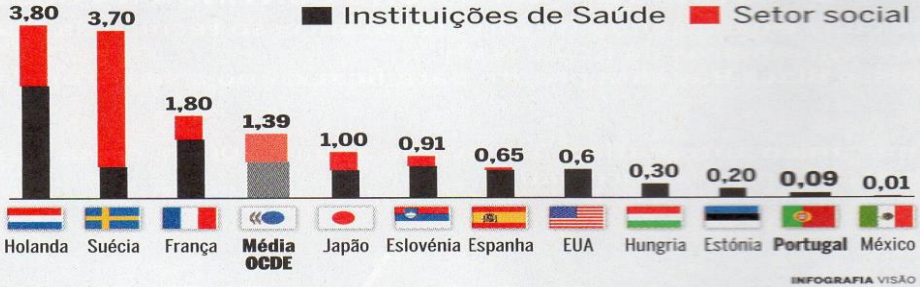
A abertura de um concurso para a contratação de médicos através da empresa que apresente a proposta mais barata foi apenas o rastilho que levou os médicos a convocarem dois dias de greve, para ontem, dia 11, e hoje, 12. Mas o setor já era suficientemente explosivo, sobretudo depois das notícias de que estavam a ser contratados enfermeiros a menos de 4 euros por hora. Apesar dos protestos da Ordem e dos sindicatos, o ministro da tutela, Paulo Macedo, tem invocado, para justificar todos os cortes efetuados desde que tomou posse, os gastos crescentes no setor. No entanto, os dados mais recentes publicados pela OCDE mostram que, em Portugal, as despesas públicas com a Saúde são um pouco mais baixas, em percentagem do PIB, do que a média. Já os gastos privados, são superiores. Uma das áreas em que Portugal menos investiu foi na rede de cuidados continuados, que permitiria libertar os hospitais de boa parte da sua população mais habitual, os idosos.

Gastos totais em % do PIB



FONTE Dados publicado pela OCDE em 2011 e relativos a 2009 (ou ao ano mais próximo)

Gastos com Cuidados Continuados em % do PIB



INFOGRAFIA VISÃO

A 'troika' põe-nos doentes

O Observatório Português dos Sistemas de Saúde dedicou desta vez o seu relatório de primavera exclusivamente aos efeitos que a crise económica tem provocado na saúde dos portugueses. O documento faz uma análise exaustiva das doenças que dispararam neste período e também de como tem sido mais difícil o acesso aos cuidados de saúde devido a várias repercussões da crise, como o aumento das taxas moderadoras ou o preço dos medicamentos. E conclui que os mais afetados foram os desempregados, os endividados e os idosos

Capa do relatório agora divulgado

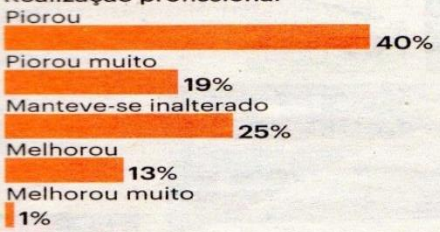
Consumo de antidepressivos e ansiolíticos

Dívidas e doenças mentais

Percepções dos profissionais de saúde no terreno

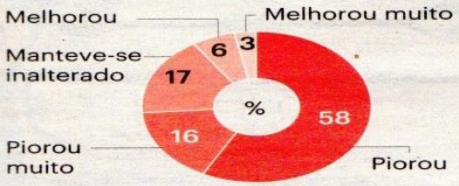
Médicos

Realização profissional

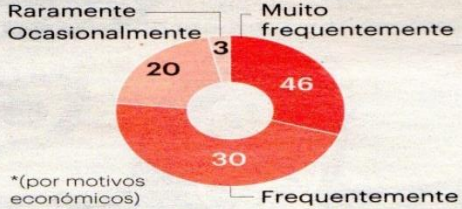


Perspectiva de futuro profissional

Acesso dos utentes aos cuidados de saúde



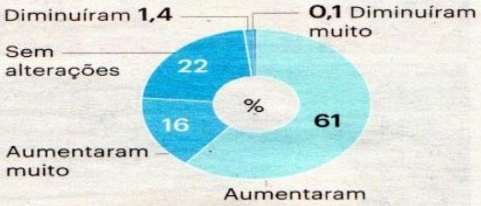
Dificuldades dos utentes no acesso aos medicamentos*



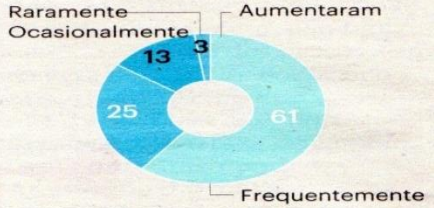
*(por motivos económicos)

Profissionais das USF

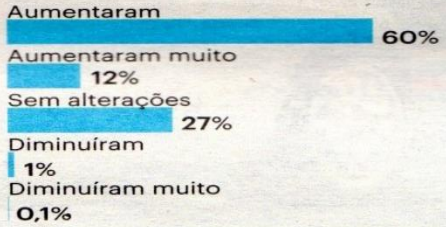
Dificuldades associadas às "taxas moderadoras"



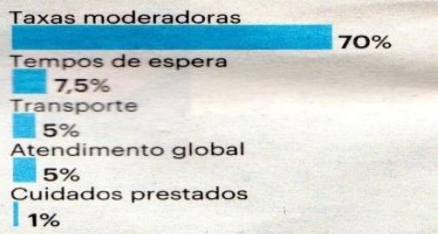
Dificuldades com aquisição de medicamentos



Dificuldade com a realização de exames complementares



Motivos de insatisfação dos utilizadores das USF



Inquérito online realizado entre 28 de Abril e 18 de Maio de 2012. Responderam 741 médicos, 51 % trabalham em hospitais públicos, 21% em USF, 10% em UCSP, 4% em hospitais PPP, 4% em hospitais privados, 2% em consultório privados e 7% noutros locais

(questionário aos membros da Associação Nacional de USF entre 11 e 31 de Maio de 2012, com 878 respostas (53% do total de inquiridos)

Nota: Os dados disponibilizados nem sempre perfazem 100%, porque nalguns casos não foram feitos os arredondamentos e noutros só foram usados os exemplos mais significativos

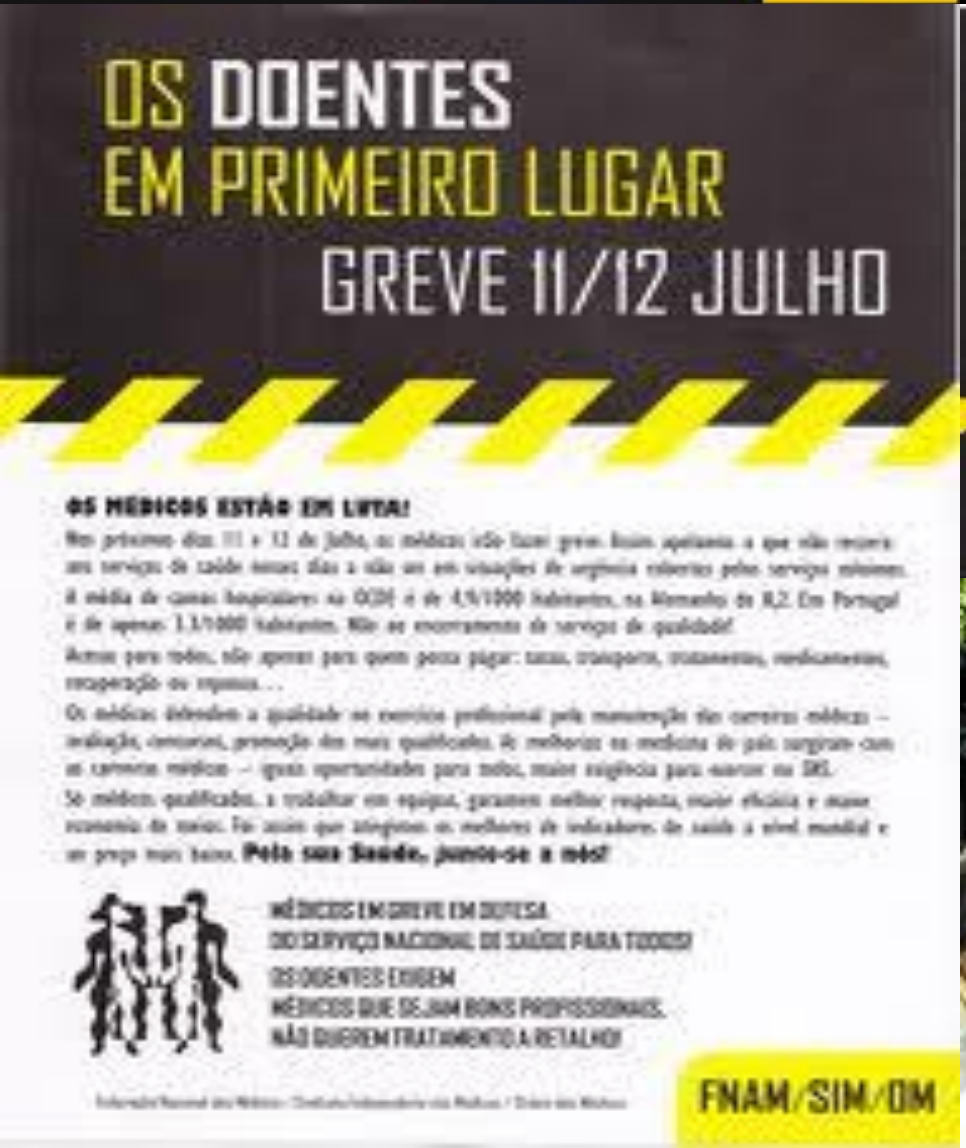
Fonte: Relatório de Primavera 2012 do Observatório Português dos Sistemas de Saúde

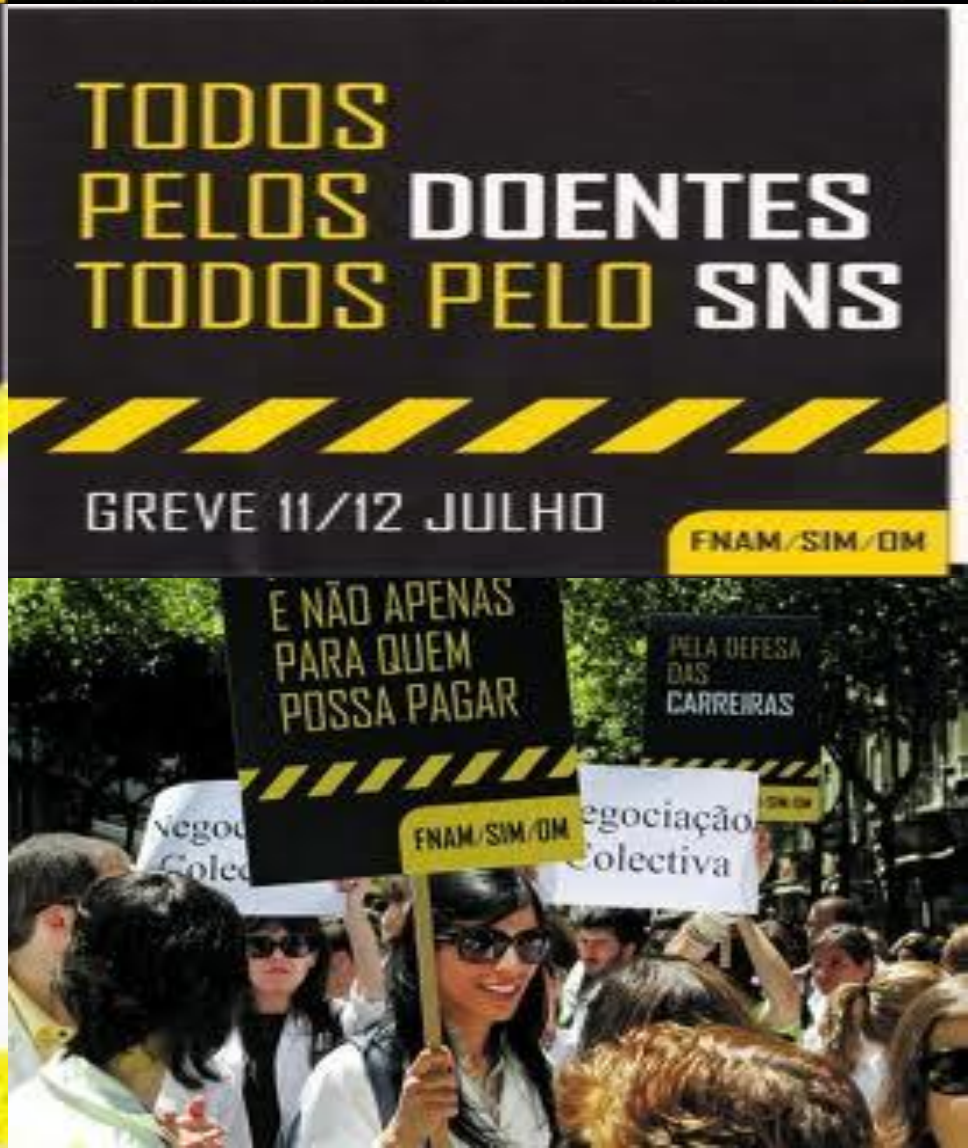
- "... qualquer alteração ou manipulação do código genético do SNS implica a destruição ou, pelo menos, a amputação da sua Alma ... a defesa do direito à saúde não é tanto uma questão ideológica, mas um imperativo moral ... governar é tornar o país mais justo, a sociedade mais harmoniosa e as pessoas mais felizes. Nesta lógica Humanista, o SNS não é uma Econometria, mas uma Deontologia ..." (sic.) (António Arnaut 2012/05/23, in Congresso Nacional de Medicina Interna)

- "... sou do tempo em que ter uma boa carreira médica era motivo de orgulho e satisfação ... o SNS estruturava-se em carreiras que asseguravam um excelente conjunto de profissionais, disponíveis para os doentes e em permanente atualização técnica ... há anos tudo acabou ... interessam os números e pouco importam as pessoas .... não existe qualquer exigência de qualidade ... a lógica parece assim ser a de contratar ao mais baixo custo ... os médicos contratados têm que fazer 4 consultas/hora ... a exigência do trabalho em equipa, característica dos bons serviços de saúde está agora comprometida ... não é possível fazer de conta que nada se passa ... é caso para dizer que a saúde dos portugueses é um assunto demasiado importante para ficar só por conta do Governo. Compete aos profissionais denunciar estas medidas .... dos cidadãos espera-se vigilância permanente, porque a hora é de atenção e de protesto ..." *(sic.) (Daniel Sampaio, in Público, 2012/06/17)*


MÉDICOS EM GREVE EM DEFESA
DO SERVIÇO NACIONAL DE SAÚDE
PARA TODOS!
OS DOENTES EXIGEM MÉDICOS
QUE SEJAM BONS PROFISSIONAIS.
NÃO QUEREM TRATAMENTO A RETALHO!
TODOS
PELOS DOENTES
TODOS PELO SNS
GREVE 11/12 JULHO
Federação Nacional dos Médicos
Sindicato Independente dos Médicos
Ordem dos Médicos
FNAM/SIM/OM


GREVE
NACIONAL
DOS MÉDICOS
11 e 12 de JULHO
Em defesa do Serviço Nacional de Saúde e dos Portugueses


OS DOENTES
EM PRIMEIRO LUGAR
GREVE 11/12 JULHO
OS MÉDICOS ESTÃO EM LUTA!
Pela sua Saúde, junte-se a nós!
MÉDICOS EM GREVE EM DEFESA
DO SERVIÇO NACIONAL DE SAÚDE PARA TODOS!
OS DOENTES EXIGEM
MÉDICOS QUE SEJAM BONS PROFISSIONAIS.
NÃO QUEREM TRATAMENTO A RETALHO!
FNAM/SIM/OM


TODOS
PELOS DOENTES
TODOS PELO SNS
GREVE 11/12 JULHO
FNAM/SIM/OM
E NÃO APENAS
PARA QUEM
POSSA PAGAR
PELA DEFESA
DAS
CARREIRAS
FNAM/SIM/OM
egociação
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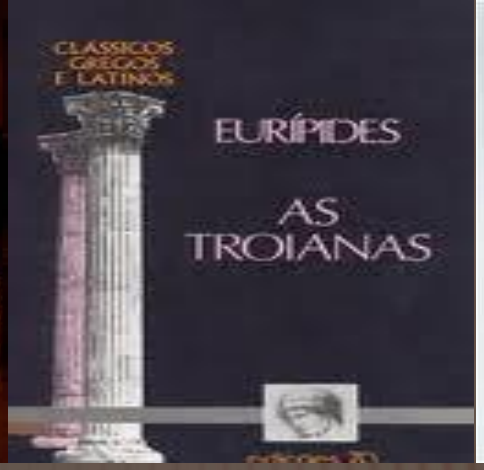
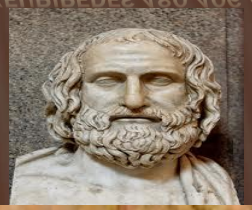
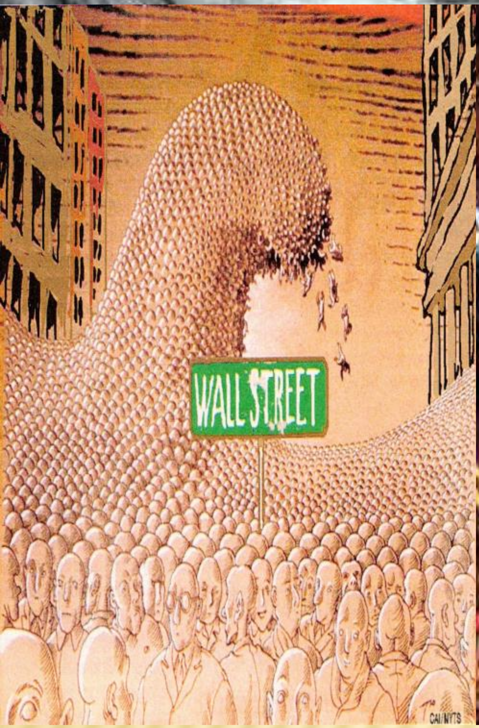


A RELATIVIZAÇÃO dos CONCEITOS ...

"... OS QUE DE UMA SITUAÇÃO DESAFOGADA CAEM NUM ESTADO DE PENÚRIA QUE LHES É ESTRANHO, ESSES, SOFREM MAIS CRUELMENTE DO QUE QUEM FOI SEMPRE MISERÁVEL..." (SIC.) *(EURÍPEDES 480-406 AC)*

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people
United States
Israel
democratic
must
change
region
rights
security
Egypt
power
support
Middle
America
Palestinians
world
peaceful
reform
Tunisia
North
East
democracy


DEMO
CRACIA


Somalia Famine


ENERGY PRICES
?
INFLATION
FINANCIAL CRISIS
THE CONSUMER.

VI)- E o que FAZER ENTÃO?

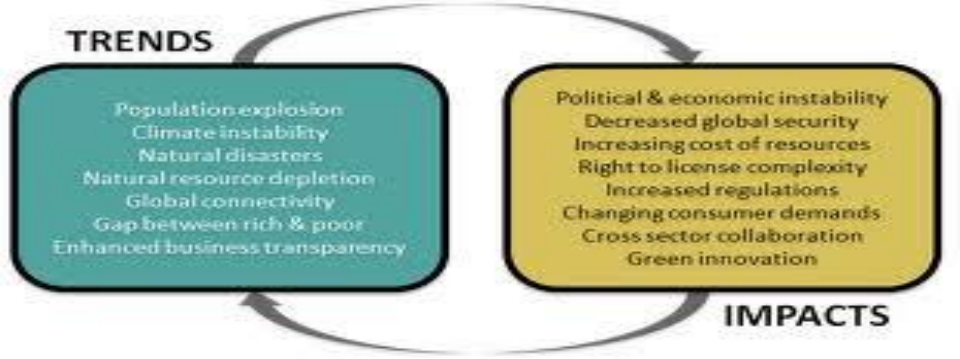
"… ONDE RESIDE A ESPERANÇA? O ÚNICO LUGAR SEGURO PARA A ESPERANÇA É O DA CERTEZA DA ÉTICA. O IMPERATIVO DE RESISTIR, PROCURAR ENCONTRAR SOLUÇÕES, FAZER O QUE É JUSTO …"

(SIC.) (VIRIATO SOROMENHO MARQUES IN VISÃO, 2012/06/21)

UNIVERSIDADE DE LISBOA

Universidade de Lisboa
FACULDADE DE LETRAS


Work Hard
Work Smart

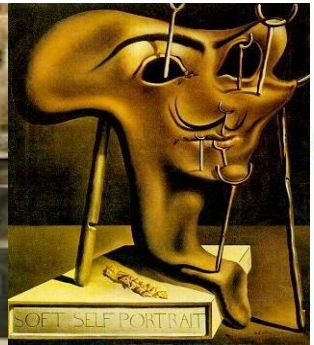

TRENDS
Population explosion
Climate instability
Natural disasters
Natural resource depletion
Global connectivity
Gap between rich & poor
Enhanced business transparency
Political & economic instability
Decreased global security
Increasing cost of resources
Right to license complexity
Increased regulations
Changing consumer demands
Cross sector collaboration
Green innovation
IMPACTS

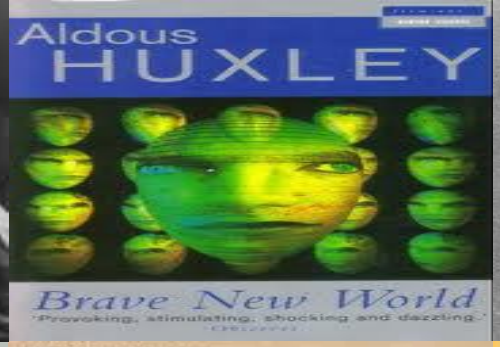

Análise de Prioridade
Análise de Falha
Análise de Decisão
Análise de Risco


Environmental Protection & Resource Conservation
Economic Prosperity & Continuity
Social Well-Being & Equity

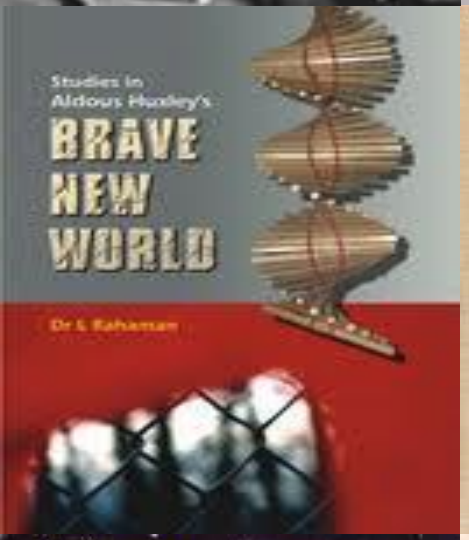

ação
Médico
Diretrizes clínicas
curiosidade
Estudos de análise econômica
Revisões sistemáticas
Pesquisas primárias

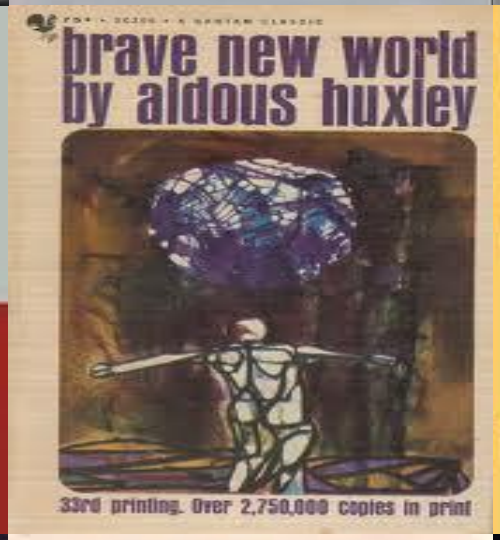

People
Bearable
Equitable
Sustainability
Planet
Viable
Profit


SOFT SELF PORTRAIT


Aldous
HUXLEY
Brave New World
"Provoking, stimulating, shocking and dazzling"

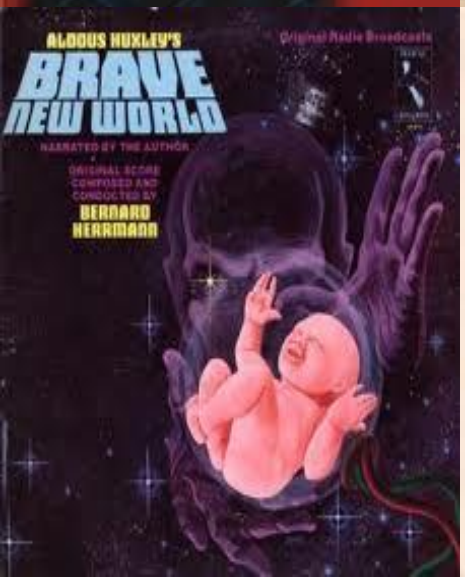

WAR IS PEACE
GEORGE ORWELL'S
1984

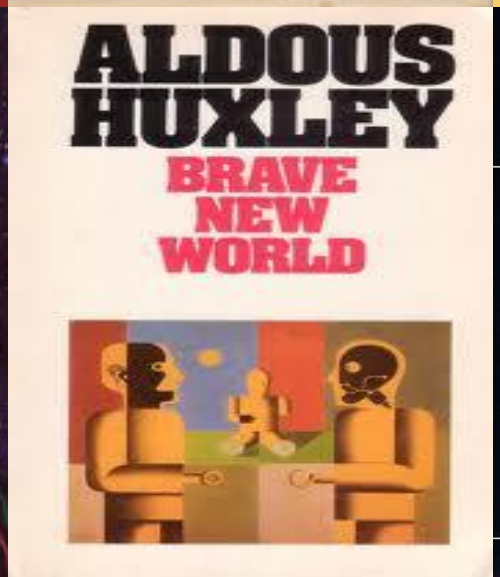

Studies in
Aldous Huxley's
BRAVE NEW WORLD
Dr S. Rahaman

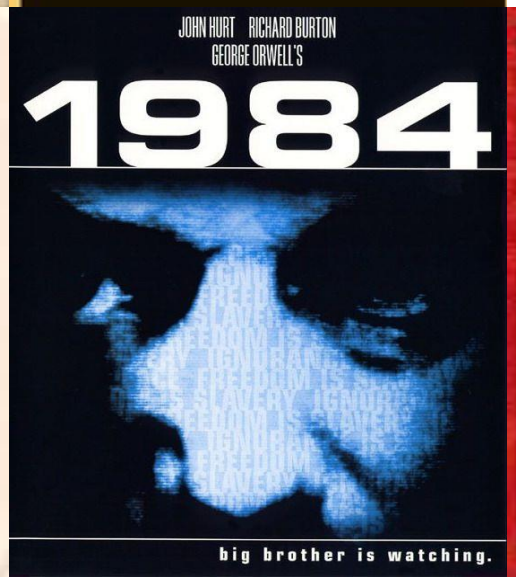

brave new world
by aldous huxley
33rd printing. Over 2,750,000 copies in print

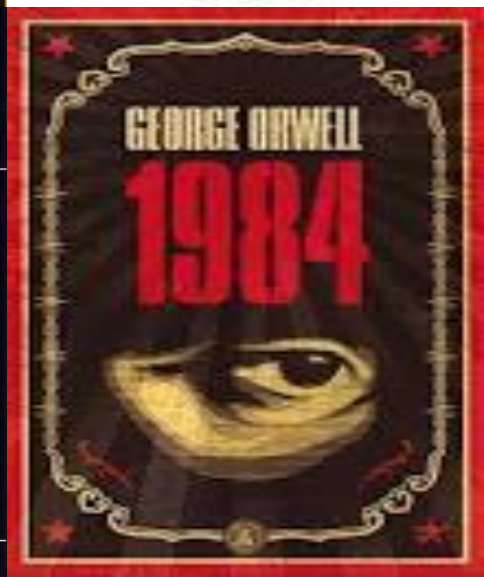

BIG
BROTHER
is watching you


BIG BROTHER
IS WATCHING
YOU

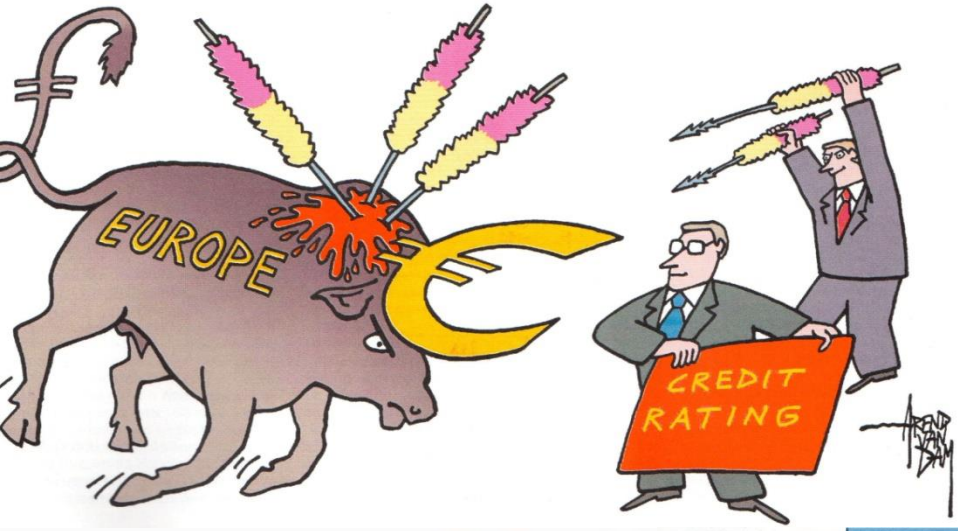

ALDOUS HUXLEY'S
BRAVE NEW WORLD
Original Radio Broadcasts
NARRATED BY THE AUTHOR
ORIGINAL SCORE COMPOSED AND CONDUCTED BY
BERNARD HERRMANN


ALDOUS
HUXLEY
BRAVE
NEW
WORLD

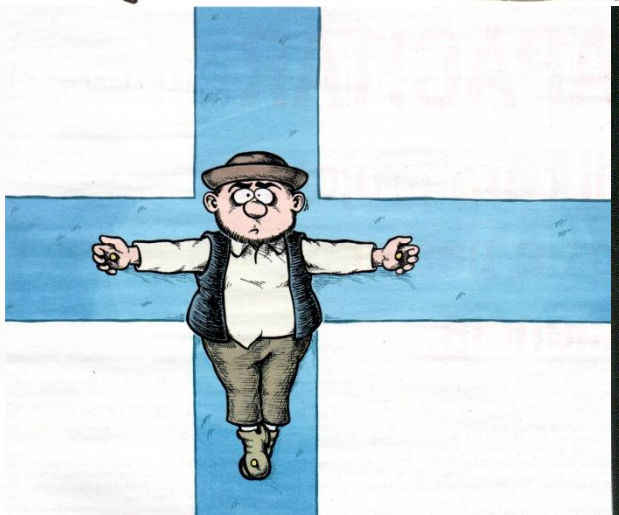

JOHN HURT RICHARD BURTON
GEORGE ORWELL'S
1984
big brother is watching.

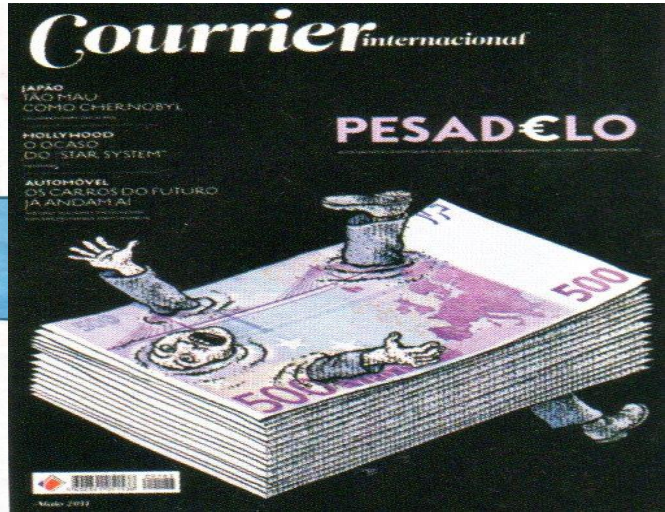

GEORGE ORWELL
1984


DEPTH GAUGE
50%

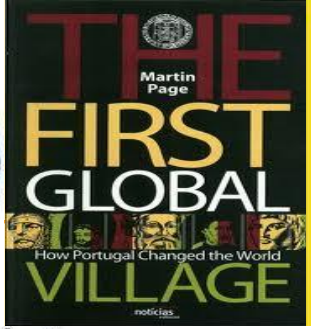

EUROPE
CREDIT RATING


HAUSSE DU PRIX DU PÉTROLE...



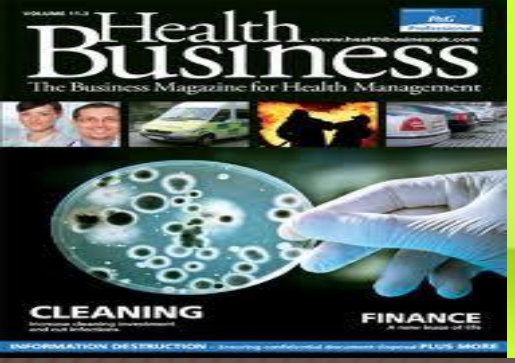

Courrier internacional
JAPÃO
TÃO MAU
COMO CHERNOBYL
HOLLYWOOD
O OCASO
DO "STAR SYSTEM"
AUTOMÓVEL
OS CARROS DO FUTURO
JÁ ANDAM AÍ
PESADELO
500

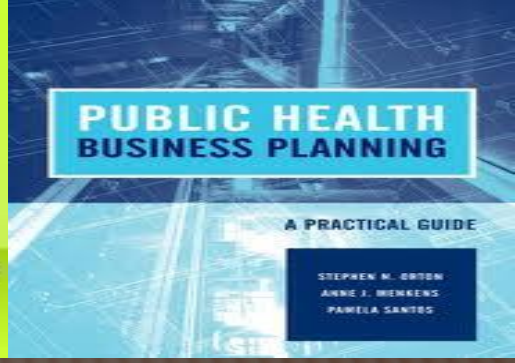

Global Village
with Chris Helm


THE
Martin Page
FIRST
GLOBAL
How Portugal Changed the World
VILLAGE
notícias

Global
Village


WAR





VII)- CONCLUSÃO

"... A PRÁTICA CLÍNICA DA MEDICINA NÃO É NEM NUNCA DEVERÁ SER UMA MERA QUESTÃO DE NEGÓCIO ..." *(SIC.) (SIR WILLIAM OSLER, 1849-1919)*

GREDOS
activo