

The relativistic, naturalistic nature of ethics and other issues

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Evidence can guide us, but in the real world of clinical practice, we must often make decisions in areas of complexity and uncertainty from the perspective of an individual patient. Many things contribute to the choices we make, including both our own values and those of our patient, patient attributes and other contextual cultural, social, moral and policy issues.¹ In medicine ethical decisions abound. Do we give antibiotics to a chronically ill elderly person with pneumonia? How do we allocate our limited resources? Twenty-five children can get grommets in their ears for the cost of one hip replacement. It has been estimated that it costs an average of US\$129 000 per additional year of quality life (QALY—quality-adjusted life year) to provide kidney dialysis for someone with end-stage renal disease, but the distribution is wide (from \$65 496 per QALY for the first percentile to \$488 360 for the ninety-ninth percentile) with higher costs associated with older age and more comorbidities.² How shall society decide who gets treated?

In a thought-provoking article in this issue's *Ethics* column, Professor Glynn Owens argues that ethics are not absolute, they are relative to the context.³ Choices about what is ethical and what is not change across societies, times and cultures. They also evolve. What is right for one society may not be right for another. What is right is what a society chooses to reward, and cultures which make unwise choices may not survive.

The *Back to Back* debate this month addresses one of these ethical issues. Should we give influenza vaccine to a demented elderly patient living in a rest home? Associate Professor of Microbiology Lance Jennings argues that we should, because studies show that this will reduce mortality and hospitalisation in the elderly.⁴ Director of the Immunisation Advisory Centre Nikki Turner counter-argues that for the frail elderly it is more

about the way we die. If influenza is managed well and the patient kept comfortable, there is no need for a preventive vaccine even if it may slightly prolong life expectancy.⁵

While a focus on population health has directed doctors to take on more social responsibility, the general public may not consider social justice a major component of medical professionalism. In a study by Hutchinson and Reid, the qualities in a doctor of concern for patient welfare and patient autonomy were ranked much higher by the public than social justice.⁶ On the other hand, previous research has demonstrated that most doctors consider providing equitable benefit to all is an important element of their professional role.

Funding restraints certainly impact at all levels of primary care. Lovell and Neuwelt's study finds that the introduction of Primary Health Organisations (PHOs) led to funding for health promotion spread very thinly between PHOs, non-government organisations and Public Health Units.⁷ Carryer et al. find that lack of funding streams, in addition to lack of attention to policy development, employment creation and professional regulation, is a barrier to the development of a strong nurse practitioner workforce.⁸ Wallis and Dovey have modified a framework which could be introduced into New Zealand (NZ) general practices to facilitate learning about improving patient safety and team communication, but acknowledge that this uses resources and practices would require some incentive to adopt this.⁹

Ashworth and Thomson cite inadequate funding as a significant barrier to the delivery of long-term condition management in rural NZ.¹⁰ However, not only funding will be required for delivery of programmes which are effective in clinical improvements in people with health inequities and chronic illness. Evaluation of a

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nurse-led clinic offering education and preventive care did not show improvements in parameters such as weight, blood pressure, smoking, glycosylated haemoglobin levels, waist circumference nor cardiovascular risk, although the patients did score better on understanding their diagnosis, medication and treatment plans.¹¹

Motivating patients for self-management and adopting healthier lifestyles is a huge challenge facing primary care over the next few decades. Communicating concepts such as cardiovascular risk and the possible health benefits that might be gained from behaviour change is not simple and there are many different ways that this can be done. Wells and colleagues have designed an electronic risk visualisation tool called Your Heart Forecast which doctors and nurses can use in communicating risk management strategies with patients. Initial testing increased general practitioner and practice nurse understanding and confidence in explaining cardiovascular risk.¹² It remains to be seen whether this will translate into improving patients' understanding of cardiovascular risk and the benefits they might achieve from changing lifestyle behaviours.

This issue also includes a study examining general practitioners' encounters with complementary and alternative medicines in their consultations, whether they choose to engage and how they negotiate difficulties they encounter.¹³ A *Case Series Review* of the complementary treatment Bowen therapy (involving light touch on muscles and other connective tissues) suggests some promise in improving neuromuscular function in people with chronic stroke, but it will take a randomised controlled trial to demonstrate whether this is truly effective.¹⁴ Our *Charms and Harms* column concludes that the herbal remedy Hawthorn may have some benefit as an adjunct therapy for mild chronic heart failure, but efficacy in other cardiac conditions is unconvincing.

This month's *Pounamu* describes the development of a specially designed gown to protect Maori patients' modesty when an electrocardiograph or echocardiogram is performed, and how this is also appreciated by non-Maori who have access to it.¹⁵ We introduce a new column, *Nuggets of Knowledge*, providing succinct summaries of evidence

about pharmaceutical treatments of common conditions and possible drug interactions, along with our regular features, *String of Pearls* and *Cochrane Corner* and a summary of NZ guidelines for weight management.¹⁶ We round off the issue with three diverse essays^{17–19} and a *Letter to the Editor* cautioning the use of Ibogaine.²⁰

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