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ABSTRACTS

Who belongs to us? The right to advanced medical interventions among non-citizens in Sweden

Ahlzén, Rolf
ahlzenrolf@gmail.com

Sweden has, until 2020, received the highest number of immigrants per capita in Europe. During 2015 around 163 000 immigrants reached Sweden. Most of these, like those arriving before and after, have by now been awarded permanent residence, but some have been expelled, some remain in the country without permission, some await final decision – and there is also an unknown number of persons living in a shadow society while not registered as immigrants and hence in no files. Different numbers have been proposed for how many persons there are in these respective categories, but their exact numbers remain unknown.

Since some years, the access to the Swedish health care system has been regulated by directives where the crucial formulation, in regard to immigrants, is that persons who are in Sweden but do not have permanent residence here have a right to, in Swedish, "vård som inte kan anstå" – "care which cannot be postponed". This is a somewhat cryptic formulation, very hard to handle in practice. Hence, clinicians interpret differently, sometimes resulting in strong reactions in public media.

On request from a number of thoracic surgeons dealing with heart transplantation, the Swedish "State Board for Medical Ethics", Smer, during 2020 launched a project to explore the ethical basis of such decisions in order to provide some recommendations. Smer's reports should be seen as exactly recommendations and the board has no legal capacity to initiate changes in the guidelines for prioritization of advanced medical interventions – but they may still be influential.

Smer presented a report in the spring of 2021 where the conclusion, in very short, was that even very advanced and very resource consuming medical care should, when urgently needed, be given to persons in Sweden, irrespective of their legal status. This means that persons without permanent residency, persons who are awaiting or keeping away from a decision to leave the country, or so called "paperless", who are not registered at all, should be prioritized on the same premises as Swedish citizens and persons who have permanent residency.

I will discuss this conclusion and point to a number of aspects which I think that Smer too quickly brushes aside as well as some weaknesses in their analysis. This dilemma illuminates with harsh sharpness how exceedingly difficult priority setting may be in a world of nation states where persons increasingly migrate over borders.

Managing Expectations and Technology Hype Cycles in Market Pressure: The Case of IVG

Ahola-Launonen, Johanna
johanna.ahola-launonen@helsinki.fi

In this paper, I explore the management of expectations and the formation of technology hype cycles in the medical context, using In Vitro Gametogenesis (IVG) as a specific example. IVG means developing gametes in vitro by reprogramming somatic cells. Notably, successful mouse pups have been born from implanted embryos with IVG-created eggs and "natural" sperm. Potential applications in humans include the provision of easily available gametes for facilitated reproduction and potentially gaining a deeper understanding of embryo development between days 14-28 - if the 14-day rule regarding embryo research is altered. Both the potential harms and benefits are substantial, encompassing a wide spectrum of expectations ranging from realistic to unscientific fiction.

IVG products face a classification dilemma. From a regulatory point of view, In Finland and in EU, clinical regulation varies greatly depending on whether a product is human tissue or whether it is a medical product. If tissue undergoes significant modification, it becomes classified as a medical product, like gene therapies. Medical products require highly regulated clinical trials, whereas tissue transplants typically necessitate only a physician's recommendation, assuming responsibility for the transplant. Are IVG products, that is, reprogrammed and differentiated somatic cells, human tissue or medical products? If IVG gametes are classified as tissue, human trials would easily be available to fertility clinics, as volunteers to new reproductive methods are easily available. This situation may change in three years, when the EU renews regulations for experimental transplant treatments. As of the time of writing this abstract, the European Commission is deliberating on how to classify IVG products.
As of now and to the best of my knowledge, scientists remain skeptical that an IVG human egg ready for fertilization will become a reality within the next decade. However, the medical industry is already expressing interest in initiating clinical trials in collaboration with fertility clinics. The early phase of the medical industry's pursuit of IVG clinical trials may indeed be motivated by expectations of hype formation. By informing funders that negotiations regarding human trials are in progress in certain countries, the industry aims to attract funding. Such funding can then facilitate cooperation elsewhere, potentially in countries with less stringent regulatory practices. This premature hype can lead to false expectations and costs of hype. In the paper, I delve into responsible management strategies for IVG expectations.

The 14-day rule and human embryo models

Árnason, Garðar
gardar@unak.is

In 2021 The International Society for Stem Cell Research (ISSCR) revised its guidelines, suggesting that the so-called 14-day rule for research on human embryos may be eliminated, at first on a case-by-case basis. The guidelines did not propose any new limit on human embryo research. Renewed pressure on the 14-day rule has arisen because of stem cell derived embryo models that model embryo development past 14 days. This pressure arises in part because human embryos are needed for the validation of the models, and in part because the embryo models themselves may be or may become legally defined as embryos in some jurisdictions. I argue, first, that accounts of moral status that are based on intrinsic characteristics, in particular capacities, cannot help us setting a non-arbitrary limit on human embryo research, except for the emergence of sentience at the fetal stage; and, secondly, that species-based arguments for moral status are not only unhelpful but have also fatal weaknesses. Instead of looking for morally relevant characteristics emerging in embryo or fetal development, what is needed is an approach based on relational or derived moral status, ascribing moral value to embryos and fetuses based on such aspects as personal relationship (e.g., of would-be parents), moral sense, cultural norms, and religious values. This does not mean that finding a new limit for human embryo research is a matter of a compromise between different subjective moral convictions and norms, but rather that a well-informed social debate is needed to evaluate the relevant moral views and scientific and social needs. Such a debate must be both inclusive and critical of different cultural norms and religious views, since continued progress of embryo research is only possible in so far as it finds trust and acceptance in society.

Public-private partnerships in digital health: a review of ethical aspects

Bak, Marieke
marieke.bak@amsterdamumc.nl

Digital health encompasses the use of data-driven tools such as wearables and artificial intelligence models to benefit health. Increasingly, digital health applications are developed in collaborations between public institutions and private companies, e.g. between a public academic hospital and Google's DeepMind. These public-private partnerships (PPPs) are stimulated by the European Union, among others. PPPs in the field of digital health can promote more accessible, affordable and high-quality care, but they can also raise questions about the ethics and governance of patient data being shared with commercial companies. When asked, but without being informed about details of the collaboration, the majority of people would rather not share their health data with industry. This reluctance stems from growing power imbalances, worries about privacy invasions, and conflicts of interest. Further study of these aspects is crucial because there are no ethics guidelines or regulations specifically for digital health PPPs, and experiences in the field of *big pharma* cannot be copied directly to *big tech.* It is imperative that collaborations between healthcare organisations and large digital companies avoid the socialization of risk and the privatization of rewards. But how should the different values and interests be weighed? In order to provide input for practical ethical guidelines and further empirical research, we conducted a systematic search of the literature about the ethics of PPPs in digital health. We searched PubMed, EMBASE and Web of Science for papers published in the last ten years leading up to 28 November 2023. A total of 46 studies were included that critically analysed the ethical aspects of PPPs within digital health. From the literature, key ethical aspects specific to digital health PPPs were distilled, both in relation to health data collection and sharing in PPPs, as well as related to the implementation and use of tools resulting from PPPs. Themes include privacy and consent; trust and the social license for PPPs; stewardship, transparency and engagement; and public benefit and access. We illustrate these themes, and the open questions they raise, with the three examples of digital health PPPs that were most often discussed in the ethics literature. The presentation concludes with initial recommendations for practical ethics guidelines for digital health PPPs.

Trading off Lives and Livelihoods

Bognar, Greg
greg.bognar@philosophy.su.se

Public health emergencies, such as the recent COVID-19 pandemic, often require the restriction of civil liberties through social distancing. Such measures can decrease mortality and morbidity, but they also cause social and economic harm. Thus, policy makers have to make trade-offs between "lives and livelihoods," while introducing only the minimally necessary restrictions on civil liberties.

The traditional approach to making such trade-offs is to use cost-benefit analysis (CBA). CBA compares the expected economic costs and the health benefits of different policies. While it has long been criticized on technical grounds, a more recent objection is ethical: it targets the fact that cost-benefit analysis is aggregative, involving the addition of costs and benefits and evaluating policies by their overall sum. The problem with aggregation is that it countenances sacrificing some people's interests for the greater benefits of others.

Some critics go on to propose an alternative theory: contractualism. This view is based on the idea that policies must be justifiable to all, rather than evaluated by the balance of their expected costs and benefits. Contractualism is claimed to be well-suited for assessing interpersonal trade-offs, especially those that involve conflicts between civil liberties and public health objectives.
In this paper, I assess the proposal to use contractualism in public health policies and the allocation of health care resources. I argue that a plausible version of contractualist policy assessment must accept partial aggregation—allowing the trading off of life-saving when there is a greater number of people who would otherwise suffer a comparable, though slightly smaller harm than death, but prohibiting trade-offs when a greater number of people would suffer only minor harms. I show that partial aggregation leads to a dilemma when loss of life is compared to harms that accrue within a single life—for instance, the cumulative long-term negative effects of loss of schooling due to a lockdown. I show that whichever horn of the dilemma contractualists choose, their view leads to unpalatable implications. Therefore, the ethical objection against cost-benefit analysis does not succeed.

Personalised communication: the right message for the right patient at the right time - DEEPEN-iRBD project

Borovecki, Ana; Sattin, Davide; Curkovic, Marko; Picozzi, Mario; Grossi, Alessandra; Corvino, Serena
abor@mef.hr

This contribution will present project DEEPEN-iRBD. The project aims to develop a proof of concept for prediction of phenoconversion based on pre-clinical/clinical research and data analysis in order to implement correct early diagnosis, accurate individual prognosis, and facilitate personalized therapeutic interventions in patients with REM sleep behavior disorder (iRBD). Patients with this disorder have a high risk of conversion to Parkinson's disease, dementia with Lewy bodies or multiple system atrophy. The project has an ethical dimension. The researchers coming from different backgrounds will identify clinical and ethical dilemmas concerning iRBD patients' decision risk stratification (low/high risk) and develop strategies for communication of phenoconversion information to patients. They will also analyze attitudes of families on care processes (Personalised communication: the right message for the right patient at the right time) all to define a possible strategy for implementation of a preventive population screening for iRBD. This will be done through semi-structured interviews with patients, caregivers and healthcare professionals who during the course of their work encounter patients with IRBD. Participants will be enrolled both from retrospective and prospective patient cohorts as described in figure 1. Inclusion criteria will be set to balance selected sociodemographic information (e.g age, gender, education, income, employment, etc) across subjects progressively involved in the prospective and retrospective samples (in the last group subjects will be involved taking into consideration the time from the communication of phenoconversion and the presence of iRBD). We will explore the methodology and possible ethical issues raised by the proposed research.

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Development of a template for psychiatric advance directives

Gaillard, Anne-Sophie; Gather, Jakov; Haferkemper, Iris; Scholten, Matthé; Braun, Esther
esther.braun@rub.de

Psychiatric advance directives (PADs) are documents that allow users of mental health services to express their treatment preferences for future mental health crises. Despite high rates of interest among service users and empirically confirmed benefits of their use, completion rates for PADs remain low. An accessible template for PADs may improve their implementation in practice. This talk will present a project for the development of a template for PADs for the German context which takes the perspectives of relevant stakeholders into account.

We first performed two systematic reviews of empirical studies on (1) service users' perspectives on PADs and (2) the content of PADs. The first review found that service users face difficulties in completing PADs, have concerns about clinicians' compliance with their PADs, and strongly endorse receiving support in creating PADs. The second review found that the information provided in existing PADs is generally clear, clinically relevant, and compatible with professional standards.

Based on our findings, a preliminary template for a PAD was developed by our research group which includes one expert by experience. The template was discussed and evaluated in five homogeneous focus groups with service users (n=6), peer support workers (n=5), professionals (n=5), legal guardians (n=5), and relatives (n=5), respectively, which were recorded, transcribed, and analyzed using qualitative content analysis. Protocols of feedback sessions conducted with the research group's advisory board consisting of service users and relatives as well as with legal and clinical experts were integrated into the data analysis. The preliminary template was adjusted based on the identified concerns and suggestions raised by stakeholders and will be made publicly available. This talk will present an overview of the stakeholder feedback we obtained and introduce a preliminary version of the template.

Research and Development Challenges for Innovative Technologies in Medicine and Healthcare

Brukamp, Kirsten
k.brukamp@eh-ludwigsburg.de

Health technologies, including medical devices in particular, constitute a highly relevant area of innovation with promises to substantially transform future healthcare. Nevertheless, numerous obstacles may obstruct the route from initial conception to the market and to clinical practice for both academic research and the medical device industry. Ethical perspectives conflict regarding the principles of beneficence, non-maleficence, and justice.

Regulatory frameworks have been established or planned for oversight of medical device development and digital applications in many jurisdictions, such as the Medical Device Regulation (MDR) and the Artificial Intelligence Act (AI Act) in the European Union (EU). Regulation and oversight are commendable from a standpoint of non-maleficence and safety. Nevertheless, bureaucratic barriers prevent for-profit companies to invest into potentially beneficial health technologies. Emerging clinical decision-support tools frequently rely on artificial intelligence, leading to insecurities about associated risk categories.

The approaches and intentions of health technology research and development differ immensely between academic research and the medical device industry, a fact that renders a full understanding of industry difficult from an academic standpoint and that precludes knowledge transfer by founding new spin-off companies. Due to their for-profit status, small and medium enterprises (SME), including start-up companies, are required to consider costs, investments, and intellectual property rights (IPR) from the very beginning. Academic research, which is

often collaborative, possesses the advantage to be capable of easily integrating participation, co-design, as well as co-development together with patients, relatives, healthcare personnel, and stakeholders. At the same time, gaps in knowledge and experience may hinder a transfer from academia to viable products for clinical care.
Aspects regarding justice concern the utilization of novel technologies in health care systems. Expensive technologies for individuals appear more sustainable when they possess features that allow repeated use for several or many patients and when they facilitate personalization. The access to technological innovations in regulated markets may be restricted in some health systems. Costs of innovation are distributed differently between countries, with expert advice, administrative support, and financial funding unevenly available in health care systems.
In summary, research and development for novel health technologies take place in complex regulatory frameworks and heterogeneous settings. Ethical considerations concern the principles of beneficence, non-maleficence, and justice as well as safety and participation. Improved interaction between academic research and the medical device industry may strengthen both in their specific endeavors by widening methods and perspectives.

The use of AI in pediatrics - an assessment matrix for consent requirements
Bruni, Tommaso; Heinrichs, Bert
t.bruni@fz-juelich.de

Inside bioethics, extensive attention has already been devoted to the ethics of medical AI. However, in the extant literature there's little discussion about how to ethically regulate the development and use of pediatric AI. In this paper, we argue that informed consent requirements for using AI in pediatrics should not be of a "one-fits-all" nature but should rather be gauged to the kind of AI use at hand. We also argue that informed consent requirements ought to be relaxed relative to current standards. This is in line with a long-standing tradition in bioethics, according to which existing informed consent requirements are unduly burdensome for researchers, especially when the risk accruing to participants from research is low. In the paper, we only deal with pediatric AI that is used in the framework of a clinical encounter, in the sense that, if the AI tool is to be autonomously used by the minor patient, it must have been recommended or prescribed by a pediatrician. We argue that informed consent requirements in research must be adapted to an experimental intervention's risk level. However, in the case of pediatric AI it's not always easy to make a direct risk assessment. We hence put forth two parameters that can act as proxies for the level of risk. First, the level of involvement of the physician, i.e. the extent to which the AI acts on the physician (rather than the patient) or the physician is monitoring or controlling what the AI does. Second, the invasiveness of the AI intervention, i.e. how directly it involves the patient's body and mind. We explore the plane created by these two dimensions by focusing on four archetypical cases of AI intervention. For instance, so-called "cognitive interventions" in which AI provides a physician with enhanced access to the medical literature (e.g., through mining and summarizing) feature a high level of physician involvement and a minimal level of invasiveness. We claim that in such cases consent can be merely oral and framed in an opt-out fashion. It's the parents that must provide such consent, unless the minor patient is 14 or older: in this latter case, both parent and child must be given the chance to opt-out. In middle-range cases, for instance when the AI provides the physician with a treatment recommendation, consent should be given in written form, for instance by crossing a box in a form, and in an opt-in fashion, but without requiring the full informed consent procedure. When the AI tool is a clinical intervention proper, like in some psychiatric conditions where the AI system provides therapy, the traditional informed consent procedure is to be used, and the consent of the cognitively mature, competent minor is

necessary. Legal requirements (for instance for health data treatment) change according to jurisdiction and must be upheld. However, we focus on the ethical requirements for consent and hope that ethical inquiry will guide the legal regulation's future evolution.

Rare Diseases and the Reverse Problem of Numbers

Bruns, Andreas
Andreas.Bruns@med.uni-heidelberg.de

This talk explores the question of how it can be morally justified to prioritise rare diseases in healthcare priority settings. Rare diseases are those that affect only a small percentage of the population (in the European context, this is usually defined as 1 in 2,000 people). Rarity is often associated with a lack of research into diagnosis and treatment, such that people suffering from rare diseases generally have it harder to get effective treatment or to receive an explicit and timely diagnosis. In addition, there are very limited economic incentives for private companies to research rare diseases and develop marketable treatment options. It seems almost certain that without special attention to rare diseases, these patient groups will be left to fend for themselves, as it is also illustrated by the many ways in which rare diseases groups have learned to organise and help themselves by connecting to others with similar medical histories.
Many healthcare systems today give special priority to rare diseases, funding research into rare conditions more generously and setting up special research tracks focused on rare diseases. However, considering that resources are limited, it seems morally justifiable, to say the least, to give priority to a small minority of patients over the significantly larger part of the patient population.
This talk looks at the problem of rare diseases in healthcare priority settings through the lens of a long-standing philosophical debate about the moral relevance of numbers. The "classical" problem of numbers is whether the mere number of individuals we would help makes a difference when considering whether we should help a larger or a smaller group of people. According to common moral intuition, it seems that, if we cannot help everyone, we should help as many as we can and thus prioritise helping the greater number. The case of rare diseases raises the reverse problem: Can it ever be morally appropriate to prioritise helping the smaller number? I argue that this can be morally appropriate in situations where a failure to help the smaller number is morally more significant than a failure to provide the amount of help we could provide to the greater number if we would decide to disregard the smaller number. I then show that the case of rare diseases in healthcare constitutes precisely this kind of situation.
The talk closes with a discussion on how this way of looking at the problem of rare diseases could help to develop ethical frameworks for priority settings more generally. The case I discuss in particular is that of diseases largely concerning people living in developing countries, which are not rare but pose similar challenges, for instance, with regard to lacking economic incentives.

More ethics in the laboratory, please! Scientists' perspectives on ethics in the preclinical pase

Buedo, Paola; Prieto Eugenia; Perek-Białas, Jolanta; Odziemczyk-Stawarz, Idalina; Waligora, Marcin
paolabuedo@gmail.com

In recent years there have been calls to improve ethics in preclinical research. Promoting ethics in preclinical research should consider the perspectives of scientists. Our study aims to explore

researchers' perspectives on ethics in the preclinical phase. Using interviews and focus groups, we collected views on ethical issues in preclinical research from experienced (n = 11) and early-stage researchers (ESRs) (n = 14) working in a gene therapy and regenerative medicine consortium. A recurring theme among ESRs was the impact of health-related preclinical research on climate change. They highlighted the importance of strengthening ethics in relations within the scientific community. Experienced researchers were focused on technicalities of methods used in preclinical research. They stressed the need for more safeguards to protect the sensitive personal data they work with. Both groups drew attention to the importance of the social context of research and its social impact. They agreed that it is important to be socially responsible – to be aware of and be sensitive to the needs and views of society. This study helps to identify key ethical challenges and, when combined with more data, can ultimately lead to informed and evidence-based improvements to existing regulations.

Implications of theoretical assumptions of computational psychiatry for the allocation of psychiatric resources

Buhr, Elke
eike.buhr@uni-oldenburg.de

AI-based approaches are increasingly finding their way into psychiatric research and practice. In addition to more precise prediction, diagnosis and treatment, proponents of computational psychiatry (CP) are hoping for the development of new classification systems for mental disorders. Many hope to detect biomarkers as indicators of causation of mental disorders. Such an approach deviates from the diagnostic procedure of the DSM that refers to symptom complexes to diagnose mental disorders. By contrast, opponents of CP emphasize that different kinds of information are necessary for the description and classification of mental disorders, especially the verbal articulation of subjective meaning, e.g. regarding the experience of trauma. As there is no consensus on the concept of mental illness, there is also no agreement on what type of data may claim relevance for the classification of mental disorders. Accordingly, the emergence of CP runs the risk of reducing our understanding of mental disorders. This can also have problematic consequences in clinical practice. For example, since the concept of a mental disorder serves as the basis for the allocation of healthcare resources, a reduced or distorted concept might lead to pathologizing individual symptoms or ignoring the subjective experience of those affected.
The contribution examines the theoretical assumptions regarding psychiatry underlying different CP approaches and discusses their ethically relevant consequences for psychiatric care and the allocation of respective resources. To this end, we conducted a literature-based analysis of various CP approaches regarding existing theoretical concepts of psychiatry and mental disorders, as well as regarding their ethical consequences. We discuss ethically relevant implications of the use of AI-based approaches to the diagnosis, treatment decision and classification of mental disorders for psychiatric practice and the allocation of resources. For example, this concerns the impact of the possibility of making more targeted diagnoses based on individual symptoms on the care of people with mental disorders. Especially pharmaceutical companies have a particular economic interest in such diagnostic procedures so that they can develop and market pharmaceuticals which only target isolated symptoms. Without a fundamental understanding of the concept and cause of mental disorders, there is a risk that economic incentives will supersede medical arguments. In this context, it is also essential to address the role of patients' subjective perceptions in the diagnostic process – especially when individual suffering and CP-supported diagnosis do not correspond. Not least to avoid aspects of epistemic injustice.

Hence, we argue against a hasty revision of psychiatric classification systems and in favor of an examination of the psychiatric concept of a disorder and the theory of individual disease entities, as well as for a fundamental understanding of the basis on which psychiatric resources should be allocated and in which categories the success of a therapy should be measured.

The Challenge of Determining When Conscientious Refusal is Discriminatory

Byrnes, Jeffrey; Robinson, Michael
byrnesj@gvsu.edu

Though there is broad agreement that there are at least some kinds of conscientious objection that should be accommodated and some that should not, there is little agreement about which kinds of conscientious objection belong in the former category and which should be placed in the latter. One of the positions on this issue most likely to garner consensus is that we should not accommodate conscientious objection (by permitting objecting practitioners to engage in conscientious refusal) when doing so would be discriminatory. But determining when conscientious refusal is discriminatory turns out to be much more challenging than one might think. The first thing this will require is an account of when conscientious refusal is discriminatory. It is easy enough to identify clear instances of each. A nurse who refuses to treat Jewish patients, for example, would clearly be acting in ways that are discriminatory, whereas an obstetrician who refuses to provide abortions or an internist who refuses to participate in physician-assisted suicide would not. Whereas the latter have objections to providing certain kinds of *procedures*, the former has an objection to treating certain kinds of *patients*. But some examples, such as refusals to provide IVF to lesbian patients, do not fit neatly into either of these categories. Suppose we were to agree to count as discriminatory any refusal to provide care that is based on a conscientious objection that is *even partly* an objection to the patient being treated (and not merely to the treatment itself). Even then, whether an instance of conscientious refusal counts as discriminatory will depend on whether it gets categorized as (i) an objection to providing a particular kind of procedure, (ii) an objection to treating a certain kind of patient, or(iii) an objection to providing particular kinds of procedures to certain kinds of patients. One point that has gone entirely unnoticed in the literature is that this, in turn, is going to depend on how we define the procedures at issue and distinguish them from other procedures. Consider, for instance, objections to participating in infant male circumcision and objections to participating in various kinds of gender affirming care (e.g., female-to-male top surgery). Are these (i) objections to certain kinds of procedures (viz., infant male circumcision and female-to-male top surgery)? Or are they (iii) objections to providing certain kinds of procedures to certain kinds of patients(viz., providing circumcision to infants and providing mastectomies to transgender patients), which would then get counted as discriminatory? This depends entirely on how we define and individuate the procedures at issue. Our aim in this paper is to explain why this is the case and draw attention to the need to develop an agreed-upon account of this sort.

Quality of informed consent in aesthetic medicine and insights for botulinum neurotoxin A treatment

Calderon, Pacifico Eric Eusebio
calderon.pe.f@slmc-cm.edu.ph

In aesthetic medicine, where elective cosmetic procedures often blur the line between medical need and personal choice, ensuring robust informed consent is essential. In this paper, we present the initial findings of our ongoing project* which evaluates the quality of consent in aesthetic medicine, with a specific focus on botulinum neurotoxin A (BoNT-A) treatment. Our primary objective is to assess the quality of informed consent and provide insights to enhance patient safety and guide practitioners. Despite the widespread clinical use of BoNT-A treatment, there remains a notable gap in research on informed consent in this context. Given emerging concerns surrounding BoNT-A immunoresistance and varying comprehension levels among healthcare providers and patients, this study is particularly relevant. Using a scoping literature review, we have identified a paucity of empirical research addressing the quality of informed consent within aesthetic medicine. This finding suggests a deficiency in patient-centered care and safety discourses within the field. We likewise underscore potential hazards associated with uninformed decision-making among patients and insufficient guidance for practitioners. Furthermore, our analysis identified several factors contributing to suboptimal consent, including insufficient provider awareness and inadequate patient education. To address these issues, our study proposes targeted measures aimed at enhancing informed consent practices related to BoNT-A treatment. These measures include tailored training programs for healthcare providers and initiatives designed to improve patient education and shared decision-making processes in aesthetic medicine.

*Disclosure: This project received funding from the Merz Institute of Aesthetics.

Informed Consent Aggregate Scores (ICAS): A brief methodology for evaluating knowledge and quality of informed consent practice by healthcare professionals in resource-constrained settings.

Chima, Sylvester C.
chima@ukzn.ac.za

Background: Informed consent is an ethical and legal doctrine protected by constitutional rights to bodily integrity, well-being, and privacy. The South African National Health Act codified informed consent regulations, requiring that all healthcare professionals inform patients about diagnosis, treatment risks, benefits, options, and the right of refusal while considering patients' language and literacy levels. However, healthcare professionalspracticing in multicultural resource-poor settings are inherently challenged by problems of poverty, education, language, and the power asymmetry between patients and healthcare professionals, which may influence informed consent during clinical practice.

Methods: A cross-sectional quantitative study was designed to evaluate the knowledge and quality of informed consent practiced by healthcare professionals in the KwaZulu-Natal province of South Africa. The semi-structured questionnaire deployed for the study included critical elements of informed consent, including questions on *information disclosure, capacity, voluntariness, comprehension, and agreement*.

To enable statistical comparison across occupational and professional ranks of healthcare professional groups and categories. An aggregate informed consent score (ICAS) was computed using 13 items from the study questionnaire. Each selected item was

given a rank-score of one, and the aggregate represents ICAS. The 13 items used for ICAS computation had a *Cronbach alpha* of .676, denoting moderate to high reliability and adequate internal consistency.
Results: Five hundred and ninety-seven (597) healthcare professionals completed this study, including 168 medical doctors, 355 professional nurses, 49 physical therapists, and 25 occupational therapists. The ICAS among doctors showed that interns and registrars scored lower than medical officers and consultants/specialists. ICAS was statistically significant by specialty ($p = 0.005$), with radiologists and anesthetists scoring lowest, while internists, general practitioners (GPs), and Obstetrician/Gynaecologists (OBGYN) had the highest cores. Median ICAS among physical and occupational therapists was 8, with a maximum of 12, while minimal scores were 2 and 4, respectively. Scores were the same among all categorized rehabilitation therapy professionals. A comparison of the ICAS between professional nurses with a minimum of 4 years of professional training and enrolled nurses with a minimum of 2 years of professional training showed that professional nurses scored nine (9) on average, while enrolled nurses scored 7. However, this difference was not statistically significant ($\rho = 0.090$). A comparison of ICAS between medical doctors and nurses showed that professional nurses scored significantly lower than doctors ($\rho \leq 0.001$).
Conclusions: ICAS provides a reliable method for evaluating the quality and reinforcing knowledge and practice of informed consent among healthcare professionals in multicultural and resource-constrained settings, particularly in developing countries.

Autonomy, consumer-driven healthcare, and the ought to cure and care: the case of complementary and alternative medicine.
Chiurco, Carlo
carlo.chiurco@univr.it

During the CoViD-19 pandemic, we have witnessed the diffusion of alternative curing narratives, such as homeopathy, naturopathy or anthroposophical medicine, that were loudly claimed by non-negligible sectors of society as their right to follow instead of, and often against, lockdowns and vaccination campaigns backed by official medicine. To assume that nature-driven remedies are a lesser social and economic phenomenon constituting only a market niche would be spectacularly wrong: in 2022, the value of herbal medicine alone in the European market was $90 billion, up 10% from $81 billion in 2021 [1], whereas complementary and alternative medicine (CAM) accounted for $33 billion in 2021 and is projected to reach an astonishing $125 billion in 2028 [2]. Such figures dispel at once the “no-Big-Pharma”, anti-market narratives by which CAM and their followers loves to portray themselves, showing they are instead no less prone to the pervasiveness of the market – albeit and admittedly peculiar one.
The great ethical and philosophical importance of the rise of CAM could be hardly underestimated. Firstly, CAM marks the unavoidable rise of the new figure of the patient-consumer, welding or driving together factors as different as essentially liberal consequentialist ethics, radical-inspired free choice ideology, and, more often than not, spiritualist approaches deeply suspicious of science, institutions, and common good; it also substantiates, as well as accelerates, the shift from the “medicine of needs” to a “medicine of desires”, an approach so far rather vaguely described in the debates about the ethical feasibility of human enhancement. Such patient-consumer-driven approach has already set foot in legislation: for instance, since 1996, when Tuscany first included homeopathic remedies in the list of fully reimbursable medical treatments, other Italian regions have been under increasing pressure to follow.

Secondly, deep ethical concerns arise for the unintended consequences for the health of patients-consumers; and thirdly, it urges medicine and bioethics to imagine an approach capable to counter such outcomes, on the one hand, without resorting to a re-edition of a long-disowned medical paternalism on the other, even if too many CAM remedies clearly verge on the anti-scientifical or the openly irrational. Such approach should be three-fold, involving ethics, education, and politics.
Many questions arise: from an ethical perspective, while is clear to ethicists that "free choice" never comes without knowledge and responsibility, is nudging the sole viable option left? Or, given that sometimes the choice to resort to CAM expresses social malaises rather than ideological divisive-ness, is global bioethics the right and more effective answer? Have physicians, ethicists, and politicians the right to intervene in the name of the ought to care, or should autonomy prevail? Are health-oriented education campaigns truly effective without parallel efforts at educating citizens to science (which in turns involves a "responsible science" approach on scientists' and physicians' side)? Finally, should politics limit itself to co-ordinate such efforts, or should respond more decisively (for instance, by means of regulation) to the inherent risks of a consumer-driven healthcare, given the role markets clearly, and too often stealthily, play in it?

Notes
[1] https://www.fortunebusinessinsights.com/herbal-medicine-market-106320
[2] https://www.grandviewresearch.com/industry-analysis/europe-complementary-alternative-medicine-market-report

Navigating the Intersection of New Technologies, Healthcare Professionals' Skepticism, and Ethical Considerations in Healthcare Markets

Consolandi, Monica
mconsolandi@fbk.eu

In recent years, the advent of novel technologies in healthcare has sparked both enthusiasm and skepticism within the healthcare professionals' community. This dichotomy underscores a fundamental tension between the potential benefits of innovation and the apprehensions surrounding its implementation. This presentation critically examines the implications of emerging technologies on healthcare delivery, focusing on their impact on accessibility, equity, and ethical considerations within healthcare markets.
While new technologies promise to revolutionize healthcare by offering unprecedented opportunities for diagnosis, treatment, and patient care, skepticism persists among healthcare professionals regarding their efficacy and reliability. Concerns about the accuracy of diagnostic algorithms, the security of patient data, and the potential for technology-driven errors have led many practitioners to question the feasibility of integrating these innovations into clinical practice.
However, it is imperative to consider whether these concerns are solely detrimental or if new technologies can indeed enhance accessibility to care. By streamlining processes, reducing costs, and overcoming geographical barriers, innovative technologies have the potential to democratize healthcare, particularly for underserved populations. Telemedicine platforms, wearable devices, and remote monitoring systems can bridge the gap between patients and providers, offering timely interventions and personalized care irrespective of geographic location or socioeconomic status.
Yet, from an ethical standpoint, the proliferation of new technologies presents a complex dilemma regarding equity in healthcare. While advancements in medical science hold the promise of improving health outcomes for all, disparities in access to technology can exacerbate

existing inequities. Vulnerable populations, including those with limited digital literacy or financial resources, may face barriers to accessing and benefiting from these innovations, widening the gap between the privileged and the marginalized.
In conclusion, this presentation posits that the ethical implications of new technologies in healthcare are multifaceted and contingent on the way they are developed and implemented. Rather than viewing technology as a panacea, healthcare stakeholders must approach innovation with a critical lens, prioritizing ethical principles such as beneficence, justice, and autonomy. By fostering collaboration between technologists, healthcare professionals, policymakers, and ethicists, it is possible to harness the potential of new technologies while mitigating their unintended consequences. Ultimately, the ethical imperative lies in ensuring that advancements in healthcare technology are guided by principles of equity, accessibility, and patient-centered care, thereby shaping a more inclusive and sustainable healthcare landscape for all.

How to democratize artificial intelligence in medicine

Daus, Zachary
zachary.daus@monash.edu

Advocates of artificial intelligence (AI) in medicine suggest that one of its greatest advantages will be its ability to resolve issues in the distribution of medical care (Topol 2016). By offloading work from human clinicians, AI will make quality medical care more abundant, encouraging clinicians to take on more empathetic roles and bringing medical interventions to patients with reduced access. There is real potential for medical AI to alleviate medical resource scarcity and consequently improve health outcomes. Nonetheless, I argue that the potential for medical AI to resolve issues in the distribution of medical care by alleviating resource scarcity may seduce regulators from acknowledging the potential disadvantages of medical AI. Medical AI are complicated systems that, while potentially improving health outcomes and simultaneously reducing expenditures, may also conflict with a variety of non-health values. A racially biased clinical decision support system (CDSS), for example, may result in improved health outcomes for both minorities and non-minorities, but at a substantial cost to racial equality (Abràmoff et al. 2023). Should this system be allowed for the improved gains it makes in health at a cost to racial equality? To take another example, a black box CDSS may arrive at decisions that are incapable of meaningful explanation despite providing better health outcomes than humans (London 2019). Must such black box systems incur the cost of being engineered for explainability, thus eating into funds earmarked for health care, or can we allow certain illnesses to be diagnosed without explanation? In order to justly resolve the various conflicts between improved health outcomes and non-health values, I argue that we must turn to the principles of deliberative democracy. In search for a solution, I first turn to the Rawls-inspired conception of health care justice developed by Norman Daniels (2008). I nonetheless argue that Daniels's Rawls-inspired approach unduly prioritizes a conception of autonomy that privileges negative freedom and the individualistic pursuit of one's own conception of the good. Using the case of racially biased CDSS as an example, I argue that Daniels's approach forecloses an important category of reasons for determining the just distribution of medical resources: mutual recognition. I conclude by turning to the theory of justice as mutual recognition developed by Axel Honneth (1996), arguing that it is more sensitive to arguments that could be used against justifications in favor of racially-biased CDSS.

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Mobile health technology, oppression, and empowerment

De Proost, Michiel
Michiel.DeProost@ugent.be

Mobile Health (mHealth) technologies, such as wearables and apps, are increasingly advertised by companies as means for health and well-being empowerment. Although several scholars have analysed the notion of empowerment at play in mHealth discourses and identified crucial elements for its fulfilment, one theoretical framework that is especially absent in this discussion is that of relational theory developed in feminist philosophy. In this presentation, I aim to correct this deficit by offering two ways to scrutinize mHealth technologies from a feminist perspective. Specifically, I start evaluating mHealth through the lens of a feminist conception of self-respect. Doing this reveals a puzzling tension: prima facie, it is not obvious whether the use of mHealth undermines self-respect or promotes it. Another route to resolve this tension is to refocus the empowerment debate on its early intersectional underpinnings, that is more politically orientated and grounded in collective contestation. I conclude that an intersectional lens helps to elucidate the limitations of some empowerment discourses and open the door to further rethink its political dimensions.

Bridging ethics & science in pharmaceutical research: Public Possibilities & Practical Realities

Dennison, Corey
dennisonc@duq.edu

Integrating ethics and science is often both challenging and complex for many reasons. One such reason is that the speed of innovation regularly outpaces the ethical and moral considerations of an innovation's very existence and use. Far too often, however, the factors that take the highest priority are economic and political incentives. With pharmaceuticals this is certainly the case when one considers cost, distribution and access. This analysis seeks not to argue that economics and politics has no place in innovation or research design, rather, that the wrong type of politics are frequently overrepresented in the delicate process of developing policies and ethics regarding pharmaceutical research.
This viewpoint is not singularly moralistic nor wholly antagonistic towards market-based philosophies, rather it examines end-goals and intentionality. By using intentionality and end-goals as benchmarks, the reality that medical and pharmaceutical research (should) inherently have foundational beneficent end-goals/intentions is undeniable. Further, this analysis examines the incongruity between classical Western economic philosophies such as:(laissez-

faire, protestant work ethic, neoliberalism, intellectual property) and the current behaviors of some of the largest medico-pharmaceutical research entities. Mission statements, value statements, corporate responsibility decrees and other forms of ethical rhetoric often employed by these institutions are routinely widely disparate from their own operational practices at the executive levels. Comparing and contrasting pronouncements of these ethical statements with the legal and corporate practices of these conglomerates is essential in addressing the ethics and innovation gap.
Using the practical and public tools accessible within numerous global north nations such as taxation, research design policy, campaign finance reform, and intellectual property law the citizenry, both technical and lay, can effectuate meaningful ameliorative change in numerous lives globally. This philosophical analysis seeks to inquire why tools borne from pharmaceutical research are being employed against their seemingly innate utilitarian aims and reroute our medical research philosophies on a path of beneficence. Lastly, attention is given to the constrictive practical reality of the current economic political structure and potentiality of galvanizing the public towards support for genuine and robust ethical input regarding pharmaceutical research.

On health and medical overconsumption

Devisch, Ignaas
Ignaas.Devisch@ugent.be

‘Health and happiness to you in the New Year’ is what we say to each other at the beginning of each new year. Right after these wishes, most of us consume a considerable amount of alcohol. It is not the only paradox in this area and not only for this reason we need to think about our health and its place in today’s society. While thinking about health promotion, time and again we have to conclude that often the ones who are sick, enter hospital too late; while others who are not sick yet but ask for another screening to assure themselves of a perfect health, enter hospitals too early. Both sides of this coin – medical underconsumption and medical overconsumption – are a financial burden to an equitable health care system. When interviewing the CEO of one of the biggest hospitals in Belgium, a blunt statement was made: at least 20% of the medical interventions in Belgian hospitals is considered to be ‘waste’, he stated, but they need this overconsumption to keep up the financial balance. In their report on ‘Sustainability and Resilience in the Belgian Health System’ (2023), Muriel Levy and Lieven Annemans confirm this overconsumption and its burdens to the objective of an equitable health care system.
Of course, we should think of well-balanced healthcare payment system. In Belgium, e.g. the current system is mainly based on FFS (fee for service) which leads to a performant system but is also an incentive to overconsumption. While we largely debate on medical underconsumption, we hardly discuss the medical overconsumption while we should. First of all, we should think about the place of health and sickness in our society. Health today is much more than a clinical-medical given. It has become a normative and liquid - dixit Zygmunt Bauman - ideal without limits. If we are supposed to live a healthy life, be fit and flexible, this can obviously have a positive impact on, our health – this is called prevention - but there is also a downside. Because of this normativity, we are never really healthy anymore. As a result, health has become a persistent source of concern that crosses our everyday lives, with all the turmoil and uncertainty that comes with it. And with consequences to medical overconsumption. In my book ‘And a good health to all of you’ (à votre bonne santé, Owl Press, 2024), I sketch some main characteristics of this evolution. In my presentation, I will discuss some of these characteristics.

Human flourishing, the goals of medicine and integration of palliative care considerations into intensive care decision-making

Donaldson, Thomas
thomas.donaldson-2@postgrad.manchester.ac.uk

Aristotle's ethical system was guided by his vision of human flourishing (also, but potentially misleadingly, translated as happiness). For Aristotle, human flourishing was a rich holistic concept about a life lived well until its ending. Both living a long life and dying well were integral to the Aristotelian ideal of human flourishing. Using Aristotle's concept of human flourishing to inform the goals of medicine has the potential to provide guidance to clinical decision-makers regarding the provision of burdensome treatments, such as intensive care treatment, where pursuing a chance of survival must be balanced against the risk of exposing patients to a negative dying experience. By conceptually uniting potentially competing goals of medicine, such as prolonging life and the promotion of peaceful deaths, Aristotle's understanding of human flourishing creates an argument for the integration of palliative care considerations into intensive care decision-making and for advanced care planning with healthy patients.

The Ethical Significance of Temporality and Collectivity for Intergenerational Perspectives in Resource Allocation

Ellerich-Groppe, Niklas; Bozzaro, Claudia; Koesling, Dominik; Rehmann-Sutter, Christoph; Schicktanz, Silke; Schweda, Mark
niklas.ellerich-groppe@uni-oldenburg.de

Current challenges in healthcare ethics – which we use as an umbrella term for clinical ethics, medical research ethics and public health ethics – show that intergenerational perspectives are becoming increasingly relevant. This also concerns debates on resource allocation and priority setting. Thus, established proposals of age-based rationing like the 'natural lifespan account', the 'fair innings argument' or the 'prudential lifespan approach' touch upon questions of intergenerational justice. However, at closer inspection, the underlying notions of generations in these approaches are often vague and heterogeneous. While some refer to birth cohorts, others rather allude to positions in the reproductive cycle of the family, or to groups shaped by certain shared historical experiences. This results in different, sometimes even contradicting moral claims. A clarification of the concept of generations is necessary to fully bring to bear the potential of intergenerational perspectives for ethical analyses in healthcare.
In our contribution, we argue that a theoretical elaboration of the concept of generations with regard to dimensions of temporality and collectivity can help to explicate, systematize, and reflect intergenerational perspectives in healthcare ethics debates. We first clarify the concept of intergenerationality and point out the general relevance of intergenerational perspectives in debates on the allocation of healthcare resources. We then elaborate these intergenerational perspectives by applying theoretically enriched understandings of temporality and collectivity. In view of temporality, this implies the rejection of presentism and a more pronounced understanding of aspects of processuality. In view of collectivity, the distinction between voluntary and unvoluntary or coerced collectives as well as questions of collective identity and action turn out to be important. We illustrate the ethical significance and productivity of these considerations with regard to questions of resource allocation and priority setting in healthcare. In doing so, we identify theoretical shortcomings and blind spots as well as new perspectives in the pertinent ethical debates. For example, an enriched perspective on the life course, the temporality of one's life and the corresponding intergenerational relations can open new

possibilities for a resource allocation that considers the relevance of aspects of intergenerational solidarity, intergenerational responsibility, and sustainability. Finally, we sketch a research agenda that addresses desiderata for intergenerational perspectives in healthcare ethics regarding clinical ethics, research ethics, and public health ethics, as well as meta-ethical questions.

What is Evidence-Based Medicine? Two Overlooked Dimensions

Fedyk, Mark
mfedyk@ucdavis.edu

Evidence-based medicine is one of the most successful research paradigms to emerge in the last century. From its beginnings in the early 1990s it quickly became almost universally accepted among both researchers and clinicians.[1–4] But despite the tremendous amount of discussion over the last three decades, there are two aspects of evidence-based medicine which have been almost universally overlooked. I wish to present a paper — written from my perspective of a philosopher who works at a large medical school in the United States — that offers an analysis of these two dimensions. Crucially, these dimensions help explain why evidence-based medicine thrives in a market-based environment.

So, what is evidence-based medicine? It is an epistemology, an ideology, and an economic framework. The latter two aspects are of course the dimensions of evidence-based medicine that are commonly overlooked, despite the fact that evidence-based medicine's epistemology is both logically and practically connected to the existence of the other two dimensions.

The epistemology of evidence-based medicine proposes an ordered hierarchy of types of evidence, ranked in terms of their relative reliability.[5–7] The hierarchy is meant to be universal and practically comprehensive: all the types of evidence relevant to clinical medicine can be mapped into this hierarchy. It is an ideology because the political economy of medical research (in the US at least) is organized around the production of high quality — i.e. highly-ranked in the EBM hierarchy — trials and studies, and so it is normally the case that the only beliefs about evidence held by practitioners of EBM that are rational are just those beliefs that largely cohere with evidence-based medicine's epistemology. It is an economic framework because it assigns precise economic value to all sorts of local choices and activities that scientists and administrators can take, and because of this, it has the appearance of rationalizing — even naturalizing — the ideology and the epistemology.

I will use both case studies and working examples from my own career to illustrate these claims. I intend thereby to illustrate the complex ways in which evidence-based medicine is interconnected with various putatively non-scientific market forces, such as the price of skilled labor in the healthcare sector. This shows that the epistemology of contemporary medical research is not separate from its economic analysis, and that, therefore, standard tools of economic analysis (e.g. cost-benefit analyses, modeling for different equilibria) may be important for both understanding the history of evidence-based medicine and anticipating its future. But more importantly, this also shows that some of the standard ethical principles used to assess economic actions and policies — e.g., the ideal of pareto efficiency and the welfare theorems[8,9] — may also be fruitfully applied to evidence-based medicine.

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Is two-tiered solidarity an oxymoron … or just awkward?

Fleck, Leonard
fleck@msu.edu

Two-tiered solidarity is an oxymoron. A society committed to solidarity will assure everyone secure access to a thick, comprehensive package of health care benefits independent of anyone's financial status. This reflects a commitment to equal concern and respect in meeting health care needs. However, extremely expensive health care interventions, such as gene therapies that cost more than $2 million, or CAR T-cell therapies for advanced blood cancers that cost more than $500,000, are making single-tiered solidarity unaffordable. Must solidarity be given up as an unaffordable sentiment? Alternatively, is it possible to articulate criteria that would distinguish solidarity-permissible differential access to needed health care from solidarity-corrosive differential access? I will argue for an (awkward) affirmative answer to this question. Here are some considerations for distinguishing solidarity-permissible differential access to needed health care from solidarity-corrosive differential access. (1) Co-pays and deductibles are clearly solidarity-corrosive because poorer patients unable to meet a co-pay or deductible will be denied needed and effective health care. (2) Extremely expensive therapies that are only very marginally beneficial may be excluded from the public benefit package, and that will be solidarity-permissible, even though some identifiable patient group, such as women with triple-negative breast cancer denied Trodelvy, will die a bit prematurely because of that denial. (3) Low-value care that is extraordinarily expensive in the aggregate, such as aducanumab for early-stage Alzheimer's or the Galleri multi-cancer screening test, may also be excluded from the public benefit package but be solidarity-permissible. (4) It should be solidarity-permissible for individuals to purchase low-value care, either out-of-pocket or with private health insurance as long as the social health care financing system is not adversely (unjustly) affected. (5) It will be solidarity-awkward (but permissible) for a society to fund some very expensive targeted cancer therapies that are very effective (minimum gain of one year life expectancy) while denying funding for other targeted cancer therapies, such as Trodelvy with median gains of five months. One can argue that precision medicine that creates numerous genetically identified tribes of cancer patients is itself a threat to solidarity among cancer patients. (6) It will be solidarity-awkward (but permissible) to create a Cancer Drug Fund for targeted cancer therapies not socially funded but with a wide range of effectiveness (less than five-month gain in life expectancy to a gain of three years for some patients with a median of eleven months). Strict medical criteria, very reliable biomarkers that identified patients likely to gain more than a year, would determine just access to those funds. This is relevant to the Coverage Lock process in

the Netherlands. It will be solidarity-awkward but not unjust, I argue, to exclude those patients with likely small gains in life expectancy. It will be awkward and not clearly just to support a Cancer Drug Fund and not a Heart or Liver or Lung Fund for drugs with similar life-prolonging consequences.

A Bioethical Review of Prospective In Vitro Gametogenesis Applications in the Light of Medical Consumerism

Forejt, Kristyna
kristynaforejt@gmail.com

In vitro gametogenesis (IVG) refers to the laboratory-based generation of gametes (sperm and eggs) from donor somatic cells, detaching the process from the donor's body. This method entails deriving gametes from pluripotent cell cultures and nurturing them until they reach functional maturity suitable for assisted reproduction purposes.
IVG has so far garnered only sporadic attention from ethicists, philosophers, and lawmakers, possibly due to the notion that such a technological feat is not realistic at this time. To the contrary, the successful creation of such gametes has already been fully achieved in mice and near-fully achieved in humans. Consequently, proposals for initial clinical trials employing these artificially produced gametes in human reproduction are to be expected in the foreseeable future.
The author endeavours to raise awareness regarding IVG applications among scholars in ethics, provide a brief overview of its current status, and outline potential applications along with their associated ethical dilemmas. The applications include genetic parenthood for opposite-sex couples suffering from previously untreatable infertility, same-sex genetic parenting, genetic motherhood beyond the natural reproductive age, assisted reproduction involving multiple DNA contributors, and large-scale preimplantation genetic screening of embryos. Although in vitro gametogenesis holds the potential to revolutionise human reproduction in a very desirable way, it also threatens to raise a new wave of medical malpractice driven by sensationalism, create new targets for reproductive tourism, influence the sex ratio within populations, and aggravate social inequalities.

Global Health Ethics in the Covid-19 Pandemic. Comparative studies on good practice in healthcare

Forster, Sophia
sophia.forster@fau.de

The Covid-19 pandemic had a particular impact on older people, who are classified as vulnerable. On the one hand, older people are at a high risk of suffering a severe course of the disease, on the other hand, protection of well-being threatened by a Covid-19 infection is to be ensured primarily by restricting social contacts. However, this has huge negative consequences, such as social isolation and loneliness, which in turn also increase the risk of morbidity and mortality. Particularly affected are older people in nursing homes or hospitals; geriatric patients can often even be attributed the two most relevant COVID-19 risk factors: old age and comorbidities. In addition, long-term care facilities and hospitals combine a very high risk of infection due to essential nursing and medical contacts and a high risk of social isolation and loneliness due to strict visiting restrictions, resulting in severe encroachments on fundamental and human rights. Fair and rapid distribution of effective vaccines worldwide is one of the main

opportunities to protect the vulnerable and to strive for an end of the pandemic distribution of the Coronavirus.
In the context of preventive measures fighting the global COVID-19 pandemic, contact regulations in nursing homes and hospitals as well as fast and equitable distribution of effective vaccines worldwide are challenges faced by global society that require in-depth scientific research in real time focusing on a medical ethics perspective.
Firstly, there is a detailed comparison of the situation in nursing and old people's homes in five different countries during the first year of the pandemic in 2020.
Secondly, the legal provisions on visiting restrictions and bans within European hospitals in 2021 and their impact on mental and physical health of older patients are discussed.
Finally, there is a detailed analysis of the first year of COVAX' global vaccine distribution in 2021 identifying problematic aspects of its allocation framework regarding the implementation of its fundamental ethical principles – as fair and rapid vaccine distribution could not be achieved through COVAX. Based on the analysis the 'Prioritized Distribution of Equal Shares' allocation framework, which combines the concepts of equality (proportional allocation) and equity (weighted allocation) right from the outset, in order to achieve both main principles: ethical and practical feasibility.

Global Fait-Based Healthcare Systems: Global health tendencies between care and equity
Galvagni, Lucia
lgalva@fbk.eu

In global health, faith-based organizations play a main role in offering and guaranteeing primary care to people living in extremely precarious conditions and contexts around the world. Starting from the issues that arose in the project "Global Fait-Based Healthcare Systems" (Georgetown University, Washington, D.C., and Bruno Kessler Foundation, Trento, Italy), where local communities and healthcare professionals coming from Kenya, India, and Bangladesh have been involved, the presentation will reflect on the care and equity issues relevant in these scenarios and on the relevance and limits of international collaborations in this field, underscoring the mutual exchange that different healthcare systems can obtain when they try to collaborate and move on in caring for and offering assistance to people most in need.

Regulatory frameworks promoting ethical practices: the case of Covid-19 pandemic response
Gefenas, Eugenijus; Lukaseviciene, Vilma
eugenijus.gefenas@mf.vu.lt

This presentation aims to analyze the role that government bodies and regulatory frameworks play in promoting ethical standards in clinical trials, specifically, those focused on developing new vaccines and other clinical trials for the prevention or treatment of COVID-19 as a means of pandemic response.
First, we identify the main ethical issues addressed in the COVID-19 guidelines focused on research activities. The list of pandemic-specific ethics issues has been generated by analyzing English language recommendations and guidelines on ethics in pandemics adopted during the COVID-19 pandemic and issued by an international or national body.
Second, the identified pandemic research ethics issues are matched with those addressed in the European Medical Agency (EMA) Guidelines, a key regulatory document issued to harmonize clinical trials during the COVID-19 pandemic. It is important to note that EMA guidelines

concentrate only on a few ethically relevant topics, such as prioritization of clinical trials for the prevention or treatment of COVID-19 as compared to other types of research; trade-off between patient safety and data validity, prioritizing trial participant safety in case these two conflict, informed consent modifications, such as delayed consent, contacting participants via phone, video-calls, e-mail, mail, etc.; publishing research data with immediate public health implications without concern that this will preclude subsequent consideration for publication in a journal.
The concluding part of our presentation concentrates on the research ethics issues that are not included in the clinical trials regulatory framework. On the one hand, some important research ethics issues, such as modifications of ethics review by RECs, are not included even in the EMA Guidelines. On the other hand, such issues as prioritization of pandemic response-specific research, consent modifications, and urgent data sharing/publishing do not feature in the national regulatory guidelines of different European countries. These and other key research ethics and integrity issues seem to be left to the oversight of RECs and not harmonized even in the highly regulated field of clinical trials. Therefore, taking into account the complexity of research governance during the pandemic, an operational regulatory framework promoting ethical practices and addressing all relevant stakeholders, such as regulatory bodies, industry, RECs, and researchers is needed, which is particularly important for the efficient pandemic response.

Scarce welfare resources and the ethos of medical practice

Gelhaus, Petra
Petra.Gelhaus@regionostergotland.se

A current example of a conflict between acutely diminishing resources and trying to continue offering sufficiently acceptable healthcare happens 2024 in Swedish healthcare. Swedish healthcare is nearly completely financed by taxes. Inflation, high energy prices and organisation failures have produced a severe deficit in healthcare in 20 of 21 regions in Sweden. In the region of Östergötland in 2023, 6 % of the staff in all units had to be taken in, with insufficient effect on the budget. In order to balance economy, the region announces to discharge another 900 persons (another 6%) in spite of already existing queues and high overtime burden.
A bitter reality: the result is a hardening conflict of care unit against care unit, team against team, care professional against care professional in order to survive and to offer at least some meaningful care. The one who defends his unit best against patients gets the best working situation and the patients who get into the well-defended unit get better care.
This actual case is a telling example of what happens if distribution of resources happens in the procedural way of spreading the burdens ‘equally’ without analysing the needs and leaving the prioritisation to bedside decisions.
Because of the ethos of medical practice, medical staff is intrinsically obliged to see and treat the individual patient and act in his best intents. In the negotiation between just prioritisation of resources and patient-centred care, the responsible physician and the directly involved health care staff are not the best stakeholders for limiting resources in a rational and effective way.
In my presentation, I want to argue for the necessity to use both, a procedural just distribution of resources that includes an analysis of need and prioritisation, AND a patient-centred approach in the direct meeting with the patients who actually get healthcare under the circumstances of scarcity. This negotiation is necessary on all levels of decision, with the highest responsibility of justice in the top of the organisation, and the highest responsibility of patient-centred care on the ‘bottom’ (the centre?) of practical healthcare. It is not possible, however, to neglect one of the moral oppositions completely on any level.

Priority to the worse off and diagnostic measures

Gustavsson, Erik; Juth, Niklas
erik.gustavsson@liu.se

The extent to which a condition is severe constitutes an important part of several approaches to health care priority setting. For example, the Netherlands, Norway, Sweden, and the UK are all countries with explicit criteria for priority setting that apply severity as one of their considerations. However, these criteria are mainly applied to treatments rather than diagnostic measures. When the criterion of severity is applied to treatments, it is often applied as follows: the more severe a condition is that a treatment targets, the higher cost can be accepted per health improvement. For example, a health care system may be willing to spend twice as much for a comparable treatment effect on a condition that is considered to be very severe compared to a condition that is considered to be merely moderately severe. However, to apply this approach to diagnostic measures gives raise to several challenges. We shall focus on three of them. First, a conventional method for priority setting is the systematic ranking of different health conditions and their treatments. The matching of a specific treatment to a specific condition is helpful since it allows for considering several relevant aspects for priority setting such as severity of disease and the patient's capacity to benefit from the intervention as well as its degree of cost-effectiveness. Consequently, the conventional method allows decision-makers to decide whether one group rather than some other group should be prioritized. However, diagnostic measures will often target larger segments of patients – segments that cut across the typical patient group in the conventional model. How should severity be guiding priority setting with regard to such products? Second, medical technology may often constitute a part of a diagnostic procedure. If a specific product targets a very severe condition, should each product that constitute a part of the diagnostics be judged as targeting a very severe condition? Or should the severity be downplayed with regard to how large part of the diagnostic procedure it constitutes? Third, diagnostic measures, such as whole genome sequencing, will often generate secondary findings. Several guidelines for opportunistic screening (using e.g. whole genome sequencing) suggest that identifying or diagnosing secondary indications should only be done when it is proportional to do so, i.e., when the potential benefits outweigh potential risks with identifying the condition in question. To determine if the criterion of proportionality is fulfilled, some limit of sufficient severity has to be settled: how severe should a condition be in order for it to be worthwhile to identify as a secondary finding? So, considerations of severity enter the determination on what to do opportunistic screening for from the beginning, but it remains unclear how it should make a difference more specifically.

Moral Compass in Elderly Home Care: Perspectives of Families Employing Migrant Care Workers for Loved Ones with Severe Dementia

Halevi Hochwald, Inbal; Yakov, Gila; Arieli, Daniella
inbalh@yvc.ac.il

Older individuals with severe dementia and migrant care workers from impoverished countries represent two distinct vulnerable groups. In Israel, approximately 80,000 migrant care workers serve as live-in caregivers for older individuals requiring round-the-clock nursing assistance. When they come together as caregivers and recipients, they form an intimate relationship that raises moral questions due to the employment relationships and different cultural backgrounds within the home environment.

Research Objective: To examine the perceptions, moral dilemmas, and needs of family members regarding their relationships with employed caregivers.

Method: A qualitative study comprising thirty-five semi-structured interviews with family caregivers for the elderly with dementia in households where older individuals reside with migrant caregivers.
Results: A complex and rich picture emerged, including a theme that deals with negotiation, responsibility, and moral dilemmas. The home, once a sanctuary, transforms into a junction for mobilizing global human capital, serving as a contact zone where both the dependent elderly and their displaced caregivers employ strategies to ensure their dignity. There is a dynamic relationship moving between trust and suspicion, the interplay between unfamiliarity and intimacy, and the balance between emotional connection and utilitarian motives.
Conclusions: Alongside feelings of relief stemming from the presence of the caregiver in the home, family members who are the actual employers also experience an increased burden due to the responsibility of employing the workers and the moral distress involved. Given the global aging population and the increasing prevalence of "aging in place" as a caregiving solution for older adults requiring constant care, understanding the vulnerabilities and moral challenges of home care becomes imperative for policymakers, individuals, and families alike.

A needs-based perspective on long-term care, obesity, and old age: Exploring the ethical terrain through a scoping review and selected cases

Hansen, Solveig Lena; Preuss, Benedikt; Frisina-Doetter, Lorraine
sohansen@uni-bremen.de

Obesity is a burgeoning challenge for health care systems. In times of demographic change, it affects an increasing number of older persons in long-term (LTC) settings. Despite the growing number of older persons living with obesity (OPLO) in European and North American countries, the issue constitutes a research gap in both empirical data, normative reflection, and policy making. Our study explores ethical challenges associated with the LTC of OPLO and puts forth a new research agenda.
Through the example of geriatric care, we gain a nuanced understanding of ethical considerations. On the one hand, geriatric care is characterized by a lack of resources, including staffing levels, equipment availability, financial constraints, or educational resources, which has important consequences for access and quality of care. We define the means to address this lack of resources as a matter of need – that is, something that can be measured and quantified as in the “need for” bariatric beds, lifts, more time, etc. On the other hand, geriatric nursing ideally adopts a holistic approach to patient care, considering physical, psychological, and social aspects of health. Training caregivers according to ethical standards is essential to ensure that older adults receive compassionate, respectful, and dignified care. Thus, they respond to “needs of” OPLO.
In contrast to need, needs cannot be quantified or measured. Rather, they are analysed with qualitative or hermeneutic approaches. We argue that such a needs-based approach is morally important in addition to standard economic need-based evaluations. In particular, we argue that “constitutive needs” (Sarah Clark Miller) serve as a foundation for moral demands. They require an adequate response from individuals or institutions because they imply that a person would experience serious harm arising from factors beyond their control. Care recipients have constitutive needs towards a dignified care in a professional context. Specified standards can only be met by professional caregivers, which is of particular relevance for OPLO. Following a biopsychosocial model of health, unmet needs can be physical, psychological, and social, include the respective potential harm.
Clustered within four categories (inadequate and insufficient resources, harmful norms and attitudes of carers, unequal quality of care and treatment biases, vulnerability and justice), our

study presents a comprehensive mapping of the ethical terrain through a mixed methods perspective (scoping review and selected cases). We demonstrate that such approaches are necessary to understand both the systematic factors in LTC and the individual, relational and context-specific consequences of such systematic factors.
Our findings point to a lack of research on ethical issues related to the LTC needs of OPLO and the challenges faced by their professional carers. A series of ethical concerns emerge that have direct import for access, utilization, and quality of equal care. Future research should provide criteria for balancing needs, allocating resources and developing practical solutions for people who are confronted with multiple stigmas.

Regulating health AI – Why risk-based regulation is insufficient

Holm, Søren
soren.holm@manchester.ac.uk

The EU AI Act proposal implements a risk-based regulatory approach to artificial intelligence (AI) placing specific obligations on developers and deployers of AI systems. AI systems in health care will fall under the definition of high risk systems in the Act.
This paper will first briefly outline the obligations that apply to developers and deployers of high risk AI systems, and explain how they protect patients when AI advice plays a role in their care or treatment.
The second and main part of the paper will analyse why the risk-based approach to regulation is insufficient to adequately protect the interests of patients. It will focus on two issues:

1. The lack of uniformity of patient interests
2. The dynamic effects of introducing many AI systems in the health service at the same time

It will be shown that these two issues have profound implications for how AI in health should be regulated, and that they entail a need for patients to be given specific rights.

Hesslow and Walzer: what can they tell us about the concept of disease?

Hubbeling, Dieneke
ahubbeli@sgul.ac.uk

Hesslow (1993) argued - contrary to, for example, Boorse and Wakefield - that we do not need a general concept of disease. A general concept of disease is not clinically relevant, according to Hesslow. Health professionals do not need to establish whether there is a disease and then determine what kind of disease and which treatment to offer. They usually investigate what the cause of the complaint is, and they offer treatment. It will be argued here that one needs a general concept of disease but that the idea of disease is not always the same.
Walzer (1983) argued that there are no general concepts of justice and equality but that they vary in different situations. For example, fairness has different implications when considering income inequality or punishment. One can allow income disparity, but people should receive the same punishment for the same crime committed under similar circumstances. In education, fairness varies with the type of education. In primary education, there should be equal opportunity, and at university, access should be based on merit. Walzer claimed that each sphere has their own internal moral logic. Walzer also argued that different communities can make different choices; for example, countries may vary in the level of social security they provide.

A criticism of Walzer has been that there is overlap between different atmospheres; on the other hand, there is no universal criterion of equality such as Dworkin's equal concern and respect we can apply all the time. Hence, various authors have argued for an in-between position, a form of mitigated pluralism.
This paper will argue that there is no universal disease concept with clear boundaries that can be applied in every situation, but we still need a general concept of disease. Hesslow's original example is that like a mechanic repairing a lawnmower, we have no general concept of disease; health professionals need to investigate what is wrong.
However, health professionals work in a particular society with specific rules, and they cannot just investigate everything and everybody. There are limited resources, and if somebody seeks professional advice, health professionals are limited by what insurance companies and the government (in the case of a nationally funded health service) are allowing them to do, and they will focus on diseases.
Furthermore, like mitigated pluralism, there are also connections between different spheres. Disease (or illness) can entitle somebody to income substitution if they cannot work. However, it would be inconsistent to pay somebody who cannot work for loss of income and not pay for treatment of his or her condition. On the other hand, there are differences. Somebody can be not guilty of a crime because of health problems, but still the condition may not be treatable.
Therefore, there is a general concept of disease, but the exact description varies between different areas of society.

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First-in-human clinical trials and participant safety: What's on and off the table in existing guidance?

Hug, Kristina
kristina.hug@med.lu.se

A first-in-human (FIH) clinical trial is a phase of clinical research where an experimental intervention is tested on a human body for the first time and usually provides an insight about intervention's tolerability. When the experimental intervention is administration of advanced medicinal therapy products (e.g. cell or gene therapy) or other innovative treatments (e.g. transplantations performed on a human for the first time; novel anticancer medicinal products), FIH trial participants are usually patients suffering from the condition which is intended to treat. Such patients often lack effective treatment alternatives while being seriously sick and are therefore especially vulnerable. It is an ethical imperative to safeguard that by volunteering for an FIH trial they do not jeopardize their safety beyond what can be considered as justifiable by the expected benefit. The decision when the state of knowledge is sufficient to launch an FIH trial can become an arena of balancing the interests of a number of stakeholders. Besides prospective trial participants whose safety is at stake, research groups and manufacturers of studied therapeutic products can have scientific and economic interests to test these products or procedures sooner. In this light, any missing knowledge about potential risk of harm (magnitude and probability) is of ethical importance. Decision-making about launching FIH trials takes place in the realm of the existing guidelines and regulations (e.g. EMA Guidelines, EU directives) or policy statements issued by different societies. The ***objective*** of the presented study is fourfold:

1. *To outline* the state of knowledge sufficient before launching FIH trials as required in selected regulations, guidelines and policy statements from different societies;
2. *To analyse*, where relevant, the background of the existing regulations, guidelines and policy statements (e.g. how they have been adopted; on what they have been grounded);
3. *To identify* which, if any, safety-related issues are poorly addressed (or are left "off the table") in the analysed documents;
4. *To discuss* the ethical bearing of the identified knowledge gaps on the safety of prospective FIH trial participants.

To achieve this objective I conduct (a) a review of the recent academic debate on this subject; (b) a systematic overview of selected regulations, guidelines and policy statements issued by different societies; (c) where relevant, analyse the preparatory work documents; and (d) perform an ethical analysis of the findings with the focus on the safety of prospective FIH trial participants.

Healthcare Student Placements in Lower-Resource Settings Might Be Unethical by Design – Unless Payments are Involved

Jenkins, Simon
S.Jenkins.4@warwick.ac.uk

Students who are training for healthcare professions like medicine often undertake placements in different healthcare settings, commonly referred to as "electives". Often, a student will do their elective in a lower-resource setting than the one in which they are living and studying, for example travelling from Europe to sub-Saharan Africa to study and gain experience in a new clinical environment there.

Much of the ethics literature on these placements has focussed on ethical challenges that arise for students *during their elective*,[1-4] like students being asked to perform procedures that might be deemed beyond their clinical competency at home. The general response to dilemmas of this type is that appropriate pre-departure training, including learning that aims to develop cultural awareness, can mitigate the moral distress and discomfort that students can feel in these settings, and help them to respond appropriately to dilemmas that arise.

We can distinguish between moral problems that arise during the elective, and moral problems that exist in the elective *by design*.[5] The latter question has received less attention, and raises potentially troubling questions that may not be resolvable by pre-departure training, and may require a more wholesale overhaul of the concept of medical electives and how they are organised and conceived. I will follow the standard moral-theoretical considerations and consider both the *purpose* and *consequences* of medical electives.

The British Medical Association previously advised that the purpose of the elective is primarily *educational* for the student. Therefore, students who go into the elective believing that they will help to deliver local care may be misguided, an attitude which may be morally problematic in itself (especially if it borders on "white saviourism").It may also generate negative consequences, since a student may cause harm to patients if they think that they are there to help them when they do not have the competency to do so.

However, it is not obvious that a medical trainee from a high-resource setting attending a low-resource setting with *no* intention of helping those in that setting is particularly laudable. We do want medical trainees to have an accurate sense of their own abilities and limitations. And perhaps a general principle of reminding medical students to be more modest is appropriate. But if we are then in the situation of insisting that these encounters are solely for the purpose

of educating the visitor, how can we justify the burden – in terms of time, attention, and other resources – that is placed on host communities when students visit?
This paper argues that the burdens placed on host institutions during these placements are significant and under-considered, but that they can be justified in either of two ways: A) payment is made to the host community to offset the resource burden imposed by the medical student's visit, or B) the student uses their learning to provide some benefit to similar communities in the future. Students may also be able to provide benefit during the elective in ways other than payment, but this approach should be regarded with caution.

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Large Language Models in Healthcare – A Call for a Rights-Based Ethical Assessment

Kaaya, Emmi
emmi.kaaya@ut.ee

Large Language Models (LLMs) are a variety of generative Artificial Intelligence (AI) models designed for natural language processing tasks, and they are making their way to healthcare. While LLMs promise to revolutionise healthcare for example by providing support for clinical decision-making, and streamlining administrative tasks, the use of LLMs is said to carry a significant risk to individuals' privacy. Is the risk ethically justifiable? In public policy, the standard approach to justifying risk is consequentialist: a risky practice can be considered as justifiable if the expected benefits balance out the associated risks. A problem with this approach is that it provides a static risk-benefit assessment of a risk that is highly dynamic. The privacy risk involved in the use of LLMs can evolve with rapid changes in the behaviour, capabilities, and vulnerabilities in LLMs. A risk-benefit calculation is simply unable to capture the dynamic nature of the privacy risk hence, it provides insufficient grounds for assessing the ethical justifiability of the risk. It is thus argued that to assess the ethical justifiability of the privacy risk involved in the implementation of LLMs in healthcare, a more comprehensive approach is needed – one that goes beyond risk-benefit calculation. It is proposed that the assessment of the ethical justifiability of risks involving a great deal of future uncertainty should address questions of rights.

Exploitation in Biomedical Research: Who and How Should Be Paid for Participating in Clinical Trials?

Kaczmarek, Emilia
emilia.kaczmarek@uw.edu.pl

Exploitation can be broadly understood as a disproportionate division of burdens and benefits - the burden is borne by one party in a given relationship, and the benefits associated with this burden are gained by the other. But what does this actually mean in the context of paying research participants in clinical trials? For instance, is the situation in which the participant covers the costs of a scientific experiment inherently exploitative?
In my presentation, I will discuss a recent change in Polish medical law that prohibits experiments funded by patients. I will use actual examples of practices that intuitively seem to be exploitative to elaborate on this term. My goal is to develop a payment model for clinical trial participants that would be immune to the allegation of exploitation.

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How cold war drug markets were crossing the borders: the methaqualone story

Kakuk, Péter
kakukp@ceu.edu

The paper follows the story of methaqualone (Quaalude/Revanol/Durmil/Sopor), which was developed in 1951 in India, entering the medical markets of East and West in the 1960's and became one of the most prescribed sedatives. However, methaqualone became increasingly popular as a recreational drug and club drug in the 1970s and became a prime target of the Drug Enforcement Administration (DEA) in the USA. Tonnes of the drug were produced in Chinoin, a state-owned high prestige drug company in Budapest. The methaqualone transports were organized by Medimpex, which was founded in 1949 and operated as a state governed pharmaceutical foreign trade company. The company exclusively managed the export-import turnover of the Hungarian pharmaceutical industry and the import needs of the health service in the cold war period. The Medimpex drug transports were sent to a subsidiary in Switzerland, called Labatec, which organized the drug further travels to Columbia, before the shipments could enter the final destination: the illegal drug markets of the USA. The paper focuses on this interesting episode in the history of science and technology that highlights the "nylon curtain" of postwar Europe, where a strange set of actors became interconnected in the cold war politics of (il)legal drug markets.

Anti-Roma racism and ethnicity-based discrimination in state socialist health care: a historical perspective on postwar Europe

Kakuk, Péter
KakukP@ceu.edu

Currently, the average life expectancy for people in the European Union is about 80 years. But for Roma people, it is 10 years shorter. Roma people in Europe—like Blacks and Hispanics in the U. S.—experience considerably worse health outcomes than ethnic majorities. The paper investigates postwar medicine in Europe with a focus on the continuities and discontinuities of Anti-Roma racism and ethnicity-based discrimination in healthcare. Based on the analysis of

Hungarian public population debates of the 1960's, 70's and 80's and medical journals of the same period the paper aims to capture the specific features of racist thinking in state socialist environments. The paper contributes to discussions on postwar racism in health care with understating the historical precedents and patterns of thought in the second half of the last century.

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Dr Bot? Trust, Reliance, and Responsible Marketing for AI Therapy Apps

Katz, Rachel
ra.katz@mail.utoronto.ca

Philosophical work on artificial intelligence (AI) has proliferated over the last few years. Much of this work consists of compelling research on the nature of AI's so-called intelligence, or the promise of its usage in medicine or other fields that aim to serve the general population. However, a significant amount of misinformation about the capabilities of AI has made it difficult for the public to decipher its limitations. One space where this is particularly true is in mental health care, specifically the development and promotion of AI-powered psychotherapy apps. There are a variety of types of psychotherapy apps on the market, not all of which make use of AI to deliver content to users. Increasingly though, app developers are incorporating conversational AI (or chatbots) to interact with users as a therapist would. These apps often use AI-powered chatbots as part of the therapeutic relationship, altering the experience of therapy and removing one of the central agents in the relationship: the human therapist.

In this talk, I argue that the relationships forged in each of these scenarios are fundamentally different from one another. A relationship with a human therapist is founded on trust, while a relationship formed with an AI-powered therapy app is one of reliance. The roles in each relationship are different too. In "traditional" psychotherapy the typical roles are that of the patient and the therapist. In the context of AI-powered therapy apps, the relationship consists of a service user interacting with an information source. I will draw on the work of Onora O'Neill and Annette Baier to scaffold a working definition of trust, and contrast that with Facundo Alonso's definition of reliance. Initially, this distinction may seem inconsequential to service users, but I will argue that this is the difference between a dynamic, adaptable relationship and a one-sided facsimile thereof. If app users do not understand the relational differences between meeting with a human therapist and interacting with a therapy-adjacent app, they may misunderstand the limits of the range of benefits they can expect from their app usage. In the context of using AI-powered apps for psychotherapeutic programming, the brushing over of this difference may prove particularly disastrous for users. The private companies that develop these apps attempt to humanize them, blurring the line between human and non-human interlocutor for service users. This false advertising may further confuse app users, at best alienating them from the app and at worst having negative effects on their mental health. These apps may have a place in the mental health care landscape, but that cannot come at the expense of users' understanding of these apps' capabilities.

Ultimately, I argue that AI therapy apps cannot provide therapy, largely because trust is an essential component of the therapeutic relationship. As I will show, it is not technically possible for a trust relationship to form between a human patient and an AI therapist. In the final section of this talk I will discuss the role of accountability to propose a more responsible approach to educating would-be users on the abilities and limits of AI-powered psychotherapy apps. I will propose some options for how the developers of these apps can hold themselves and their peers

more accountable to honestly representing what AI-powered therapy apps can - and cannot - do.

Health Justice and Bioethics: Beyond Access to Treatment

King, Nancy
nmpking@wakehealth.edu

Because bioethics is a field rather than a discipline, it has long been a misfit in a discipline-based world. To be successful in academia today, bioethics scholars often become specialists in narrow empirical areas in which they can establish a track record of grant funding and publication. And to be effective in applied areas, clinical ethics consultants often focus exclusively on decisions and actions within the hospital's walls.

This is a change from the field's beginnings, when bioethics scholars and practitioners worked to stimulate moral imagination through multidisciplinary collaboration, communication, and critical reflection. Social justice has recently become a hot topic in American bioethics, but it is largely treated as a specialty area, most often pursued by academics based in law or public health and by bioethics scholars of color. Justice theory can be complex, incorporating focus on institutions, communities, and policies. It may thus appear more challenging to pursue than autonomy and beneficence, which concentrate on relationships between individuals. However, to write and practice in bioethics without seeking to address considerations of justice or to incorporate the principle into our daily work is no different from saying "Sorry, I don't specialize in autonomy so I can't help you with your informed consent question."

What does justice require of bioethics scholars? First, we must remain committed to talking and working with scholars of many disciplines in order to learn about real-world applications of health justice. Social epidemiology, public health, health law, medical anthropology, medical sociology, and others are all areas from which bioethics scholars can learn much about justice and about methods for addressing it. Second, we should maintain an awareness of the complex relationship between theory and context. For example, distributive justice problems, which are highlighted during public health emergencies like the COVID-19 pandemic, are often viewed as arising only within hospitals and other healthcare institutions; however, as we learned from the pandemic, health justice clearly requires a far broader consideration of how life before hospitalization matters for health. And finally, justice requires us to consider the impact of structures, systems, and institutions on individuals' actions and choices. This means acknowledging not only how individual injustices are influenced or determined by social context, but also that injustices cannot be effectively addressed without significant social change.

This makes doing justice work challenging, controversial, perennial, and unbounded, thus reminding bioethics scholars that the questions we address are deeply human questions, often without neat answers. Justice in bioethics may thus require advocacy and activism, which can stretch scholarship beyond our comfort. Justice should play a central role in the field, alongside autonomy and beneficence. This requires us to learn and teach more about non-ideal justice theory and especially to cultivate an interdisciplinary perspective that looks "upstream" from the hospital to the social and structural inequities that profoundly influence health disparities. Only by moving beyond institution-based health care can we do health justice.

Ethical Challenges of Novel Clinical Trial Designs

Klas, Katarzyna; Waligora, Marcin
katarzyna.anna.klas@doctoral.uj.edu.pl

New methodological approaches to improve the process of conducting clinical trials have been intensively developed in recent years. Increasing attention is being paid to adaptive clinical trials. Adaptive trial design is a clinical trial design that provides pre-specified opportunities for modification of an ongoing trial based on accumulating trial data (i.e., based on the results of an interim analysis, trial design features can be modified). In my presentation, I will focus on the master protocol and seamless design as examples of adaptive trial design. A master protocol is a clinical trial design that allows the evaluation of multiple interventional hypotheses. A seamless clinical trial combines two different stages of the drug development process to address multiple objectives that are traditionally addressed in separate trials.
The aim is to discuss the ethical aspects of clinical trial conduct in the context of adaptive clinical trials. I will debate the issues of the lack of transparency in the reporting of results and the need to adapt existing tools, such as clinical trial registries, to better track the entire trial process and to accommodate the complexity of novel trial designs. I will also address the issue of risk-benefit analysis and try to answer the question of whether the new solutions implemented have a favorable risk-benefit ratio. Conclusions will be supported by the results of available meta-research studies.

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Conflict between patient welfare and financial incentives for out-patient care in cancer medicine

Koenig, Julia FL; Aufenberg, B; Sommerlatte, S; Schildmann J; Greiner, W; Winkler, EC; Mehlis, K
Julia.Koenig@med.uni-heidelberg.de

In its statement “Patientenwohl als ethischer Maßstab für das Krankenhaus” (patient welfare as the ethical yardstick for the hospital) from 2016 the German Ethics Council declared patient welfare the guiding principle of in-patient care and extended the guiding principle of patient welfare from the micro level of the patient-physician relationship to the meso level of hospital-community relationship. Unlike most in-patient care, out-patient care in Germany is mostly private practice. To translate the principle of patient welfare to the out-patient setting therefore presents a special challenge. In Germany physicians who work in private practice are also small business owners who face the challenge to make profit to keep their businesses running. This is especially interesting in cancer medicine as cancer treatment is largely administered in the out-patient setting. The ELABORATE-Project funded by the German Cancer Aid (Deutsche Krebshilfe) investigates the connection of economics and cancer medicine and their ethical implications. To understand economic influence on cancer medicine we conducted 16 qualitative interviews with physicians who had experience in budgeting and controlling about how decision-making situations were influenced by economic considerations. Participants describe six different financial reimbursement scenarios in out-patient cancer care that present a dilemma to them: reimbursement of brachytherapy, oral cancer treatment, subcutaneous cancer treatment, radiotherapy fraction schedules, radiotherapy target volume and cancer treatment that can be administered intravenously and subcutaneously. In each of these reimbursement scenarios they have to decide whether to but patients’ welfare before their business interests.

In this presentation we would like to examine how the concept of patient welfare as it is defined by the German Ethics Council translates to the out-patient setting. Further, we want to examine the implication the concept of patient welfare has on physicians as small business owners on the micro level and explore if these implications hold, if they are extended to the meso level of the small business owner in the health care system-community relationship. What does the concept of patient welfare, as defined by the German Ethics Council, demand from small business owners? Do these demands need to be limited?
For each of the six scenarios the different claims of patient welfare and business interests are weighed against each other to underline the conflicting interests that come with the respective financial incentives. Consequences and the solutions presented by the participants of the qualitative interviews are discussed to find recommendations that help physicians faced with similar choices and could inform health care policy.

Is therapeutic privilege just? Ethical dimensions of selective information disclosure in medicine and care

Kropf, Mario
mario.kropf@uni-graz.at

Communication between healthcare professionals and a patient usually relates to the patient's state of health, possible interventions, or prognosis. A fundamental value is at the center of all forms of interaction, namely the health of the person. For some years now, there has been a tendency in medical discussions not to provide the full truth to protect the person concerned from harm or to act in a caring manner. This withholding of important information is expressed by therapeutic privilege. In a first step, different understandings of therapeutic privilege are examined. The question of the extent to which considerations of justice theory are associated with the deliberate withholding of information is then explored. In a second step, these challenges relate to the relationship between healthcare professionals and patients, age-based discrimination, and the extension of therapeutic privilege. While the issues of self-determination, truth and the avoidance of harm have been discussed in detail in scientific research, the idea of justice seems to be missing in therapeutic privilege. This article will deal with precisely these problems and show that deliberate information selection discriminates against certain people or groups because they are denied important access to healthcare. From an ethical point of view, the aim is to raise awareness of these problems and to promote those ways of acting that internalize justice as the standard for the conditions that make individual life possible for all human beings.

Whose Home? Which Belongingness? Making Feminist Sense of Phenomenology of 'Illness as Unhomelike being-in-the-world

Lin, Ya-Ping
arete@nycu.edu.tw

Fredrik Svenaeus draws on Heidegger's concept of 'being-in-the-world' to understand health and illness. Health, Svenaeus argues, is a state of 'homelike being-in-the-world' characterised by being 'balanced' and 'attuned' with the world. Illness, on the other hand, is a state of 'unhomelike being-in-the-world' characterised by being 'out of tune' and alienated from one's own body. While Svenaeus' analysis is seen as illuminating and promising, some scholars argue that the complex notions of home and homelikeness need further explication and development.

For example, Ahlzén (2011) is concerned about the difficulty of translating philosophical analysis into useful clinical practice, questioning the link between unhomelikeness and illness. In this article, I propose that a critical and feminist phenomenology, as exemplified by the work of Luna Dolezal, Kirsten Jacobson, and Corinne Lajoie, among others, can enrich our understanding of the concepts and experiences related to illness, home, being at home, and belongingness. This approach underscores that one's lived experience of health, illness, and healthcare are constructed in and through social, political, and historical processes. In particular, it draws attention to the metaphor of home as a ground for unity and stability, which needs to be carefully re-examined. While for many, home represents familiarity and security, it can evoke feelings of oppression and suffocation for others. When we idealise home as a peaceful sanctuary, using the rhetoric of nostalgia or utopia, we need to acknowledge that home may carry negative connotations for survivors of domestic violence. We must also recognise the complex and diverse meanings that home and dwelling hold for individuals who are homeless or lead nomadic lifestyles. According to Svenaeus, the goal of medicine is to restore health, i.e. to bring the patient back to homelikeness, highlighting the lived body's seamless compatibility with the world. However, this perspective may dismiss or even marginalise certain non-mainstream ways in which bodies inhabit the world, such as "embodied feelings of disorientation, unease, queerness, misfit, alienation, or jarring incompatibility" (Lajoie, 2019, 558), making them seem even more out of place, and causing additional distress and discomfort to patients.
Overall, this article strives to broaden our understanding of home and belongingness through a critical feminist phenomenological lens, allowing the phenomenology of medicine to genuinely resonate with the diverse experiences of embodiment in clinical settings. Furthermore, the article emphasises the ethical importance of fostering inclusive worlds that embrace various ways of being at home.

Framing of patient information to promote healthcare objectives – an obstacle to shared decision-making and autonomous patient choice

Lindberg, Jenny
jenny.lindberg@med.lu.se

Traditionally, the doctor-patient relationship was characterized by an open form of paternalism that was widely accepted. Nowadays, paternalism is officially discouraged in favor of shared decision-making and patient choice. Although this is the general norm in health care, there may still be situations where paternalistic attitudes prevail, partly fuelled by the epistemic asymmetry of the doctor-patient relationship. Shared decision making is not truly shared unless the patient makes an authentic decision based on personal preferences and value hierarchies. But is this always the case?
As an empirical background, we conducted a qualitative study based on interviews with 14 nephrologists in Sweden. We have chosen to present one of the many findings here: Several of the participants expressed that they provide information to support decision making according to what they believe will be most beneficial to the patient. They expressed that to guide patient choice, they sometimes emphasize the benefits and underplay the potential negative side effects of the treatment option they consider to be the best, while demonizing other alternatives. This finding prompted the need to analyze how framing in this sense relates to shared decision-making and autonomous patient choice, but also to the epistemic and moral status of the patient. Because the relationship is asymmetrical, there is a risk that framing will not promote patient choice, but rather encourage decision-making according to what the clinician believes is the best treatment option, either from personal experience or according to local guidelines and

priorities. Following the pattern of doing something for the benefit of the patient without fully respecting the patient's personal preferences is clearly a form of paternalism. It is a way of discreetly manipulating the patient's choices with the intention of objectively benefiting the patient by promoting certain values (such as health, survival, long-term well-being) while neglecting other values that the patient may personally choose to prioritize. Framing carries the risk that the patient's choice will not be authentic in the sense of being in line with the patient's personal hierarchy of values.
The glorification of the 'right' alternative and the demonization of the 'wrong' alternative may also be misleading, even if the information given is accurate in itself, because the facts about the patient's condition and options are partly manipulated. There is certainly a difference between framing and persuading or even coercing the patient to make a particular choice. But misleading a patient in this way is a form of deception and will obviously promote further epistemic asymmetry in the doctor-patient relationship. The patient is not treated as a moral equal, but as morally inferior to the doctor and in need of guidance in making personal choices. Providing this guidance through the framing of information means not being honest at a time when such honesty is needed to provide the patient with the means to make autonomous choices.

Can an "Onco-Exceptionalism" be justified? Ethical problems of justice and resource allocation in precision medicine.

Münch, Nikolai; Mahdiani, Hamideh
h.mahdiani@uni-mainz.de

Precision Medicine (PM) promises treatment and prevention measures that are better tailored to individual patients. From the perspective of just health care an urgent question is: who can expect to benefit from such new precision treatments? The problem of inclusion of marginalized patient groups in research and the balancing of benefits and burdens of PM across societal groups has recently come into the focus of ethical debate. While this question is very important, it is not the only potential ethical problem of PM. Although more individualized and effective interventions may (one day) even reduce health care costs, up to now precision strategies, which are today primarily used in cancer care, are in many cases comparably very expensive interventions. Critics argue that many of these expensive interventions don't have a reasonable degree of effectiveness that legitimizes the use of health care resources on them. Doing so would be an "Onco-Exceptionalism" that might undermine a just allocation of health care resources and even damage societal solidarity, or so critics complain.
On the other hand, regarding advancements of medical technologies and treatments like combination immunotherapies and biomarker testing there exists a multitude of arguments for the need to change the standard cost-effectiveness methodologies which have guided the policy makers in their decision to reimburse a particular drug or not. It has been argued that cancer drugs are more expensive, the disease is scarier, the R&D highly costly, it is an end-of life disease, and more severe- among others- and therefore a higher cost of drugs can be justified. Put differently, cancer patients require more support so that the equity of distribution in healthcare resources is fairly achieved.
The talk will evaluate the pros and cons of Onco-Expectionalism from the perspective of justice in allocation of health care resources. Therefore, the following questions will be addressed:
a) Is there something special about precision oncology? Is there something (like its proponents argue) that distinguishes precision oncology qualitatively from other (non-precision) treatments that might be of normative importance for resource allocation?

b) What are the mechanisms that facilitate reimbursement of precision oncology compared to other medical interventions? And what ethical arguments may support this? Internationally, there are different ways of adjusting reimbursement decisions for oncology. In the UK, for example, cancer drugs are funded by an extra fund. In the Netherlands or Norway cancer treatments are not covered separately qua being cancer treatments but through the inclusion of severity of disease in reimbursement decisions. This, in many cases, applies to cancer treatments.
c) Based on the reflections on precision oncology and different ways to adopt reimbursement decision we will try to answer the question: can an Onco-Excpetionalism be justified and if so, what kind?

Addressing social vulnerabilities in joint cancer treatment planning

Mainka, Christine; Bozzaro, Claudia
Christine.Mainka@uksh.de

Long distances to the hospital, unstable housing, care responsibilities, language and / or other cultural barriers, and financial challenges can all negatively impact a patient's capability to realize a chosen therapy. This presentation will focus on these challenges. As a first step, the corresponding project “KUSS” will be presented: The overall aim of the KUSS-project is to develop, test and implement a culture and diversity sensitive screening tool to identify social vulnerabilities in joint cancer treatment planning.
In a second step, the underlying bioethical concept of vulnerability will be explained. Social barriers to a chosen therapy can theoretically be understood as dynamic and context-specific layers of vulnerability (cf. Luna 2009: p. 128; cf. Luna 2023: p. 97). Florencia Luna's layer approach avoids essentialism and takes into account both structural barriers and situational challenges. Different layers interact and can influence each other in unique ways. For example, a patient may not be able to realize the chosen therapy in the best way possible, due to infrequent or expensive public transport and experiences of healthcare discrimination. Both can then be understood as layers of vulnerability that can be mirrored by items in a questionnaire.
Finally, we will share initial findings from focus group interviews with medical and non-medical experts in the field: Which kinds of layers of social vulnerability do they experience in the context of cancer treatment? Based on their answers, a prototype questionnaire will be developed at a later stage, which will then be evaluated by the patients themselves. The idea is that, once layers of vulnerability have been identified, appropriate support can be offered and the patient's range of actions and choices regarding their treatment can be expanded.

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Exploring the Ethics of Conversational Artificial Intelligence in Mental Health: A Scoping Review

Rahsepar Meadi, Mehrdad; Metselaar, Suzanne; Bernstein, Justin; Batelaan, Neeltje
m.rahseparmeadi@amsterdamumc.nl

Background Conversational artificial intelligence (CAI), or embodied AI, is seen as a promising new digital technology for mental healthcare. One common application of CAI is the AI-driven chatbot. Such psychotherapeutic chatbots are already available in app-stores. The aim of this scoping review is to provide a comprehensive overview of the ethical considerations surrounding the use of CAI as a therapist for individuals with mental health disorders. The secondary aim is to delineate potential future directions for research in this evolving field.
Methods We carried out a systematic search in PubMed, Embase, APA PsycINFO, Web of Science, Scopus, The Philosopher's Index, and ACM Digital Library. The search consisted of three elements that concern embodied AI, ethics, and mental health, separated by AND commands. We have included all articles that discuss ethical challenges of the use of AI-driven conversational agents that are aimed at functioning in the role of a therapist, aimed at persons coping with mental health problems. We additionally added all relevant articles through snowball searching. All the included articles were subsequently charted.
Results We included a total of 73 articles. Ninety percent of these articles were published in 2018 or later. Ten articles used empirical data collection methods such as surveys or other qualitative methods. The following themes were distinguished: harm (reduction) and safety are discussed in 38 articles, the most common topics within this theme were suicidality and crisis management, harmful or wrong suggestions, and risk of dependency on CAI. Explicability, transparency, and trust were discussed in 18 articles. Responsibility and accountability were discussed in 19 articles. Empathy and "the human touch" were discussed in 15 articles. Justice was discussed in 24 articles, this included themes such as health inequalities due to differences in digital literacy. Furthermore, anthropomorphisation and deception were discussed in 13 articles, autonomy in 8 articles, effectiveness in 22 articles, privacy and confidentiality in 47 articles, concerns for healthcare workers' jobs in 8 articles, and other themes were discussed in 11 articles. These themes are subsequently discussed in further detail.
Conclusion Our scoping review has comprehensively covered various ethical aspects of CAI in mental healthcare. However, certain themes, including the climate impact of AI, the nuanced examination of therapeutic processes, and the responsibility gap, are less explored. Additionally, the scarcity of qualitative studies and underrepresentation of key stakeholders highlight areas for future research to deepen our understanding of the ethical implications of CAI in mental health.

Moral responsibility in the era of digital health technologies

Meier, Eva
e.meier@amsterdamumc.nl

Recent policy and scientific publications on digital health technologies commonly use the notion of 'responsible' rather than 'good' or 'ethical'. Descriptions like "responsible digital health" and "responsible use of technology" create a sense of authority and accountability for the implementation of these new technologies. However, the concept of 'responsibility' often lacks definition, resulting in ambiguity about its precise meaning. This ambiguity creates an obstacle in terms of regulating and overseeing the appropriate deployment and use of digital technology in healthcare, as it is unclear what "responsible digital health" entails and how it should be organized. Furthermore, particularly in healthcare it is critical to address these

uncertainties since misunderstandings regarding responsibilities can have significant impact on the quality and safety of healthcare delivery. Therefore, we aimed to investigate how the notion of responsibility is framed and interpreted in the context of digital health technologies. Our specific emphasis was on moral responsibility, because the notions of 'responsible use' allude to the question whether an actor can reasonably be blamed or praised for their actions. We conducted a systematic search in PubMed, Web of Science, Embase, CINAHL and the Philosopher's Index for articles published between 2013 and 2023. A total of 34 articles were included, which used the notion of responsibility in conjunction with any form of digital health technology. The various interpretations of responsibility were categorized using the theoretical responsibility framework by Vincent. This analysis revealed two main findings. First, we found that digital health technologies can expand existing responsibilities and shift the distribution of responsibility among formal and informal caregivers, patients and technology itself. Particularly when technologies based on artificial intelligence are used, there is an emerging 'responsibility gap', in which no one can be held fully responsible. Second, responsibility is often equated with accountability. On the one hand, articles use the notion of 'responsibility' to describe new ways in which physicians can be held accountable, notably for incorrect outcomes of artificial intelligence tools. On the other hand, it is noted that m-Health technologies can make patients more accountable for their own ill-health. However, there was limited discussion in the reviewed literature on whether these attributions of accountability are appropriate, leading to questions whether these accountability claims are justified. Our analysis highlights that these top-down accountability claims, and the inconsistent use of the term 'responsible', hamper the appropriate usage of digital health technologies. Therefore, we formulated four recommendations aimed at tackling the improper usage of the term 'responsible' in order to benefit from the positive utilization of digital health technologies. At the conference, we will present the findings and recommendations following from this scoping review and we will emphasize the importance of clearly defining and justifying interpretations of responsibility. Moreover, the value of our attempt at clarifying the operationalization of 'responsibility', will be illustrated using preliminary findings of a case study about the impact of telemonitoring technologies on the experienced responsibilities of formal caregivers and patients.

Public Health and Phenomenology: Questioning the Notion of Health

Mirikermanshahi, Saba
saba.miri.k@gmail.com

During the 19th century, experimentalism and scientific thinking gradually dominated different areas of knowledge, including medicine. This process eventually led to evidence-based medicine which aims to eliminate the individual side of disease and define diseases through universal principles of casualty by using the detached third-person perspective towards the human body. Consequently, the first-person narrative was considered to be irrelevant.

In the 1970s issues like burnout among clinicians, patient-physician relationship struggles, and patient dissatisfactions caught the attention of scholars, philosophers, and healthcare professionals. The importance of understanding and embedding first-person experience and the insufficiency of merely scientific medicine was realized. Philosophy of medicine aims to approach and understand this problem and make way for Rehumanizing Medicine by way of philosophy, human science, and art emerged at this point to bring back humanity and subjective aspects of patient and professional experience into medical education and clinical practice.

The phenomenological concept of health was first described by Hans Georg Gadamer in Enigma of Health. scholars like Fredrik Svenaeus, Kevin Aho, and Havi Carel have explored different aspects of the phenomenological definition of health and illness, the importance of

lived experience in both patient and caregiver lives, and how the human side of medical practice should be approached. Symptoms like Breathlessness, psychosomatic symptoms, conditions like grief or depression, and theoretical arguments like bioethics are among the topics explored through phenomenological thinking.
Phenomenology also touched the surface of Public and Global Health, mainly through phenomenological methods such as interviews, research action, or designing questionnaires. However, the phenomenological perspective seems to have way more potential for contribution to the field of public health. Noticing the difference between medicine and public health fields, the tendency for data-based knowledge and scientific epidemiology goes even further in public health. Since it deals with the life span of people, it includes the whole society, not only those who came to hospitals with severe symptoms; eliminating the human side of health and illness seems more problematic. Any understanding of the health concept has philosophical fundamentals and represents how we understand and perceive the human being. The main criticism is that the concept of public health has been merely reduced to statistics and epidemiology, and its philosophical aspect has not been explored appropriately. As mentioned above, the phenomenological methodology has already been used for understanding individual interviews and designing projects and guidelines. However, the idea here is to use a phenomenological understanding of health to bring a new understanding in the field of public health and discover how it can reframe our concept and definition of Public/Global Health and also reframe the problems we face in the field and help to find solutions,
Since phenomenology has been recognized as one of the best ways to approach and understand the first-person experience, we must find a way to embed phenomenological thinking in public health further. If health, according to Gadamer, is an existential phenomenon, the concept of global health cannot go without exploring the existential aspect of human life. Since human interactions and the way they respond to things play a vital role in global and public health, we must try to attain an understanding of it, and phenomenology seems to be, as in medicine, an excellent way to explore such issues.

Resolving Tensions Among Bioethical Principles and Rights to Healthcare in Market Systems

Mosteller, Timothy
tmostell@calbaptist.edu

This paper explores the relationship between ethical principles (autonomy, non-maleficence, justice, and beneficence) and rights within markets and health care systems. I consider whether the principles of autonomy and non-maleficence entail that all rights to healthcare in market systems are negative rights. Negative rights are such that the exercise of a negative right entails no obligation on others for an individual to exercise that right. This implies that a market system of which healthcare is a part will necessarily have a system of rights in which no one is obligated to provide anything to others, including healthcare, justice, or beneficence for the exercise of their negative rights. The principles of autonomy and non-maleficence seem to imply that there is no such thing as a positive right to health care (or anything else) in a market system.
However, beneficence and justice also seem to be real principles for philosophy of medicine, healthcare, and bioethics which pull against this implication of negative rights when they apply to markets and health care systems. Therefore, the notion of free markets and healthcare grounded in the view that all rights are negative faces a trilemma. It appears that we must: 1) give up the principles of autonomy and non-maleficence along with the idea that they imply that all rights to healthcare in market systems are negative; 2) jettison the principles of beneficence and justice as principles for bioethical reasoning; or 3) demonstrate whether the

principles of beneficence and justice are compatible with the way in which the principles of autonomy and non-maleficence imply that all rights are negative rights.
This paper will proceed in three parts. First, I explain the apparent tension among four principles of bioethics and their connection to the nature of rights in markets and healthcare systems. Second, I show how this tension logically entails the trilemma indicated above and indicate the strengths and weaknesses of each of the three possible options. Third, I suggest that a plausible way to solve this tri-lemma hinges upon a metaethical ontology of goodness which informs the nature of the principles of bioethics for markets and health care systems.

Equitable access to reproductive health care in the context of Polish socio-economic system: a multipolar problem

Nawara, Agnieszka; Ruciński, Kuba
aa.nawara@uw.edu.pl

Starting from the 1990s, Polish conservative legislators have been successfully restricting reproductive rights of Polish women. This trend has culminated in the 2020 ruling of the Polish Constitutional Tribunal, which subsequently almost completely eliminated the possibility of legal abortion. In recent years, there have been high-profile cases of deaths of pregnant women in Polish hospitals in which — despite the medical reasons for performing an abortion — doctors refused to do so, which resulted in death of the pregnant woman.
The parliamentary elections at the end of 2023 have brought a change in the approach to reproductive health, especially in the funding of IVF and unrestricted access to emergency contraception. Nevertheless, in 2023, Poland once again ranked in last place in the Contraception Policy Atlas Europe, and the almost complete ban of abortion remains.
During our talk we will present results of analysis of the current state of Polish legal, administrative and organizational solutions regarding reproductive rights. This includes ongoing and planned legislative changes, in particular the proposal of the abortion referendum. Unique social involvement of conservative voices, especially connected with politically active members of the Catholic Church is another factor that heavily influences public debate in Poland and should be considered. We wish to examine how Polish debate on reproductive rights still — despite the ongoing political and legislative changes — excludes and ignores those coming from the least privileged social groups — uneducated, poor and addicted. Few examples of said exclusion are: (1) inequalities in access to effective infertility treatment; (2) limited extent of the contraception reimbursement; (3) absence of reliable sexual education within the scope of school curriculum and stigma surrounding sexual education itself and (4) an access to abortion largely depending on having financial ability to take advantage of the abortion underground which have been created in the last three decades, since the adoption of the so-called abortion compromise of 1993.
Based on our analysis we suggest that current solutions effectively limit the ability of Polish women to exercise their reproductive rights, making it available only to those who already have adequate cultural and socio-economic capital. Furthermore, we conclude that those changes remain embedded in the market-driven approach to healthcare, thus not being sufficient to eliminate inequalities in the field of reproductive health. We use the recent legislative changes to illustrate how, although the impact of economic factors on access to healthcare, including reproductive health, remains widely known, it seems to be absent both in the reforms of the Polish legislator and in the public debate regarding them. While the Polish legal and organizational landscape finally begins to meet generally accepted procreative rights standards, more actions aimed at eliminating inequalities in healthcare access are desperately needed.

The Problem of Collective Therapeutic Misconception in Global Clinical Trials: Defining Responsibility Floors and Ideals for Researchers

Pan, Qingxuan
panqingx@msu.edu

International clinical research has often been considered as an important way to generate scientific knowledge that could address the priority health needs of host communities, thereby contributing to the aim of reducing global health inequities. In practice, however, there has been an increasing number of cases of ethics dumping which occurs when certain studies which could not have been approved in high-income countries (HICs) end up being accepted by researchers conducting trials in low- and middle-income countries (LMICs). The problem of exploitation of research subjects raises the awareness among scientific communities that a fundamental element of responsible research is adherence to high ethical standards, independently of where the research takes place. In this paper I argue that the problem of exploitation arising in the context of international clinical research is further exacerbated by the fact that research subjects in LMICs are vulnerable to a collective therapeutic misconception, which gets produced and maintained when social institutions, policy guidelines, and bioethical discourse all contribute to blurring the distinction between the goal of research and therapeutic care. To mitigate the potential for exploitation under the condition of therapeutic misconception, I argue that researchers conducting global clinical trials have special role responsibilities to ensure that they do not utilize it to exploit research subjects in LMICs. Specifically, I propose three responsibility floors which are minimum standards that should not be violated as well as a responsibility ideal which I suggest could be framed as non-epistemic aims of doing clinical research. These aims extend beyond merely generating scientific knowledge to incorporate broader goals of utilizing science to improve well-being of people in LMICs and so to mitigate global health inequities. Lastly, I applied the responsibility floors and ideals to the case of cervical cancer screening trials in India between 1998 and 2015 to show that the structure of floors and ideals is useful for framing a set of criteria for assessing success and failure of clinical trials. My assessment of the cervical cancer screening trials is that while they were successful in generating knowledge that was instrumental in facilitating policy development targeting cervical cancer, the inclusion of a “no screening” control arm lacks ethical justification. My broader aim in this paper is to show that having clear criteria (in terms of responsibility floors and ideals) for assessing whether researchers fulfil their responsibilities contributes to the idea that the quality of scientific knowledge generated from research and the ethics of conducting research should both be considered for evaluating success and failure of clinical research.

Navigating the Complex Landscape of Artificial Intelligence in Medical Liability: Errors Extend Beyond Human Capabilities

Pegoraro, Renzo; Caenazzo, Luciana
cancelliere@pav.va

The burgeoning integration of Artificial Intelligence (AI) in medical settings has garnered extensive attention, presenting both potential advantages and ethical-legal concerns. While AI has the capacity to alleviate clinicians' workloads and enhance diagnostic accuracy, uncertainties regarding liability in the event of AI-related errors and patient harm persist. The literature underscores the growing focus on these issues, including concerns about the use of unrepresentative populations during AI development and the completeness of patient information. Furthermore, discussions have emerged surrounding the impact of AI on the fiduciary relationship between physicians and patients, as well as considerations related to

empathy. The transformative impact of AI on the doctor-patient relationship has introduced various potential medico-legal consequences. Critically, the current regulatory framework on medical liability in AI applications is deemed inadequate, necessitating urgent intervention. The absence of a comprehensive regulation governing the liability of diverse parties involved in the AI supply chain, including end-users, underscores the need for focused attention. It is also necessary to highlight the importance of addressing inherent risks in AI and establishing regulations pertaining to product safety, coupled with the maintenance of minimum safety standards through timely updates. The entrance of AI into the doctor-patient relationship has prompted significant legal and ethical considerations, with debates over the necessity of a dedicated legal background for AI in healthcare. Our aims will be to analyze the potential role of AI in civil liability within healthcare practices, emphasizing the challenges of attributing liability in a field where certainty is paramount. The contrasting views on the need for new laws to define AI's role in healthcare are explored, contributing to the ongoing discourse on the legal and ethical implications of AI in medicine.

Periviable Birth and Epistemic Injustice

Peterson, Jennifer; Mahoney, Daniel
jennifer.peterson@hotmail.co.uk

Periviable birth is the gestational age at which after birth survival is possible, however, unlikely. In 2024 in the United Kingdom, this is generally regarded to be around 22 - 23 weeks gestation; just over halfway through a pregnancy. Birth at these gestations confers significant risks of mortality and morbidity for the baby. Therefore, there is a decision that needs to be made prior to the birth about how appropriate instigation of active, survival-focused care is for that individual infant. The alternative option is comfort care, where the infant's comfort is prioritised and they are permitted to die peacefully in their parents' arms, rather than undergo the brutality of intensive care. This is an intensely difficult decision for everyone involved.

Whilst modern medicine within the UK encourages a shared decision-making approach, in the case of periviability, this may well be more the goal, rather than the reality of current practice. Shared decision making proposes the knowledge and perspectives of the involved parties be put forward and represented respectfully within the discussion, achieving a management plan that integrates the medical evidence alongside the ethical and social priorities of the family. This becomes problematic in the case of periviability due to a pervasive medical paternalism that persists. This is expressed at numerous points along the periviable birth journey, starting with the medical terminology for the pre-birth conversation itself, which is colloquially referred to within maternity services as 'counselling'. Indeed, the very term counselling emphasises the power imbalance between parents and clinicians, placing the clinician in the role of the wise and knowing doctor who will bestow important knowledge onto the parents and guide them through processing this. In reality there is limited data about how to optimally manage this group of unique infants and therefore, counselling should instead reflect a sincere bidirectional dialogue between the clinician and the parents around this uncertainty.

An additional area of concern is the issue of epistemic injustice that persists in maternity care. The way information is presented and shared with pregnant women and their partners is highly variable and often poorly orchestrated. Despite prematurity accounting for 1 in 13 births, there is scarce and vague information shared via approved sources: for example, the NHS website. Parents are therefore reliant on the information that their individual clinician chooses to share with them in relation to periviable birth. Due to this power imbalance between parents and clinician, the consultation is at high risk of being conducted according to clinician priorities. There are numerous maternity reviews, including the recent Ockenden report, which emphases

that women's voices are consistently dismissed and diminished to the detriment of their, and their baby's, care. To ignore women's knowledge of their own bodies and their own pregnancies reduces any potential they have to meaningfully engage and assert their perspective during these pre-birth conversations. This paternalistic dismissal of the perspective and knowledge of the mother raises and attempts to solidify the doctor as the voice of evidenced reason, being, therefore, best placed to be the decision-maker and conductor of the pre-birth conversation. These circumstances cannot result in meaningful shared decision-making, the term becoming tokenistic in its current actualisation.
Whilst evidence-based medicine (EBM) is lauded as an essential aspect of clinical care, it does not consider the individual's own unique perspective, concerns, and circumstances. Integration of a narrative medicine approach has the potential to equip clinicians with the skills required to merge recommendations from EBM with the individuality of their patient, improving clinician reflexivity and strengthening the care clinicians are able to deliver.

Reimagining participation – what kind of science for what kind of society?
Pichl, Anja
anja.pichl@uni-potsdam.de

Experimentation with different participation formats in recent decades has given rise to an impressive and diverse participatory landscape. Participatory health research is practiced in many contexts and different forms and desirable in many respects. However, it is often limited, above all by conditions and factors arising from project formats and the lack of participatory (infra)structures in science and society. The enormous popularity of participation in research stands in contrast to its far-reaching depoliticization and containment which has been observed by critics. This is also visible in the ethical debate on participatory health research which has a strong focus on procedural questions and evaluation aspects. Though of course relevant, their prevalence and the absence of more fundamental questions concerning visions and realities of science and society reveal certain limitations of the ethical debate on participation in research.
Against this background, this talk attempts to reconstruct the - pathetically speaking - revolutionary core of the idea of participation in research: participation as involvement in social co-determination or as taking part in shaping social conditions and the knowledge production required for this. Such an understanding goes beyond a purely instrumental justification of participation in research and technology development, which is based on the fact that those affected (whether patients or future users of a technology) have relevant expertise for the respective project, which should be tapped into for better quality. In particular, it challenges the widespread positivist notions of science and representative democracy as separate spheres. Such an (implicit or explicit) separation stands in contrast to findings of Science and Technology Studies (STS) in recent decades on the relationship between science and democracy, in particular work in the tradition of co-production, which has also been productively applied to participatory research itself recently (Chilvers & Kearnes, 2015, 2020).
Such a co-productionist conception of participation will be reconstructed because it provides important insights into the relationship between science and politics and the construction of publics in the process of participatory research, which are essential for the understanding and ethical reflection of participatory research. However, the role of normativity in this debate appears to be in need of more thorough ethical reflection. How to do so will be hinted at or left for discussion. In any case, I'll argue that an ethics of participation needs to go beyond procedural questions and take into account the role of science in society, democratization and future imaginaries.

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Ethicists as Gatekeepers? Is There a Place for Ethical Concerns in Health Technologies Assessment and Implementation?

Pouliot, Francois
francois.pouliot@chudequebec.ca

Background and Central Ethical Issue: A large number of technologies and procedures used in daily healthcare never received proper assessment. Tradition, professional guidelines, a few articles or congress abstracts were sufficient to justify their use. Health Technologies Assessment (HTA) represents a methodological response to such a situation, but is there a place for ethical concerns in the process?
Arguments: In line with two documents on the topic (VALIDATE Handbook. Values in doing assessments of healthcare technologies from Oortwijn and Sampietro-Colom, and Integrating ethics and the knowledge-to-action cycle from the Canadian Institutes of Health Research), we argue the following:

1. HTA is a multidisciplinary process integrating science, evidence-informed deliberative processes with ‘’the purpose of informing decision-making to promote an equitable, efficient, and high-quality health system’’;
2. Ethical concerns are involved at every step of the process (the involvement of stakeholders; the scientific, normative and contextual assessment; the appraisal expressed in recommendations; the decision to implement the recommendations).

Conclusion: Ethicists can play a significant role in assessing the appropriateness of healthcare technologies and procedures leading to their implementation. In that sense, they belong to the gatekeepers of our healthcare system.

A Call for Paternalistic Interventions in Online Porn Consumption

Räsänen, Joona
joona.rasanen@utu.fi

The aim of paternalistic policies in public health is to improve people’s well-being by limiting their available options. Examples of such policies include restrictions on who can purchase and consume harmful and addictive products such as alcohol and tobacco. In this paper, I argue that public health paternalism should be applied to the consumption of online pornography. Based on neuroscientific research, I claim that online pornography is both harmful and addictive. Therefore, I call for paternalistic health interventions to be implemented in the context of online porn. I consider two challenges to my claim. The first challenge is the well-being challenge, which asks whether people are truly better off for having their options reduced. The second challenge is the distribution challenge, which asks whether paternalistic policies are justified since they produce both losers and winners. However, I believe these challenges can be overcome. I propose that access to online pornography should be more strictly regulated, and I

offer practical proposals for policymakers on how to alleviate the harms of pornography through paternalistic interventions including age-restrictions to porn websites to protect children from seeing things they should not see. The proposal would be in line with the recent age verification rules in the UK's Online Safety Bill as well as a Utah law requiring adult websites to verify the age of users.

Pharmaceuticalization, Immunologization, and Nanotechnization of Metaphors? How Pharmaceutical Market and Regulation have shaped the Metaphors of Diseases

Ravan, Navid; Namazi, Hamidreza
navidravan1998@gmail.com

The process of drug development has changed considerably during the past decades. Despite the old-fashioned serendipitous drug discoveries, it is more rational and based on cost-benefit trade-offs to candid a new molecule as a specific medication nowadays. The motivations for developing conventional drugs are decreasing due to the cost of complying with the expensive regulation requirements and the high risk of failure. Besides, the variety of medications used for many conventional diseases makes it expensive to prove the advantage of a new molecule with randomized clinical trials. Rather, developing novel medicines for stubborn diseases or novel drug delivery methods using nanotechnology and biotechnology for old molecules to acquire a new patent is beneficial for pharmaceutical companies. We aim to investigate the effect of this change in drug development incentives on the metaphors and narratives in scientific communities and public discourse.

Due to the absence of a robust treatment, cancer, and autoimmune diseases, on top of stubborn diseases, are interesting targets for developing novel medicines (i.e. monoclonal antibodies). The pathophysiology of both is defined with immunology. Cancer is generally perceived as the proliferation of alienated cells and autoimmune diseases as the attack of the body on itself. The hegemony of immunology over the describing diseases leads to the occupation of militarized metaphors over medical science and practice. This is what supports an aggressive version of medicine instead of recently reintroduced gentle medicine.

Furthermore, the trend in drug development is shifting from developing new molecules to the delivery enhancement of existing molecules to the target tissue, for example, increasing the passage of paclitaxel from the blood-brain barrier using carriers to treat central nervous system cancers. Nanotechnology and biotechnology provided various ways such as nano-carriers and monoclonal antibodies for targeted drug delivery. Nanotechnology can increase the bioavailability of the molecule and biotechnology can mainly enhance the selectivity of molecules for the target cells. The latter also leads to reinforcing the magic bullet metaphor which shapes the expectations of the effectiveness of such medications in public discourse and the scientific community.

In conclusion, the costs and risks of contemporary drug development affected by market and regulation rules require a new approach toward medical sciences. Stubborn diseases like cancer and autoimmune disease are trending targets for new beneficial medications for both patients and pharmaceutical companies. The refractory essence of these diseases and the lack of guaranteed treatment methods make them enigmatic and mysterious and result in shaping mostly non-gentle metaphors of diseases. Metaphors can shape the way medical scientists think about their subjects as well as the values of research. In this manner, immunology obtains a hegemony over a scientific description of diseases, and nanotechnology and biotechnology achieve an advantage in scientific communities. Furthermore, non-gentle metaphors alter the lived experience of patients and their perception of their diseases and treatments.

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Health in Climate Crisis. An intergenerational continuum view on health injustice

Rehmann-Sutter, Christoph
christoph.rehmannsutter@uni-luebeck.de

Free market capitalism is a major system factor that contributes to anthropogenic climate change. It is now well established by the WHO that global warming and the disruption of climate stability will increasingly harm human health. Improvements of medicine will hopefully soften some of them, but medicine is not available to all and medicine alone will certainly not be capable to cope with this 'climate crisis of health'. A social transformation is necessary. In this context, a new regime that sets incentives and constraints for innovation in the free market is key for cultivating a rapid transition to carbon neutral technologies in an ecologically sustainable economy.

In this paper I will focus on intergenerational responsibilities that we share. Intergenerational relationships however don't need to assume future persons as not-yet existing people. These responsibilities rather develop as duties of care within sequentially overlapping generations. Older people are responsible for the wellbeing and flourishing of younger people who again will care for their descendants. I argue that ethical issues of climate justice in regard to health must be addressed as intergenerational issues in regard to what Australian feminist political philosopher Janna Thompson has called 'temporal vulnerability'.

I will discuss parts of Thompson's work on intergenerational justice, in particular her proposals for an intergenerational political ethics within intergenerational polities. Regimes in a 'free market' are intergenerational institutions that organize an 'intergenerational continuum'. This view is contrasted to a mainstream 'subsequent generations view' on the future generations problem. An ethical framework for climate health justice will then be briefly outlined, based on (i) temporal bidirectionality, (ii) moral non-reductionism, and (iii) a comprehensive account of human practices. Not only future generations are vulnerable by being affected by the impacts of the climate crisis but also those in the present are morally vulnerable because they live in powerful socio-technical and political structures that they cannot change quickly enough. The reasons why intergenerational obligations are justified (and can also be demanded from others who might not be aware of them) become considerably clearer when bioethics adopts an intergenerational continuum view.

Preconception carrier screening and individual freedom of choice

Reyneke, Maryn; Sims, Kadri; van der Hout, Sanne; de Wert, Guido
m.reyneke@maastrichtuniversity.nl

Most pregnant women in the Western world expect their gynaecologist or midwife to screen their unborn child for severe abnormalities. But her gynaecologist would be surprised to hear she knows the carrier status of her and her procreating partner. The surprise might soon fade away as countries consider rolling out reproductive screening programs that do not just screen all pregnant women but also give all couples with a child-wish the option to know if they are carriers of severe genetic conditions. Offering different screening tests to all who want a child, not just those at risk, can create the idea that morally responsible parents make use of them. The mere presence of reproductive screening tests can also create a shadow of eugenics swaying individual couples to avoid the birth of a less desired child. Proponents of reproductive screening argue that a well-crafted screening program ensures voluntary participation and supports prospective parents with non-directional counselling. Furthermore, individuals or families can avoid significant suffering by avoiding the birth of a child with a severe genetic condition. The aim to enable autonomous reproductive choices is endorsed by the European and American Societies of Human Genetics and most Western countries with universally accessible prenatal screening programs, follow, at least officially, this recommendation. Countries that implement a second universally accessible reproductive screening program (like a preconception carrier screening program) could trigger unintended shifts in societal norms with the presence of a compilation of screening tests. I will explore these individual pressures and social side effects and ask if the compilation of screening tests unduly compromises prospective parents' freedom of choice. Conversely, I will explore if the focus on freedom of choice is enough to prevent social side effects.

Healing People and Planet through Sustainable Food Practices: A Case Study from the EU

Teulings, Anouk; Mogollón, José; Richie, Cristina
cristina.richie@ed.ac.uk

Despite progress in healthcare access and food security, the EU faces critical issues: malnutrition remains prevalent, with unhealthy diets contributing to one out of five deaths (European Commission, 2023). Privatization within the EU's healthcare sector has led to unequal access to services, underscoring the ethical imperative for reform (Stan & Erne, 2020; André & Hermann, 2009; Maarse, 2006). Both the health and food systems are often regarded separately when economic or environmental reforms are proposed in either sector (OECD, 2020). Moreover, the existing EU governance structures struggle to fully integrate ethical considerations into health, agriculture, and sustainability policies (Barling & Trébuil, 2009; Caraher & Coveney, 2004; Whitmee et al., 2015).

This presentation explores an environmental bioethics approach to reframe EU governance on food, agriculture, and public health, aiming to bridge the gap between human health and environmental well-being. It will first provide the current landscape of EU governance on food and agriculture, which is decentralized and includes unhealthily food options. Both structural challenges and proposed solutions to more sustainable agriculture and consumer food options will be discussed. The paper will then analyse the impacts of the current EU model of food consumption and production on human health—particularly around avoidable disease and consumer alienation from food source. At that point, the paper will invoke environmental bioethics as a theory which can reconcile, in part, the values of health, food, and sustainable

agriculture through policies that engage consumers, utilize technology, and integrate food and health concerns. The conclusion will affirm that humans are not isolated entities, but integral parts of a larger ecosystem. This realization reinforces a deep connection and interdependence with the environment, reflecting a symbiosis between not only food and human health, but also food ethics and health ethics.

Medical Sovereignty and Health Care Economics

Cristina, Richie
cristina.richie@ed.ac.uk

Medical sovereignty, in contradistinction from clinical autonomy, starts from a critical hermeneutics of suspicion, in line with the intellectual traditions of the medical gaze and medicalization. With strong roots in green bioethics, public health, and crip/ queer theory, medical sovereignty echoes in the words of feminists everywhere: “hands off my body.” The scope medical sovereignty is what happens before one becomes a patient, in addition to one’s disposition to health care.

Hence, while entering the clinic and accepting medicine as voluntary, desired, indeed, necessary to continue life can be morally legitimate; a decision made without coercion; or even a conscious rational choice, the limits of medical sovereignty are left at the door of the health care facility. At that point, biomedical ethics may only offer autonomy, an concession between the doctor—who has the power, the sovereignty, and the control—and the patient who submits to the mastery of another. Today, a great number of people have traded their sovereignty by handing themselves over for medical management. The concomitant implications which accompany loss of sovereignty are profound: not only in terms of human dignity and self-direction, but also on vast economic, medical, and environmental planes.

Economically, the medical industry generates a significant revenue from the economization of pathology, but people pay with bank accounts and lives. With the co-optation of health care by governments and medical companies—both of which have significant interest in the monetization of sickness and health—the health care industry is spiralling closer to an ‘égoïsme à deux’ between patient and clinician, while direct market-to- consumer advertisements allure the uninitiated towards elective services. As businesses decide who is a health risk based on their medical data (e.g., the ability to procure a COVID pass sanitaire; Fit Bit tracking), the economization of health care jeopardizes core biomedical values like justice, access, and allocation of health care resources, while the datafication of health undermines the fundamental principles of a free society, including informed consent, privacy, and choice.

This research is being developed for my third monograph, which I am currently writing. This presentation will: 1. Outline medical sovereignty as an apophatic ethical approach to the medical industrial complex, 2. Describe the economic implications of medical sovereignty for individuals and health care organizations (such as hospitals, med-tech, and health care businesses like insurance companies) and 3. Point towards ways medical sovereignty offers double-dividends in biomedical ethics by not only drawing money away from for-profit health care, but also shifting in global health care resources.

A critique of person-centred and value-based approaches to the organisation and delivery of health care

Roxburgh, Nina
Nina.Roxburgh@monash.edu

Across the world, the cost of healthcare is increasing. Global health spending prior to the COVID-19 pandemic was estimated to be US$9.2 trillion and had seen an increase in spending per person of 17.8 per cent between 2010-2018, and a further 2 per cent in 2019 (Micah et al. 2023). In short, we are delivering more health care, to more people, with more funding, yet we are not necessarily getting healthier or seeing improved outcomes and experiences overall. In response to the increasing pressure on health care systems, health care providers and policy makers alike are shifting away from measuring the impact of their work through volume of outputs – e.g., number of tests completed, patients are seen, beds in use, prescriptions written – towards ensuring that the activities and tasks delivered in day-to-day care are targeted towards creating value. Creating value in health care can be understood as doing away with unnecessary tests and procedures that may be clogging up the system and increasing patient and clinician burdens, while ensuring that the actions taken are actions that will support the end-goals of the patients in a meaningful way.
Person-centred and value-based care has already become a defining feature of the organisation and delivery of health care in many countries, including the US, UK, Netherlands, Norway, and so on. In other cases, such as Australia, the process of reorienting health care around these ideas is only just coming to fruition, through formalising these concepts in public policy documents and initiatives at both federal and state levels of government. I argue that there are several ethical concerns raised by the person-centred and value-based health care movement: (1) that person-centred and value-based health care will struggle to manage competing or opposing health goals and preferences among diverse stakeholders and does not address critical issues of equity and accessibility in health care, (2) that person-centred and value-based health care relies too heavily on outsourcing responsibility of care as opposed reducing the need for care, and (3) that person-centred and value-based health care creates a bi-directional burden of disclosure on patients and clinicians. Overall, I argue that while person-centred and value-based health care may have some promising components, it is essential to hold a magnifying glass to these ideas, so we may better understand what economic and political agendas are guiding the push towards this new way of organising and delivering health care.

Coercive offers and research payments

Rozynska, Joanna
j.rozynska@uw.edu.pl

Paying research subjects for their participation in biomedical studies (in a form of monetary or in-kind support) has become a widespread practice across different types of research involving healthy volunteers and patients. Nevertheless, it continues to raise numerous conceptual, ethical, and practical controversies. Research ethics committees/institutional review boards and regulatory bodies are often concerned that payment may constitute coercion and thus undermine the validity of informed consent. Yet, this concern is rejected by the majority of philosophers and bioethicists who claim that research payment cannot coerce, because coercion necessarily involves threats, and proposals to pay people for their participation in research generally constitute offers (e.g. Wertheimer & Miller 2008; Largent & Lynch 2017). However, several bioethicists believe that it is possible to resolve this disagreement and that research payment offers can be coercive, though not necessary in the sense of undermining the voluntariness.

In this paper I will critically analyze two concepts of coercive (research payment) offers recently presented in the bioethics literature: Joseph Millum & Michael Gernett's theory of coercion as subjection (2019) and Jonathan Pugh's theory of coercion as violation of freedom from domination (2020). Drawing from philosophical arguments for and against coercive offers and its relationship to voluntariness, given by such prominent thinkers as H.G. Frankfurt (1973), J. Feinberg (1989), V. Held (1972), R. Nozick (1969), A. Wertheimer (1987), and D. Zimmerman (1981), I will argue that none of these theories stands up to criticism and that each of them allows for conclusions that are inconsistent with everyday moral experience. Finally, I will argue that when the term "coercion" is used in research ethics and/or practice to refer to a situation in which a person has "no reasonable alternative" but to accept an offer to participate in research, it picks out a related, but conceptually and ethically distinct phenomenon, namely exploitation.

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Machine learning to support informed consent in clinical studies - an ethical analysis

Rudra, Pranab, Ursin, Frank; Salloch Sabine
Rudra.Pranab@mh-hannover.de

Informed consent has traditionally focused on patients' entitlements, including understanding, voluntariness, and consent, with an emphasis on the individual's capacity to comprehend and decide. However, a paradigm shift is prompting a critical examination of the roles and responsibilities of not only patients but also healthcare providers, particularly in the context of emerging Machine Learning (ML)-mediated interactions. This prompts the question: what competencies must a physician possess to effectively obtain consent? When considering ML, it is important to identify the necessary performance that machines must exhibit to support patient autonomy. The objective is to gain a better understanding of how physicians can be supported by automated systems in facilitating informed consent.

In our analysis, we adopt the framework proposed by Faden and Beauchamp (1986) to delineate the five essential components of ethically sound informed consent: information disclosure, comprehension, competence, voluntariness, and the act of consent. These elements find

recognition on a global scale and are acknowledged within the worldwide ethics literature. While these five components only focus on the patient, we extend our inquiry to the capacities of the agents who are responsible for respecting the autonomy of the patient, namely health care professionals who inform patients, ensure their comprehension and voluntariness, their competence to decide and notice their decision.
Against this background, the following conceptual and philosophical questions will be addressed: Could a machine, without human consciousness, potentially meet the requirements of obtaining informed consent? Can machines mimic the nuanced interactions inherent in the informed consent process, navigating the intricacies of human cognition and emotional response? The fundamental aspects of informing, comprehending, and consenting, which have always been considered uniquely human activities, raise doubts about the effectiveness of machine-mediated consent processes.
The transition from physician-patient-centric to a holistic AI approach demands a revaluation of the properties and competencies required of those entrusted with procuring informed consent. It necessitates an introspective exploration into the essence of informational exchange and decision-making processes in the research context.
The inquiry into machines supporting the informed consent procedure for clinical studies explores the ethical and epistemic dynamics of human-machine interactions. While machines demonstrate advanced performance, informed consent entails more than just procedural actions. It involves understanding individual autonomy and values, which are crucial aspects of human agency. This inquiry highlights the importance of ongoing interdisciplinary dialogue and ethical scrutiny to navigate the evolving role of technology in healthcare and research.

Between Biopolitics and Healing. On the role of medicine in an economized health care system

Sahm, Antonia
a.m.sahm@outlook.de

The aim of medicine is to reduce suffering and, at best, to cure illnesses. Medical ethics examines what regulations are needed so that medicine can pursue its goals. Framework conditions, such as economic pressure, influence medical actions; indications, for example, are made within an economic margin and the medical assessment competes with this. Furthermore, socioeconomic status has been shown to correlate with health. If health depends on income, and health services themselves are under economic pressure, the question arises as to whether medical categories are independent from economic interests and whether these only have an external impact on medicine. Is there an area that remains unaffected by general conditions: does “pure medicine” exist? To what extent do economic forces influence medical categories? Does medicine operate throughout its categories biopolitically?
The presentation aims to explore the tensions that arise between medical action and economic conditions. The aim is to investigate the way and the extent to which political and social conditions affect medical decision-making. What scope remains to pursue the above-mentioned goals of healing or alleviating suffering in an economized system? What role does medicine play between biopolitics and healing?

Healthcare Ethics Committees and Healthcare budget allocations

Sandona, Leopoldo
leopoldo.sandona@fttr.it

The role of ethics committees for clinical practice can be relevant for the issue of resource allocation. In the Italian context, the committees have this function in some regions. Although a survey conducted during the pandemic period shows that this function is used very little in comparison with the others - analysis of ethical-clinical cases, training of healthcare workers and information for the population, drafting of guidelines on specific topics - this function plays a strategic role in economic terms, both in order to share ethical-clinical issues with organisational ones, and to accompany an increasingly important process of hybridisation between national service and private healthcare.
Moreover, in accompanying this dynamic, the connection between ethical competence in the organisation, the moral competence of certain individual healthcare workers, and the ethical-moral skills that an individual may naturally possess becomes evident. Currently, it is only the latter that are implemented in organisations, leaving the development of an ethical sensibility to the individual. On the other hand, it is essential that the moral competence of ethics members and the Ethics Committee becomes an organisational competence. This can be achieved through training and sharing of ethical issues also in the economic field. A possible model for the implementation of organisational ethical competence is one that starts with data collection with respect to the experiences of both decision-makers in healthcare and practitioners. Starting from this data collection in terms of quantitative and qualitative empirical bioethics, it is possible to define working tables and focus groups at local and regional level to identify priorities and urgencies. At this point, large-scale training can intervene building economic-clinical guidelines to conclude with a review at least every two years. In this process, we can also see a parallelism between the development of these practices and the development of ethics in the use of artificial intelligence.
Finally, it should be emphasised that this dimension gives voice to the principle of justice, which is much more relevant to current bioethics than the principles of beneficence and autonomy. Although these remain central, the principle of justice, in the dynamics of global bioethics, also shows its effects in the economic allocation of health care expense, since good care in ethical-clinical terms also becomes appropriate and proportionate expense.

The Patient, the Client, and the Donor. Revisiting the Principle of Non-Commodification

Sándor, Judit
sandorj@ceu.edu

The principle of non-commodification is deeply rooted in European biomedical law, and it is, indeed, a truly European concept. Article 21 of the Oviedo Convention states that "[t]he human body and its parts shall not, as such, give rise to financial gain." This phrasing, initially, leaves open the interpretation whether a tissue or a cell of the human body constitutes a body part in this meaning. However, paragraph 132 of the Explanatory Report on the Oviedo Convention solves this ambiguity by including tissues among the body parts that cannot be commodified: "Under this provision, organs and tissues proper, including blood, should not be bought or sold or give rise to financial gain for the person from whom they have been removed or for a third party, whether an individual or a corporate entity such as, for example, a hospital." According to this interpretation only the so-called "discarded parts" of the body, such as hair and nails, fall outside the scope of the Convention.

In the field of reproductive medicine, the principle of non-commodification is an exceptionally challenging concept as there are different parties involved in the process: intending parents, surrogate mothers, gamete donors, and so on. This presentation will investigate the principle of non-commodification from the perspective of patients, clients and donors in those situations when commercial motifs may be present, such as the case of reproductive medicine, genetics or plasma donation. There are numerous instances of conceptual imprecision and controversial incoherence. For example, in the case of tissue donation, blood donors are treated as altruistic donors, while plasma donors receive payment/reimbursement and are considered more as clients. While in biomedical law the terms 'patient', 'client', 'consumer', and 'donor' are routinely used interchangeably, these categories in fact have different meanings: some of which indicate a departure from the traditional norms of bioethics. Thus, the treatment of patients is clearly within the realm of biomedical norms, but when reimbursement or payment is involved, it shifts the discourse to a more commercial one.

What are the current ethical issues of equity attendant with the rise in retainer-based ("concierge") primary care in the US?

Shandera, Wayne X
w.shandera@gmail.com

Background: At least 0.5% of the US patient participate in retainer-based medicine in which a fee is used to supplement payments for outpatient medical services. Patients obtain accelerated access to providers and in turn providers have a limited base of patients and spend more time with such patients.
Purpose: Are aspects of equity impaired when increasing amounts of provider primary care resources are used for a select set of relatively wealthy patients?
Methods: A literature review using as search terms: primary care, retainer=based or concierge, over the last ten year, limiting to English of translated into English articles.
Results: Retainer concepts for reimbursing medical care are not a new development. But the number of patients opting for retainer-based care in the US is increasing yearly by about 10% resulting in an estimated 2.5% of patients currently using this modality. The higher costs of this care however, result in a higher amount of total medical expenses. Because subspecialty care is not participatory to such care, the total monetary amount will never dominate in calculations of total medical expenses. But because the wealthy are increasingly using retainer care, questions continue to arise whether this phenomenon is affecting the equity of medical care and whether distributive justice is severely impacted by this development. The field received considerable attention in the early 2010s but more recently has not been subject to critical studies, except for one study showing no impact on overall mortality and one emergency room-based study showing faster time to provider care but longer disposition,
Discussion; The corporate proponents of retainer care claim that the additional time and monetary resources available to providers allows them to the opportunity to use their resources charitably. This argument depends on provider generosity and has not been of proven benefit in published data. The increasing percentage of patients who do not have access to retainer care suggests that ultimately care to the indigent is impaired. Additional studies are needed but the past social desire of making primary care available to more individuals by training more primary care workers or limiting salaries of providers enabling greater access of the indigent to primary care conflicts with this phenomenon.
Assessing this development using the four classic theories of distributive justice, utilitarianism, egalitarianism, libertarianism, and communitarianism, the trend toward retainer=based medicine fails three: it is not utilitarian in that it seeks the best for a small set of wealthy

individuals, it is not egalitarian, and it does not consider the community-at-large. It is libertarian almost in extremis.
Conclusion: Published corporate data are supportive or retainer medicine. The continued impact on medical care in a capitalist system however may exacerbate the issues of distributive justice in medicine and the trend toward retainer-based medicine fails several key criteria for distributive justice.

Exploring Ethics Work: A Qualitative Study of Clinicians' Experiences in Estonia
Simm, Kadri
kadri.simm@ut.ee

This qualitative study looks into the ethical challenges and decision-making processes of clinicians in Estonia through the lens of the “ethics work” framework, as proposed by British social work scholar Sarah Banks. Banks (2016) defines "ethics work" as the effort professionals exert to identify „ethically salient aspects of situations, developing themselves as good practitioners, working out the right course of action and justifying who they are and what they have done.” Work, in this context, encompasses „psychological and bodily processes of noticing, attending, thinking, interacting, and performing “, all aimed at becoming and embodying certain ethical virtues and fulfilling ethical responsibilities. Through the theoretical framework of "ethics work," which encompasses seven interconnected layers ranging from framing and role-playing to emotion and identity work, the study addresses the complex nature of ethical decision-making in clinical settings.
Interviews with Estonian clinicians, who have all been members of the clinical ethics committees, offer a unique opportunity to examine historical shifts within the medical profession over the past three decades, particularly in the aftermath of the Soviet occupation. By exploring how these changes have influenced physicians' experiences, especially regarding the ethical dimensions of their practice, the aim has been to enrich our understanding of the evolving landscape of medical ethics in Estonia and the broader post-communist space.

Some (positive?) thoughts on death, dying and the market.
Simonstein, Frida
fridafux@gmail.com

“In February 1995, Tzili and Yusuf Abrahami, 83 and 85 years old respectively, committed joint suicide after living together 62 years. They planned their death carefully. A bottle of champagne and two emptied glasses of champagne laid on the table, near the flask of pills they used to kill themselves. The house was tidy, and a letter had been written for every member of the family. They wrote in this letter that they had had a good life. And explained also that they had always decided for themselves how to live their lives. So, they had also made their last decision: how they wanted to die. During their funeral, Beethoven was played. It was their last wish”.
This research looks at the interface between death, the dying, and the market. And includes personal experiences on death and dying people.

Expert views on how to decide whether research is in the public interest

Smedinga, Marthe
Marthe.smedinga@nus.edu.sg

There has been an increasing demand for research data. In response, large government-funded data platforms are being set up to utilize existing data (e.g. from hospitals, government ministries or research institutes) for research purposes.
An oft-used requirement for using data on these platforms is that the research is in the 'public interest'. Data Access Committees (DACs) are tasked with applying this 'public interest criterion' when reviewing data access requests on a case-by-case basis. However, the term 'public interest' is rarely clearly defined, and DACs often lack guidance for applying the public interest criterion consistently in practice. Given that the term 'public interest' is open to multiple interpretations, ways to apply the criterion in practice can vary greatly. For example, anecdotal evidence suggests that it depends on the data platform whether providing data access to private industry can be considered to be in the public interest.
Research into the ways in which the public interest criterion is applied in practice by different DACs and the ethical considerations underlying these practices can provide valuable insights for the discussion on how public interest should be defined. This could be helpful for DACs who are currently struggling to apply the criterion in a meaningful or consistent way. In addition, it provides transparency about the decision-making process for those who want to apply for data use. Without the public interest criterion being clearly defined, it can (in theory) be used to prohibit any type of data use. Defining the criterion would take away this arbitrariness.
Therefore, we are interviewing members from DACs in Australia, New Zealand, Singapore, the UK and the US on their experience applying the public interest criterion in practice. During the interviews, we include questions on which research DAC members consider not to be in the public interest and how they think public interest should ideally be reviewed. The semi-structured interviews will be analyzed using directed content analysis.
During this presentation, I will show the findings of the interviews and lay out what we can learn from them when providing guidance on how to apply the public interest criterion.

Depathologizing gender dysphoria and consumer-driven gender-affirming healhcare: an analyis of the harms to trans people and healthcare workers

Smids, Jilles
j.smids@erasmusmc.nl

In many countries, gender affirming medical care (GAMC) has shifted to a depathologizing approach, which involves working with the diagnosis of gender incongruence, defined by the ICD-11 as 'marked and persistent incongruence between an individual´s experienced gender and the assigned sex. This diagnosis replaces gender dysphoria (GD), which is gender incongruence accompanied by distress and/ or social impairment. In my paper, I argue that this involves a problematic shift away from the proper goals and methods of gender medicine (reducing GD and thereby improving quality of life and functioning), towards full-blown consumer-driven healthcare. Drawing examples from Dutch practice, I will explore several of the paradoxes, problems, and harms, that result, and argue that a consumer model in GAMC ultimately harms both patients and doctors.
Most fundamentally, it remains highly unclear what might justify medically treating, and hence medicalizing, non-pathological gender incongruence, an increasingly common human experience. This in turn leads to interrelated problems and, ultimately, harms. First, in most

healthcare systems, only medically necessary care is collectively funded or insured by health insurance schemes. Hence, non-medically necessary treatments are permanently at risk of being defunded, which would harm those with gender dysphoria who may need expensive and life-long GAMC.
Second, treating persons with gender incongruence on the basis of their "desire to 'transition'" in practice leads to a strained patient-physician relationship, which harms them both. If the proper aim of GAMC would be to 'medically affirm' the trans person's stated identity, thereby reducing their felt incongruence, then the patient is completely in the lead: first by stating their gender identity, and second, by requesting or demanding whatever particular medical intervention(s) they believe will best affirm their identity. Indeed, such a consumer-centered orientation is evident in talk about, e.g. 'embodiment goals', which make no reference to distress or impairment but for which patients can demand physician assistance.
However, drawing on the medical and psychological literature, I will argue that there are several reasons why patients may well fail to successfully predict which or even whether GAMC will benefit them. For example, the lack of knowledge regarding the etiology of GD and of the effectiveness of GMAC, the changed case-mix (many adolescent natal girls with psychiatric co-morbidity), and the fact that after treatment GD may arise at other body parts or persists due to changed social responses to a changed bodily appearance. Given these unknows, it becomes impossible for physicians to justify the harms brought about by GAMC, which may include infertility, substantially elevated risks of cardiovascular disease and cancer, sexual dysfunction, surgical complications, chronic pain, and more. In terms of their professional clinical and ethical responsibilities, it becomes puzzling how healthcare workers could have good reason to think that non-pathologized GAMC provides a clear balance of medical benefits over harm. In practice, patient 'demands' for medically unnecessary GAMC may lead to moral distress and thus harms these physicians.
For these reasons, GAMC is a particularly bad candidate for the consumer model. Instead, only a 'standard' medical approach, which balances medical benefits with medical harms, reduces risk of medical harm to patients. Such reduction enables healthcare workers to fulfil their ethical responsibilities. Moreover, the standard approach allows for medical research into whether and when GAMC leads to real benefits for patients with GD, as distinct from merely fulfilling their desires for invasive medical care. All this presupposes shared decision-making in which the physician respectfully works with the self-reported gendered feelings of the patient, and in which the patient has the opportunity to engage in serious reflection on whether or not GAMC is likely may benefit their health.

Involuntary Treatment for Anorexia Nervosa: Medically Obligatory, or an Exercise in Futility?

Smolenski, Joanna
Joanna.Smolenski@bcm.edu

Ideally, the establishment of a treatment plan for a patient is done in collaboration with the patient and her doctor and depends on her capably accepting or refusing the interventions offered consistent with her overarching goal of care. However, some patients are limited in their ability to collaborate with their clinicians due to a lack of capacity. Where capacity is lacking in this way, patients may not only be unable to consent (and require a surrogate to consent on their behalf), but also unwilling to accept treatment that would be necessary to achieve their overall goals (or, absent established goals, their best interests). In such circumstances, not only would a surrogate potentially be consenting to treatment, but they may also be asked to consent to treatment that would be provided involuntarily.

In this paper, I consider the case of severe treatment-refractory anorexia nervosa (AN), which is primarily characterized by severe food avoidance or restriction, intense fear of gaining weight, and disturbance as a result of one's body weight or shape. AN is a unique disorder in that it carries with it the highest mortality rate of any psychiatric illness, and is also the only eating disorder that guarantees a medical cause of death if untreated. Given the nature of anorexia – which involves not only delusional beliefs about one's body, but also impaired cognition caused by starvation – patients with this diagnosis often adamantly resist any efforts at treatment. In some cases, extended periods of involuntary treatment (sometimes over the course of years or even decades) can result in positive results, even remission or cure. In others, AN patients are subjected to repeated, costly treatment against their will, which they actively resist and believe will fail.

AN can lead to intractable refusals of treatment, such that even treatment under restraint may not be enough to generate meaningful clinical improvement. Though patients may indicate that they want to live, and that they know artificial nutrition and hydration (ANH) is necessary to achieve this goal, they may nevertheless remain unable to permit its administration. They may even appear to consent to being restrained at various times; however, the level and duration of restraint necessary for improvement tends to be inconsistent with more general practices regarding involuntary treatment (i.e., that it should be used as briefly as possible, as infrequently as possible, and thus is generally not considered practicable for long-term interventions). Furthermore, it is not antecedently obvious that such extended involuntary treatment would even work (let alone be in the patient's overall best interest).

Finally, in keeping with this year's conference theme, potentially multi-year involuntary treatment for a patient who, whether capacitated or not, is actively refusing its administration, also raises concerns about the allocation of resources under conditions of scarcity. Allocation questions are already raised when patients desire resource-intensive treatment that is unlikely to work. How ought we consider such questions when the patients themselves continually refuse? This could bring anorexia nervosa into a hotly contested domain – that of a potentially medically-futile psychiatric disorder.

Prioritization by urgency - challenges in the operationalization of the urgency criterion in the context of oncology

Sommerlatte, Sabine; Hense, Helene; Kraeft, Anna-Lena; Lugnier, Celine; Schmitt, Jochen; Schoffer, Olaf; Reinacher-Schick, Anke, Schildmann, Jan
sabine.sommerlatte@medizin.uni-halle.de

The COVID-19 pandemic has fueled public and scientific attention on and debates about the equitable distribution of health resources. Although the debate focused initially on the care of COVID-19 patients and the distribution of intensive care resources, it quickly became evident that areas not primarily involved in the care of COVID-19 patients, such as cancer care, were also affected by resource scarcity and the necessity to prioritize medical measures, for example tumor surgeries. In case of resource scarcity, any prioritization should be based on transparent and comprehensibly justified criteria and must take into account the supply reality of a country. We aimed to explore ethical criteria for prioritization and their application in cancer practices during the COVID-19 pandemic from the perspective of German oncologists and other experts. We conducted fourteen semi-structured interviews with German oncologists between February and July 2021 and fed findings of interviews and additional available data on prioritizing cancer care into four structured group discussions, in January and February 2022, with 22 experts from medicine, nursing, law, ethics, health services research and health insurance. Interviews and group discussions were recorded digitally, transcribed verbatim and analyzed using content

analysis. Based on combined empirical-ethical analyses, we focus on the operationalization of "urgency" in oncology and complementary criteria, which should guide allocation decisions.
Narratives of the participants focus on "urgency" as criterion for prioritization decisions. Further analysis indicates that "urgency" can be distinguished according to at least three different dimensions: "urgency" to 1) prevent imminent harm to life, 2) prevent future harm to life and 3) alleviate suffering. In addition, "urgency" was modulated by the criterion of "success," which can be reached by means of a specific intervention, and the "likelihood" of reaching that "success." Our analysis indicates that while "urgency" and "likelihood of success" are well-established criteria, their operationalization in the context of oncology is much more challenging than, for example, in intensive care medicine, where "urgency" is usually equated with "urgency" to prevent imminent harm to life and "likelihood of "success" is usually defined as the probability of surviving intensive care and getting discharged. In oncology, however, different dimensions of harm and, thus, diverse corresponding therapy goals, such as a cure, lifetime prolongation and the alleviation of suffering, must be taken into account. Given the conflation of several dimensions of the criterion observed and confusion with the criteria of "success" and "likelihood of success," we argue that combined conceptual and clinical analyses are necessary for a sound application of the criterion of "urgency" to prioritization in cancer care.

Information and templates for creating advance directives on the internet - An analysis of German online service providers

Stange, Lena; Simon, Alfred
lena.stange@uni-oldenburg.de

Advance directives legally count as an expression of the authors' self-determined will regarding their medical treatment in case they can no longer make decisions for themselves. If a person wishes to draw up an advance directive, the internet offers numerous opportunities to find out about creating advance care documents, to use online tools or to easily download templates, and it is promised that one can get an applicable advance directive with just a few clicks. As advance directives are still a rather underrepresented topic in the public eye, increasing their visibility on the internet is basically to be welcomed. Such online offerings have great potential in that they can encourage users to consider their own preferences in order to be able to exercise their right to self-determination by means of an advance directive in the event of an incapacity to consent. At the same time, there are difficulties and problems associated with the provision of written impersonal and sometimes quite general information. A wide range of educational texts and videos can be found online, providing information of varying quality and depth. This raises ethically relevant questions on two levels: To what extent do online service providers provide information about the factual framework conditions for the creation of advance directives? To what extent is the individual competence of the person seeking to draw up an advance directive taken into account?
To explore the abovementioned issues, nine websites of public and private providers offering templates and/or online tools for advance directives were reviewed and analysed with regard to several criteria, such as factual information, transparency of the offer, appeal to purchase, quality of the resulting advance directive and other aspects. The results show that there are indeed a few helpful offers of support to create an advance directive. Whereas sometimes the market of online advance directives leads the right to self-determination ad absurdum with dubious sales arguments by providers of the public sector. The resulting lack of patient information and, as a consequence, limited self-determination will be discussed in terms of medical ethics with regard to their scope and significance for healthcare.

Why Should I Care?

Stempsey, William E
wstempse@holycross.edu

Although profit-driven medicine may provide good health care outcomes, it does so at the expense of an important motivation for health care workers, so often exemplified in the challenging circumstances of the COVID-19 pandemic. Profit-driven medicine at best ignores and at worst threatens the altruistic motivations of individual health care workers. I here argue for more explicit recognition of the virtue of charity in such altruistic care.

Distinctions between for-profit and not-for-profit medicine are not as clear as sometimes presented, especially when focused on financing aspects. The essential difference I consider here concerns a value dimension. For-profit medicine takes health care as an economic good, with competition and market forces producing a system that is most efficient and responsive to consumer demand for services. Not-for-profit medicine takes health care as a social good, applying biomedical science for the benefit of patients and community needs.

A multitude of health care workers during the COVID-19 pandemic exemplified altruism very much in line with the value of health care as a social good. Empirical studies from places as diverse as China, Kazakhstan, and Poland suggest a central altruistic motivation of volunteers for work in high-risk circumstances and even a link between religiosity and volunteerism for the sake of the community

The virtue of charity has a strong historic link with the kind of altruism honored by such health care providers. When the Christian Church was given official status by the state in the fourth century, institutions of hospitality devoted to giving shelter to the poor, the pilgrims, the sick, orphans, and the aged, were first established; over centuries, these gradually turned into hospitals with the primary mission of caring for the sick. The driving virtue behind these hospitals was charity, not just in the sense of giving care freely but in the sense the ancient Greeks called agapē, a self-giving type of charity. I here recommend that the virtue of charity be recognized and valued as a primary motivation for altruistic care, whether in for-profit or not-for-profit medical institutions. It is good and necessary for hospitals to have money. Nonetheless, the emphasis in “Why should I care?” should not be on the I that drives the economy of an institution, but rather on the other who suffers and the social good of care for them.

Indirect Reciprocity Principle Should Be Added to the Ethical Grounding of Human Tissue Donorship

Karoly, Tomas; Tomasovicova, Jana; Sykora, Peter
peter.sykora@ucm.sk

Since R. Titmuss seminal book *The Gift Relationship: From Human Blood to Social Policy* (1970) altruism was considered the only acceptable ethical principle governing medical donations. The main reason was to prevent the commodification of human body parts and to promote social cohesion. However, with the advancements in cell technology tissue samples traditionally considered as waste with no value have become a biocapital. The issue of commodification of human tissue has been analysed for over two decades from various perspectives including classic legal cases such as Moore, Catalona, and Greenberg. However, this analysis has largely taken place within academic circles. It was not until the publication of 'The Immortal Life of Henrietta Lacks' in 2010, later adapted into an HBO TV drama film in 2017, that public awareness of this complicated bioethical issue was raised. In her bestselling non-fiction book, American author Rebecca Skloot investigates the story of HeLa cells, the first

human cell line cultivated in vitro in laboratories. The HeLa cell line was created from a cancerous cervix tissue sample taken from Henrietta Lacks in 1951. The impact of HeLa cells on progress in medicine, particularly in virology and vaccination, from polio to HPV and COVID-19 has been staggering. The book highlights the intuitively absurd and unfair legal setting when everyone has benefited from HeLa cells except Henrietta Lacks family. The moral intuition of the family members is expressed in the book pregnantly through the authentic words of Henrietta's daughter, Deborah:

"But I always have thought it was strange, if our mother cells done so much for medicine, how come her family can't afford to see no doctors? Don't make no sense. People got rich off my mother without use even knowin about them takin her cells, now we don't get a dime."

As a result of increased public awareness, tissue-rights activists are demanding that potential financial gain from their samples be disclosed. This is a big challenge to altruistic model. However, academic debates about models that would include donor compensation tend to focus on the nuances of informed consent and property rights in human tissue, rather than addressing the deeper ethical issues at stake, namely the principle of altruistic donation.
We argue here that it is not possible to develop an ethically comprehensive model based solely on altruism, while also allowing compensation for donor, either financial or non-financial. To resolve this conundrum, we propose that indirect reciprocity should be accepted as an additional moral principle for biomedical donation. Indirect reciprocity can hardly be considered immoral, since all forms of human solidarity and cooperation are based on it. Therefore, we propose that indirect reciprocity should be used alongside altruism, not to replace it, in the ethical grounding of tissue donation (Sykora 2009/2016) and we explore some examples of regulatory policies.

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Are health nudges empowering?

Tengland, Per-Anders
per-anders.tengland@mau.se

The idea of nudges became well-known through Thaler and Sunstein's book on nudges. A nudge influences a person (unconsciously) to do something he or she would not otherwise have done, while retaining the individual's freedom to refrain from doing what the nudge suggests. Nudges are primarily, at least according to Thaler and Sunstein, thought to be used paternalistically (libertarian paternalism). Nudges have been used in health promotion and, like many paternalistic actions, appear to be morally approvable and recommendable. However, nudges have also been questioned on various grounds, being, e.g., said to undermine autonomy, lack transparency, involve manipulation or deception, or be coercive.
I suggest that empowerment (as a state) is of great importance in a person's life. In this context I argue that being empowered means being well-equipped to control the determinants of one's (good) life. Empowerment (as a process) might also refer to how professionals work with users, patients, groups etc., namely, a professional practice that gives as much power or control as possible to the person or group that is facilitated in reaching whatever goal is agreed upon, e.g., increased health or well-being.

The question this paper addresses is to what extent nudges are empowering, in one or in both of the senses described above. Thus, empowerment (as a state and as a process/practice) is taken to be an evaluative standard for assessing health nudging practices, in order to see whether, and to what degree, they can be morally recommended.

The place of justice and vulnerability in 'resilience' to climate change

Timmermann, Cristian; Wild, Verina
cristian.timmermann@uni-a.de

When it comes to climate change adaptation, a concept that regularly comes into the discussion is 'resilience'. Building resilience has been defended as a political ideal, as something healthcare and food systems should aim at, as a goal within communities, and as an aim one should personally aspire. However, particularly individualistic interpretations of the concept of resilience are not necessarily aligned with commonly shared ethical principles, such as providing care during the different stages of vulnerability in life, minimising harm, and integrating marginalized people. Yet, also interpretations of resilience that are in line with the original understanding of the concept within ecology, which recognize the importance of diversity, build room for potential redundancies, and protect regenerative capacities, are challenging for social justice, as such understandings are often indifferent to who is burdened to withstand additional pressures, at what price and under what motivation. The capacity to absorb stress and shock is analysed at a systemic level, with little reflection on distributing the societal tasks of bouncing back fairly. We therefore examine whether efforts to improve resilience to climatic disruptions can be made compatible with addressing demands of social justice and major concerns brought up in feminist bioethics.

Responsibility-Sensitive Healthcare Policies with or without a Golden Opportunity: (Harmfully) Discriminatory or Not?

Tsiakiri, Lydia
lts@ps.au.dk

The epidemic of noncommunicable diseases (NCDs), like cardiovascular disease, cancer, and diabetes, is currently responsible for 74% of the global death toll. It entails devastating health consequences for individuals and communities and high socioeconomic costs, threatening to overburden health and economic systems (WHO, 2023). Based on that, it makes perfect sense to argue that NCDs' prevention and control constitute a major development imperative for the 21st century (WHO, 2023). But how could this end be realized? Aiming at contributing to this purpose, among many other suggestions and already implemented practices, responsibility-sensitive healthcare policies (RSHPs) have also been considered. RSHPs are policies that treat certain groups of people differentially on the justification that they have certain traits or are in a condition of need due to chosen and reasonably avoidable actions, behaviors, or habits for which they could be counted responsible. A supplementary idea to the initial conception of RSHPs – the idea of golden opportunities (GOs) – has come relatively recently to the forefront. According to this approach, responsibility is still the main criterion for determining resources and treatment allocation. However, here, it is responsibility for rejecting a GO, and not for your past choices, that matters more. In brief, under this conceptualization, as soon as people's critical and self-inflicted condition is assessed, they should be provided with a GO, namely a realistically adoptable alternative healthier lifestyle, and be considered responsible only for their denial to seize that chance (Savulescu, 2018; De Marco et al., 2021; Davies and Savulescu,

2019). Yet, the justifiability of such policies has been questioned with them being more recently criticized for being agents of wrongful discrimination. This paper contributes to the ongoing discussion on whether these policies constitute indeed an agent of (wrongful) discrimination, providing, at the same time, a response to a much broader question of whether the presence of responsibility for one's current need and condition can affect considerably our assessment of what counts as (wrongful) discrimination. To provide a plausible response to these questions, I initially examine these policies' compatibility with Kasper Lippert-Rasmussen's (2013) seminal definition of non-moralized direct group discrimination. Then, I discuss whether these policies impose unjustified harm on imprudent individuals by wrongfully discriminating against them. Overall, the paper aims to suggest that under a responsibility-sensitive policy supplemented by a GO, non-moralized direct discrimination, but not harmful discrimination, could occur.

Advertising a Disruptive Innovation: Normative Implications of Metaphors for Medical AI

Ursin, Frank; Fürholzer, Katharina; Salloch, Sabine
Ursin.Frank@mh-hannover.de

Metaphors play a crucial role in shaping individual and collective perceptions and actions. In the context of artificial intelligence (AI) agents in medicine and healthcare, metaphors become ethically relevant due to their (sometimes unwanted) normative implications. The metaphorical landscape regarding medical AI is not only fueled by medical specialties such as radiology, but also by AI developing corporations. Corporations advertising innovative and potentially disruptive medical AI systems face a dilemma. They aim to create trust and acceptance while avoiding exaggerated expectations that may leave stakeholders disappointed. Striking the right balance between portraying AI as a groundbreaking new technology or something familiar to medical doctors is challenging. It makes a difference whether AI is depicted as "revolutionizing healthcare", or as a time-saving "companion". Building upon a prior metaphor analysis of AI applications in radiology, this paper expands its focus to the marketing language of AI metaphors. We aim to explore the ethical implications of using metaphors for medical AI in radiology.
Our analysis identified three key metaphors used in advertising medical AI within the specialty of radiology:

1. "AI as a wonder weapon": This metaphor emphasizes AI's transformative power, akin to a miraculous solution.
2. "AI as a time-saving tool": Here, AI is portrayed as an efficient assistive yet humanly controlled technology that saves time without having agency itself.
3. "AI as a new colleague": This metaphor anthropomorphizes AI, positioning it as a collaborative partner that may have some agency and moral responsibilities.

We hypothesize that corporations may attempt to conceal own responsibilities for their products by suggesting that efficacy of medical AI is controlled by physicians and/or AI itself. We will back our analysis with theories for the diffusion of innovations, which allow us to identify and understand the motivations of corporations to use a certain metaphorical language.
In particular, we address the following normative questions: Are deceptive metaphors ethically permissible in AI advertising? Or should companies be obliged to use advertisement material that does not distract from the actual character of decision support delivered by medical AI? Should we ban all metaphorical language from medicine due to its potentially deceiving

character and oftentimes unwanted normative implications? Or should we rather increase public awareness of the implications of AI metaphors in medicine and marketing?

Ethical considerations of responsible gambling in metaverse

Uusitalo, Susanne
Susanne.Uusitalo@oulu.fi

Responsible gambling has been argued to be ethics washing by the gambling industry and service providers in order to maintain integrity and to protect their economic interests, and it has received a great deal of criticism. This has increased various stakeholders' interest in attempts to improve the practices of responsible gambling for instance with the means of machine ethics. However, those measures, e.g. machine-based ethics advisors, still heavily rely on individuals' being informed and rational decision makers that avoid excessive risk and harm. In this presentation, I consider gamblers from the perspective of predictive processing and argue that when the gamblers are considered as boundedly rational, the common harm prevention measures of this kind of responsible gambling may turn out to miss their targets. This issue becomes especially pronounced in the context of the metaverse, where the immersive nature of virtual environments allows for an unprecedented level of control and manipulation of user experience.
Online gambling has yet provided new challenges for societies to regulate and individuals to use in a controlled manner the gambling services. The technology is evolving and the current trend in virtual reality is to develop metaverse. According to the Finnish Metaverse Initiative, "the metaverse is a collective virtual shared space that encompasses and transcends physical, digital, and augmented realities." This may provide further possibilities and means for the gambling industry to provide services that are even more immersive and entertaining for the individuals. This is likely to have an effect not only on regulation and control but also on ethical aspects for individuals who gamble in metaverse.
Following the predictive processing perspective of understanding gamblers and the event of gambling in metaverse in which the gambling can be considered rational even when there are great risks or losses in play, I suggest that responsible gambling framework should be reconsidered and reframed. Providing the platform and the means for the immersive user experiences means that it is the service providers who carry more responsibility of risks and harms of gambling. Metaverse may allow more possibilities for the industry to develop addictive and harmful gambling but, at the same time, it provides possibilities for developing safeguards that do not rely on false control imposed on the gambler. The responsibility of developing safeguards and maintaining them lies on the industry and service providers, not on the people who experience the harms.

What money would buy: understanding current resistance to commodification of bodily materials from a historical perspective

van der Zee, Florian; Jacobs, Noortje; Schermer, Maartje
f.r.r.r.vanderzee@erasmusmc.nl

It is a commonly held position that markets in healthcare reach their moral limits where the procurement and distribution of human bodily materials as medical resources are concerned. The World Health Organization, for example, promotes voluntary and non-remunerated donation (VNRD) and condemns profiting from transactions involving human bodily materials. However, current procurement practices cannot keep up with the demand for substances of

human origin. This leads to continued debate about procurement and distribution practices and the moral limitations imposed upon them, like rejections of commodification of human tissues.

To enrich such contemporary philosophical-ethical debate on the moral significance of markets for human bodily materials, we trace the historical development of an ethic proscribing the commodification of human bodily materials in one of the first countries to establish such an ethic: the Netherlands. Contemporary philosophical debate can benefit from this historical perspective, as moral positions and the moral horizons within which they are justified and contested are products of history, and historical research can excavate the historically contingent presuppositions of their emergence and spread.
Our history traces the Dutch organization of the therapeutic availability of blood, the first transplant substance to be collected and distributed in an organized, routine manner. We first show how in the 1930s, backed up by the Dutch Red Cross, a consequentialist ethic of VNRD emerged from an unsettled moral landscape. Secondly, at the eve of the Second World War, mobilization efforts reconfigured blood as a national resource, simultaneously challenging and nationalizing the Red Cross ethic. Finally, after the war, discourse shifted to its presently still popular deontological register: donation of bodily materials should always be voluntary and non-remunerated, regardless of circumstances and consequences. By reconstructing this history, we not only recollect and contextualize different moral meanings of the intersection of market forces and the body. We also reflect on how moral self-evidence may develop as bodily materials come to symbolize the moral conclusions reached about them. We draw on the notion of "script" as developed in cognitive psychology in doing so.

Funding for ethics or paying for ethics? A critical appraisal of ethics in the EU4health programme.

Van Hoof, Wannes
wannes.vanhoof@sciensano.be

This paper explores the intricate relationship between medicine, healthcare, and the market within the framework of the 5.3 billion EU4health programme, with a particular focus on the financing of ethics in joint actions. The EU4health program is a comprehensive initiative aimed at advancing best practices and guidelines while facilitating the integration of cutting-edge technologies such as AI and genomics into the European healthcare system. As part of this programme, joint actions are designed to encourage national authorities, academic and non-profit organisations to join forces with the European Commission to address major public health issues where the added value of EU-level involvement is high.
In essence, the Commission sets an agenda (e.g. personalized risk stratified prevention for all, a European genome database, a European health data space, …) and then funds member states to turn that agenda into a reality. This has led to a concerning trend in which ethics is marginalized due to a preset framework and fragmented and minimal funding allocation.
Firstly, the limited funding for ethical aspects of projects contributes to a situation where ethics becomes a secondary consideration, overshadowed by other objectives. This leads to a high degree of tokenism, where ethics is treated merely as a symbolic inclusion rather than an integral aspect of project development.
Furthermore, the fragmented, project based financial support for ethics has inadvertently fostered duplicate work. Researchers and institutions find themselves independently addressing ethical concerns in isolation, resulting in redundant efforts and a lack of cohesive collaboration. This fragmented approach has led to the development of different, and at times incompatible, ethical frameworks across various projects within the programme.

The design of regulatory frameworks promoting ethical practices is a critical aspect of ensuring the responsible integration of advanced technologies into healthcare. However, ethics has been commodified within the program, where many researchers and institutions provide a service to the EU agenda, rather than making a genuine contribution to the development of a European ethical framework for health.
In conclusion, this paper advocates for a revaluation of the financing structure within the EU4health programme, emphasizing the need for increased, translational investment in the ethical dimensions of healthcare projects. By addressing the current challenges of minimal funding, tokenism, inadvertent duplicate work, and the development of incompatible ethical frameworks, the EU can foster a more robust and integrated approach to ethics in the rapidly evolving landscape of healthcare technologies. This recalibration will not only strengthen the ethical foundation of the EU4health programme but also contribute to the establishment of a coherent and harmonized European ethical framework for health.

Cultural determinants that influence end-of-life decisions: An Indian Philosophical Viewpoint

Vaswani, Vina
vinavaswani@yenepoya.edu.in

In India, the definition of death has evolved significantly, transitioning from the cessation of circulation, respiration, and brain functions to the contemporary focus on brain death and brain stem death. This shift creates a paradox where a patient might be declared 'dead' in one country but 'living' in another due to differing criteria. Technological advancements have further complicated the definition of death, transforming it from a well-defined moment to a prolonged process. This raises the question: Is there truly a single moment of death, or is it a myth? Should this moment be determined solely by doctors? The Vedas, the most ancient Hindu scriptures, and the subsequent Upanishads, which are more prescriptive, provide a perspective on death that emphasises living without pity and facing death without pain. The concept of a "dignified" death is deeply rooted in Indian ethos. For instance, Santhara, a Jain ritual of fasting until death, involves taking a vow of sallekhana and renouncing food, medicine, and water to prepare for death. This practice, mirrored in certain Hindu traditions, aims to clear karmic debts and ensure a peaceful separation of the soul from the body.
Indian society, characterised by extended family structures, often involves multiple stakeholders in decision-making processes, particularly concerning end-of-life care. This contrasts with the individualistic autonomy model prevalent in Western medical practices. Indian allopathic doctors, trained in systems emphasising self-determination, often face conflicts between professional training and societal values. Consequently, decisions about prolonging life or withdrawing life support are influenced more by familial and social dynamics than by the individual patient's wishes. Many doctors, not sensitised to religious beliefs, view requests to withdraw treatment as contrary to their notion of beneficence. Hence, this study explores the existing published literature on medicalization of death in the context of traditional Indian beliefs, shedding light on the complex interplay between cultural values and medical practises in end-of-life decision-making.

Norms for Responsible AI-enabled Population Screening

Vitale, Michel; Boenink, Marianne; Prokop, Mathias; Jacobs, Colin; Vegter, Mira
Michel.Vitale@radboudumc.nl

The claimed opportunities of using Artificial Intelligence (AI) in the context of population screening could challenge established norms for responsible implementation of screening programs. Recent development of AI-based systems for imaging with performance that can reach or even surpass that of expert clinicians makes these tools attractive to help implement screening programs; especially regarding the possibility of employing them to automate part of the processes via triage or pre-screening. However, these prospects will likely change earlier considerations concerning social acceptance and ethical acceptability, as well as introduce novel challenges to the ethical and legal norms of responsible screening.
Population screening for disease has been a topic of discussion in the field of ethics of healthcare for decades. Assessment of screening programs is often carried out through the use of screening criteria, which usually refer to the classic Wilson & Jungner's principles for screening, developed for the World Health Organization back in 1968. These criteria have stood the test of time and have often been reconfirmed as the gold standard for assessing screening programs. Nevertheless, over the last half-century, they have been challenged by several authors, who have attempted to adapt or reinvent them to better fit within their specific context of screening, particularly in the field of genetics.
In this article, we will briefly reconstruct the debate around Wilson & Jungner's principles for screening to show how they have been challenged and how they have developed in current practice. Subsequently, we will outline promises and expectations of using AI in imaging-based population screening presented in the literature. Based on these anticipated developments, we will critically analyze the renewed Wilson & Jungner's criteria to shed light on whether and how these criteria could accommodate responsible screening when using AI and contribute to their possible adjustment for the AI age.
Throughout this analysis, we will draw examples from different types of AI-enabled screening under study, especially Lung Cancer Screening and Diabetic Retinopathy Screening. Furthermore, we will consider critical aspects arising from the use of AI in screening programs, such as the issue of automation, the management of incidental findings and informed consent, as well as potential soft impacts of AI in the context of screening.

How to embed ethics into laboratory research

Buedo, Paola; Odziemczyk, Idalina; Perek-Białas, Jolanta; Waligora, Marcin
m.waligora@uj.edu.pl

Health-related innovation in biotechnology requires anticipating potential bioethical implications. In this article, we present a strategy to embed ethics in a group of early-stage researchers performing research in gene therapy and regenerative medicine in the laboratory phase. We conducted a series of focus group meetings with early-stage researchers who work in biotechnology laboratories. The objective was to reflect on the bioethical challenges of their own work and to promote the integration of research ethics with laboratory practice. The activity was assessed with questionnaires completed by the researchers before and after the meetings, and the analyses of the focus groups' content. As a result of the focus group series, all participants changed their perspectives about ethical issues regarding their planned research, developed the ability to reflect and debate on research ethics and had increased awareness of ethical issues in their own research activities. Half of them made changes in their research work. The study provides a concrete strategy to embed ethics and to strengthen responsibility in

laboratory research. It is a strategy that allows to perform ethics reflection “on site” and in “real time” and complements the classic strategy of ethics assessment of the research protocol before starting the research procedure.

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HEADS Study: ‘Healthcare Ethics and AI – a UK Doctor Survey’
Warrington, Daniel; Holm, Søren
daniel_warrington@hotmail.co.uk

Introduction: Artificial Intelligence (AI) has become an integral part of modern healthcare, playing a crucial role in tasks such as interpreting ECGs, correcting medication dosages, managing electronic medical records (EMRs), and even contributing to new drug discovery. The recent surge in optimism surrounding AI, particularly with the development of large-language models (LLMs) like Chat-GPT, has intensified discussions on its potential to significantly enhance various facets of healthcare, from diagnostics to treatment methodologies.
Ethical Challenges: The integration of AI, particularly LLMs, in healthcare introduces significant ethical challenges. Privacy concerns arise as sensitive patient information is processed, requiring robust measures for compliance. Biases in AI algorithms and reliance on 'junk data' pose ethical questions about fairness and accuracy, demanding transparent processes. Accountability is a key concern, with legal implications for healthcare providers. The ethical dilemma of AI autonomy prompts consideration of the balance between automated processes and human oversight. Additionally, the ethical issue of informed consent requires ongoing communication about data usage and impacts on patient care.
The right of patients to contest AI decisions adds complexity, emphasizing the need for transparency and patient-centric approaches. Addressing these multifaceted challenges is crucial to ensuring ethical AI integration in healthcare, preserving patient well-being and trust in the system.
Existing Guidelines and the Call for Doctor Involvement: Given the rapid evolution of technology and the influx of 'big data,' we argue for the necessity of seeking doctors' opinions and insights. In this context, new guidance is needed from doctors' regulators to ensure that ethical considerations align with the evolving landscape of healthcare technology.
The HEADS Study: Healthcare Ethics and AI – a UK Doctor Survey: To bridge this gap between technological advancements and ethical guidelines, we initiated the 'HEADS Study: Healthcare Ethics and AI – a UK Doctor Survey.' This is an anonymous cross-sectional e-survey containing five sections, demographics, use of AI, concerns about AI, requirement for introduction of AI, and views on necessary AI regulation. The survey was conducted online from January 2024 to March 2024. Outreach efforts included social media campaigns and direct email invitations to institutions encouraging them to share the survey with their members.
Anticipation of Results and Conference Presentation: While the survey results are pending at the time of this abstract submission, we anticipate that the HEADS Study will offer valuable insights into doctors' perspectives on AI ethics. We look forward to presenting the nationwide findings at the 36th European Society for Philosophy of Medicine and Healthcare (ESPMH) Conference – 'Medicine, healthcare, and the market.' Our aim is to contribute to the ongoing ethical discourse surrounding AI in healthcare and to inform future guidelines and regulations in this rapidly evolving field.

Conclusion: As the healthcare landscape continues to evolve with the integration of AI, it is imperative to carefully consider the ethical implications that arise. The HEADS Study seeks to amplify the voices of doctors in shaping ethical guidelines for AI implementation in medicine. We eagerly anticipate the opportunity to share our findings and engage in meaningful discussions at the upcoming conference.

Reproductive Justice - a challenge for practitioners of reproductive medicine?

Weigold, Stefanie
Stefanie.Weigold@uksh.de

Ethical debates surrounding the use of reproductive technologies often center on individual ethical considerations, such as reproductive autonomy. This concept refers to the ability to make choices about reproduction and plan one's life accordingly. It is important to negotiate and expand this understanding in the context of cultural, economic, and individual differences in reproductive choices and forms of reproductive oppression. Given the increasing privatization and economization of reproductive technologies, the question arises to what extent the professional ethics of reproductive physicians and gynecologists can or should be guided by a justice perspective that considers reproductive autonomy and social justice together. This challenge is currently being addressed through the concept of Reproductive Justice.
In a first step, the talk will illustrate the conceptual principles of Reproductive Justice and its relevance to reproductive medicine. In a second step, Reproductive Justice will be applied as an analytical framework to a future technology in reproductive medicine: artificial amniotic and placental technology. This technology is used as an example to problematize how private funding is part of a progressive commercialization of pregnancy processes potentially superseding public, deliberative decision-making processes. In the third step, the discussion focuses on the extent to which the concepts of justice within Reproductive Justice can be viewed as a professional ethical challenge and an area of conflict between individual welfare and socio-political demands but should certainly be demanded and promoted in the sense of sustainable, ethical practice.

Journeys in Care: Exploring Ethical Dilemmas as' Professional Guests 'in Home Palliative Care

Yakov, Gila; Hochwald, Inbal Halevi ;Weiss, Moran, Sabar, Ron
gilay@yvc.ac.il

In the past, home care for the sick and end-of-life patients was a socially accepted norm. During the 20th century, the institutional model became widespread, with hospitals considered the most natural and safest option. However, in recent years, OECD countries have been shifting towards a more comprehensive approach to healthcare and well-being. This approach emphasizes preventive and proactive measures, often based on home care by multidisciplinary teams providing both curative and palliative care.
The unique nature of home care presents challenges stemming from defining the roles of both the patient and the caregiver within the domestic environment. Caregivers have to balance their roles as both hosts and specialists, which brings forth unique needs and challenges that require high levels of attention and sensitivity from the caregiving team.
Research Objective :This study aims to understand the experiences of healthcare professionals working in the home care setting, specifically in caring for individuals at the end of their lives. It also seeks to explore the ethical implications of providing unique home-based palliative care.

Method : This qualitative study involved gathering responses from 20 healthcare professionals, including physicians, nurses, and social workers, who were asked about the differences between home care and hospital care and how they adapt their caregiving approaches accordingly. The responses were analyzed thematically. Additionally, semi-structured interviews were conducted with nine management personnel from a healthcare organization. These interviews were recorded, transcribed, and subjected to thematic analysis.
Results : Thematic analysis revealed a nuanced understanding of home care, with a central theme emerging: 'the professional gust 'providing palliative care in the home setting. One recurring sub-theme across all interviews addressed the ethical dilemmas faced in homecarereduring end-of-life stages. These dilemmas involve balancing patient preferences with clinical considerations, meeting patient needs alongside those of their loved ones, navigating the caregiver-patient relationship, understanding the patient's cultural background, and optimizing home care as the preferred option while considering alternative treatment frameworks.
Conclusions :Home care presents challenges in terms of defining responsibilities and managing caregiver-patient relationships, which encompass both professional and ethical considerations for caregiving teams. Organizations involved in home care need to develop strategies to address these challenges. Over the course of this three-year study, the organization introduced the concept of 'the caregiver as a professional gust ',which helped tailor training programs for caregiving teams to better handle the ethical dilemmas arising

Who's afraid of better health? A moderate defense of appeals to emotion in public health communication
Zameska, Jay
jay.zameska@uj.edu.pl

Both public health communication and medical advertising frequently rely on appeals to emotion. However, appealing to strong emotions, particularly fear, has sparked significant philosophical debate. Such appeals to emotion have been strongly criticized in public health ethics and bioethics, often on the grounds that appeals to emotions "bypass" reason. I call this claim that emotions bypass reason the "bypass claim." The bypass claim is used to ground arguments that appeals to emotion involve manipulation, infringements of autonomy, and other unethical behavior, and as such, forms the basis of several distinct but interconnected arguments in the public health ethics and bioethics literature.
However, in this talk, I criticize the bypass claim, and argue for a more nuanced understanding of the relationship between emotion and rationality. I argue that the bypass claim does not line up with current work on the philosophy and psychology of emotions, which holds emotion to be an important element of rationality. To make this argument, I canvas contemporary work on philosophy of emotions to show how emotions are often an instrumental part of reasoning, focusing in particular on the role emotions play in epistemic justification, decision making, and practical rationality. As such, there are good reasons to believe that emotions are often an instrumental element of rationality, and consequently, that the bypass claim is likely false or, at the very least, significantly more restricted in its scope than commonly acknowledged. In short, we should be skeptical of the claim that emotions bypass reason, and arguments that rely on such a claim.
This has practical implications for the ethics of both public health communication, and medical and health-related advertising. For example, appeals to emotion in medical marketing and advertising are sometimes accused of "exploiting" emotional responses in order to increase sales of prescription medications, private health insurance, and other similar health-related

products. As such, undercutting the view that emotions are necessarily opposed to rationality requires a more nuanced exploration of the ethics of public health communication and medical marketing that involves appeals to emotion.

Consumerism and healthcare - Patient Empowerment versus Medical Paternalism. Patient Empowerment as a Way to Build a Chronic Patient Ethos

Zanetti, Matteo
matteo.zanetti@univr.it

The understanding of patient empowerment often follows two conceptual paths. The first relies on the concepts of self-management and 'consumer choice'. In this way, empowerment is reduced to the ability to decide for themselves and choose a healthcare provider among different options. In the second, patient empowerment pursues the eradication of paternalism and focuses on reinforcing patients' decisions.
That conception of empowerment is based on the autonomy model, founded on the assumption that if patients are given adequate information, they can make autonomous decisions consistent with their sense of well-being. The main focus of this concept of empowerment is decision as the essential element of any therapeutic relationship. Here, the decision is absolutised, becoming an end in itself. The risk is structuring a clinical relationship where the decision becomes an act wholly isolated from a context and deprived of any argument or explanation except for its mere existence.
Such a model is rejectable from the perspective of relational ethics, which is also a vital aspect of decision-making in the clinical dimension. The importance of decisions is contextualised within the life project that patients want to pursue because they need to find a space for suffering, disease and medical needs in their lives. In other words, patients' decisions are preparatory to realising life projects.
In acute conditions, those needs do not always emerge. Acute patients have a precise goal (the cure), and the project implied by their decisions is usually fixing their bodies and returning to their previous lives. On the contrary, chronic patients live in a completely different condition. They cannot achieve any cure, and the disease profoundly changes their lives. In those cases, for patients' sake, it would be better if the concept of empowerment included not only the idea of enabling patients to decide for themselves (which must remain) but also helping them structure their own ethos (namely, an ethical perspective on what they are going through) and their life projects (how to live the new life that the disease forced them into). In this way, decisions are the last element of ethical work done with the help of healthcare professionals, and the therapeutic relationship can be understood as a shared path where patients (with their needs, fears and desires) meet physicians (with their knowledge, ability and experience).
I will analyse the gaps and shortcomings of the first empowerment model for chronic patients, explaining what a life project is and how it can be expressed in the physician-patient relationship (the patient's needs, what physicians can do, and why their role is essential). Finally, I will provide a possible enrichment of the concept of empowerment for chronic patients by looking at virtue ethics as an ethical approach and narrative medicine as a methodological approach.

The Risks of Silence: ICRC Ought to Speak Up Now for Sake of the Israeli Hostages and its Own Core Values.

Zuckerman, Shlomit
shlomitz2@tauex.tau.ac.il

From a mainstream Israeli public point of view, the only role ICRC played in the October 7th war was transferring 100 hostages from Hamas to Israel defense Force hands in a weeklong truce deal in late November. This is, for many, too little too late. In this paper I argue that the ICRC management of the hostage situation in Gaza violates its own values and vision as articulated in its Mission Statement and Code of Conduct. Mainly, it breaches the humanitarian imperative, impartiality, neutrality, and independence. I discuss the violations of those ethical principles by ICRC using public content of Israeli and international media. Finally, I call the organization to speak up against Hamas cynical use of Humanitarian principles to achieve its unjustified goals and move on to public denunciation of it or else it betrays its own core principles and may regret it as it did following its past experience of not going public on the holocaust.

PARTICIPANTS

First name	Last name	Email
Rolf	Ahlzén	ahlzenrolf@gmail.com
Johanna	Ahola-Launonen	johanna.ahola-launonen@helsinki.fi
Samer	Armanious	samersadek@hotmail.com
Gardar	Arnason	gardar@unak.is
Marieke	Bak	marieke.bak@amsterdamumc.nl
Marianne	Boenink	marianne.boenink@radboudumc.nl
Greg	Bognar	greg.bognar@philosophy.su.se
Martine	Boonk	martine.boonk@rivm.nl
Ana	Borovecki	abor@mef.hr
Kirsten	Brukamp	k.brukamp@eh-ludwigsburg.de
Tommaso	Bruni	t.bruni@fz-juelich.de
Andreas	Bruns	andi.bruns@gmail.com
Eike	Buhr	eike.buhr@uni-oldenburg.de
Jeffrey	Byrnes	byrnesj@gvsu.edu
Pacifico Eric	Calderon	calderon.pe.f@slmc-cm.edu.ph
Jean Enno	Charton	jean-enno.charton@merckgroup.com
Sylvester	Chima	chima@ukzn.ac.za
Carlo	Chiurco	carlo.chiurco@univr.it
Monica	Consolandi	mconsolandi@fbk.eu
Zachary	Daus	zachary.daus@monash.edu
Michiel	De Proost	michiel.deproost@ugent.be
Corey	Dennison	dennisonc@duq.edu
Ignaas	Devisch	ignaas.devisch@ugent.be
Thomas	Donaldson	tmd28@doctors.org.uk
Niklas	Ellerich-Groppe	niklas.ellerich-groppe@uni-oldenburg.de
Mohamed	Faraj	sabah.habib2002@yahoo.com
Mark	Fedyk	mfedyk@ucdavis.edu
Leonard M	Fleck	fleck@msu.edu
Kristyna	Forejt	kristynaforejt@gmail.com
Sophia	Forster	so.fo@gmx.de
Lorraine	Frisina Doetter	frisina@uni-bremen.de
Lucia	Galvagni	lgalva@fbk.eu
Eugenijus	Gefenas	eugenijus.gefenas@mf.vu.lt
Petra	Gelhaus	petra.gelhaus@regionostergotland.se
Namita	Ghimire	meetnamitag@gmail.com
Bert	Gordijn	bert.gordijn@dcu.ie
Erik	Gustavsson	erik.gustavsson@liu.se
Inbal	Halevi Hochwald	inbalh@yvc.ac.il
Solveig Lena	Hansen	sohansen@uni-bremen.de
Søren	Holm	soren.holm@manchester.ac.uk
Dieneke	Hubbeling	ahubbeli@sgul.ac.uk
Martina	Hueber	martina.hueber@merckgroup.com
Kristina	Hug	kristina.hug@med.lu.se
Simon	Jenkins	s.jenkins.4@warwick.ac.uk
Emmi	Kaaya	emmi.kaaya@ut.ee
Emilia	Kaczmarek	emilia.kaczmarek@uw.edu.pl
Péter	Kakuk	Kakukp@ceu.edu
Tomáš	Károly	tomas.karoly@ucm.sk
Rachel	Katz	ra.katz@mail.utoronto.ca
Gerrit	Kimsma	gk.kimsma@me.com

Nancy M.P.	King	nmpking@wakehealth.edu
Katarzyna	Klas	katarzyna.anna.klas@doctoral.uj.edu.pl
Julia	König	julia.koenig@med.uni-heidelberg.de
Szilárd Dávid	Kovács	kovacs.szilard@phd.semmelweis.hu
Mario	Kropf	mario.kropf@uni-graz.at
Ya-Ping	LIN	arete@nycu.edu.tw
Jenny	Lindberg	jenny.lindberg@med.lu.se
Simon	Lucas	simon.lucas@merckgroup.com
Hamideh	Mahdiani	h.mahdiani@uni-mainz.de
Christine	Mainka	mainka3@posteo.de
Eva	Meier	e.meier@amsterdamumc.nl
Saba	Mirikermanshahi	saba.miri.k@gmail.com
Timothy	Mosteller	tmostell@csusm.edu
Nikolai	Münch	nimuench@uni-mainz.de
Agnieszka	Nawara	aa.nawara@uw.edu.pl
Floor	Oosting	floor.oosting@springer.com
Qingxuan	Pan	panqingx@msu.edu
Renzo	Pegoraro	cancelliere@pav.va
Jennifer	Peterson	jennifer.peterson@hotmail.co.uk
Anja	Pichl	anja.pichl@uni-potsdam.de
francois	pouliot	fpouliotop@hotmail.com
Mehrdad	Rahsepar Meadi	m.rahseparmeadi@amsterdamumc.nl
Joona	Räsänen	joona.rasanen@utu.fi
Navid	Ravan	navidravan1998@gmail.com
Christoph	Rehmann-Sutter	rehmann@imgwf.uni-luebeck.de
Maryn	Reyneke	m.reyneke@maastrichtuniversity.nl
cristina	richie	cristina.richie@ed.ac.uk
Michael	Robinson	michaelrobinson@chapman.edu
Libby	Roughead	libby.roughead@unisa.edu.au
Nina	Roxburgh	nina.roxburgh@monash.edu
Joanna	Rozynska	j.rozynska@uw.edu.pl
Kuba	Rucinski	kurucinski@gmail.com
Antonia	Sahm	a.m.sahm@outlook.de
Leopoldo	Sandonà	leo_sandona@yahoo.it
Judit	Sándor	zsukoty@ceu.edu
Maartje	Schermer	m.schermer@erasmusmc.nl
Wayne	Shandera	w.shandera@gmail.com
Kadri	Simm	kadri.simm@ut.ee
Frida	Simonstein	fridafux@gmail.com
Marthe	Smedinga	marthe.smedinga@nus.edu.sg
Jilles	Smids	j.smids@erasmusmc.nl
Joanna	Smolenski	joanna.smolenski@bcm.edu
Sabine	Sommerlatte	sabine.sommerlatte@medizin.uni-halle.de
Lena	Stange	lena.stange@uni-oldenburg.de
William E.	Stempsey	wstempsey@holycross.edu
Peter	Sykora	petersykora111@gmail.com
Per-Anders	Tengland	per-anders.tengland@mau.se
Cristian	Timmermann	cristian.timmermann@uni-a.de
Jana	Tomasovicova	jana.tomasovicova@ucm.sk
Lydia	Tsiakiri	lts@ps.au.dk
Frank	Ursin	ursin.frank@mh-hannover.de

Susanne	Uusitalo	susuus@utu.fi
Florian	van der Zee	f.r.r.r.vanderzee@erasmusmc.nl
Wannes	Van Hoof	wannes.vanhoof@sciensano.be
vina	vaswani	vinavaswani@yenepoya.edu.in
Michel	Vitale	michel.vitale@radboudumc.nl
Marcin	Waligora	m.waligora@uj.edu.pl
Daniel	Warrington	daniel_warrington@hotmail.co.uk
Stefanie	Weigold	stefanie.weigold@uksh.de
Gila	Yakov	gilayak@gmail.com
Jay	Zameska	zameskaj@gmail.com
Matteo	Zanetti	matteo.zanetti@univr.it
Shlomit	Zuckerman	shlomitz2@tauex.tau.ac.il