

# **Ethical conflicts in medicine: a cross-cultural comparison of norms, attitudes, and subjective evaluations**

## **Final Report** **INTAS-project Nr. 97-30221** **1. 10. 1999 – 31. 7. 2003**

**Coordinator**

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## **1. RESEARCH**

The project attempts to identify by qualitative and quantitative research ethical conflicts in medicine and basic values of medical staff and patients. The design is cross-cultural, with a comparison of four countries (AT, NL, UA, GE) with different cultural traditions, and cross-sectional within cultures, focusing on differences in specialized knowledge (experts and laymen).

### **1.1 Research Activities**

The following tasks were realized:

The first year of research:

- Formulation of the open questions (by the teams in AT, NL)
- A pilot study (AT, NL)
- Interviews with 20-30 medical experts and 20-30 laymen in the four countries AT, NL, UA, GE (201 extended interviews altogether)
- Translation and transcription of the interviews into English (except interviews with Austrian respondents)
- Training of the teams in NL, UA, GE by the Austrian Team (2 scientists) in the method GABEK and in the use of the WinRelan-PC-Program
- Qualitative analysis of the verbal data using GABEK and WinRelan (AT, UA, GE. The verbal data of NL was evaluated by the Austrian Team): fundamental coding, construction of the “gestalten tree”, “evaluation profiles” etc.
- Participation of all the INTAS-scientists in the 3<sup>rd</sup> International GABEK-Symposium in Sterzing, Italy with lectures about the INTAS-research in AT, NL, UA, GE

The second year of research:

- Working meeting in Leiden, The Netherlands (AT, NL)
- Working meeting in Innsbruck, Austria (AT, NL)
- Formulation of the closed questions on the basis of the qualitative results obtained by the GABEK-analysis (by the teams in AT, NL)
- A pilot study (AT)
- Translation of the interviews from German into English (AT, NL)
- Translation of the interviews from English into Russian, Dutch, Georgian and German (AT, NL, UA, GE)

- Revision of translations (AT, NL, UA, GE)
- A pilot study (AT, NL, UA, GE)
- Quantitative inquiry (193 questions) of 50 medical experts and laymen in AT, NL, UA, GE (together 800 extended quantitative interviews)

The third year of research:

- Continuation of the quantitative inquiry
- Preparation of the quantitative data for processing in SPSS
- Working meeting in Innsbruck, Austria (AT, NL, UA)
- Working meeting in Leiden, The Netherlands (NL, GE)
- Revision of the analysis of the Dutch and the Georgian results of the qualitative research
- Feeding quantitative data in SPSS (AT, NL, UA, GE)

From December 2002 – July 2003

- Statistical evaluation (NL)
- Revision of the analysis of the Ukrainian results of the qualitative research (AT)
- Construction of (social) mind maps for all the eight verbal data bases (AT)
- Documentation of qualitative results (AT)
- Preparation of the final Report (AT)

The research was conducted in accord with the work programme. However, we have so far not been able to analyze qualitatively the causal assumptions of the respondents. Also, the statistical evaluation of the quantitative data couldn't be completed. Furthermore it was not possible to organize a final workshop in Kiev with the aim to prepare joint publications. Further, we were unable to keep to the time schedule of the work programme.

To conclude everything as planned a further meeting of all participants and training workshops would be necessary, to be precise, a further training in the qualitative method GABEK (by the coordinator in AT) and in methods of statistical evaluation (by our Dutch partner). Due to a lack of funds this was not possible. Yet, we will try to find a way next time.

The delay in time resulted from the fact that our scientific co-worker Mag. Karin Mühlbacher left the project for a better job. After some time we found another student who wanted to use the project for her PhD-thesis. Yet she got a baby and has been unable to conclude the work until now. Another reason for the delay was the fact that our participant in NL did not receive any additional funds for the project. One of the main problems for the delay in the work programme was also the translation of the quantitative questionnaire from German into four different languages: English, Russian, Dutch and Georgian. To ensure validity the German, Dutch, Russian and Georgian questionnaires had to be translated back into English to control the comparability of results. This took more time than initially assumed.

## 1.2. Scientific Results

As a first result **the main ethical conflicts** in medicine were identified (see Summary). We will here present **the main results for the eight groups of respondents** in form of summaries:

**Austria, experts:**

The state has an influence on the formation or avoidance of ethical conflicts in medicine. On the one hand the influence is achieved by legislation and on the other hand by the curriculum of the medical studies. However, the legislation should not be too strict, because every single member of the medical profession should know what is permissible in ethics and what not. Especially in genetic engineering, cloning and transplantation medicine ethical conflicts always arise or will arise in future, and therefore everyone should be aware of ethics and ethics in medicine. In Austria the state provides a good health care system, in other states medical availability probably will become a problem in future.

**Austria, patients:**

It is important that the doctor shares information with the patient and does not withhold medical knowledge. It is ethically not correct if the doctor just makes a diagnosis, decides on the treatment or operation without completely informing the patient. In the doc-pat-relationship the doctor should be more interested in the patient. The problem of medical education is that it is based on diagnosis and treatments rather than on interest in the patient's well-being.

In the doc-pat-relationship the doctors sometimes make mistakes mostly because of lack of responsibility. The patient usually gets compensation, but his physical and psychical condition suffers damage. Most of the present ethical problems will increase in the future. For example genetic engineering is developing and if the reproductive medicine succeeds in cloning people new problems will appear. A possible problem in the future could be that the mothers will sell their embryos (children) for medical experiments. Also, increasing costs of treatment will become a more important problem in the future.

**The Netherlands, experts:**

Through medical development the treatment possibilities in the future will improve, but more expensive and the question is how to deal with new costs in medicine. Concerning ethical decisions the state or government should participate, but only in consultation with doctors or medical associations.

The most important decision about the treatment of patients depends on the medical point of view, but the doctors should take part in psychological courses about how to handle the patient. The diagnosis of a patient's illness and treatment must be clearly described.

An ethical problem may arise within the doc-pat-relationship regarding the implementation of a proposed treatment plan. Primarily the decision concerning the patient's treatment depends on the medical diagnosis, but the doctor is obliged to inform the patient, to consult and decide with him/her about the further treatment.

**The Netherlands, patients:**

An important ethical problem in the future is genetic manipulation. The technological development (advances) in medicine and medical science (medical research) could increase new ethical problems in the future.

Ethically incorrect behaviour in the doc-pat relationship occurs when the doctor withholds information about the patient's treatment. It should be within the autonomy of the patient to decide about his/her own treatment (pat desire)

**Georgia, experts:**

Existing ethical problems in medicine are results of the government's attitude to medicine, people and country in general, especially of doctor's income. The state refrained from making crucial changes. This causes: unhealthy competition among colleagues for patients and positions, an indifferent attitude towards a patient, unqualified treatment, no means of payment. In hospitals there are informal structures and relations which affect care quality.

The government should finance the medical system.

**Georgia, patients:**

Almost all the problems in medicine can be traced to a bad economic condition of the country. The state does not want to do anything; it does not care for the health of its citizens; in fact it

does not finance the medicinal system. So doctors have to rely only on the patient's payments. Therefore they do not treat even urgent cases without payment. Doctors display a superior attitude towards patients, often treat them as objects of work rather than human beings, do not explain diagnoses to them, do not treat medical information confidentially. Doctors make serious mistakes due to their low qualification and a bad selection procedure. All this leads to a diminished trust in doctors, which would be so important for recovery. Information as to which doctor to visit is not readily available.

Doctors cannot be kept accountable for all these problems. Due to a lack of medical education of the population and lack of money patients visit doctors only when their condition is severe. This renders successful treatment difficult. Besides, the conditions in which doctors work are far from satisfactory.

Every person should be able to obtain qualified medical help. The solution lies first of all in the improvement of the quality of life in general and in the reform of the health system by introducing medical insurance, in a better selection and education of doctors and in bringing medical knowledge to the population.

#### **Ukraine, experts:**

The health care system as well as the state hospitals are faced with financial problems (lack of money). Because of lack of drugs and financial relationship between the doctor and the patient the level of the treatment is decreasing and medicine is full of ethical conflicts.

#### **Ukraine, patients:**

Rudeness, a non-professional attitude, low level of the education from the side of the doctor or the medical staff lead to professional mistakes and as a result the patient is psychologically stressed and suffers. Especially in state hospitals this behaviour sometimes is a result of bad working conditions and low income (financial problems).

The government should solve the financial problem of the healthcare system. It should control and change the system and support it financially. Especially old people have no money and no treatment possibilities. Financial problems are also a negative influence on the relationship between the doctor and the patient.

Without these changes the problems in the future will remain the same.

Let us now present **the fundamental ethical values** proposed by most of the respondents in the four countries: We quote first the value and then the number of weightings expressed in the responses

<b>Fundamental value</b>	<b>weighting</b>				
communication	50	responsibility_doc	24	responsibility	10
honesty	40	listen_to_pat	21	openness	9
confidence	33	awareness_ethical	20	helping	7
empathy	28	freedom_personal	17	conscience	6
value_of_life	26	respectfulness	17		
		maintain_life	11		

In contrast to fundamental the values, aims and goals are not the same in the four countries. It would take to much space to present these here. But at least we would like to present some of the **measures proposed by the respondents:**

<b>Measure</b>	<b>Eval. Sum</b>				
financial_support	33	med_studies	15	ask_pat_for_permission	2
health_care_system	33	medical_service	13	bill_to_report_the_illegals	2
ethics_committee	31	private_hospital	9	financed_privately	2
qualification_doc	31	med_equipment	8	official_regulation	2
med_tests	22	advice_of_doc	7	acceptance_of_law	1
psycholog_care	20	old_people_treatment	7	birth_control	1
official_regulations	18	psycholog_instruction	7	consultation_with_doc	1
control	16	Media	6	consultation_with_family	1
guidelines	16	ask_doc	5	record_on_paper	1
		consultation_with_pat	4	supervision	1
		private_funding	3		

In the second stage of the project **quantitative research** was carried out. On the basis of the gestalten trees as found by means of Winrelan in the first qualitative part, a questionnaire was constructed for the different countries. The common language basis was English and it was then translated into the respective languages. This questionnaire comprised 193 items with Likert scale answers (0 to 5: don't agree to fully agree), 42 paired comparisons for the seriousness of violations of ethical rules, and five little stories with multiple-choice answer alternatives.

The Likert scale part of questionnaire was factorized for all countries together and resulted in five dimensions, explaining 45% of the variance. Factor scores were calculated for all respondents, which allowed us to look at different group-specific perspectives.

- Factor 1, which is a common ethics factor (optimal treatment in mutual respect and understanding, adequate information given to patients) had its highest values for the Ukrainian respondents.
- Factor 2 (violations of ethical rules, corruption, unbalanced communication, irresponsible use of patients as a guinea pigs, seen as part of reality) had its highest values for the Netherlands.
- Factor 3 (respecting the privileged position of doctors [semi-gods in white], they have the main responsibility for the well-being of the patient and to behave ethically, no euthanasia) showed high values for Austria and the Netherlands.
- Factor 4 (quality of life as an indicator for further treatment, death has to be accepted as natural, euthanasia permitted) had its highest values for Georgia.
- Factor 5 (technical and commercial aspects of medicine, things that are possible should be accepted, prevention of handicaps by abortion) had its highest values for Austria.

A discriminant analysis using 3 canonical variables, i.e. the regression scores of the five factors in three weighted combinations resulted in an 86% correct regrouping of the countries with almost no overlap between the two Eastern European countries and some overlap between Austria and the Netherlands. This result shows clearly that the questionnaire was very well suited to reflect the existing differences in the ethical attitudes in the 4 countries. On the basis of this result as background information a more critical attitude of the Dutch and a more reality-bound attitude of the Austrians can be inferred. The Ukrainians still foster the ideal of an ideal doctor-patient relation; the Georgians regard medical progress more from a social, and possibly more cost-related point of view.

Factor 4 was the only one to differentiate significantly between the experts (health care professionals) and the laymen (patients). Experts (in congruence with the Georgians) here had much higher values.

Finally the five factors were interpreted by results of the qualitative part, i.e. of the gestalten trees.

For the achievement of each of the project's objectives as stated in the work programme see the information sub 1.1 and the annexes 1 – 9.

### **References:**

The following articles use results of the INTAS-project as examples for the presentation of the method of research GABEK:

Josef Zelger: WINRELAN. Short Manual. With examples from the INTAS-project 97-30221, Internal Report, Department of Philosophy, Innsbruck University

Zelger, Josef: "Theoriebildung auf der Basis verbaler Daten durch das Verfahren GABEK" in: Ulrich Frank (Ed.): Wissenschaftstheorie in Ökonomie und Wirtschaftsinformatik, Wiesbaden (DUV) 2004, S. 57-84.

Zelger, Josef:” Qualitative Research by the Method GABEK“ in: Fikfak, Jurij (Ed.): Qualitative Research, Ljubljana (in print).

	<u>ALL PUBLICATIONS</u>			<u>ONLY: Jointly by INTAS and NIS Project teams</u>
	published	in press/accepted	submitted	
<i>Scientific Output</i>				
<b>Paper in an International Journal</b>				
<b>Paper in a National Journal *)</b>				
<b>Abstract in proceedings (conferences, workshops)</b>	5	2		
<b>Book, Monograph *)</b>				
<b>Internal Report **)</b>			1	
<b>Thesis (MSc, PhD, etc.) *)</b>				
<b>Patent</b>				

### 1.3. Impact and Applications

The **impact** of the project **on scientific research** lies in a innovative way of theory building on the basis of verbal data in ordinary language and in a new way of integration of qualitative and statistical procedures. The impact on society is given in fundamental values, aims and measures accepted by the individuals concerned who are experts on the basis of their own experience.

The results can form the basis for further discussion by experts and institutions concerned with ethical problems. Through the potential conversion of implicit presumptions into explicit conjectures critical issues and behaviour can be highlighted and the results can be applied in the search for adequate measures for the prevention of ethical conflicts. They can also point to newly arising issues and can be used as an information base for the introduction of changes in the event they should be regarded as necessary.

## 2. MANAGEMENT

### 2.1 Meetings and visits

The first year of research:

There was one training-visit for the method GABEK-Winrelan of 12 days in Tbilisi, GE. All the INTAS-scientists did participate (28. 4. – 9. 5. 2000).

Uwe Hentschel, NL

Karin Mühlbacher, AT

Josef Zelger, AT

Eduard Krainikov, UA

Leonid Burlatchuk, UA

Nana Sumbadze, GE

Kathuna Dolidze, GE

Revaz Kvatskava, GE

The same holds for the 3<sup>rd</sup> International GABEK-Symposium in Sterzing, Italy (19. – 23. 9. 2000)

The second year of research:

01. 01. 2001 – 31. 12. 2001:

There were three meetings for formulation of the closed questions on the basis of the results obtained by the GABEK-analysis:

- Leiden, The Netherland's (08.03.2001-12.03.2001)

Uwe Hentschel, NL

Josef Zelger, AT

Maša Guštin, AT

Andreas Oberprantacher, AT

- Innsbruck, Austria (19.02.2001-20.02.2001 and 20.05.2001-25.05.2001)

Uwe Hentschel, NL

Josef Zelger, AT

Maša Guštin, AT

There was one coordination meeting on the procedure in quantitative research:

Leiden, The Netherland's (15.09.2001-17.09.2001)

Uwe Hentschel, NL

Nana Sumbadze, GE

The third year of research:

There were two meetings on coordination of the quantitative research:

- Innsbruck, Austria (22. 09. – 25. 09. 2002)

Uwe Hentschel, NL

Josef Zelger, AT

Maša Guštin, AT

Leonid Burlatchuk, UA

- Leiden, The Netherland's

Uwe Hentschel, NL

Nana Sumbadze, GE

<i>Visits</i>	<b>Number of scientists</b>	<b>Number of person days</b>
West ==> East	3	36
East ==> West	9	52
West ==> West	6	34
East ==> East	3	24

## 2.2 Collaboration

The intensity of collaboration can be assessed as follows:

01. 11. 1999 – 31. 12. 2000:

<i>Intensity of Collaboration</i>	<b>High</b>	<b>Rather high</b>	<b>rather low</b>	<b>low</b>
West <=> East	x			
West <=> West	x			
East <=> East	x			

There was no major cooperation with additional (inter)national organisations and institutions not mentioned in the Co-operation Agreement.

## 2.3 Time Schedule

- We were 20 months late compared with the original Work Programme.

## 2.4 Problems encountered

The main problem was that our Participant in NL did not receive any additional funds for the project. This was also the main reason for the delay referring to the work programme. The Austrian team could manage the problem by taking over the work of qualitative evaluation of the verbal data for the NL-team. We could do it thanks to the additional funds which we received from the Ministry of Science in Austria.

The second problem came from the fact that our scientific co-worker Mag. Karin Mühlbacher, who intended to write a PhD-Thesis, left the project for a better job. In the meantime we found another student willing to use the project for her dissertation. But this student, Masa Gustin, got pregnant, which inevitably also to a delay. In contrast the eastern partners finished their work more or less in time.

The 3<sup>rd</sup> problem was connected with the export of two laptops from Austria to Georgia and the Ukraine. This was necessary for reasons of possible software-incompatibilities. Therefore we had to install the PCs in Austria with all the programmes that were needed. Finally we took the laptops to Georgia personally, when we went to the training visit to Tbilisi.

Another reason for the delay referring to the work programme was the translation of the quantitative questionnaire from German into four different languages: English, Russian, Dutch and Georgian. For reasons of validity, the German, Dutch, Russian and Georgian questionnaires had to be translated back into English to verify the comparability of results. This took more time than we had assumed.

During the quantitative part of the project we had problems with the length of the quantitative questionnaires. We decided to use an extended questionnaire in order to get responses on almost all relevant topics in medical ethics, which were articulated within the qualitative results of the first project year. The questionnaire comprises more than 20 pages with 193 questions. The first section is a questionnaire with five different steps of agreement. In the second section experts and patients had to compare a number of alternatives to make their choice of preference. The third section contains some short stories on which the respondents must rank suggested answers. Respondents who answered everything very quickly needed about a 60 minutes.

<i>Problems encountered</i>	<i>Major</i>	<i>minor</i>	<i>None</i>	<i>Not applicable</i>
Co-operation of team members			x	
Transfer of funds			x	
Telecommunication			x	
Transfer of goods		Transfer of Laptops		
Other:	Lack of funds in The Netherlands Coworker 1 left the project for a better job Coworker 2 got a baby Problems of translation in Dutch, Russian, Georgian, English The quantitative questionnaire was very extended			

## 2.5 Actions required

The financing of the activities in the West should be secured.

## 2.6 Manpower invested

In the East I assume 4 person-years were invested in the project. These were funded by INTAS.

In the West the project took about the same time, 4 person-years. About one person-year was financed by the Austrian Ministry of Science.

### 3 FINANCES (in EURO)

	Participant	Individ. Grants Labour	Overheads	Travel and Subsistence	Equipment	Consumables	Other Costs	Total (Euro)
1	Inst.f. Philosophie, Ibk, AT	1.245,11		1.679,59			1.901,49	4.826,19
2	Dept. of Psychol. Leiden, NL	3.044.-	395.-	1.199.-		162.-		4.800.-
3	Psychodiagnostic & Medical Psychol. Kiev, UA	12.360.-		4.079,90	2.334.-		757,40	19.531,30
4	Dept. Social Psychology Tbilisi, GE	12.360.-	415.-	1.550.-	3.195,40		1.740,20	19.260,60
		29.009,11	810.-	8.508,49	5.529,40	162.-	4.399,09	48.418,09

Additionally the cost of the participation of Kathuna Dolidze, GE, at the 3<sup>rd</sup> International GABEK symposium in Sterzing could be paid by an INTAS conference grant.

In Addition to the grant of INTAS we received **36.115,17 Euro** from the Austrian Ministry of Science. We spent the money of the Austrian funds as follows:

1	Inst.f. Philosophy, Ibk, AT Additional support from the Austrian Ministry of Science	25.860,99		6.375,95	2.230,92		1.647,31	36.115,17
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We got further funds for expenses at the 3<sup>rd</sup>. International GABEK-Symposium from the regional government of South Tyrol, Bozen, Prov. di Bolzano, Italy, which we spent on travel and subsistence for the following INTAS-scientists: Nana Sumbadze, GE, Uwe Hentschel, NL, Eduard Krainikov, UA, and for two non-INTAS-scientists (one of which was Prof. D. Pal'chunov coming from Novosibirsk).

1	Inst f. Philosophy, Ibk, AT Additional Support from the Regional Government South Tyrol, IT			4.128.-				4.128.-
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- The money spent have been in accordance with those foreseen in the Work Programme
- Up until now we didn't spend a major amount on a) travel, b) equipment or c) other costs.

### 4 ROLE AND IMPACT OF INTAS

<i>Role of INTAS</i>	<i>Definitely yes</i>	<i>rather yes</i>	<i>rather not</i>	<i>definitely not</i>
Would the project have been started without funding by INTAS?				x
Would the project have been carried out without funding from INTAS?				x

The most important achievements of the project:

<i>Main achievement of the project</i>	<i>very important</i>	<i>quite important</i>	<i>less important</i>	<i>not important</i>
Exciting science	x			
New international contacts	x			
Additional prestige for my lab		x		
Additional funds for my lab			x	
Helping scientists in NIS	x			

Will the project continue? Definitely, yes.

Will the co-operation among the project Contractors continue in the future? Definitely, yes.

## **5 RECOMMENDATIONS TO INTAS**

What should not be changed?

The support provided for NIS-Partners.

The organization without much bureaucracy. Easy contact with INTAS-representatives.

What should be changed?

The financing of activities in the West should be secured.

## **5 ANNEXES**

Summary reports of each team in relation to the work programme and results achieved.

Qualitative Results: Appendix 1 to 8

The Quantitative Questionnaire: Appendix 9