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The magazine of healthcare co-operativism

HEALTH
Herpes zoster

HEALTH CO-OPERATIVISM
Moncloa Hospital

MONOGRAPH
Healthcare Professionals' Perspective on Bioethics

CULTURE
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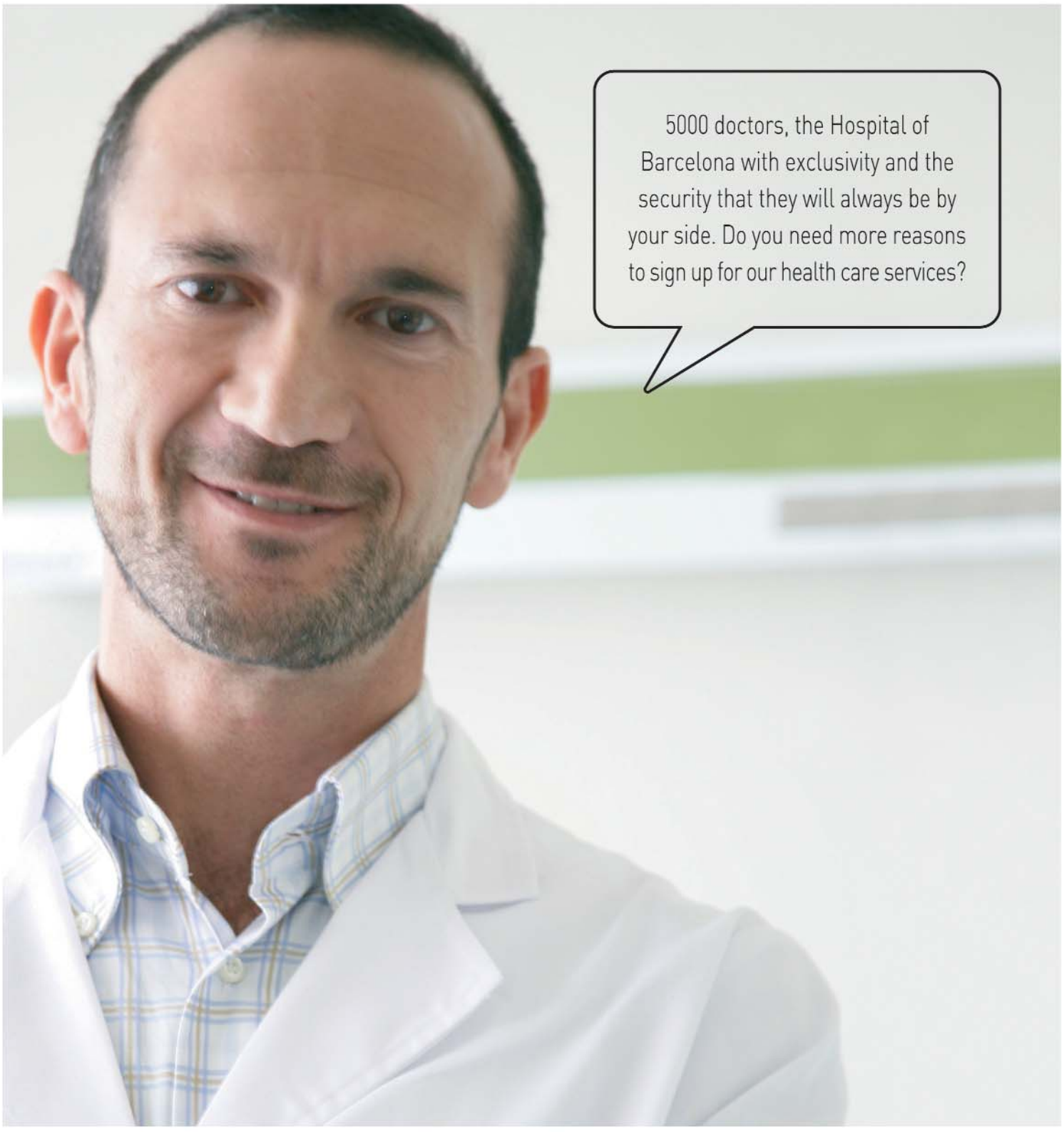

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SUMMARY | Issue 76

Bioethics, while little known just a decade ago, now forms an important part of medical practice. One need only consider the bioethics Committees which are today commonplace in most hospitals. This is a result of the increased complexity of new treatments, the growth in lawsuits caused by differences of opinion, doctors and nurses reflecting on the nature of healthcare practice and the increasing involvement of users, patients, in healthcare structures.

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The healthcare co-operativism magazine

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EDITORIAL

The evolution of medicine over the course of the second half of the 20th century led to a situation in which technical progress and advances in the treatment of illnesses have increasingly raised questions of an ethical nature. What is best for the patient in each case? Is it right to pursue all the technically possible treatments? How should one act when a treatment, because of its exorbitant cost, cannot be made available to all patients in a society? These and many other issues gave rise to the emergence of bioethics: ethical reflection applied to the biomedical sciences. It is a field involving a far-reaching dialogue among many disciplines, since this crossroads of knowledge is the meeting point for biomedical and biological science, the humanities (philosophy, ethics, theology, law) and also the social sciences, since medicine covers the conceptual ambits of sociology, economics and political science.

The evolution of this discipline does, however, have a huge impact on the relationship between doctor and patient. The professional environment must ensure that patients know they are being treated with respect. Bioethics is in essence an approach or a mentality that is applied when treating patients. This is the point stressed by Núria Terribas, of the Borja Bioethics Institute: "if we do not observe such respect and attempt to impose our own judgement and value system, we are not acting with a bioethics mentality which should be based on dialogue and the quest for consensus, meaning that patients may feel they have not been properly tended to and that their rights have been violated".

Dialogue, consensus, violation of rights... Because it is by no means only medical advances which raise issues. Often the question arises from the new context in which the healthcare relationship takes place: the pluralism of values in a complex society. In the words of Dr Benjamín Herreros, "problems of clinical ethics have increased exponentially since the liberal revolution was extended to medicine, with the *de facto* recognition (not only in law) that patients have the right to decide as to their health". An open and tolerant society, marked by a pluralism of values, raises ever more questions. This necessarily calls for specific training for health professionals. Meanwhile, patients and their relatives when confronted with ethical issues such as the meaning of life, the meaning of care, scientific progress and its limits etc., reflect on these and this in turn raises among them many questions that need answers.

These debates have a social dimension and impact on the guiding principles of healthcare models, hence the fact that the Espriu Foundation gives them a lot of consideration. It was at a General Assembly of the ASISA-Lavinia co-operative, at the proposal of a representative from Guipuzcoa in the Basque Country, that work began a year ago to set up a Bioethics and Healthcare Law Committee. As its president, Dr María Tormo, explains, "the committee operates as a consultancy for Lavinia doctors, in other words the co-operative members, and also for doctors and other healthcare staff belonging to the organisation's medical lists. [...] We aim to make it a practical consultancy, genuinely dealing with the issues which concern professionals in their daily tasks. [...] Bioethics must, however, provide a response within the existing legal framework".

Herpes zoster

Dr Adolf Cassan

Herpes zoster, a condition also known as herpes zona, or colloquially as shingles, is caused by a viral infection giving rise to an eruption of blood vessels in the skin where there is a sensory nerve path, hence forming a line or ring. It is a fairly frequent illness, estimated to affect around two out of every thousand people a year. It occurs most commonly in those of middle age, and above all the elderly, peaking between the ages of 60 and 70.

Eugènia Carrasco

The infection is caused by a virus known as the varicella-zoster virus (VZV) or *Herpesvirus varicellae*. It is the same virus which causes the common childhood complaint, chickenpox, the subject of an earlier article in this magazine. While it is rare that one single virus should be responsible for two different illnesses, one typical of childhood and another generally occurring in old age, this is in truth a highly distinctive organism: it first of all causes chickenpox, and once that has cleared up generally remains in the body in a latent state, concealed in the tissue of the nervous system, far removed from the activity of the immune system. Those suffering from herpes zoster have not, then, recently contracted the virus, but are experiencing a reactivation of the virus which previously emerged many years earlier, although they may not remember it, not only because of the passage of time but because chickenpox on occasion takes a sub-clinical form and goes practically unnoticed.

It is also possible, of course, and in fact often occurs, that once an individual has overcome a childhood bout of chickenpox the virus will not return to cause any further condition. Nonetheless, in some cases after a long period of inactivity it is reactivated and invades the tissue where it has remained latent, around some sensory nerve, leading to inflammation. And via the affected nerve, which runs under the surface of the body, it reaches the skin and invades the cells of the epidermis. It thus affects both a sensory nerve itself and the skin along the path which the nerve follows.

The reason why the varicella-zoster virus suddenly becomes active once again and gives rise to a clinical condition has not yet been fully explained. In some cases it occurs in individuals who are not ill and do not appear to have any predisposition. This is not, however, the most common situation, as the condition typically occurs when an illness in general reduces the immune system's effectiveness, or in patients who for some specific reason are being treated with medication which suppresses immunity. It is for this reason particularly common in the elderly

who, for whatever reason, are in a weakened state. Ultimately, when the body's defences are low, the virus, which has remained latent for a long period, finds itself in a situation in which it can become active once again and affect the body's tissues.

The first sign of the illness comes in the form of a stinging or painful sensation, at times extremely intense, located in an area of the skin more or less defined as a band or ring corresponding to the path of a nerve, on just one side of the body. It is most commonly affects the torso, for example following the route of an intercostal nerve, never crossing the central line of the body, although it will at times emerge on the back or on an arm, and even on the face where, if it affects the region around the eye, it can have an impact on the patient's sight, although this is an extremely unusual complication. The band of skin affected is generally highly sensitive, and will be painful both spontaneously and to contact, however slight. In some cases this initial phase may also be accompanied by a high temperature, headaches and general discomfort.

After a few days there will be an eruption of a number of reddish papules grouped in a band or ring in the area where the pain is felt. After a few hours, or a day, the initial lesions become vesicles which, a few days later, turn into pustules, which will over the course of a week gradually dry out and form scabs. The scabs last for two or three weeks and finally heal over, sometimes leaving a slight scar.

Although this eruption can undoubtedly prove uncomfortable, the most significant impact of herpes zoster is the pain felt in the whole area affected, relating to the inflammation of the nerve where the virus becomes reactivated. It is a very severe pain which, as mentioned earlier, is intensified by the slightest contact, such as rubbing against a bedsheet, or any movement, even just a shift in position. Although in younger people the pain may be more mild, or even almost imperceptible, in adults, and particularly the elderly, it is usually very intense. The relatives of the sufferer will sometimes express surprise at their complaints, finding it difficult to understand how such apparently slight lesions could give rise to such considerable discomfort. The truth of the matter, though, is that there are cases where the pain becomes almost intolerable. What is more, it will on occasion persist even after the lesions on the skin have healed, a condition known as post-herpetic neuralgia, although it will normally subside within six months.

In terms of treatment, the first point to be made is that there is no effective means of curing the condition. Treatment thus focuses on alleviating the discomfort, since although there are a number of anti-viral drugs available these days, they are only relatively effective and if they are administered from the initial phases of the disorder, the most that can be achieved is to alleviate or shorten its development. Their main use lies in sometimes reducing the residual discomfort experienced after the skin has healed over. Treatment will, however, as far as possible deal with the pain suffered, as many different procedures exist which can help to alleviate it. When the discomfort is particularly intense, everything possible is done to reduce its impact. Painkillers will first of all be administered, at an appropriate level. If the pain persists after the skin lesions have healed and does not subside with painkillers, corticoids may be prescribed in some cases, acting to reduce the inflammation of the nerve. Powerful sedative drugs may even, in some cases, be required in order to reduce the sense of discomfort. If this also proves insufficient, anaesthesia may be applied to the affected nerves, or in truly exceptional cases, they may be cut by means of a surgical procedure. The most important factor is in one way or another to attempt to relieve the pain which constitutes the main symptom of this illness.

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Moncloa: the road from Clinic to Hospital

Juan José Fernández Ramos
Managing Director

Moncloa Hospital opened as a clinic in December 1993, and as a hospital of the ASISA group offers multi-disciplinary and top-quality healthcare to all the organisation's policyholders, along with private users.

Over the course of more than 15 years, Moncloa Hospital has successfully achieved its main objectives: to offer hospital care at the highest level in the Greater Madrid region, establishing itself as a centre offering users excellence in the quality of care.

The qualifications of its professional staff and its high standard of equipment have placed our institution at the forefront of private medicine in Madrid. A permanent focus on ongoing improvement has allowed us constantly to revise our objectives and goals, helping us achieve the aim of setting up a Daycare Unit for cancer patients, implementing information technology throughout the centre, incorporating modern radiology equipment and introducing the digitisation of imaging techniques, while also putting in place a tele-radiology service in permanent contact with other healthcare centres.

The Diagnosis and Arrhythmia Treatment Units, the Haemodynamics Unit, the Ophthalmology Department and the Oncology Department have, meanwhile, established themselves as national flagships of excellence.

Over and above the building itself, the technology, the beds and the statistical indicators, however, are the staff and, the true focus of our activity, the patients. They are the reason behind our efforts to make constant improvements, a challenge which we meet with the sole intention of delivering the quality which our users deserve.

Recognition by the health authorities of our status as a level three hospital, along with the institution's own philosophy, have led Moncloa Hospital's management team and the majority of the professional staff performing their daily work here to the belief that the term "clinic" does not do justice to the high level of healthcare provided. Hence our conclusion that "Moncloa Hospital" is a title much more representative of the care which we offer to our users, and the decision therefore to change the institution's name.

RECOGNITION BY THE HEALTH AUTHORITIES OF OUR STATUS AS A LEVEL THREE HOSPITAL, ALONG WITH THE INSTITUTION'S OWN PHILOSOPHY, HAVE LED THE MANAGEMENT TEAM AND THE MAJORITY OF ITS PROFESSIONAL STAFF TO THE BELIEF THAT, GIVEN THE HIGH LEVEL OF CARE PROVIDED, THE TERM "HOSPITAL" WOULD BE MORE APPROPRIATE, HENCE THE CHANGE FROM MONCLOA CLINIC TO MONCLOA HOSPITAL

Quality care at the highest level

Moncloa Hospital has advanced facilities and infrastructure with provision for all medical and surgical specialties for healthcare of the highest quality in line with its users' needs.

The hospital building has four floors and 224 individual rooms with a bed for a friend or family member, 12 suites with sitting room, 13 ICU places, 10 operating the-

THE QUALIFICATIONS OF ITS PROFESSIONAL STAFF AND ITS HIGH STANDARD OF EQUIPMENT HAVE PLACED OUR INSTITUTION AT THE FOREFRONT OF PRIVATE MEDICINE IN MADRID

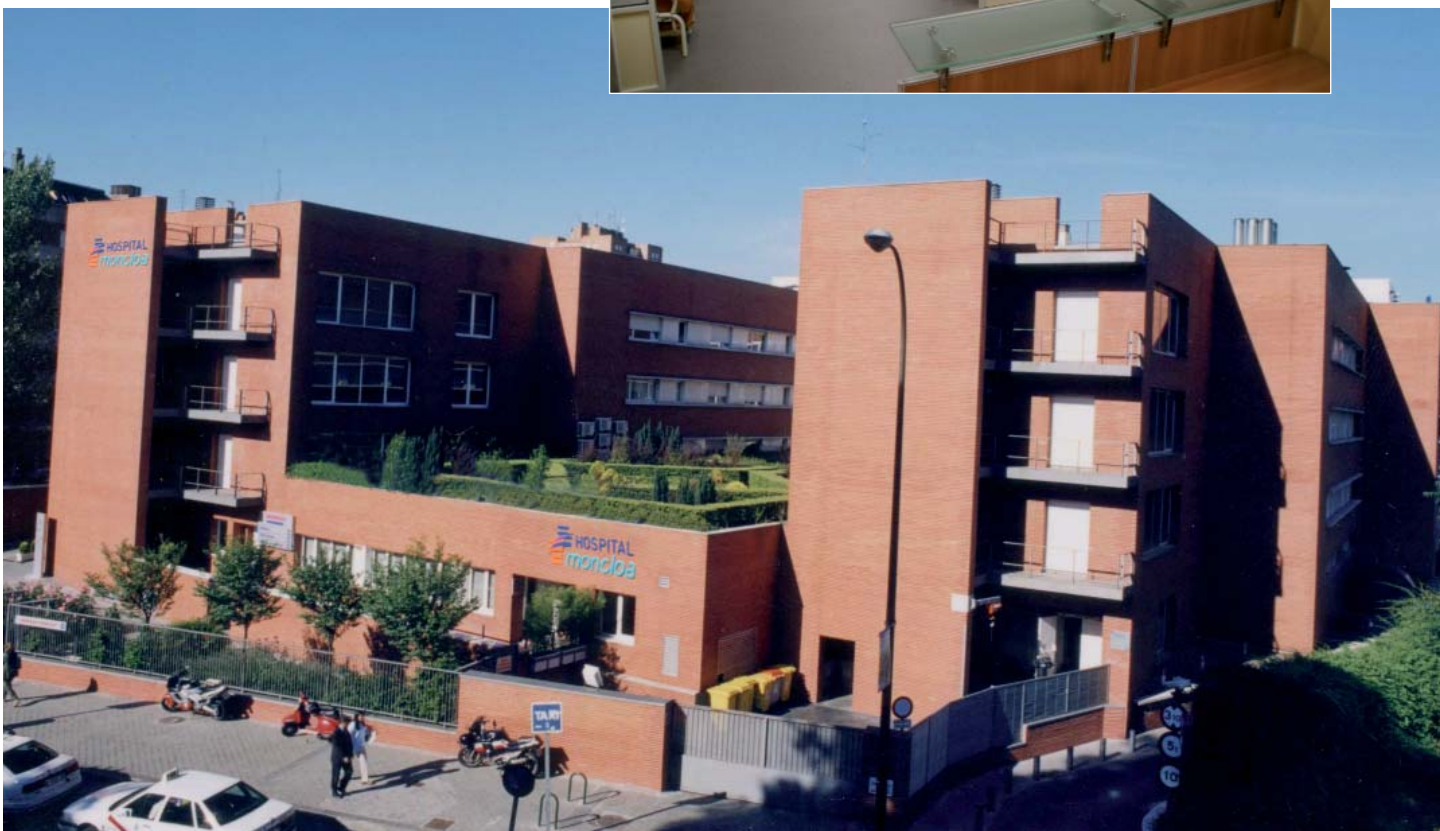
atres for complex surgery, 2 delivery rooms, 39 specialist care departments and units, 28 specialist consultancy rooms, a Medical Care and Postsurgical Reanimation Unit, Infant Observation Unit and Sterilisation Centre.

Moncloa Hospital is currently undergoing a phase of redesign involving the creation of a new observation area in A&E, along with the refurbishment of in-patient rooms, where the baths are being replaced with adapted showers in order to provide users with greater comfort, while a new kitchen is also being built. One further project worthy of mention is the creation of a new teaching area planned for the ground floor of the hospital.

The range of services offered by Moncloa Hospital has, meanwhile, gradually expanded, with the following healthcare units and departments currently in place: Allergology, Pathological Anatomy, Anaesthesia and Reanimation, Angiology and Vascular Surgery, Cardiological Intervention (Haemodynamics), Cardiac Surgery, General and Digestive Tract Surgery, Maxillofacial Surgery, Paediatric Surgery, Plastic and Restorative Surgery, Thoracic Surgery, Dermatology, Cardiac Electrophysiology (Arrhythmia), Endocrinology, Pharmacy, Gynaecology and Obstetrics, Clinical Analysis Laboratory, Internal Medicine, Pneumology, Neurosurgery, Neurology, Ophthalmologist, Oncohaematology, Medical Oncology, ENT, Paediatrics, Psychiatry, Radiodiagnosis, Radiological Intervention, Rehabilitation, Rheumatology, Workplace Risk Prevention Service, Traumatology and Orthopaedic Surgery, Intensive Care Unit, Daycare Unit, Pain Clinic, A&E and Urology.

The expansion of the Outpatients Department has also allowed us to increase the choice of specialties available to our users to almost 30.

At Moncloa Hospital we are aware of the importance of access to the very best technology in order to provide patients with an optimum response. The diagnostic appa-



An ongoing commitment to quality

Since its very beginnings, the hospital has been committed to quality management. We were the first Spanish hospital to receive the European Seal of Excellence awarded by the Quality Management Club, the Spanish representative of the EFQM, at consolidation level (>401-500). We were also the only hospital in Europe, along with the Kantonsspital Obwalden in Switzerland, to be Recognised for Excellence in Europe at 4-star level by the EFQM itself.

In the year 2000 Moncloa Hospital was awarded certification of its quality system in accordance with standard UNE EN ISO 9002:1994. In 2002 we made the transition from UNE EN ISO 9002:94 to the UNE EN ISO 9001:2000, receiving certification under this new standard for all our services, both healthcare and non-healthcare. We have also since 2001 held certification of our environmental management system under standard UNE EN ISO 14001:96 for all the hospital's services, and in 2005 made the transition to certification under standard UNE EN ISO 14001:2004.

In 2006 we took a further step along the path of excellence when we received the European Seal of Excellence at Excellence level (>500 points) , issued by the Excellence in Management Club. We were at the same time the only hospital to receive be Recognised for Excellence in Europe at the 5-star level by the EFQM itself.

Moncloa Hospital was the first in the Autonomous Region of Madrid to obtain a licence to use the Madrid Excelente mark. Meanwhile, and no less importantly, we have since 1999 held the QUALI-AIR certificate for our ambient air, making us to this day the only hospital in Spain which can guarantee users healthy ambient air.

Our institution was once again the only hospital in Spain to receive the European Seal of Excellence at the Excellence level of over 500 points, once again awarded to us by the Excellence in Management Club, the Spanish EF QM representative. Meanwhile, in October we will be certifying the health and safety at work system in accordance with standard OHSAS 18001:04.

Lastly, this year we produced our first Corporate Social Responsibility Report, the expression and reflection of our desire to undertake the commitment demanded by society in terms of sustainability and social responsibility. We furthermore believe in the need for ethical consistency between our healthcare mission and our desire to cooperate and contribute, as an organisation, to the development of a sustainable society.

ratus employed by our specialists thus includes 64-slice computerised axial tomography with helicoidal systems, two magnetic resonance systems of 0.5 and 1.5 Teslas, a vascular radiology intervention room, a cardiac electrophysiology room, a haemodynamics room, digital remote control, portable radiology devices, mammographs, ultrasound scanners, etc.

We are proud of the fact that the results of our centre are extremely favourable in terms of both the satisfaction of our clients (excellent humane and medical treatment and comfort) and the volume of business and investment. Naturally, none of this would be possible without the efforts of the hospital's staff of over 600 employees.

Operational principles

- Patient focus. The patient is at the centre of all our actions.
- Quality. The best results. Excellence.
- Efficiency. Using our resources in the most appropriate manner.
- Profitability. Guaranteeing the solvency and future of the centre.
- Respect. For people, our surroundings and the environment.
- Shared commitment. We work as a team to achieve our goals. Communication and dedication of all. Professional and personal development.

BRIEF STATISTICAL REVIEW OF 2008

Number of in-patient admissions	90,531 1
Number of new hospital admissions	12,544
Average time of stay	6,3
Number of consultations	21,121
Total A&E treatments handled	99,522
Average A&E treatments/day	267
Surgical procedures:	8,215
Births	500
Conventional radiology	50,044
CAT	9,113
NMR	8,613

We are a University Hospital

One of the most significant achievements of Moncloa Hospital is the signing of two partnership agreements with Madrid-based universities with the aim of promoting the optimum usage of the human and material resources available at the hospital for both graduate and undergraduate level university tuition.

On 14 February, Francisco Ivorra, President of ASISA and Daniel Sada, Rector of the Francisco de Vitoria University, signed a co-operation agreement whereby Health Science and Bio-health Science students, along with those studying the future medical degree course, will receive practical experience at our hospital.

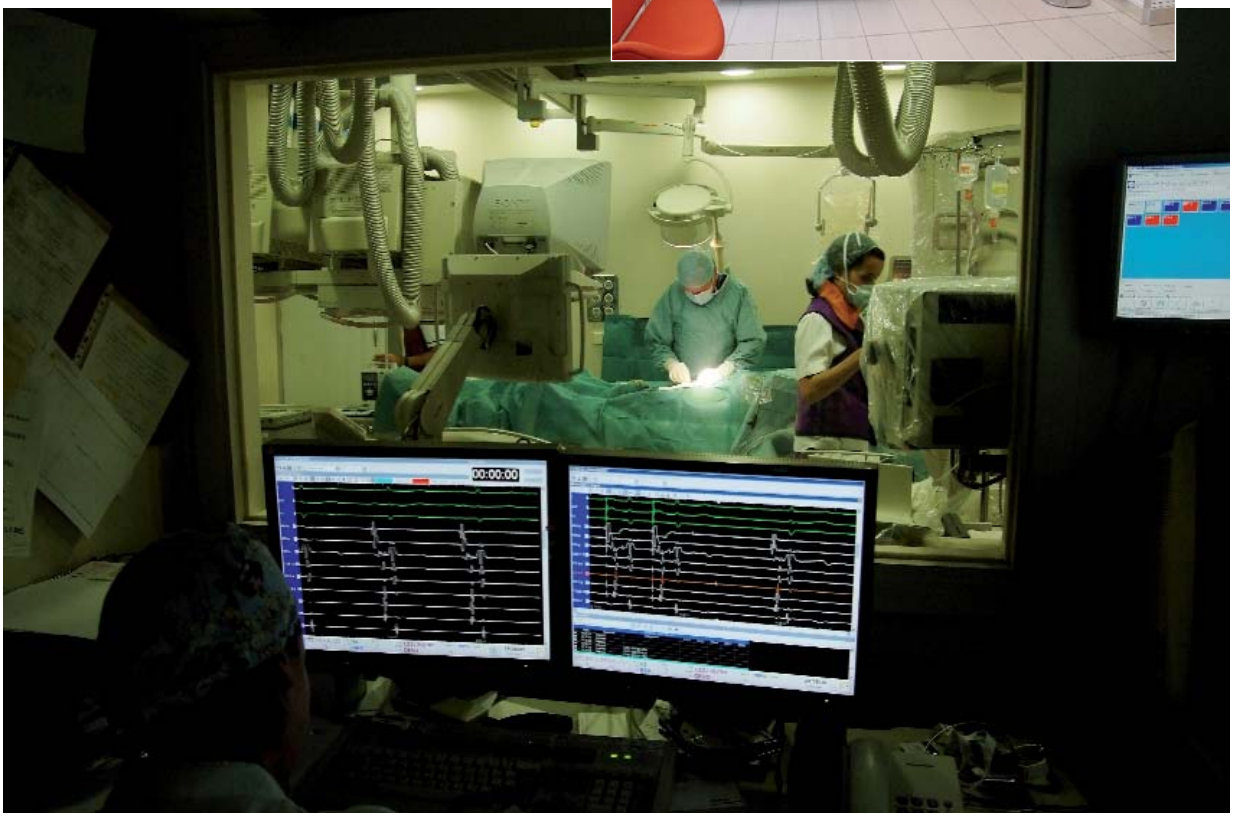
This partnership applies both to curricular tuition and work experience undertaken at Moncloa Hospital, and will facilitate access to the university for teaching staff from the hospital.

An agreement has also been signed with the European University of Madrid for co-operation on the practical training of Medicine and Health Science students at Moncloa Hospital, along with the furtherance of healthcare and research areas.

2008 healthcare initiative award

As the Managing Director of the hospital I am very proud to run a healthcare institution which has been recognised for its excellent administration. At the 7th Madrid Awards ceremony staged by Madridiario on 25 May, Moncloa Hospital receive the Healthcare Initiative award in recognition of its record in quality care and excellence in health management, also honouring our spirit of innovation, improvement and modernisation.

Such garlands serve to spur us on in the quest for excellence in care and provide further motivation in our prime task of improving the health of the population. Receiving such an award alongside such figures as the actor Manuel Alexandre, Professor Jesús Neira and actress Blanca Portillo is a source of great pride for those of us who work at Moncloa Hospital.

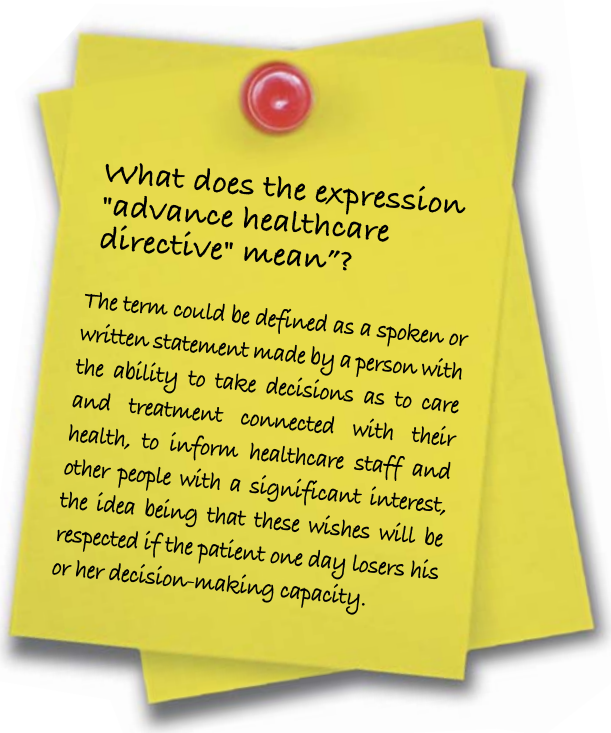


Advance healthcare directives

Dolors Borau

We all as individuals have rights we enjoy and duties we must fulfil. In the field of health, for example, we are aware of our duty to look after ourselves and to provide clear information regarding our state of health. We likewise know that everyone is entitled to receive healthcare and to receive information about their state of health and the procedure for diagnosis or treatment which the doctor considers appropriate. We now also have the right to express our will in advance, and to know that it will be respected.

What does the expression "advance healthcare directive" mean? The term could be defined as a spoken or written statement made by a person with the ability to take decisions as to care and treatment connected with their health, to inform healthcare staff and other people with a significant interest, the idea being that these wishes will be respected if the patient one day losers his or her decision-making capacity. Anyone intending to make such a statement is advised to leave a written record of their Advance Healthcare Directive, what was until recently known as a "living will".



Good professional practice assists individuals in playing an active role in the process of their illness, ensuring that their wishes be respected. In order to make this possible, each individual must receive information that is understandable and suited to their profile and current needs. But what happens if one loses the ability to decide for oneself? Life expectancy is these days much greater, meaning that we may expect to live many more years. What we cannot know is the physical and intellectual state we will be in. We also have knowledge of advances in diagnosis, treatment and medication which can cure, alleviate or treat the symptoms and after-effects of illnesses. As a result of all this, we should all reflect in depth on our future, on the inevitable fact of death, and on the decisions which we would wish to be taken in the event of a critical situation, since every individual has a different perspective on life and death in accordance with personal beliefs, culture and values. The aim of an Advance Healthcare Directive is thus on the one hand to facilitate communication between patient and physician, and on the other to provide security for the individuals involved in terms of decision-making. This is a very useful written testimony allowing people to express their own wishes in advance, and permitting professional carers and those connected with the sufferer to know how to act if a patient loses the ability to communicate.

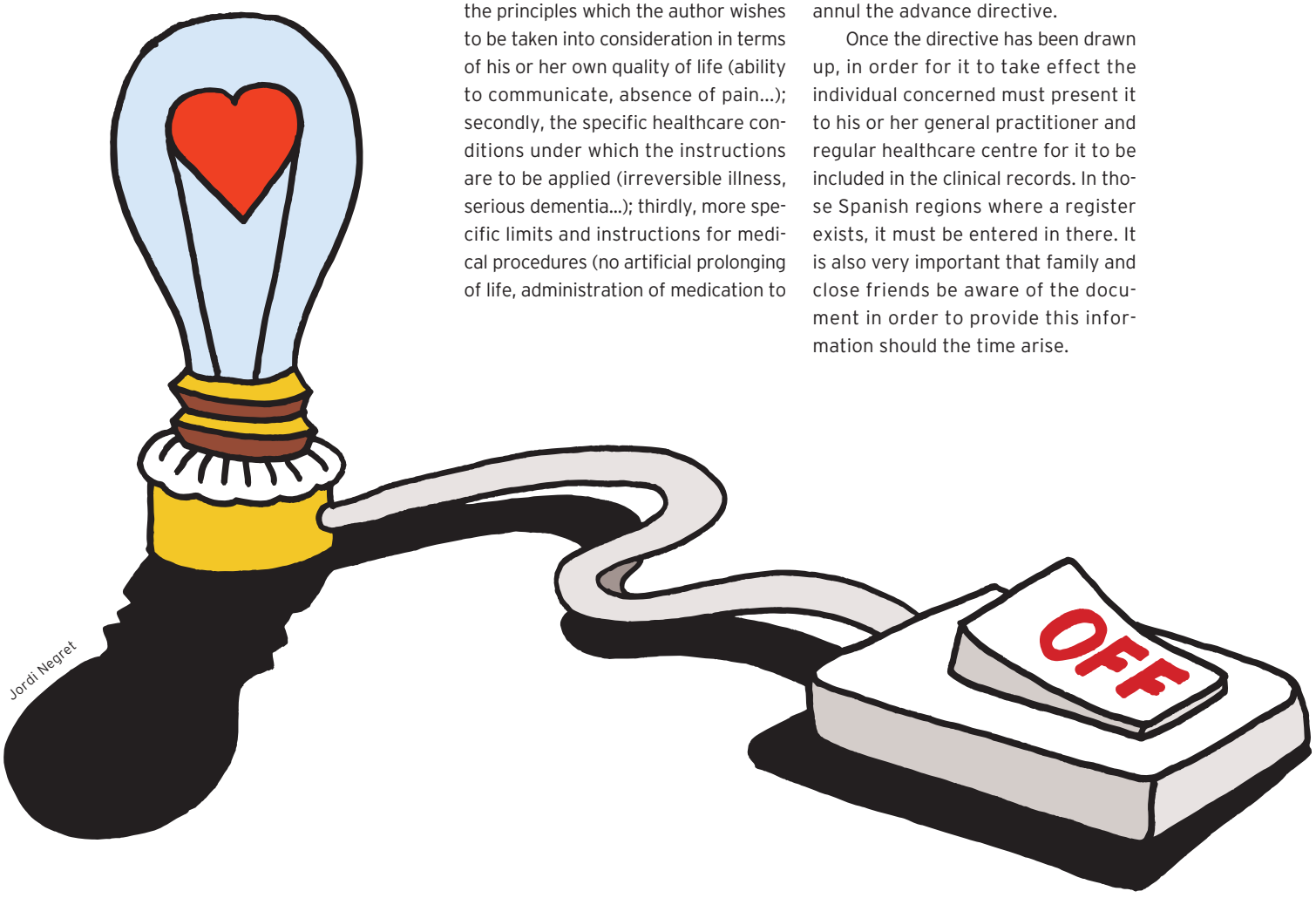
In order for an advance directive to be drawn up, under the terms of the corresponding law (in Spain, the Basic Patient Autonomy and Clinical Documentation and Information Rights and Obligations Act, Law 41/2002, of 14 November 2002, published in Official State Gazette of Spain number 274, on 15 November 2002), its author (the "principal") must be of legal age, fully capacitated and be acting of his or her own free will. Provision is also made for the appointment of a trusted representative, who may but need not be a relative of the individual, who will be familiar with the contents of the document and act as an

interlocutor with healthcare professionals. The document setting out the instructions which the author wishes to be taken into consideration should he or she at some point prove unable to state these preferences personally can be drawn up privately or by a lawyer or notary. In Spain, if a notary is involved then no witness is required. The notary must be familiar with the contents of the document and attest as to the capacity of the individual, and will also be responsible for the safekeeping of the document. If an advance directive is drawn up privately, there must be three witnesses familiar with the contents and certifying as to the identity of the author and his or her capacity to act. The witnesses must sign the document, and two of the three must be completely unrelated to the author, and have no connection with his or her assets.

AN ADVANCE HEALTHCARE DIRECTIVE IS A VERY USEFUL WRITTEN TESTIMONY ALLOWING PEOPLE TO EXPRESS THEIR OWN WISHES IN ADVANCE, AND PERMITTING PROFESSIONAL CARERS AND THOSE CONNECTED WITH THE SUFFERER TO KNOW HOW TO ACT IF A PATIENT LOSES THE ABILITY TO COMMUNICATE

The recommendation of bioethics committees is that the following sections be included: first, reference to the principles which the author wishes to be taken into consideration in terms of his or her own quality of life (ability to communicate, absence of pain...); secondly, the specific healthcare conditions under which the instructions are to be applied (irreversible illness, serious dementia...); thirdly, more specific limits and instructions for medical procedures (no artificial prolonging of life, administration of medication to alleviate pain...); fourthly, a section appointing a representative, with the corresponding personal details and signature; fifthly, the section with the details and signatures of the three witnesses, and lastly a sixth section stating that the author can revoke and annul the advance directive.

Once the directive has been drawn up, in order for it to take effect the individual concerned must present it to his or her general practitioner and regular healthcare centre for it to be included in the clinical records. In those Spanish regions where a register exists, it must be entered in there. It is also very important that family and close friends be aware of the document in order to provide this information should the time arise.

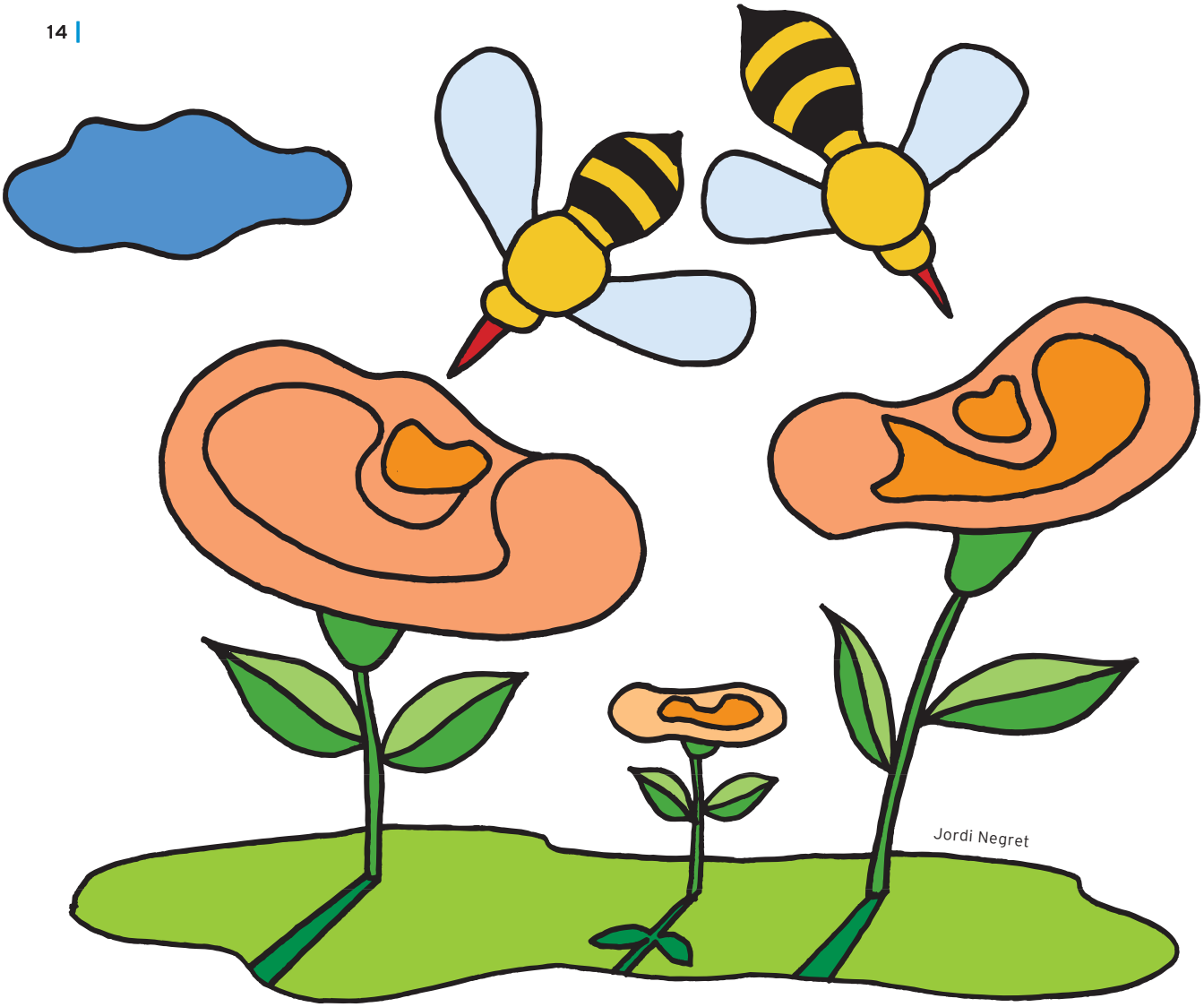


Jordi Negret

Otitis: the dreaded earache

Dolors Borau

My younger daughter couldn't wait for her swimming classes to start, and so we went to buy her a new swimsuit for the pool. Her enthusiasm was cut short after just a few weeks, though: she had developed an earache. When she was little, for the first five years of her life, practically every time she caught a cold she would end up with an ear infection which would have her crying all through the night. After a few visits, the ENT specialist stressed the importance of properly clearing out her nose to make sure it was free of mucus. He explained that the ear, nose and throat are connected by means of the Eustachian tube, which acts as a valve regulating the pressure in the middle ear. This tube is connected to the outside by means of the tympanic membrane, or eardrum, and is kept closed, but opens when we yawn, when we swallow, climb a high mountain or travel by plane. At times you will hear a slight sound when the tube opens to balance out the air pressure on either side of the membrane. When you catch a cold, the Eustachian tube becomes blocked and closes up, and the ear does not ventilate pro-



perly. In the case of a throat infection, the virus or bacteria causing it can also reach the ear and lead to considerable inflammation and an accumulation of fluids which press on the tympanum. That is what causes the pain and loss of hearing.

We spent a number of years to-ing and fro-ing between home and the ENT clinic. On occasion they had to make a slight incision in the tympanic membrane (known as a myringocentesis) to allow the infection to drain and avoid damage to the internal structures. What is more, a controlled perforation in the right place will close on its own with no after-effects, as each new perforation of the tympanum caused by an infection leaves a scar on the membrane and prevents it from vibrating properly. Nonetheless, our daughter still had to take antibiotics (completing the full course of treatment and taking each dose at the right time), along with an anti-inflammatory or painkiller. She would often catch cold, and so her bouts of ear infection, or otitis, were recurrent. These successive infections of the ear were far from ideal and could even have jeopardised her future hearing, so the doctor recommended that a minor operation be performed to fit grommets to the tympanic membrane allowing it to ventilate properly and expel secretions. This very simple procedure achieved considerable improvements. On occasion it may prove necessary to remove the adenoids, or pharyngeal tonsils, if they have become overlarge. In her case this was not required, and she needed only mild sedation for the grommets to be fitted. Cristina was less than five years old at the time, and although this type of infection generally improves spontaneously from the age of seven onwards, the doctor advised us not to wait as she was such a frequent sufferer.

Now she is nine years old her earaches, the fever and general discomfort, even vomiting and diarrhoea at times, are all in the past. Until the grommets fell out of their own accord we had to make sure that the ear was kept free of any liquid which could make its way inside and lead to a new infection. We had forgotten about all those hardships, and so were taken by surprise when, a few days after she started swimming, she was once again in such pain. Cristina was in a desperate state, and we made an appointment to see the specialist.

She knew exactly what to expect at the surgery: the doctor would look inside her ear with an otoscope (that device with a funnel-shaped tip) and would then examine her nose and throat. But this time the pain was much more acute, and she could not bear anyone to touch her ear. This was not otitis media as she had had when she was little, but an otitis externa affecting the outer ear canal, a particularly painful condition. The infection develops because the moisture and water cause alterations to the skin and affect its balance. Hence the fact that it is known as swimmer's ear. The mouth of the canal had been closed up by the inflammation and blocked by a viscous secretion. The doctor prescribed her painkillers for the discomfort and antibiotics for the infection. She would not be able to go back to the pool for a few weeks, and when she took up swimming again she would have to use earplugs which we bought at the chemists.

The advice to avoid such infections is to dry the outer ear well with a towel even after showering, and above all never to scrape around in the ear with cotton buds, fingers or any other object. Wax is our natural defence system, serving to protect and lubricate the skin and avoid infections. If you feel that the wax is blocking your ear you should go to see the ENT doctor, who will clean out the ear canal professionally, avoiding any kind of complication.

THE EAR, NOSE AND THROAT ARE CONNECTED BY MEANS OF THE EUSTACHIAN TUBE, WHICH ACTS AS A VALVE REGULATING THE PRESSURE IN THE MIDDLE EAR. WHEN YOU CATCH A COLD, THE TUBE BECOMES BLOCKED, THE EAR DOES NOT VENTILATE PROPERLY AND, IN THE CASE OF A THROAT INFECTION, THE VIRUS OR BACTERIA CAUSING IT CAN ALSO SPREAD TO THE EAR

What to do?

The advice to avoid such infections is to dry the outer ear well with a towel even after showering, and above all never to scrape around in the ear with cotton buds, fingers or any other object. Wax is our natural defence system, serving to protect and lubricate the skin and avoid infections. If the ear becomes blocked with wax, you should visit the ENT specialist to have your ear canal cleaned out.

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Bioethics and nutrition

Dr Perla Luzondo

Edmon Amill

The World Bioethics Congress held in Gijón in 2002 recognised of the importance of bioet-hics in every aspect of sustainable development, and in particular those aspects involving nutrition and agriculture, called on governments and civil society to guarantee justice, equality and the universal right to nutrition.

The conclusions of the congress included:

- Maintain the right of all to access to reliable, nutritious food, as an intrinsic aspect of the right to life.
- Guarantee the utmost access to clean water and effective healthy living conditions.
- Recognise the right of smallholders worldwide to use indigenous plants for the conservation and sustainable development of biological diversity in agriculture.

In light of the globalisation of agrarian operations which first-world companies are attempting to impose, organisations such as the KOKOPELLI foundation in France have created their own network to harvest organic seeds, producing more than 900 traditional varieties. Along with other organisations, such as the World Resources Institute, it fights for food safety and sovereignty in countries of the developing world, creating indigenous seed banks in countries such as India, Sri Lanka, Nigeria, Senegal, Burkina Faso, Mexico and Guatemala.

Oxfam's Fair Trade stores make direct purchases of goods produced in developing countries by Fair Trade cooperatives.

Molecular genetic engineering development programmes have created transgenic plants with different colour, taste, size and resistance to certain insects and herbicides, as in the case of potatoes, maize, cotton, oilseed rape, pumpkins and tomatoes.

Various studies suggest that by 2015, 25% of crops grown in Europe will be of transgenic origin. In order to guarantee public health and consumer rights, the EU places controls on every step taken by foodstuffs until they reach the table, ensuring that the label specifies if the food contains genetically modified produce.

Spain has its own Biodiversity Foundation, and all of the country's autonomous regions have plans to restore and develop their indigenous varieties through the creation of a living, traditionally based Germplasm Bank. Its catalogue is a lengthy one, with just the entries for the Madrid region being given below:

- Chinchón fine white garlic
- Aranjuez "Cuatro Cascos" peppers
- Aranjuez strawberries
- "Mochuelo" melon
- "Puchero" melon
- Villaconejos "Largo Negro Escrito" melon
- Felipe melon
- Villavieja beans
- Round dwarf tomatoes

FEDERAPES was set up in 2006 by official associations of breeders of domestic animals in danger of disappearing from Spain.

The SLOW FOOD project in Bizkaia (a province of the Basque country) is encouraging individuals and restaurants to consume vegetable and animal produce raised within a radius of less than 100 km.

I would urge readers to focus their attention and taste buds on the local produce of each region, appreciating biodiversity, a taste for the authentic and seasonal produce.

ASISA to provide healthcare services for municipal civil servants in Huelva

Elvira Palencia

Pedro Rodríguez, Mayor of Huelva, and Dr Pedro Azcarate, ASISA's provincial representative in Huelva

ASISA has been awarded a public tender contract by Huelva City Council to provide healthcare, medical and to surgical services the council's civil service staff.

The agreement was signed on 30 June at Huelva Town Hall by the Mayor, Pedro Rodríguez González, representing the City Council, and ASISA's provincial representative for Huelva, Dr Pedro Azcarate Prieto.

The resulting improvements to the quality of healthcare, medical and surgical services will benefit all employees who joined the local civil service prior to 2 April 1993, along with those employees' entitled beneficiaries.

In the same way ASISA is offering policyholders' immediate relatives not covered by the Royal Decree of 2 April 1993, and civil service employees recruited after this date, the option of signing a medical healthcare policy on special terms, along with inclusion of all the benefits referred to under the City Council policy (refractive surgery, Visionlab and Club ASISA).

ASISA's Óscar Esplá Group perform in Palma

E.P.

On 29 April ASISA presented a concert staged at the Palma Auditorium by the Óscar Esplá Trio, an event attended by numerous dignitaries from the Balearic capital's political and social spheres.

ASISA itself was represented by the company's president, Dr Francisco Ivorra; the ASISA provincial delegate in the Balearic Islands, Dr Miguel Montserrat; the Director of the ASISA network, Valeriano Torres; the ASISA manager for the Balearics, Andrés Artigues, and the ASISA Director of Marketing and Communication, Ramón Casanova.

The ASISA Óscar Esplá Group, made up of young musicians from the Queen Sofia Advanced Music School, performed works by Mozart, Haydn, Rachmaninov and Shostakovich.

Nazaret Canosa (violin), Lucía Otero (cello) and Juan Andrés Barahona (piano)

ASISA to provide healthcare services to the Galician Golf Federation

E.P.

ASISA and the Galician Golf Federation have signed an agreement under the terms of which all association golfers taking out a policy with ASISA will have access to quality healthcare and a wide range of services on highly beneficial terms. The agreement was signed or 3 June in La Coruña by the President of the Galician Golf Federation, Daniel Fernández Fernández, and ASISA's manager for Galicia, Jesús Castillo Uceda.

Daniel Fernández and Jesús Castillo

ASISA and Ribera Salud to open a cutting-edge hospital in Torrejón de Ardoz

| E.P.

The Autonomous Region of Madrid has provisionally awarded the concession contract for Torrejón Hospital to the Torrejón Salud consortium, made up of ASISA, Ribera Salud, FCC and Concessia, which will handle the construction and administration of the hospital over the next 30 years.

The building will be erected on a site of 62,000 square metres in Soto de Henares and serve a total population of 130,144 people in the towns of Aljalvir, Daganzo de Arriba, Fresno de Torote, Ribatejada and Torrejón de Ardoz.

With an investment of over 130 million euros, the hospital complex will be a three-storey construction with a further two buildings, complete facilities with 250 beds and individual rooms, and will be equipped with the very latest medical technology for diagnosis and treatment.

Its comprehensive range of services will allow it to handle 95% of the local population's specialist healthcare needs.

The concession also includes the remodelling of the Specialty Centre in Torrejón, which will become a flagship centre working with the Primary Care Centres, to offer greater access to the local community.

The project follows on from the hospitals in Torrevieja and Elche, where ASISA is already involved in the same way, and will be equipped with cutting-edge technology, as well as being an IT-enabled centre.

ASISA funds the first medical centre for the Castile-La Mancha Football Federation in Alcázar de San Juan

| E.P.

The FFCM (Castile-La Mancha Foot-ball Federation) and ASISA have opened a medical centre in Alcázar de San Juan, Ciudad Real province, to perform medical examinations and as a base for injury rehabilitation services.

The new clinic, the local football federation's first rehabilitation and medical examination centre, will provide primary healthcare services and offer quality medical support for footballers, allowing them to play in greater safety.

The heads of both institutions stress that this initiative marks a major step forward for football in the region by providing sportsmen with facilities guaranteeing them high-quality medical care.

(Left to right): Jorge Ribé, head of the Ribé Salat Insurance Brokerage; the FFCM's head of medical services, Vicente Ferrer; The President of the Castile-La Mancha Football Federation, Antonio Escribano Ramos; The Director-General for Sport at the Castile-La Mancha Regional Government, Roberto Parra; the Mayor of Alcázar de San Juan, José Fernando Sánchez, and the Director of ASISA in Ciudad Real, Alfonso Porcel.

"The error of our time is that
men aim not to be useful, but important"

Winston Churchill (1874-1965)

In the city of Barcelona there are almost 2000 homeless people.
650 of them literally live on the streets, while the remainder
spend the night in shelters or camps. (*)

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* Figures drawn from the night-time count of homeless people conducted in the city of Barcelona on 12 March 2008

As a result of Barcelona Hospital's Oncology Plan over 3800 tumours have been analysed since 2004

Editorial

Barcelona Hospital has published the results of its Oncology Plan, including the only registers of tumours compiled by a private institution anywhere in the country. Since 2004 it has been working on the diagnosis, treatment and termination of the illness through a programme based on the coordination of all the professional staff involved and the five key aspects of the Cancer Department: operational protocols, standardisation of treatment, systematisation of surgery, the approach to the final stages of life and the tumour register itself. Analysis serves to bring about substantial improvements in results, patient care and their quality of life.

In 2004 Assistència Sanitària and Barcelona Hospital implemented protocols for the cancer department and the Oncology Plan, establishing a powerful private healthcare tool for the purpose of cancer treatment. The protocols were drawn up with three aims in mind: to provide patients with the most up-to-date resources; in terms of both diagnosis and treatment, in accordance with the wishes of both sufferer and relatives; to provide professionals with guidelines for their actions; and to provide in-house data on the results of the treatment and evolution of the illness. The approach to cancer is, then, a holistic one, from diagnosis and treatment up until the conclusion of the illness, taking into consideration the appropriate use of diagnostic resources.

Coordination is the bedrock of the Oncology Plan and is achieved by means of the Oncology Liaison Committee, which meets twice a week and is open to all doctors on the Assistència Sanitària medical lists. At its meetings, the committee performs an individual analysis of all new cancer cases, as well as the most complex ones which, in the judgement of the specialist, require a multi-disciplinary approach.

The Oncology Plan is based on five core procedures. First, operational protocols have been drawn up in line with scientific advances, which help in clinical decision-making and increase uniformity. Secondly, radiotherapy and chemotherapy treatment has been standardised, through measures such as publication of the Oncological Pharmacotherapy Guide and the opening of the Oncology Daycare Clinic at Barcelona Hospital. Thirdly, the medical procedures record has its own established protocol in the form of surgical datasheets to help standardise surgery on the most common tumours (breast, colon, prostate, lung, ovary, urinary tract and kidney). Fourthly, one key aspect of the programme involves the inclusion of treatment in the final stages of life: the palliative medical team now provides support for patients at the hospital and at home 24 hours a day, 7 days a week, guaranteeing absolute respect for the wishes and privacy of the patient's personal and family environment. All this has a direct impact on substantially improving quality of life.

Lastly, particular mention should be made of the establishment of a register of tumours, which includes all new cases of cancer diagnosed, and which are analysed in terms of a number of parameters. The results of the actions taken by Barcelona hospital provide the basis for devising future policies, since the analysis of statistics from other countries does not necessarily coincide with the figures at home. Each year approximately 800 new tumours are recorded, with more than 3800 having been analysed overall since 2004. Examination of the data drawn from the register of tumours provides information on the cancer department and can be used to produce valuable statistics.

Barcelona Hospital, which opened in 1989, is owned and managed by the SCIAS user cooperative. It belongs to the Assistència Sanitària group, an exponent of health cooperativism run in accordance with the distinctive self-management model conceived by Dr Josep Espriu some fifty years ago. This is based on the equality of doctors and users on the organisation's decision-making and management bodies. Assistència Sanitària now has some 200,000 policyholders and a list of almost 5400 doctors.

THE RESULTS OF BARCELONA HOSPITAL'S ACTIONS PROVIDE THE BASIS FOR DEVISING FUTURE POLICIES, SINCE THE ANALYSIS OF STATISTICS FROM OTHER COUNTRIES DOES NOT NECESSARILY COINCIDE WITH THE FIGURES AT HOME

Assistència Sanitària, proof of the success of health co-operativism

Oriol Conesa - Marta Liñán

Assistència Sanitària
LA MILLOR ASSISTÈNCIA DE LA TEVA VIDA

Assistència Sanitària marked Inter-national Co-operatives Day by confirming its leading position in terms of volume of premiums, demonstrating the validity of the co-operative healthcare model based on self-management and equality of doctors and users on decision-making and administrative bodies. The economic crisis is providing the spur for the creation of co-operative enterprises, in some cases serving as an essential tool for economic and social development.

Since it was founded in 1957, Assistència Sanitària has been at the forefront of the private health sector in Catalonia: it now has a list of 5400 doctors, has 200,201 policyholders and is the market leader in size of premiums (166.4 million euros). The organisation, which has become one of Catalonia's flagship enterprises, was created out of a desire to improve civil society, and is one of the country's leading exponents of the co-operative movement. First conceived of by Dr Josep Espriu, the Assistència group is based on a balance between the doctors' co-operative (Autogestió Sanitària) and the users' body (SCIAS), allowing for dialogue on equal terms, unfettered by any profit motive or shareholder returns (all the profits are reinvested in improved facilities or staff).

Despite the downturn in the incorporation of capital-based companies over recent months, co-operatives have shown themselves able to adapt to the complex economic situation, with co-operative enterprises being set up at a faster rate in 2009 than in 2008 (some one hundred such organisations are founded each year in Catalonia). Health co-operatives now serve 100 million households worldwide. With the aim of publicising the role of healthcare co-operatives and promoting their creation, Assistència Sanitària plays an active role in the Espriu Foundation, which in turn is the Chair of the IHCO (International Health Cooperatives Organisation).

Since its launch by the UN in 1995, the first Saturday in July has been International Co-operatives Day, providing recognition for co-operatives as an essential factor in economic and social development, with solidarity as their key working tool.

Assistència Sanitària to provide cover for EADA students

Oriol Conesa

Assistència Sanitària has signed a framework agreement with the EADA business School to provide health cover for members of its alumni association and sponsor its programme of networking events. The agreement will benefit more than 2000 people and forms part of the new line of products intended for companies and groups. As a result of the partnership agreement, EADA Alumni members and their families will be offered improved conditions when signing up with Assistència Sanitària. In specific terms, the Collective Plan is a full-service policy with a cross-subsidised premium making no distinction based on gender or age, including extensive health cover and an unrestricted choice from a list of more than 5000 doctors. Assistència Sanitària has also become the main sponsor of the Networking Experience Tour 2009, the raft of outdoor activities organised by EADA Alumni to act as a meeting point and develop networking among its community of former students. According to Iñaki Rodríguez, Commercial Director for Companies at Assistència Sanitària, "the agreement will benefit more than 2000 EADA Alumni members, along with their families, giving them access on preferential terms to the private health cover and medical services offered by Assistència Sanitària nationwide". The Collective Plan gives Assistència Sanitària a presence in the companies and organisations market with a line of medical insurance policies designed for groups, underpinning its range of services and consolidating its leading position in Catalonia. Its success confirms the ongoing relevance of the cooperative health care model championed by the organisation, and underpins the cycle of expansion which began with the entry into collective social provident business. Assistència Sanitària is an exponent of healthcare cooperativism, the distinct self-management model devised by Dr Josep Espriu some fifty years ago, based on equality of doctors and users in decision-making and management. The organisation now has some 200,000 policyholders and a list of close on 5400 doctors. It is also the official medical care provider of FC Barcelona.

The Espriu Foundation contributes to the new Public Health Bill

J. A. P.

The Spanish Ministry of Health and Consumption is drafting a Public Health Bill and has invited a group of organizations involved in the field of health (organised through the Spanish Association of Foundations) to take part in drawing up proposals for this future legislation, a process in which the Espriu Foundation is actively involved.

The idea is that the future Act should allow the central state authorities to develop their powers in this area, and so harmonise, co-ordinate and consolidate the National Health System. A meeting of the organizations involved in the process was held on 10 March at which representatives from those foundations taking part in the process, with Dr Jose Carlos Guisado representing the Espriu Foundation. At this initial meeting a working group was set up, coordinated by Honorio Bando of FUNDADEPS, the Education for Health Foundation, and the general aspects of interest to be considered in relation to the Ministry's approach were defined.

These ideas served as the basis for a meeting held on 23 April at the Ministry of Health and Consumption, at which Dr José C. Guisado, along with Honorio Bando and the Chairman of the AEF, Carlos Álvarez, held talks with the Director-General for Public Health, Ildefonso Hernández. On this occasion there was a discussion of the main aspects to be tackled by the Bill, including health promotion and the promotion of research in the health sciences; the problems currently created by the distribution of competencies (coordination, diagnoses, registers, flagship hospitals, funding for treatments, health alerts, etc.); the involvement of Social Economy institutions, in particular co-operatives, in the field of Public Health, and education for health and prevention.

The Espriu model at Bologna University

Josep A. Pérez

The need to deal with new challenges, such as the opening up of innovative markets as a result of the new needs of the population or the growing decentralisation and privatisation of public services, forces social enterprises to make qualitative advances in services. They must adapt to modern tools and skills, more complex systems of government, more highly qualified administration and financing instruments and use these for their own needs. All without losing sight of their main objective: the common interest and promotion of the involvement of the parties concerned and the community in general.

In accordance with these needs, the Economics Faculty at Bologna University organised the first edition of its European Summer School on Social Economy (ESSE) on the theme "The Future of Social Enterprise: Models and Experiences". The summer school was held between 6 and 11 July at the Bertinoro campus in Italy, with the aim of discussing issues such as organisation, administration, accountability and governance at social enterprises within the European context, along with the relationship between the market and the institutions or instruments financing such social enterprises.

The Espriu model of co-operative administration of healthcare institutions was one of the case studies discussed during the course. The way in which the organisations that form The Fundació Espriu work together provides an great example of a multi-stakeholder enterprise which includes different interest groups, each with different aspirations and expectations in terms of what they are looking for from the organization.

Dr José Carlos Guisado, Vice-Chairman of the Espriu Foundation, and Dr Gerard Martí, an Espriu Foundation trustee and deputy Medical Director of Barcelona Hospital, gave a presentation explaining the co-operative model of SCIAS as a paradigm of a social enterprise. A model based on Dr Josep Espriu's distinctive vision of co-operative health care, with physicians and patients at its heart. The trustees of the Espriu Foundation also explained to the course delegates the role played by the institution, which serves as an umbrella organisation for the healthcare co-operative movement in Spain, as represented by ASISA and Grup Assistència, with a particular focus on the promotion of its activities internationally and its responsibility in chairing the IHCO (International Health Co-operative Organisation).

The address formed part of the programme in support of training in the Social Economy which the Espriu Foundation is developing in partnership with the University of Barcelona's CIES (Centre for Social Economy Research).

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The response of European co-operatives to the economic recession

J. A. P.

The current economic crisis has forced governments to consider new economic and social measures, while the European Commission and social agents, including co-operatives, agree to the need for urgent and coordinated action within the EU to supplement and support actions in individual member states.

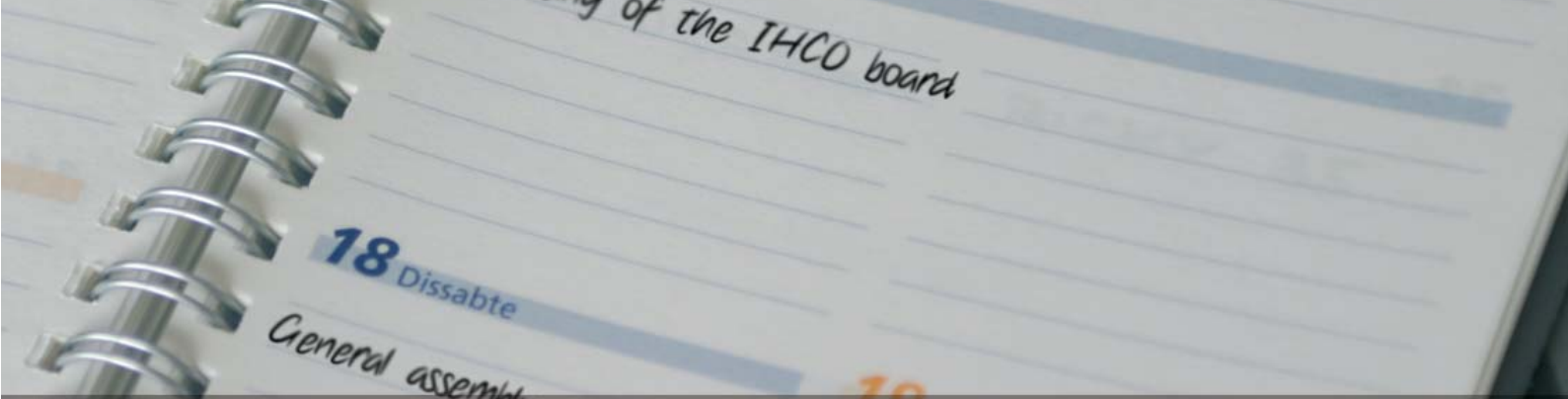
In light of this challenge, representatives of the European co-operative movement met in Sofia, Bulgaria, on 22 and 23 June, with a specific objective: to highlight the strengths of co-operative enterprises which, even in a period of crisis, offer a democratic system and an innovative dimension. The truth is that co-operatives are the engine behind a movement for sustainable and just development. Their merits were officially recognised by the President of the European Commission, José Manuel Durao Barroso, in a letter sent to the co-president of Co-operatives Europe.

The Sofia conference, which was given the theme of "the response of European co-operatives to the economic recession", served to highlight the unity and cooperation among trade unions, social enterprises and cooperatives. It also showcased best practice in maintaining employment and avoiding an increase in social inequality, promoting dialogue and cooperation among social interlocutors.

The President of the IHCO and Vice-President of the Espriu Foundation, José Carlos Guisado, made the most of his involvement at the event by meeting up with Alain Coheur, President of Social Economy Europe and with Bruno Roelants, Secretary-General of the International Organisation of Industrial, Artisanal and Service Producers' Co-operatives (CICOPA).

The conference ended with the presentation of a manifesto addressed to the institutions of the European Union setting out the main themes discussed during the event.

Pauline Green, Co-President of Cooperatives Europe, at the opening of the conference in Sofia



PROGRAMME OF ACTIVITIES

1-2 OCTOBER 2009

2nd INTERNATIONAL RESEARCH CONFERENCE ON THE SOCIAL ECONOMY

The 2nd International Research Conference on the Social Economy will be held in **Östersund**, **Sweden**, on 1 and 2 October 2009, on the general theme of "The Social Economy in a world facing a global crisis". The event is organised by the Swedish Social Economy Institute (CIRIEC-Scandinavia), the Mid-Sweden University, CIRIEC International and the Platform for the Social Economy of the Mid-Sweden region.

26-30 OCTOBER 2009

7th GLOBAL CONFERENCE ON HEALTH PROMOTION

"Health and development: closing the implementation gap" will be the title of the forthcoming Global Conference on Health Promotion to be held in **Nairobi**, **Kenya**, from 26 to 30 October 2009.

The Alliance of NGOs for the promotion of health will be presenting a technical study there entitled "Local knowledge: a community value for health promotion".

10-12 NOVEMBER 2009

36th WORLD HOSPITAL CONGRESS

The Espriu Foundation will be involved in a round-table debate on co-operative management as part of the 36th World Hospital Congress to be held in **Rio de Janeiro**, organised by the International Hospital Federation. The event will bring together some 2000 delegates representing over 100 countries and including hospital administrators and health organisations, doctors, sectoral leaders and healthcare professionals.

18 NOVEMBER 2009

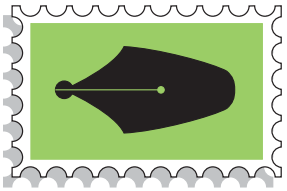
IHCO ASSEMBLY

The International Health Co-operatives Organisation will be holding its 2009 General Assembly at the **Geneva** International Conventions Centre in **Switzerland**, under the chairmanship of Dr José Carlos Guisado.

19-20 NOVEMBER 2009

GENERAL ASSEMBLY OF THE ICA

The 2009 General Assembly of the International Co-operative Alliance will be held in **Geneva**, **Switzerland**, at the International Conventions Centre, on the theme "Global crisis, cooperative opportunity". On this occasion the assembly will be dedicated to the memory of the former president of the ICA, Ivano Barberini, who passed away recently.



MAILBOX

The loneliness of the sufferer

Despite progress and changes in human society, medicine is a romantic profession. No one can replace the human relationship between doctor and patient.

What walks into the surgery is not a diseased stomach, an inflamed blood vessel, an off-beat heart, a high blood pressure reading, a rheumatic focus in a joint: it is a person, with a person's problems, doubts, fears and hopes. And we see in those eyes a desireto discover the acute phase of a diagnosis, a prognosis for good or for ill.

We must treat the anxiety involved in any illness, not merely through simple application of a treatment. We must inspire hope in our patients, feel with them, suffer with them, die with them. Patients should see us doctors as people who will give of ourselves, cure them, relieve them. It is this union between patient and doctor which lies at the crux of healthcare, which can achieve miracles. Ties of communication from one person to another, a doctor who says with a glance, with a hand: "in your suffering, in your fear, in your loneliness, I am by your side".

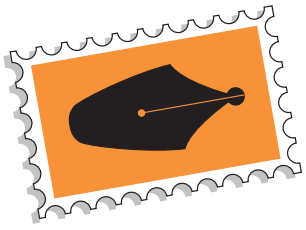
The human examination of a patient uncovers such complete and intriguing details which could never be provided by our modern electronic apparatus or test tubes. "The cordial, friendly, confidential human relationships which used to exist between doctor and patient cannot be replaced, as they also represent a factor in treatment," says Dr Nourse of the Hague.

Despite the increasing importance of teamwork, with only a very slight increase in of individual responsibilities, Hippocratic medicine dominates the profession. "There are no illnesses, but ill people". What is at stake are not the muscles, nerves, bones, bacilli and viruses, but the great miracle of dreams, of feelings, of hope and of fears. For a doctor, a patient is a clinical record, but also a person suffering.

Saint Paul, in his Second Epistle to the Corinthians, says: "You are in our hearts to die and live with you". And so doctors suffer and die a little with each person who falls ill and suffers, and feel joy as each patient they have treated regains their health.

Among all the issues of care, the loneliness of sufferers dominates the field of medicine. Those whose faith is placed in doctors who reach out their hands, look them in the eye, are not too busy to listen and dedicate all their science to assisting a human being in pain.

Dr Francisco Ruiz de la Cueta,
Seville
ASISA doctor
Member of the Spanish
Association of Author Doctors



It is with great pleasure that I write to wish you the best of health and to thank you for the wonderful material in | compartir |. I enjoy the way in which you deal with health issues, and find the articles very useful in my work with the elderly. Please do keep it up. Your magazine encourages us to live a healthier life, learning a little more about the amazing universe which is the human body.

Carmen R. García Fumero
Placetas, Villa Clara, Cuba

I am a dedicated reader of your magazine, to which my husband has been subscribing for some years. I am a graduate of Stomatological Care and have worked at my local Stomatology Clinic for 27 years. I read your article about torticollis, and was particularly interested in the treatment involving painkillers, anti-inflammatories and muscle relaxants, as I also suffer from this complaint. I have had X-rays taken and have been diagnosed with cervical arthrosis. My elder son was also born with the condition, and received treatment from the age of four months.

Mabel Morales Cepero
San Antonio de los Baños,
Havana, Cuba

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Bioethics: reflecting on healthcare services

Ethical reflection to actions in healthcare was introduced into hospitals many years ago. It is only in recent decades, however, that specific bodies have been set up within healthcare structures, through the creation of the Bioethics Committees found today at major hospitals. Thanks to them, professionals can learn of the legal consequences of their actions, and reach a joint consensus as to possible options. They also, though, provide patients with guidance in the choice of one treatment or another. Bioethics now forms part of current medical practice.

WHAT IS THE ROLE PLAYED BY BIOETHICS IN THE EVERYDAY PRACTICE OF HEALTHCARE PROFESSIONALS? RATHER THAN BIOETHICS (AN EXTREMELY BROAD TERM), I WILL REFER TO CLINICAL ETHICS, THAT PART OF BIOETHICS CONNECTED WITH CLINICAL PRACTICE, AND HENCE THE ASPECTS MOST INVOLVED IN THE WORK OF HEALTHCARE PROFESSIONALS.

Healthcare Professionals' Perspective on Bioethics

Dr Benjamín Herreros Ruíz-Valdepeñas
Member of the ASISA Bioethics and Healthcare Law Committee and the
Healthcare Ethics Committee at the Alcorcón Foundation University Hospital

Clinical practice and clinical ethics

The aim of healthcare professionals is to heal, to alleviate, to cure or prevent illness[1]. They do so by means of clinical practice, in other words the practical application of medical science. Clinical practice gathers data through clinical records and supplementary tests, before issuing a clinical judgement and establishing a plan of treatment. Most decisions taken by physicians are connected with clinical practice, the implementation of the scientific techniques of medicine. One example of a clinical decision would be a case of a digestive haemorrhage caused by a gastric ulcer. The doctor in A&E must consider what would be the best treatment to control the haemorrhage. After consulting the relevant bibliography and discussing the case with a specialist, bearing in mind the resources available at the hospital, he decides that the best approach would be an endoscopy. The patient agrees and the procedure is performed. The basis of clinical practice is science and technology, although other aspects must be taken into consideration, such as the resources available or the circumstances under which the decision is taken.

However, healthcare professionals must also deal with other types of decision which are not purely technical, but are ethical decisions (clinical ethics). Such decisions go beyond the boundaries of clinical practice, and cannot be dealt with on the basis of scientific knowledge alone. Many of the decisions involved in clinical ethics (and the problems of clinical ethics) arise in a clinical setting, adding further complexity to the already complicated business of clinical decision-making. Problems of clinical ethics have increased exponentially since the liberal revolution was extended to medicine, with the *de facto* recognition (not only in law) that patients have the right to decide as to their health[2,3]. It is often now commonplace to find conflicts between the values of healthcare professionals and the values of patients or their families. This is an inevitable consequence of living in a plural and tolerant society with a plurality of values. Returning to the above example, it may be that the patient does not agree with the doctor's decision. The physician is then faced with a conflict of values, an ethical problem which

[1] "The goals of medicine. Setting new priorities". Hastings Cent Rep. 1996 Noviembre-Diciembre; 26 (6): S1-27.
[2] SIMÓN P, JÚDEZ J.: "Consentimiento informado". Medicina Clínica 2001; 117 (3): 99-106.
[3] SIMÓN P, BARRIO IM.: "Un marco histórico para una nueva disciplina: la bioética". Medicina Clínica (Barc) 1995; 105: 583-597

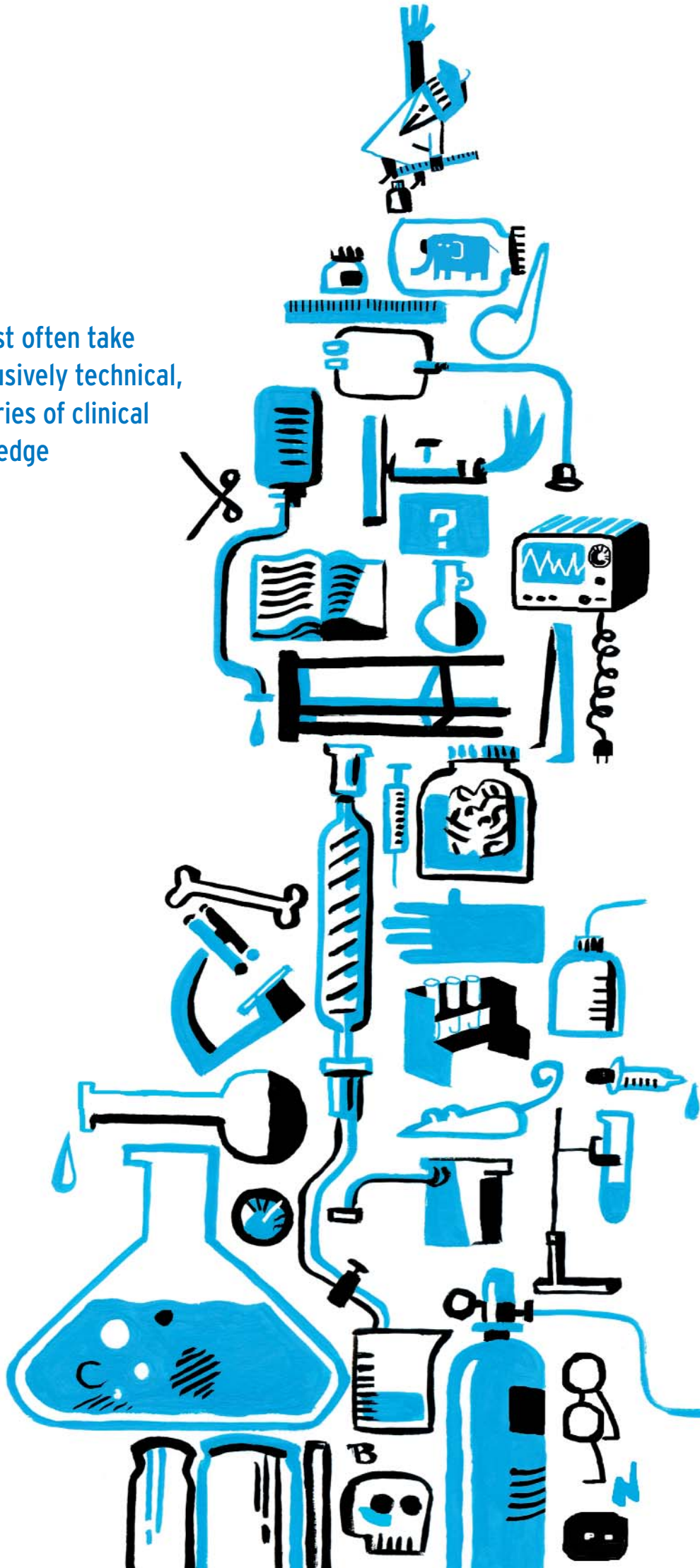
Healthcare professionals must often take decisions which are not exclusively technical, which go beyond the boundaries of clinical practice and scientific knowledge

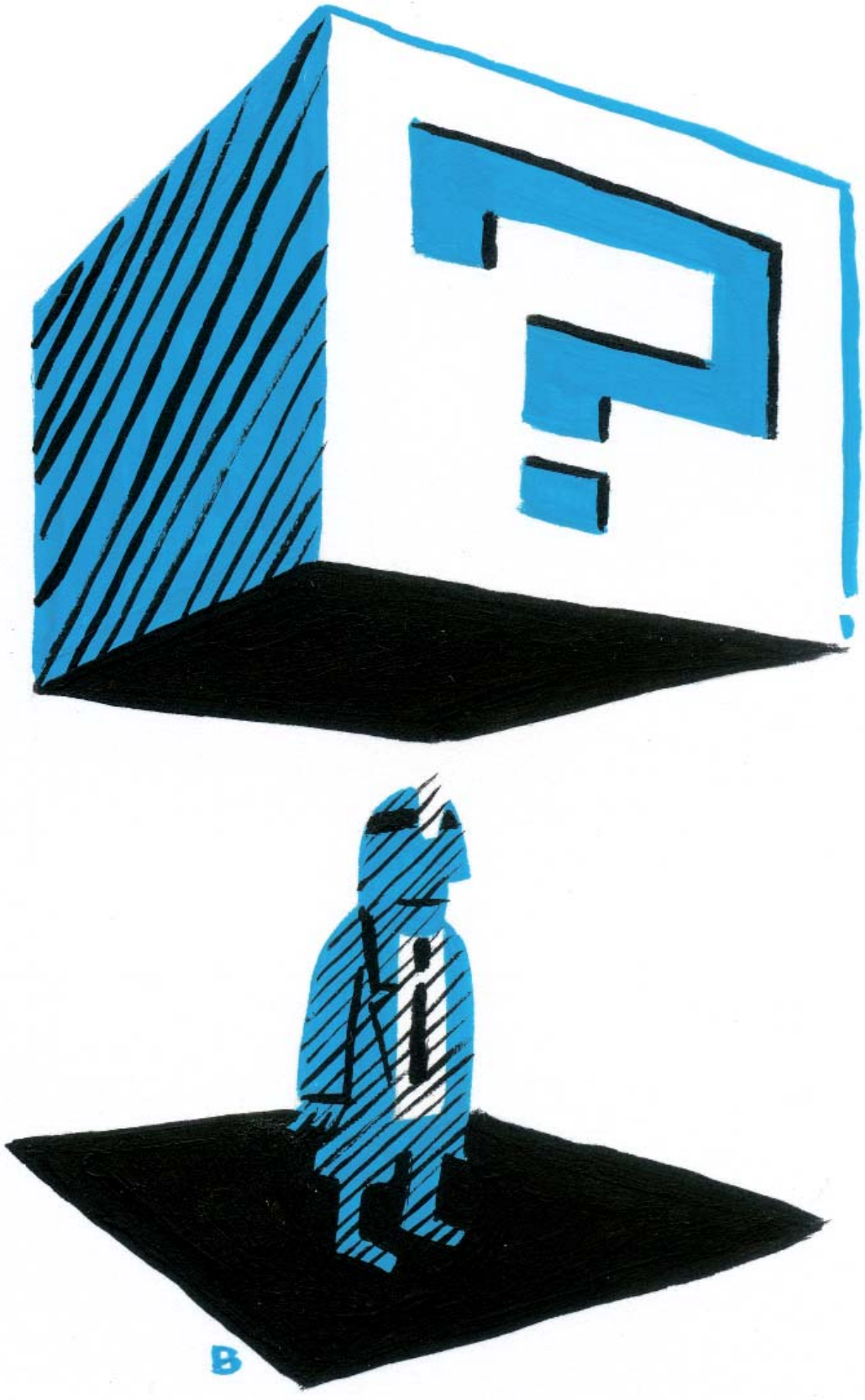
must be resolved. It pits clinical excellence (the best possible treatment) against the right of the patient to decide as to his or her health. The clinical problem is added to by a conflict between values which must also be resolved in order to provide the patient with the best possible treatment. As indicated by Diego Gracia, certainty cannot be achieved in clinical practice or in ethics, but issues can be narrowed down. And so we must act prudently.[4] All the more so if the two fields overlap, as in clinical ethics.

Importance of clinical ethics for healthcare professionals

The problems associated with clinical ethics are important to healthcare professionals not only due to their difficulty or because the involve decision that have potentially serious consequences. These are important decisions because they regularly take place in the daily work of physicians. This high level of frequency is connected with the idiosyncrasy of today's clinical medicine, with decisions no longer being linear in nature, and with value conflicts so commonplace. In an article published on the most significant ethical conflicts within hospitals in Spain, pride of place goes to ethical aspects such as problems of information or confidentiality, decisions to be taken with incapacitated patients, informed consent, social healthcare problems, problems where patients disagree as to hospital admissions or discharge decisions, conflicts with relatives or differences of opinion with patients as to their tre-

[4]GRACIA D.: "La deliberación moral: el método de la ética clínica". Medicina Clínica (Barc). 2001 Junio 9;117 (1): 18-23.

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atment (rejection of a treatment or requests which do not correspond to the *lex artis* the rules that regulate the profession)[5]. The ethics committees to which I belong have undertaken surveys of healthcare professionals at their institutions in order to uncover whether ethical problems play a major role in their clinical practice and to find out which are the most significant, so that the committee can offer support. In the questionnaire of the ASISA Bioethics and Healthcare Law Committee (answered by 25 ASISA healthcare professionals, most of them nurses), 72% of staff said that they had occasionally or frequently been faced with conflicts of an ethical nature in their daily work. Over half of these issues are resolved through discussion with colleagues. Among the most significant ethical conflicts they refer to are problems of information or confidentiality, cardiopulmonary reanimation, ethical problems at the end of the life of terminal patients and/or those with a very poor quality of life, and conflicts with patients' relatives. A further questionnaire was carried out by the Alcorcón Foundation University Hospital among 55 professionals. Here, the percentage of staff confronting ethical conflicts in their daily work was higher (81%), they were likewise resolved in consultation with colleagues (81%), while more than half felt that such issues, complicated their daily work.

Decision-making by healthcare professionals in matters of clinical ethics

Clinical decisions (clinical problems) are not simple. In order to practice clinical medicine with the most basic level of competence one requires some 11 years of training, but nonetheless certain doubts or uncertainties will remain. Each patient is different, and it is one thing to know the pathology (the study of the illness), and quite another how it expresses itself in that patient (clinical aspects). Hence the fact that healthcare professionals go on continuous refresher courses, consult with their colleagues and take decisions in teams. In the case of clinical ethics, the complexity of the clinical decisions is combined with an ethical conflict, further obscuring and increasing the uncertainty involved in the decision-making process.

For staff to deal with such complicated issues, as Diego Gracia indicates, they must learn to deliberate and to take decisions with prudence. There are two essential aspects to this: staff require training in bioethics, while the institutions themselves must have ethics committees in place to advise professionals in the event of more complex problems if they cannot adequately resolve the issue themselves. In both fields we are still at a halfway stage. Although the bioethics training of healthcare staff is improving, many have not even received the minimum input allowing them to analyse and deal with problems of clinical ethics. As for ethics committees, they are present at more and more healthcare institutions, but are still underused by both staff and users[6,7] who are often unaware of their existence and their functions. These include bioethics training for the staff at the centre.

Clinical ethical problems are commonplace in the work of healthcare professionals and often raise difficulties for clinical practice

Conclusion

Clinical ethical problems are commonplace for healthcare professionals and often raise difficulties in their clinical practice. It is essential that healthcare professionals be able to deliberate on problems of clinical ethics in order to adopt prudent decisions. To this end, training in bioethics, which is still often inadequate, is essential, along with the contribution of ethics committees where necessary. Ethics committees are furthermore responsible for bioethics training in the organisational structure of healthcare institutions. Given all the above, such ethics committees have a fundamental responsibility for ethical aspects affecting healthcare professionals. The fact that they are currently underused demands that they be more firmly embedded at healthcare institutions.

[5]LÓPEZ-SORIANO F, Y COLS: "Mapa de conflictos éticos intrahospitalarios". Calidad Asistencial. 2007; 22 (1): 50-5.
[6]RIBAS RIBAS S.: "Assistential ethics committees competency and autoevaluation of its components. CEA-CAT (2) study". Medicina Clínica (Bar) 2007 Feb 17; 128 (6): 219-25.
[7]ABEL F.: "Care ethics committees. An Sist Sanit Navar" 2006; 29 Suppl 3: 75-83.

NÚRIA TERRIBAS, LAWYER. DIRECTOR OF THE BORJA BIOETHICS INSTITUTE (RAMON LLULL UNIVERSITY)

"The principle of justice must be safeguarded in the application of new biomedical advances"

Sergi Rodríguez

Pep Herrero

Núria Terribas, lawyer.

Why bioethics and not simply ethics? What does it involve exactly?

In fact the word itself, bioethics, defines its own meaning. We are talking about ethical reflection applied to the field of the biomedical and life sciences in general: bio. Bioethics is a discipline the main characteristic of which is to create a dialogue between the fields of knowledge of biomedical and biological sciences and the humanities (philosophy, ethics, theology, law), along with the social sciences (sociology, politics, economics...), beginning at the point where the application of new advances in these sciences collides with established values in a given social and cultural context. At this point we must stop and reflect as to whether such applications are compatible with certain ethical values, and what channels of consensus can be achieved in order to resolve these conflicts (life vs. knowledge and research, life vs. quality of life, etc.).

How and when do ethical reflections concerning health arise?

It is medical and healthcare practice itself which gives voice to this need for reflection in response to the actual conflicts which doctors raise in cases of the specific treatment of patients. The greatest impetus came from medicine in the second half of the 20th century, with the development of technologies such as dialysis, life support machines, new surgical techniques, etc., leading doctors to ask themselves what was best for the patient, if all that could technically be done should actually be done, how to establish fair principles for access to technology when it is scarce and demand is particularly high, etc. This whole debate, which began at the major American hospitals, moved on to the academic world at universities, and that is where the need was raised for such reflection to be enriched through the perspectives of philosophy, ethics and the different theologies (Christian, Muslim...).

This is what gave rise to the term bioethics itself, and the foundation of the world's first centres for bioethics, specifically the Hasting Center (1969) and the Kennedy Institute of Ethics (1971), which remain the benchmarks worldwide. Following on from this, some years later, bioethics arrived in Europe and gradually developed across the world, focusing not only on the field of new biomedical advances and

research, but also making inroads into the field of the recognition of patient rights, gradually leading to a complete paradigm shift as to what healthcare represents.

How does bioethics impact on the daily work of doctors and nurses?

I would prefer to talk about the impact it should be having, as we are unfortunately still a long way off the level of awareness of such issues which would be desirable among the professional healthcare fraternity. I understand that doctors and nurses (including nursing assistants) are the individuals closest to the patient, in a situation of vulnerability, and that they are required to demonstrate both technical and human excellence. Given this context, many of the actions and decisions taken day-to-day in a hospital or healthcare institution, whether or not we are talking of extreme clinical situations or cases, have a bioethical aspect. This is because the impact they have on the patient in a given situation, which may be more of less serious, is for them, the patient, the most important factor, and also has an impact on their physical or psychological integrity. Questions such as information, personal treatment, confidentiality, respect for the patient's freedom of choice, etc. form part of daily life, and so represent a constant presence in everyday affairs.

Unfortunately, our healthcare professionals begin caring for patients without having received training in clinical relationships and communication, the rights and duties of patients, the ethical conflicts of life and death, or principles for the limitation of treatment and appropriate palliative care when a cure is no longer possible, etc. Right now, the only way to improve these aspects is to provide postgraduate training as part of lifelong learning in the healthcare professions, providing these essential elements as a supplement to their technical knowledge. That is one of the tasks we perform at the Institute.

How is its presence organised within healthcare structures?

The presence of ethical reflection within healthcare structures can be established by means of various mechanisms. On the one hand, teams must themselves promote dialogue and reflection as to clinical cases in those aspects which go beyond the specific medical problem or pathology, including in their discussions every aspect of the patient's case in personal, holistic terms, not considering simply the illness.

Meanwhile, we have for some years now in Catalonia and the rest of Spain seen the gradual development of healthcare ethics committees. These are consultancy and advice bodies for professionals, of a multi-disciplinary nature (with a rotating presence on the part of doctors, nurses, social workers, experts in ethics, lawyers...), who perform an important and helpful task of analyzing complex cases involving ethical conflicts which are difficult to resolve. This is not yet the case at all hospitals and healthcare institutions here, but more and more are being set up, and those which have been in operation for some years are developing their experience and track records, with positive results. It is also very important to highlight the fact that such committees can never serve to provide final resolution or binding judgements, but simply advise, with the ultimate decision always lying with the doctor involved.

I believe that considerable progress has been made in this field over recent years. Although traditionally references to ethics in the field of health have assumed aspects of morality and religion, we have now succeeded in making the appropriate distinction between one thing and the other, and can now see ethics forming part of the modus operandi of healthcare... but I do feel we still have a long way to go...

> It is medical and healthcare practice itself which gives voice to this need for reflection in response to the actual conflicts which doctors raise in cases of the specific treatment of patients

And how can patients be helped when making bioethical decisions?

Every individual has his or her own personal ethics, although they may not at times recognise or be able to express this... Our personal history, our cultural and educational baggage gradually shape us as people over the course of our lives, and we build up our own ethics, more or less guided by the upbringing we have received. If a person is in a weakened state, suffering an illness, any action affecting their physical or psychological integrity is experienced as an intrusion which must be undertaken with care and respect. Such procedures can lead to ethical conflicts, because the values of

the patient may not coincide with those of the professional, or the ethical justification of the measure or treatment proposed by the medical team. It is in such situations that patients will particularly appreciate appropriate handling of the resolution of such ethical conflicts, which involves listening to their opinions, taking the utmost efforts to respect their values and, in the event of an irreconcilable conflict, through recourse to other support mechanisms, such as committees or team meetings.

If the professional set-up dealing with the patient deals properly with these aspects, the perception is positive and the individual feels respected and well cared for. If we do not observe such respect and instead attempt to impose our own judgement and value system, we are not acting with a bioethics mentality this should be based on dialogue and the quest for consensus, with the result that patients may feel they have not been properly tended to and that their rights have been violated.

Today's society has lost its values, its capacity to reflect and think beyond the immediate moment and the one-off situation

What are the main current concerns within this discipline?

In academic terms, I would say that one of the main challenges, as I mentioned earlier, is that of ensuring that the discipline of bioethics is included as a subject or core module on all professional healthcare courses, meaning that individuals would begin their professional career with a good knowledge of the subject.

This is a difficult goal to achieve, as a number of different attempts have been made to revise medical degree programmes, as yet without success, and here we still lag some considerable way behind the training seen in other European countries, where bioethics has been an integral aspect for some years.

From our perspective, as a university institute we feel particular satisfaction that our Master's in Bioethics has received accreditation as an official university master's course within the European higher education framework (known as the Bologna Plan), meeting the very high standards of pedagogical and academic quality. Although it remains a postgraduate training course, it does form part of the lifelong learning of practising professionals, and therefore at least it is one way of providing essential knowledge within the formal university structure.

Does the media focus too much on one-off, dramatic cases?

I believe that the media have enormous power over society, and consequently great responsibility when they deal with such issues affecting the life and health of people. In this regard, I do not view the fact that certain events make it into the media sphere as always a negative, provided that the issue is properly handled, the information is unbiased, there is no attempt at sensationalism or a focus on the more gruesome aspects, and that the media are not skewed by a particular ideological stance, although this is a rather utopian desire in today's society.

I do believe that bioethics deals with issues of general popular interest, as we all live and die, and so could all find ourselves prey to an illness, needing assistance from science, at any point in our existence. One good example of this would be the fact that the major social debates in bioethics (when life begins, abortion, euthanasia, AIDS, etc.) clearly do arouse popular interest and grab people's attention, becoming the subject for everyday conversation as soon as a case is published in the press. Everyone has an opinion, a personal view, based on multiple factors: culture, upbringing, beliefs... That is why it is important to spread knowledge in order to create informed public opinion, and that is why I also feel that we should demand that the media operate in accordance with clear ethical principles and with social responsibility in the task which they perform.

Meanwhile, I feel that today's society has lost its values, its capacity to reflect and think beyond the immediate moment and the one-off situation, and that this is a major problem which often prevents us from reflecting seriously about issues of general interest, as other neighbouring countries have done when, for example, legislation has been proposed to decriminalise euthanasia or abortion...

Autonomy, beneficence (to do good), non-maleficence (avoiding doing harm) and justice... are these still valid principles?

I would say so. The principle of non-maleficence is as old as the ancient Hippocratic tradition of *primum non nocere*, and could be viewed as a universal or principle of the first

order. The other principles are also up-to-date, as they were initially drawn up as a result of the research involved in the Belmont Report, with its proposal for beneficence, autonomy and justice. We cannot, however, claim that these principles are fully integrated within our healthcare world, since for example there is still some considerable way to go before professionals have a clear idea of what the principle of personal autonomy means, beyond legal informed consent forms, or to ensure that the principle of justice is taken into consideration in their clinical decisions. Meanwhile, we must not overlook other proposed principles based on concepts of vulnerability or the dignity of the individual, which have also been created by a more European healthcare model, not based so much on the contract mindset of Anglo-Saxon countries governed by the law of the market, but the values of a welfare state... We must also continue our work along these lines.

How does the legal framework affect bioethics? Are we looking at recommendation or regulation?

It would be fair to say that both apply, recommendation and regulation, although over the last 25 years a great many legal provisions have been drawn up to cover issues which had previously been the subject of self-regulation by the professions or which, at the most, were included simply in scientific protocols or broad declarations of principle, with no binding power. In Spain specifically, after the transition to democracy lawmakers became very busy in areas of bioethics, in fields such as transplants and assisted reproduction, the clear definition of patient rights, biomedical research, etc. The main reason for this is the difficulty in reaching an ethical consensus as to what is right and wrong in a plural and incre-

asingly global society, with the risk of extremism, meaning that the law would seem to be the only way of establishing one common yardstick and inviolable limits.

I do, however, feel that lawmakers often attempt to cover everything by regulation, without leaving space for reflection and ethical consensus within professional bodies themselves. This has been harmful in that it has often led to defensive medicine, a call on the part of professionals for a regulatory framework providing them with security, and undermining their own initiative or innovation.

Although it is true that the law and vision of legal theorists must play its part in the bioethical dialogue, this must be to an appropriate extent, without allowing the law to replace ethics or the capacity for reflection in value conflicts. Unfortunately, ethics and the law do not always go hand in hand...

Stem cells, cloning... what will be the main problems of the future?

The issues which have always aroused the greatest attention in bioethics, since its very outset, have been those connected with the two essential moments of existence: the start of life and the end of life. Although we have been reflecting on all this for some 40 years now, we have not yet achieved a clear consensus as to these issues, and continue to debate the value of the human embryo, what is ethically

acceptable and what is not in the field of human reproduction, research, etc. The same situation arises when we consider the end of life, where we have gradually made slow progress in establishing criteria for the quality of life, the limitation of treatments to avoid unnecessary prolongment, to develop palliative care for terminal situations, etc. There is still, though, a more philosophical debate as to control over life itself, to what extent a person can choose when and how he or she is to die.

Beyond these core issues, one of the most cutting-edge aspects on the table involves genetics. Our knowledge of the human genome and the therapeutic applications of this for humanity is one of the fields arousing most concern today. In particular to ensure that proper use is made of our knowledge and that the application of genetics is not biased by personal or commercial interests.

Meanwhile, increasing globalisation demands that we engage in bioethical reflection in order properly to apply the principle of justice in the implementation of new biomedical advances, in order to ensure that they do not simply benefit a number of wealthy countries, but that international organisations can also safeguard North-South solidarity... This is a challenge which goes beyond the professional and individual sphere of each person and which is the responsibility of the great established powers in the mightiest states.

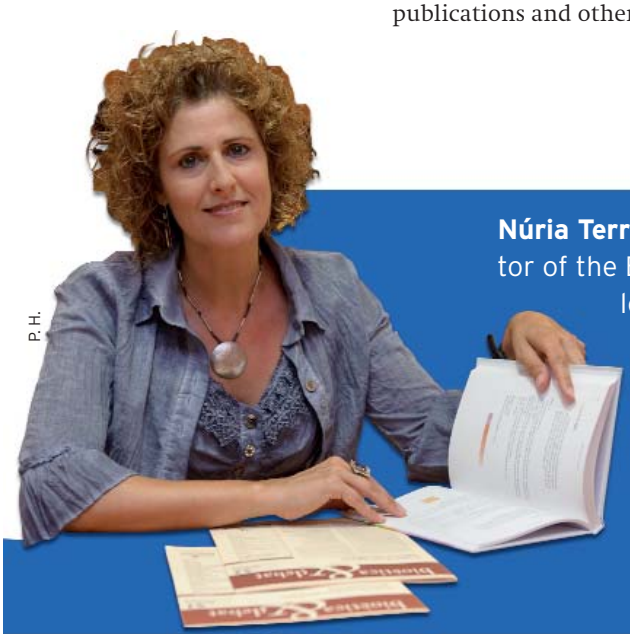
Lawmakers often attempt to cover everything by regulation, without leaving space for reflection and ethical consensus within professional bodies themselves

What role does the Borja Bioethics Institute play?

It is a University Institute, the first of its kind in Europe, established as a bioethics centre in 1976 by Dr Francesc Abel. It is a partner centre of the Ramon Llull University, with university recognition for its teaching work, its main aims being to:

- Analyse the problems raised by biomedical progress and their repercussions for society and its system of values.
- Promote interdisciplinary dialogue between scientists and humanists as a working methodology allowing us to seek out reasoned routes for the resolution of conflicts based on respect for human rights.
- Serve as a platform for dialogue between the Christian faith and other world views, exploring the scientific, philosophical and legal basis of ethics as applied to the health sciences.
- Provide a service for society at large, highlighting bioethical issues in publications and other formats.

In order to achieve these purposes, we focus on three main operational areas: **teaching**, delivering a range of courses, along with our formal Postgraduate Courses in Bioethics and the Official University Master's in Bioethics, the latter delivered in person and also virtually via our online campus (www.campus.ibbioetica.org); **research**, as the Institute has its own forum for studying the subject, and is also involved in national and international research projects where the ethical consideration of issues of biomedical research plays a key role; **consultancy and publication on bioethical issues**, through membership of healthcare and research ethics committees and various institutions, taking part in central and regional government commissions and various working groups, and developing a range of activities to spread the word and raise the profile of bioethical issues, including single-issue publications and our quarterly journal *Bioètica & Debat*, the constant updating of our bioethics portal (www.bioetica-debat.org), and the maintenance and updating of our specialist Library and Documentation Centre. All the above is furthermore supplemented by the Institute cooperating upon request with the media and large-scale information platforms regarding issues of bioethics (magazines, newsletters, etc.).



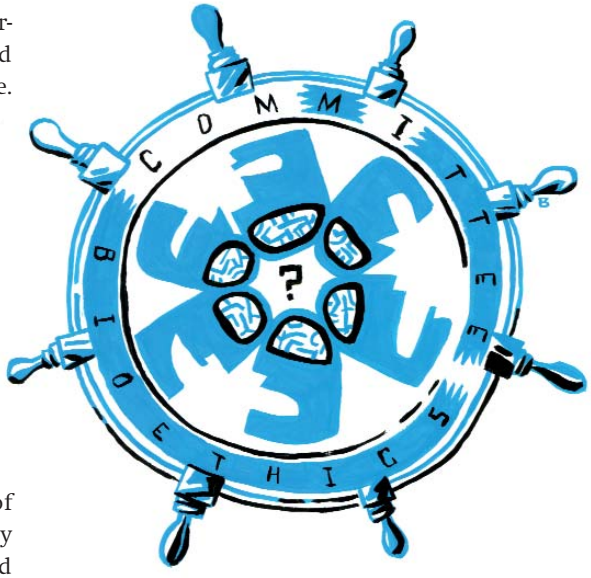
P. H.

Núria Terribas i Sala (Barcelona, 1964) is a lawyer and the Director of the Borja Bioethics Institute. She was awarded her Bachelor of Law degree by Barcelona University in 1987, and subsequently in 1995 received the Catalan Civil Law Diploma awarded by the Duran i Bas Chair at the same university. She is a specialist in Healthcare Law and Bio-Law. Since 1985 she has also been editor of the Journal *Bioètica & Debat*. She works as a legal consultant for various bodies and institutions, and belongs to the healthcare ethics committees of a number of Catalan hospitals.

As patients what do we know about bioethics committees?

Àngela Lladó

If we are sincere and demanding with ourselves and with others, ethics should always be present in every action we take. And what are ethics? Philosophically speaking, they are defined as the set of moral principles on which our behaviour is based. Moral principles (in other words values) change depending on the era and culture. If we attempt to focus on the problems raised by advances in the fields of biology, medicine and pharmaceuticals, along with the repercussion which these problems have for society, then we are talking more specifically about bioethics.



Bioethics committees were born out of necessity. Over the course of the 20th century a series of circumstances highlighted the need to set up committees of experts to study the changes and advances taking place in the field of medicine. For some years now the media (press, radio, TV...) have referred increasingly often to bioethics committees whenever they publish their studies on various current issues and those which could affect us now and in the future, such as: research with stem cells to discover new treatments; some considerations regarding abortion; the selection of embryos prior to implantation in order to select those which do not carry an illness, or to be in a position to allow a newborn child to cure a sick sibling, along with a number of studies as to the various ways of dealing with death. All those issues which, years ago, would have been unthinkable have in some specific cases rocked public opinion (such as the instance of Eluana Englaro, the Italian girl in a coma many years ago, or the Spanish baby born following an embryo selection process who provided a cure for the illness threatening the life of her brother) give rise to discussion and debate within such committees of experts. Increasingly, through the high profile of such cases and the desire of the committees themselves to publish their findings, these debates enter the public realm.

It may, however, be the case that for the general public bioethics committees seem a little distant, since they are not direct con-

sultation bodies. The situation is different from that of patients (or their companions or relatives) requiring advice when receiving medical treatment at a healthcare institution, who can draw on the support of healthcare ethics committees. These are not mandatory bodies but have gradually been set up at practically all public and private hospitals. TThey are made up of a multi-disciplinary group of individuals called on to deal with the queries presented to them by both professionals at the centre and users, who have access to them via the channels indicated by the hospital itself, with the aim of improving the quality of care.

Health professionals are required to take decisions which have direct impacts on our health, our quality of life and our death. Their task is one of great responsibility. Such responsibility existed even before the advent of all our current technology and medical advances, but as there is now more technology at the service of medicine, there are more treatments and we have much more knowledge about the human condition, medical practice has undergone certain changes. It would not be right to view the advances in science and technology used to improve people's living conditions as a problem. Nonetheless, the application of such advances can at times lead to doubt.

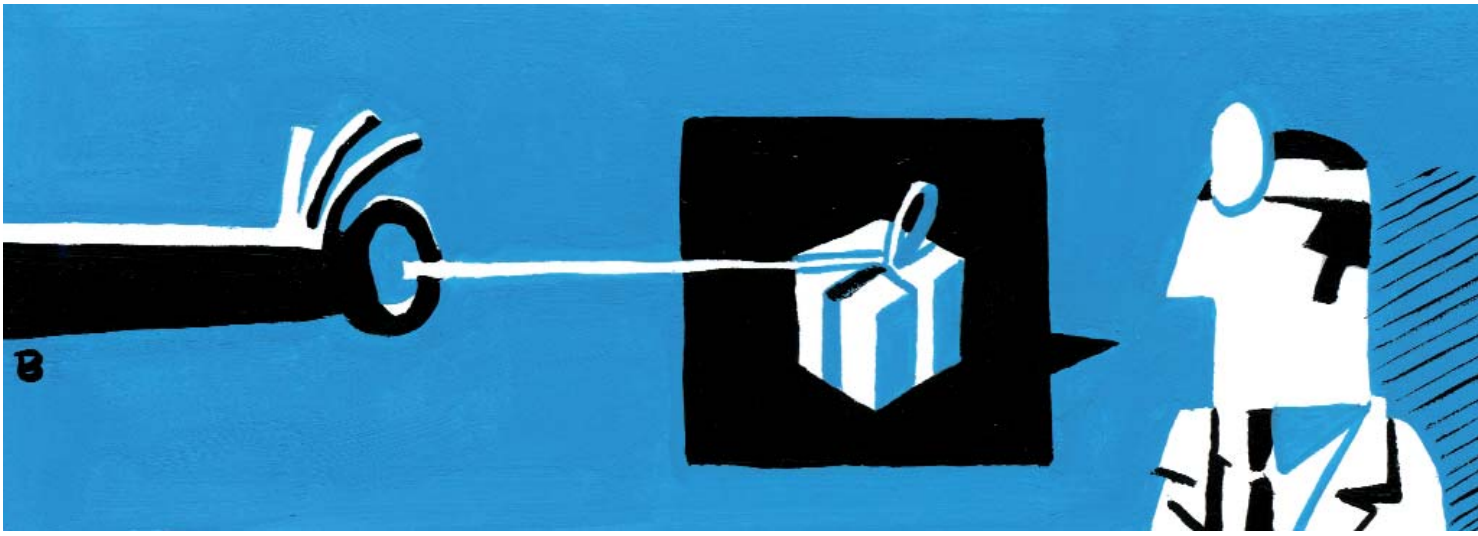
Patients (or their companions or relatives) who require advice when receiving medical treatment at a healthcare institution can draw on the support of healthcare ethics committees. These are made up of a multi-disciplinary group of individuals called on to deal with the queries presented to them by both professionals at the centre and users with the aim of improving the quality of care

In principle, what patients want is to be cured and to feel well. In the event of minor complaints, the fear of suffering and death is not so strong, but healthcare institutions deal with people suffering major illnesses and in highly critical circumstances. On occasion, during the process of some illnesses, the individuals concerned (either the patients themselves or their relatives or companions) cannot always take the decisions. In such cases it can be particularly helpful to take into consideration the perspective of all those involved (who are also represented on the committee): the doctors, the nursing staff, users, specialists... The queries which are addressed normally centre on the most decisive points in our life: birth and death. That is why these committees have to deal with such issues as: when it can be established that a person has died; when a patient should not be revived; what type of action should be taken with newborn babies in a highly critical state or with serious disabilities, or when and how life-support machines should be disconnected. Let us focus on each of these cases.

Healthcare ethics committees are required to debate when an institution decides that a person has died. The question would seem to be clear-cut: when their heart has stopped beating. But can one attempt to revive a person who arrives at a hospital dead? Yes, one can try. One must, however, establish principles in accordance with how long ago the heart stopped beating and evaluate the potential after-effects of the episode.

Could we, as patients or companions, even consider during the process of an illness the possibility of not wishing to be revived in the event of an arrest? Could one question whether or not a person admitted to hospital should be revived? This would then depend on their state of health, their age, prognosis, the quality of life they could achieve... Each case must be examined on its merits.

As premature babies can now be treated in extremely well-equipped neonatal units, a number of medical procedures can be performed in order to allow the baby to live, but is



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it right to take all these medical actions if the baby is suffering from serious conditions which will dictate its entire life?

In the event that the continuity of life depends on being connected to certain life-support machines, many doubts likewise arise. How long can such support be maintained? And if the person involved does not wish to live under such conditions? And if the person involved cannot decide, and instead his or her relatives must do so?

These are some of the questions which healthcare ethics committees are required to analyse and deal with. In all cases their advice serves simply as a guide, and the individual raising the query will decide whether or not to follow their recommendations. In other words, the function of a healthcare ethics committee is not to decide for others, but to advise them. Such committees should not act as expert witnesses or pronounce on any complaints or claims brought against healthcare procedures. They are simply a tool for consultation, a forum for reflection.

Healthcare institutions must work to promote dialogue between users, professionals and experts. And they have a great deal of work to do in terms of informing society and encouraging the general public to reflect.

DR MARÍA TORMO, ASISA'S DIRECTOR OF PLANNING AND DEVELOPMENT, AND PRESIDENT OF ITS BIOETHICS COMMITTEE

The ASISA bioethics committee, a service for Lavinia and ASISA professionals

Elvira Palencia

Dr María Tormo, President of the Bioethics Committee

Lavinia-ASISA is the only health insurance company to have in place such a pioneering and unique committee to provide advice on the ethical and legal aspects of clinical healthcare practice. To mark the end of its first year, we invited the President of the ASISA Bioethics Committee to give us an account of how things have gone.

How was the Bioethics and Healthcare Law Committee set up?

The Bioethics Committee is not just for ASISA, but ASISA-Lavinia. I would like to make that point because it was set up in response to a question raised by a representative of the Guipuzcoa Regional Office at the Lavinia General Assembly in 2007, requesting that such a committee be founded. The proposal was then examined, and the cooperative's General Assembly committed itself to the initiative.

Who does it serve? Who does it advise?

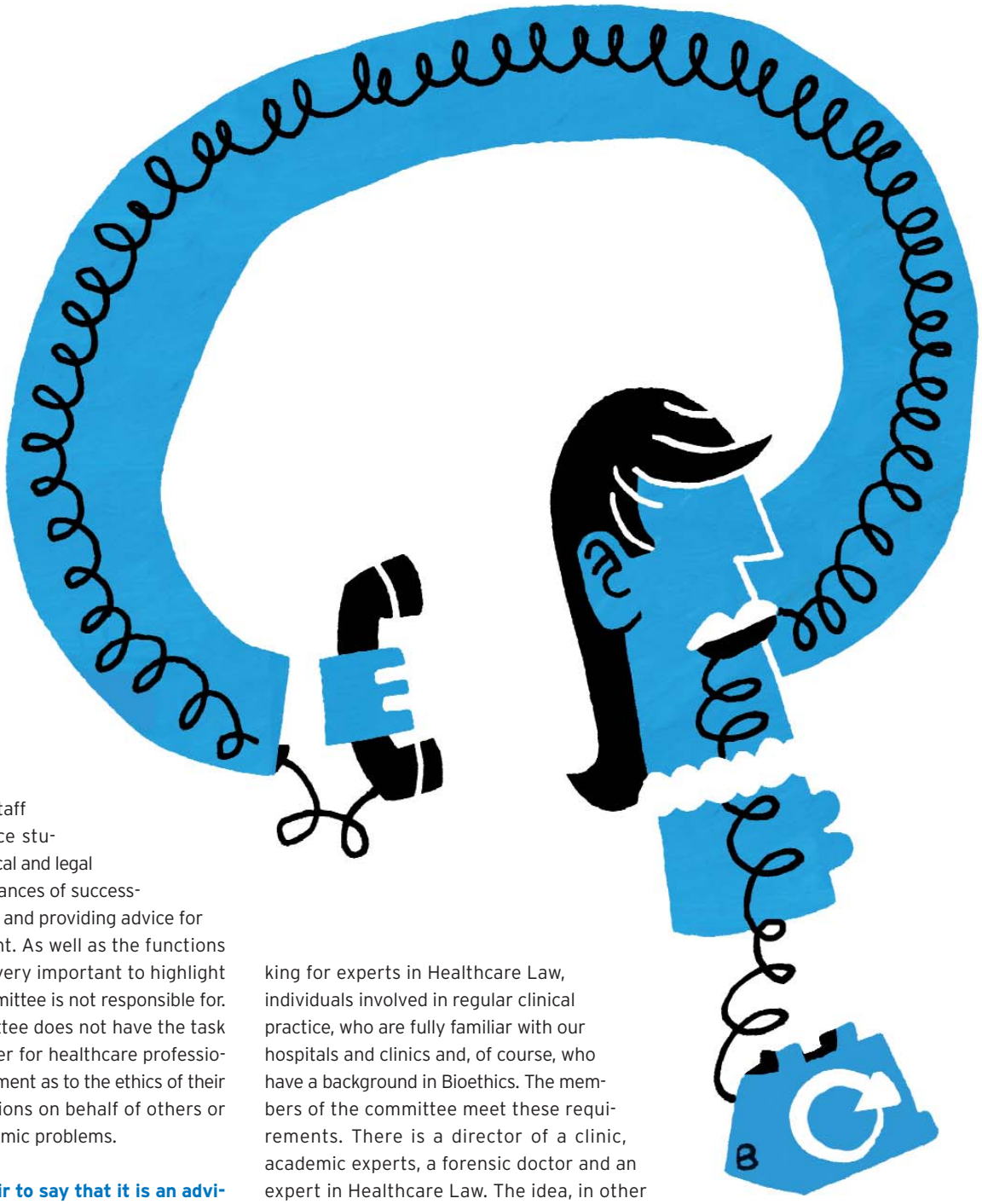
The committee is first of all a consultancy service for Lavinia doctors, in other words the cooperative members. But also the doctors and other healthcare staff who belong to our organisation's medical lists, along with all professionals working at the group's clinics and healthcare centres. Although it was born out of the cooperative dynamic, it applies to all professionals involved with our insurance body.

And why Bioethics and Healthcare Law?

This was an issue we debated within the committee. We wanted to make it a particularly practical consultancy body, genuinely dealing with the issues which concern professionals in their practice, their daily work. The committee does not, then, deal only with strictly ethical aspects, but also deals with possible problems or issues which could arise within the field of Healthcare Law. In other words, Bioethics must provide a response within the existing legal framework. We wanted to make it a useful tool in daily operations.

What are its main functions?

The Bioethics Committee was set up in July last year and held its first real working meeting in September. This involved approval of the Committee Regulations, which clearly define its functions as: providing advice for healthcare professionals, ASISA healthcare institution managers and Health Science students at those institutions in any ethical and legal conflicts which may arise in healthcare; analysing and proposing, where relevant, possible options or solutions to resolve the ethical and legal conflicts raised; proposing internal operational protocols for situations which, because of their particular frequency or gravity, generate ethical and legal conflicts in the operational area; promoting training and reflection that focus on Bioethics and Healthcare Law for ASISA's medi-



cal and non-medical staff and its Health Science students; evaluating medical and legal risk, optimising the chances of successful defence in lawsuits and providing advice for technical management. As well as the functions mentioned, it is also very important to highlight what a Bioethics Committee is not responsible for. The Bioethics Committee does not have the task of providing legal cover for healthcare professionals, issuing any judgement as to the ethics of their conduct, taking decisions on behalf of others or analysing socio-economic problems.

And so it would be fair to say that it is an advisory committee?

Exactly. Although advice is always helpful, advising does not mean assuming the responsibility of each individual professional in performing his or her work. Nor is the committee responsible, in the event of a lawsuit, for providing staff with legal consultancy.

How have the members of the committee been chosen?

All Bioethics Committees must include individuals from different disciplines, thereby enriching the work and the debates which the committee conducts. They must always be multi-disciplinary. When we select different individuals, we are looking for experts in Healthcare Law, individuals involved in regular clinical practice, who are fully familiar with our hospitals and clinics and, of course, who have a background in Bioethics. The members of the committee meet these requirements. There is a director of a clinic, academic experts, a forensic doctor and an expert in Healthcare Law. The idea, in other words, is for a group of people with a range of multi-disciplinary training to enrich the debate from their different perspectives. The ASISA Bioethics Committee is made up of three experts in Bioethics and Healthcare Law, Professor Fernando Bandrés, Director of the Tejerina Foundation Advanced Study Institute and Tenured Professor of Legal Medicine at Madrid's Complutense University; Benjamín Herreros, lecturer in Medical Humanities at the European University of Madrid and an internal doctor, and Santiago Delgado, Director of the Abascal Legal Medicine Unit and Director of the Master's in Healthcare Law at the European University of Madrid. ASISA is represented on the committee by Dr Carlos Zarco, Medi-

cal Director of the Moncloa Hospital; Mariano Caballero, ASISA's Director of Legal Consultancy, and myself.

How does the committee operate?

As I mentioned earlier in response to another question, the regulations that govern the committee were agreed in September 2008. These deal with many issues such as how often meetings are to be held, on both an ordinary and extraordinary basis. We wanted the committee to be able to provide a rapid response to any requests made by professionals and institutions, and so every possible channel for contact has been put in place, by phone, by mail, by e-mail, by fax, etc., all these methods are approved in the regulations. As well as its ordinary and extraordinary meetings, the committee also has a sub-committee, specifically intended to provide a more flexible response to any questions which may be raised. This sub-committee is made up of three members of the committee, currently Benjamín Herreros, Carlos Zarco and myself.

The ASISA-Lavinia Bioethics Committee was set up following the Lavinia General Assembly in 2007, and advises healthcare professionals and managers at the body's institutions

Could you explain how the committee can be contacted?

Queries can be made by telephone on 915 957 638 and 915 957 718, from 9 a.m. to 6 p.m., Monday to Thursday, and on Friday up until 3 p.m. Or they can be sent by fax to the number 91 595 7622 or to the Bioethics Committee's own e-mail address: comitebioetica@asisa.es. One further option is to write to the following address: ASISA, Bioethics and Healthcare Law Committee, Juan Ignacio Luca de Tena, 10, 28027 Madrid. Queries can also be made via the ASISA Professional Portal, to be found at the web address www.asisa.es/professional/index.html.

What type of activities is the committee involved in?

We held two open days to present the Bioethics Committee during its first year of operations, the first on 20 November 2008 at Moncloa Hospital, and the second on 29 April 2009 at the Vistahermosa Clinic in Alicante. On both occasions our committee was very well received, in particular by

the professional staff. At the first event, held at Moncloa Hospital, we handed out a questionnaire to all the staff at the centre to find out what problems they had faced over the course of their professional careers which could be covered by the field of Bioethics and Healthcare Law. This same questionnaire was later sent to all ASISA Group clinics, allowing the committee to focus its work on those issues identified as being of greatest concern to our professional members. In relation to what I said earlier, we are dedicated to being a consultancy and service committee, that is truly valued by our professionals because we make some small contribution to resolving their regular problems in this specific field of Bioethics.

Have those problems now been identified?

Yes, we have the responses to the questionnaires, and the first issue we have identified is that of informed consent, an area we have now begun to address.

Could you give us an assessment of the first year?

I think that when you set up a committee of this type, what you really want is for the people for whom it is intended to find it useful. And how can those aspects be assessed so far? Essentially in the responses to the questionnaires we have sent out and the attendance at the open days we have held. New events have been scheduled for the last quarter of 2009 at the Santa Isabel Clinic in Seville, the Virgen de La Vega Clinic in Murcia and the Montpellier Clinic in Zaragoza. And so I feel that it is seen as something useful, and we have also been particularly pleased with the recognition we have received from outside, such as the award from the *Diario Médico* for being one of "the best initiatives of 2008".

Are staff keen to ask questions?

We have already received a numerous of questions. Access to the committee via the ASISA Professional Portal has been in place since February, and we are receiving an increasing number of visits. The Professional Portal provides links to

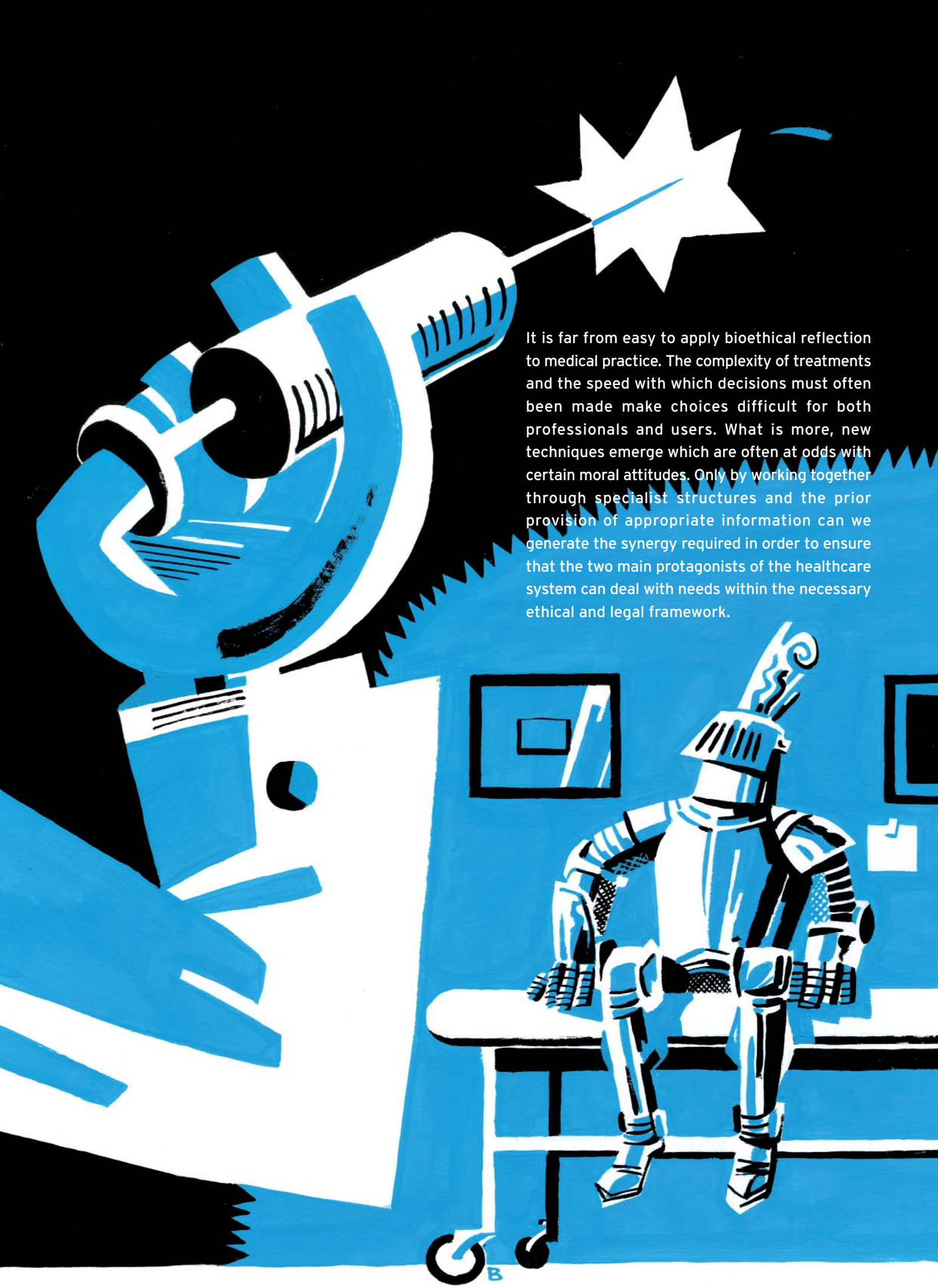
The Committee provides advice on ethical and legal conflicts, proposing alternatives, drawing up operational protocols and training professional staff

presentations, articles on Bioethics, important regulations in the field of Bioethics and Healthcare Law, judgements which illustrate how certain conflicts have been settled, etc. And so, yes, I do feel that we have opened up a fluid channel of communication with our professional staff.

Lastly, are healthcare professionals really interested in Bioethics? Is it one of their regular concerns?

It is probably not their main concern, but I do believe that we are all very much aware that in our regular clinical practice situations arise which cannot be resolved purely through medical knowledge and common sense. A knowledge of Bioethics is increasingly important, so much so that a great many medical faculties are now considering including Bioethics as a degree module, and some have already done so, given that it is a discipline which plays a role in many decisions, a situation which can only increase future.

Dr Tormo is admitted into the Royal Academy of Medicine and Surgery of Muricia



It is far from easy to apply bioethical reflection to medical practice. The complexity of treatments and the speed with which decisions must often been made make choices difficult for both professionals and users. What is more, new techniques emerge which are often at odds with certain moral attitudes. Only by working together through specialist structures and the prior provision of appropriate information can we generate the synergy required in order to ensure that the two main protagonists of the healthcare system can deal with needs within the necessary ethical and legal framework.

PAUSE

Jordi Sarsanedas

Alms

Did I stretch out my hand? Perhaps indeed,
under the breadth of my simplicity,
I play the role of mendicant,
the golden gesture of Assisi.
Moved, I take the alms
of a September-filtered light,
drops of red and blue,
weightless on my palm, on the leaves.
I still, perhaps, feel how
fleet-footed hours fly by,
tunic all a-flutter,
the alimony of air to breath.
And I give up my thanks.

(*Com una tornada, sí*. Barcelona, Barcelona. Proa, 2003. Translated by Sam Abrams)

Mar Aguilera

4 hospitals in the city of Lima

Text and photography: Guillermo Figueroa

The city of Lima, the Peruvian capital, is home to a number of State-owned hospitals. A visit to the 4 main institutions in Lima (the Hospital Loayza, Hospital del Niño, Hospital 2 de Mayo and Hospital de Collique) reveals the shortcomings that still exist in the functioning at some of these. As well as the lack of specialist staff to care for patients there is also the problem that most patients have limited financial resources and cannot afford to go to a private clinic or undergo an expensive course of treatment.

The workforce of doctors, nurses, administrative and other staff is insufficient to deal with the great mass of people attending these centres each day. Accident and emergency departments are often overwhelmed by the quantity of patients. There is limited space available, and treatment rooms, beds and even storage areas have to be improvised in order to accommodate admissions, whilst patients are swiftly discharged because of the lack of space and staff.

The Hospital del Niño children's Hospital, however, does provide better healthcare services for patients, has a good infrastructure and the latest equipment to treat its young patients. This is highly positive but nonetheless it is once again subject to a lack of qualified staff because of the low salaries paid by the State.

Changes need to be made in Peru's health system, most specifically greater commitment from the state to recruit better staff in all areas, with decent salaries in order to increase dedication to improved care for the population, something they are fully entitled to demand and receive.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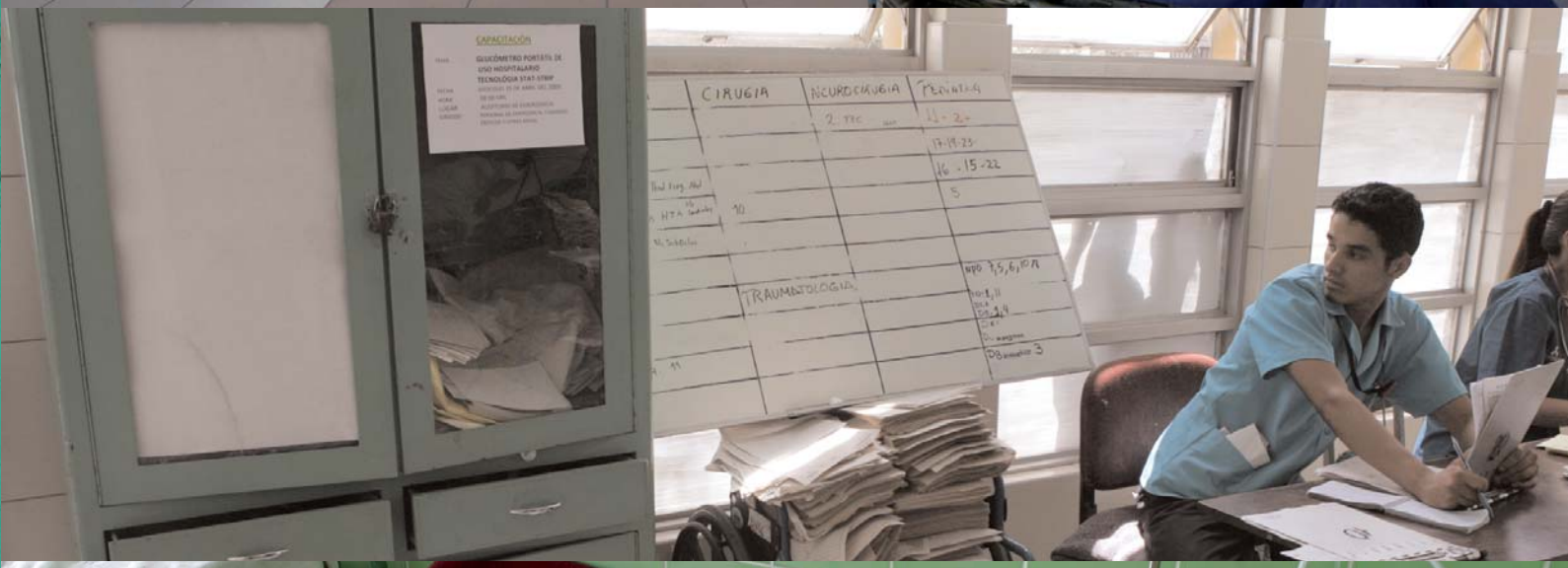
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CIRUGIA
NEUROCIRUGIA
TRAUMATOLOGIA


ALTO
7

The slow memory of days

Jordi Llavina

This is one of my favourite poems. But not only by Espriu. What I mean is that if I had to produce an anthology containing the poems I have most loved over the course of my life so far, number 2 of *Cementiri de Sinera* would be right there on the list.

In fact, I could even say that *Cementiri de Sinera* is my favourite book by Espriu. Never have so many things been said, and so well, in so few words (with apologies to Matsuo Basho)! Never has such a concentration of symbolic language been achieved in such brief poems. Espriu is a good poet, perhaps even a great poet. I must admit that having spent time reading his work, and so familiarising myself with it, there are aspects of his style, or one could perhaps say idiosyncrasies, which are not so much to my liking. His tendency to place the adjective before the noun, for example. Or his weakness for using so many adjectives in the superlative form (Estellés was also very much

Such a small homeland
surrounding the cemetery!
Sinera, the sea at hand,
hillsides of pine and vineyards,
dusty gullies. I love
nothing more, save the travelling
shadow of a cloud.
The slow memory of days
gone past forever.

Salvador Espriu.
Translated by Sam Abrams.

Quina petita pàtria
encercla el cementiri!
Aquesta mar, Sinera,
turons de pins i vinya,
pols de rials. No estimo
res més, excepte l'ombra
viatgera d'un núvol.
El lent record dels dies
que són passats per sempre.

Salvador Espriu · Cementiri de Sinera · II · MCMXLVI

Keith Adams

prone to this particular trait). But the poems in this book are so good that I do not even hear the bothersome music of those attributively positioned qualifiers.

I cannot remember when I read poem 2 for the first time, with its famous opening lines "What a tiny homeland / is bounded by the cemetery!". It must have been a good twenty-five years ago. It was my tutor Glòria Casals at Barcelona University who described the cemetery in Arenys to me, with its position high above, even towering over (and embracing) the village and the sea. The great power of the lyrical language is just that: our tutor gave us important a directions on how to step over the ground of the text, whilst I had followed my own interpretive steps along other pathways. To begin with, I had always believed that the homeland bounded by the cemetery was that of the dead, and that the poet was thus speaking not of a place of disaffection but the record of the past: the city of the dead. It made sense to me that he should begin his text with this focus, to use a photographic term, and then end with two fine, well-rounded lines which gained such a great deal when Espriu, a great one for obsessively re-polishing his works, freed them of a conjunction tying them to the lines immediately preceding ("I do not love / anything else except the passing / shadow of a cloud / and the slow memory of days / which are gone forever").

"Cementiri de Sinera" is my favourite Espriu book. Never have so many things been said, and so well, in so few words

How could one improve a text with such an apparently insignificant decision, it's so very subtle! "The passing shadow of a cloud" is, of course, "the slow memory of days / which are gone forever". It is not something separate. Espriu ties the "shadow" to the "memory": a beautiful reading (in the sense of textual criticism, but also in a moral sense). Let's get back to what I was saying before.

The poem, in my initial interpretation, began by placing the reader facing the cemetery, or even within its hallowed grounds. The specific nature of this concept became even clearer in the three lines which follow: "This sea, Sinera, / hillocks of pines and vines, dust of streams". These are lines of a radical luminosity which have always, in their excellence, reminded me of two lines from Ramon Llull's *Cant de Ramon*, in which the mediaeval philosopher and poet defines the locus of his enlightenment: "Between the vine and the fennel / love siezed me". Espriu gave a summary of the land: his Mediterranean land, the land of the Maresme, the land further north (the Costa Brava), and even further south (the Costa Dorada). Village and sea. Woodland (nature untamed) and vineyard (nature controlled). The dust: here, though, in very concrete terms. Not at all metaphorically.

This gift of concrete expression, so many things said with their roots in the ground (the dead, a village, pines and vines) ends with the formula "I do not love anything else". The poet has shown us his homeland. In a way which says: Here I came into the world. Here I first saw the light. Here I will die. All this is tucked away in a bundle of love. A moral heritage. This, the roots of life, but also of mortal conscience. And it is then that, "except for the passing / shadow of a cloud" Espriu tells us that he loves not only that which is certain, but also that which has ceased to be so. The spent fuel of the past. The dust in the stream of life. The days of our existence have passed by forever, like the fleeting shadow of a cloud. Not like a cloud in itself, mind! Like "the shadow" of that cloud. The shadow which is cast on the ground, even more ethereal than the stuff of which the cloud is made. The illusion of our days.

The lyrical purity of these lines is admirable. For me, it is one of the summits of Espriu's poetry.

We need the money that you forget

Dr. Espriu dedicated his life to integral health care co-operativism, a system in which the profits obtained are reinvested in healthcare improvements.

In Spain today, there are now many of us who can benefit from the advantages of this system, but there is still a great deal to do.

Donate to the Espriu Foundation and you will help an increasing amount of people every day to have access to improved medical care.

Yes, I would like to help spread the spirit of the Espriu Foundation.

Please fill in this form with your personal details and indicate how you would like to help. Send it to the **Espriu Foundation**, Av. Josep Tarradellas 123-127, 4a planta, 08029 Barcelona.

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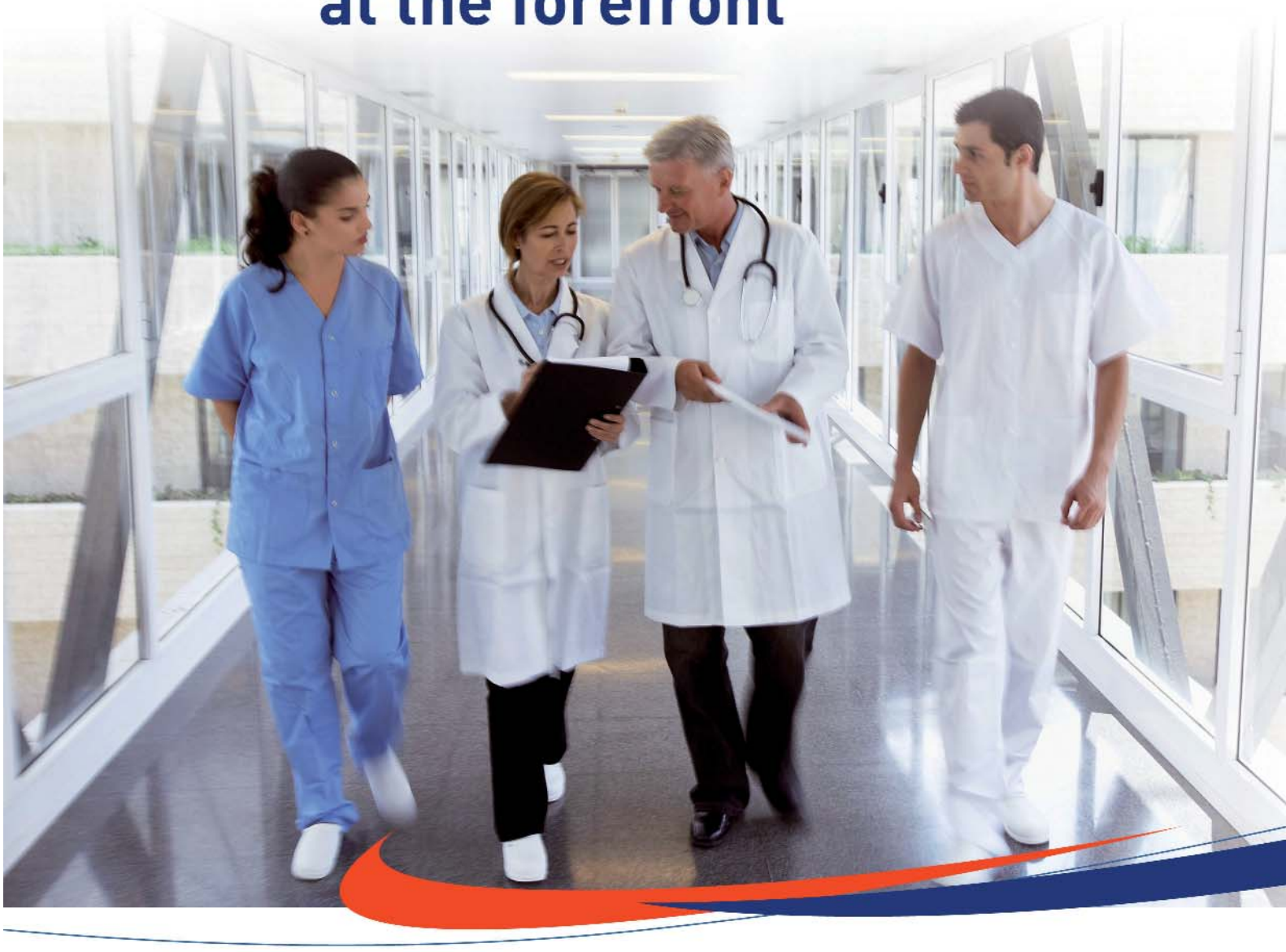
at the forefront



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