An Ethical Analysis of Evidence-Based Medicine

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Background
Evidence-based medicine is a clinical decision making framework which makes claims about what physicians ought to do. Though heralded as the cutting edge of medical science evidence-based medicine is a value laden normative theory which implicitly depends on substantive views regarding what is morally good or right.

Objectives
In this paper, I provide an ethical analysis of evidence-based medicine.

Method
I consider its normative underpinnings in three ethical theories: utilitarianism, Kantian deontology, and virtue ethics.

Results
In the face of uncertainty, evidence-based medicine endorses expected utility theory using the best available evidence in order to avoid doing more harm than good. In accordance with the Kantian respect for individuals as ends in themselves, evidence-based medicine calls for integrating the values and preferences of the patient. De-emphasizing intuition, clinical expertise, and pathophysiologic rationale emphasizes the need for the intellectual virtues of curiosity, critical thinking, and courage.

Conclusions
Evidence-based medicine is a successful clinical practice that can be morally justified by all three major ethical theories. Although its focus on maximizing good health outcomes and integrating respect for individual patients has been emphasized, the role of the intellectual virtues in evidence-based medicine remains highly under-explored.

Using Co-Design Process to Develop an Integrated Self-Management Intervention Program for COPD Patients in Nepal

Background
Globally, Primary Health Care (PHC) is recognized as central to improving health for all, yet COPD patients in Nepal are not receiving adequate PHC, because of limitations in the six building blocks of the health system as proposed by World Health Organisation in 2007. Therefore, there is a need to strengthen the capacity of community-level health institutions and health professionals by facilitating integrated care to improve self-management support for COPD patients.

Objectives
We aimed to develop and prototype a model of care linking primary and tertiary care components to improve self-management practices (SMPs) of COPD patients in Nepal. Methods: Based on a survey and qualitative study in 2018, we have developed integrated care and intervention to address locally identified problems. We refined our model (prototyping) in two small stakeholders meeting and a final co-design workshop in May-June 2019 with 60 stakeholders consisting of patients, carers, providers, researchers, and policymakers. During the co-design workshop, a series of presentation and a 50-minute brainstorming session was conducted in groups of six participants to collect their inputs on the proposed model of care and intervention components.

Results
Through a facilitated workshop using consensus decision making, patients, local government, primary health care workers, policymakers, academics, and community representatives worked together to refine an integrated model of care. The resultant integrated model will include: screening of COPD at the community and management of symptomatic patients at primary health care, establishing referral pathway for severe cases to tertiary level health care and establishing community care. Our presentation will include: steps in the co-design process and results from prototyping with stakeholders.

Conclusion
Our integrated, contextually-appropriate model of care and intervention should improve the quality of care and quality of life for COPD patients. Lesson learned Engagement of patient, carers, providers, and policymakers in developing a model of care creates a sense of ownership among the