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30 November - 3 December

ICCEC 2021

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16th Annual International Conference on Clinical Ethics & Consultation

Beyond Borders: exploring new frontiers

The 16th annual International Conference on Clinical Ethics and Consultation (ICCEC) was held at the Asara Wine Estate in Stellenbosch between November 30th and December 3rd, 2021. The hybrid conference attended by 70 delegates in person and approximately 250 registered online, went ahead after its postponement in April 2020 due to Covid-19. Physical attendance this time was curtailed by the November announcement in South Africa of the Omicron variant and subsequent travel bans imposed by several countries.

The welcome address was delivered by Prof Jimmy Volmink, the former Dean of the Faculty of Medicine and Health Sciences, after a brief introduction by Prof Keymanthri Moodley, Director of the Centre for Medical Ethics and Law and host of ICCEC 2021. As the chair of the ICCEC organising committee, Prof Sharon Kling welcomed all the delegates and described the challenging journey in hosting this conference during the pandemic.

Plenary 1:

Diversity in Philosophical Approaches in Clinical Ethics

Prof Anton van Niekerk is the Director of the Centre for Applied Ethics in the Department of Philosophy, Stellenbosch University. He provided a South African perspective on clinical ethics and public health ethics.

He noted that sometimes, these definitions and fields of ethics overlap significantly as occurred during COVID-19. A colonial past has profoundly influenced the development of clinical ethics in South Africa. Initially, bioethics in South Africa "largely took place within the framework of the authoritarian, beneficent, paternalistic behaviours of professionals supposedly adhering to the Hippocratic and related codes" (Benatar and Landman, 2006). Two events in the 1960s stimulated clinical ethics in South Africa, namely the Scribner shunt (which provided ready access to the circulatory system for dialysis in patients with chronic renal disease) (1960) and the first heart transplant (1967) when the need for a new definition of death arose. The most shocking event that awoke clinical ethics in South Africa was the death of Steven Bantu Biko. Key points included that "excellent health care" was limited to white people, there was unprofessional behaviour and cooperation with authorities by doctors, there was shocking hesitance to act against doctors by the Medical Association of South Africa (MASA) and South African Medical and Dental Council (SAMDC) and it highlighted the dire need for a culture of human rights in South Africa. The South African Bill of Rights is a testimony to the important lesson learned from the Biko Affair. It illustrates the social and political impact of a severe violation of medical morals on South African society. Challenges include that CEC's remain a rarity in Africa (currently only in South Africa and Kenya). CECs can assist in alleviating moral distress, bringing reason and clarity to moral confusion, advising policymakers, arranging online consultation services and mediating conflicts between HCPs and patients. It is important to note that the paucity of CECs does not mean that clinical ethics debates have not occurred in South Africa. "Still, hopefully, conferences such as the ICCEC can further stimulate the need for CEC development in South Africa and Africa more broadly."

Prof Godfrey Tangwa is a Senior Fellow in Governance & Ethics at the Nkafu Policy Institute. He is professor emeritus of the University of Yaounde 1, Cameroon, where he was Head of the Department of Philosophy from 2004-2009. Godfrey provided historical and current clinical and research ethics issues from an African perspective. Clinical consultation is centred on the healthcare-seeker/healthcare provider relationship. Clinical ethics is what ought or ought not to happen wherever/whenever clinical consultation occurs. There are different perspectives on healthcare. The need to maintain health, prevent disease, and identify causes of illness and treatment develops naturally along with other aspects of human culture (and their adaptation to their physical and ecological environments). Western medicine developed a sharp distinction between body/mind and matter/spirit and focused mainly on the former. Western culture, systems and practices have become dominant across the world. He also discussed the influence of research funder-driven ethics and how funding issues might influence ethical considerations. H3Africa (Human Heredity and Health) was highlighted as an example where procedural ethics are almost entirely funder driven. Clinical research in sub-Saharan Africa is necessary to improve people's health but must be carried out using local philosophies and sensitivities to local contexts and cultures.

The third talk of this plenary session was delivered by **Prof George Agich**, a Professor of Philosophy (Emeritus) at Bowling Green State University and the co-founding director of ICCEC. His talk was titled: 'Clinical ethics: cosmopolitan or local' in which he provided insight into the development of clinical ethics and its normative foundations, primarily a matter of professional authority and professional ethics. A new paradigm of clinical ethics emerged from the initial era of legal challenges to healthcare, and this was the paradigm of patient care. The practice of patient care unavoidably involves a diversity of beliefs, values, and practices among patients, also reflected among HCPs. In summary, value diversity should be accepted and respected as far as possible, consistent with patient rights and professional obligations. Members of CECs and ethics consultation services must advocate for practices that respect value differences among HCPs, patients, and families and help shape improvements in inpatient care in light of universal human rights.

Plenary 2:
Clinical Ethics, The Law and Society

Digitalisation of Healthcare: What this could mean for hospital CECs

Prof Calvin Ho from the University of Hong Kong alluded to three important considerations for healthcare institutions and providers, according to the World Health Organisation (WHO) [Annex 3] guidance for Ethics and Governance of Artificial Intelligence for Health. First, is AI technology necessary and appropriate? Second, is the context in which the AI technology will be used appropriate? Third, should a healthcare provider use AI technology? In Hong Kong, AI devices are not strongly regulated; however, the situation is very different across the border on Mainland China, where you have much stricter controls over AI devices and medical devices because of some of the health risks they would present. The context in which AI is being applied matters, and in a clinical setting, understanding the local perspectives is also critical.

Off-label drug use for COVID-19: ethical and legal implications

Prof Jerome Singh from the University of KwaZulu-Natal, Durban, South Africa discussed off label drug use in the context of a clinician prescribing a drug for different therapeutic reasons to a patient in a diverse age group or gender or in an extra dose mode of administration or length of duration than what was designated in the drug approval process. All medical treatments, including off-label treatments, have medical risks, and patients must be informed of such risks. From a legal perspective, informed consent is critical to a malpractice claim. While off-label prescribing may result in a medical malpractice case, courts in some countries held that off-label use is a matter of medical judgment and not per se prohibited or indicative of malpractice. It is rarely a stand-alone cause of action and usually appears with other malpractice allegations. Generally, a clinician has no legal duty to inform a patient of a drug's regulatory status; however, they are obligated only to provide clinical information. However, to reduce the risk that patients consider themselves under-informed and to protect against associated liability, doctors should expand their informed consent process to incorporate any off-label uses of treatments explicitly. There is a need to discuss the proposed off-label treatment's risks, benefits, and uncertainties. Before prescribing off-label, clinicians should ascertain whether published peer-reviewed scientific literature supports off-label use. Some medical professional societies have issued policies on off-label prescribing, stating that such use must be done in the patient's best interests and based on sound medical judgment and scientific evidence. Therefore, a fair and balanced evaluation of the relevant scientific evidence can help doctors consider off-label prescribing. Also, the clinician's personal bias should play no part in the off-label use. Truth-telling, informed consent and robust evidence must underlie off-label use.

Clinical Ethics Committees – can they reduce litigation?

Dr Graham Howarth from the Medical Protection Society, South Africa began his talk by stating the main goal of ethical consultation on hospital ethics committees is to minimize the risk of legal liability. He introduced the subject by mentioning the three causes of harm which is by accident (casus), negligence (culpa) and intent (doles). The main cause of harm in health care settings is negligence. The question is, does CECs diminish medical negligence? If a patient is harmed, are they entitled to compensation? If they are entitled to compensation, who should pay? The standard of care is what is expected of a doctor and what would a reasonable doctor do under similar circumstances. The court asks three key questions: would the reasonable doctor have foreseen the harm? What reasonable steps could be taken to avert the steps? Did the defendant (reasonable doctor) takes steps to prevent the harm from occurring? In negligence, the expert must prove that the harm was foreseeable, therefore, to be found guilty of neglect, the court has to decide that the reasonable doctor would have foreseen the harm, taken reasonable steps to avert the harm, and the defendant did not take those steps. If these hurdles could be crossed, the claimant will probably be successful in their medical litigation in negligence. In summary, Dr Howarth expressed his scepticism about one of the main goals of ethical consultation on hospital ethics committees is to minimize the risk of legal liability and he cited that "most of the litigation in medicine revolves around negligence. Negligence revolves around inadvertence– the harm was not foreseen, given that the harm was not foreseen there will be no reason for the healthcare worker concerned to have consulted with CECs."

Legal uncertainty and advance directives in end-of-life decision-making in South Africa

According to Anita Kleinsmidt, South Africa's legislature had spurned numerous carefully thought-out recommendations from the SA Law Commission (SALC), including that the living will be given legal status and that anomalies around a power of attorney be cleared up. The current HPCSA recommendation is that the living will be considered when deciding to continue active treatment or move a patient to palliative care. "The living will must at least be considered by the treatment team as evidence of the expression of the patient's wishes," she explained. Kleinsmidt said there was only one legal case in South Africa dealing, albeit tangentially, with a living will (Clarke versus Hurts, 1992). The court granted permission for the wife of a doctor who had suffered irreversible brain damage, having been in a persistent vegetative state for four years, to withhold consent for tube feeding and hydration. The court based its decision on the patients' medical condition, poor quality of life and the fact that he had a living will and had been a member of the Pro-Euthanasia Society. "The court did not pronounce on the legality of the living will. The courts tend not to pronounce on anything they don't have to - especially something as potentially contentious as this - they'd rather have the legislators deal with it!" she chuckled.

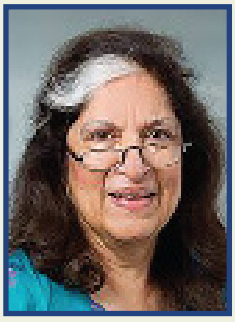
Plenary 3:
Emerging Technologies and Clinical Ethics (Sponsored by Mediclinic)

A global digital future for clinical ethics consultation

Prof Joseph Ali from the John Hopkins University, Maryland, USA said, there is increasing use of virtual communication technologies to augment the capacity of health systems, including to provide clinical ethics-related support for healthcare workers, patients and families. He suggested that we navigate this terrain carefully, considering the benefits and the ethical and legal implications. For example, ensure equitable access, maintain privacy, avoid depersonalization of care and innovate with sustainability and integration in mind. Notably, he cautioned against establishing "global" virtual consult services – given the need to understand local cultural, institutional and legal norms – and instead recommended thinking about how technology can be used internationally to support capacity strengthening for local clinical ethics services, where trained personnel and institutional infrastructure is lacking. He indicated that clinical ethicists should also be aware of what is around the corner, pointing to more advanced technologies such as applications that generate "virtual friends," which evolve as they learn from user inputs to offer social or emotional support, as well as technologies designed to preserve narratives of life experiences which could potentially be accessed interactively to get to know people, as well as chat-bots that use natural language processing and machine learning to collect or provide health-related information. In times of health-related distress and moral uncertainty, such supportive and informational platforms may be increasingly consulted by users and others. However, some questions have been raised over the efficacy and efficiency of these technologies and their capacity to avoid "learned biases". "This has the potential to challenge our conceptual and legal understanding of who represents and speaks for the interests of the patient. He added that there are also downstream issues related to data ownership, access and use," he added.

Digital death: Managing end-of-life care in electronic health records

Prof Kenneth Goodman from the University of Miami, USA began his talk with the history of medical records, dating as far back as the 18th century. He said the Kahun Papyrus is the oldest known medical record in history. Prediction programs are an increasing part of the electronic health record, but prognostic scoring systems are also available - Sequential Organ Failure Assessment (SOFA), APACHE, Pneumonia Severity Index, International Prognostic Scoring System, Paediatric Risk of Mortality, Simplified Acute Physiology Score and Therapeutic Intervention Scoring System. During the pandemic, the SOFA score has been widely adopted to rationalise the prognostic scoring system; however, numerous pieces of literature do not support the SOFA scoring system approach, citing the system as flawed. If one argues that the SOFA scoring system is flawed, one will need to provide an alternative system that offers better options. He said a flawed system is better than tossing a coin. Kenneth highlighted three main challenges facing digital death: managing end-of-life care in Electronic Health Records (EHRs). First, there are complex, challenging inconsistencies for end-of-life care standards, requests for futile/non-beneficial care (should there be a "computational futility metric"?), and documentation of resuscitation status (do not resuscitate or do not intubate?). The second set of challenges in EHRs frequently include a prognostic scoring system to guide end-of-life decisions in ordinary cases, triage and rationing (e.g., COVID) and training and educating clinicians. The third set of challenges is that institutions and individuals remain confused about computational decision support, such as failure to distinguish between AI and non-AI systems, inability to differentiate between AI knowledge-based and machine learning systems and failure to assess the appropriate use of and users of computational tools. Prof Goodman concluded with recommendations that clinical hospital ethics services should lead and embrace initiatives to improve understanding of tools in biomedical informatics. Hospital ethics services must gain experience crafting institutional policies to shape and guide appropriate uses and users. They must learn about the rudiments of software engineering ethics and recognise concerns regarding bias transparency that predate AI.



Quo Vadis, Precision Medicine? Through the lens of an LMIC Physician

Prof Farhat Moazam from the Centre of Biomedical Ethics and Culture, SIUT Pakistan said unless researchers and clinicians are careful, the same inequities as those in global vaccine distribution will hamper the development of precision medicine in LMICs, a veteran bioethicist warned an international gathering of her peers at ICCEC 2021. Prof Farhat Moazam sounded this warning at the ICCEC Conference. A paediatric surgeon and previously Professor and Founding Chairperson of the Department of Surgery, and Associate Dean of Postgraduate Medical Education, at the Aga Khan University in Karachi, Pakistan, Prof Moazam was addressing a session on 'Emerging Technologies and Clinical Ethics". Describing Precision Medicine, a form of medicine that uses information about a person's genes or proteins to prevent, diagnose, or treat disease, as 'the future of healthcare," she said that of the world's 7.7 billion people, two-thirds lived in LMIC's where ethical complexities in research abound, especially in drug trials that often have poor ethical oversight among populations unaware of their rights. Two things were needed for precision medicine to become a reality; 'Big Data' development with large biobanks consisting of genetic profiles, biological specimens and health-related data from billions of diverse patients and volunteers, and pharmacogenetics (studies to establish genetic factors that affect drug responses). The role of Big Pharma would be critical in clinical trials to test drugs targeting specific diseases because so-called 'blockbuster' drugs were extremely costly to develop. Prof Moazam said genetic material was already being collected from LMIC's with incredible human diversity. Still, there were concerns about obtaining sufficient informed consent, therapeutic misconceptions, the ownership of data, and a high risk of disadvantaged patients serving as "a means to an end, with questionable benefits to them". She gave the example of genetic research among rural Pakistan's hierarchal societies where community leaders often persuaded people to participate, despite having difficulty understanding the therapeutic concept of genetic intervention. "One mother asked why they'd take samples if they didn't have a cure. Another confidently said she knew they'd take her son to Germany for therapy once they'd found a cure!" she added. "Genetic data do not belong to the individual but the entire family in these cultures, so who should the information be divulged to?" she rhetorically asked her audience. Just as war should not be left to the generals, precision medicine should not be left to genetic scientists and molecular biologists. Instead, it should include deeper discussion and diverse voices with different professions consulted.

Plenary 4:
End of Life Challenges and Cultural Pluralism

Cultural and ethical challenges in end-of-life care during the pandemic

Prof Daniel Tsai, a professor at the National Taiwan University of Medicine, said that Taiwan sets a gold standard on epidemic response with early intervention and transparent communication with the public which helped control the spread of the virus at the beginning of the pandemic. The painful lesson of the 2003 SARS outbreak put the Taiwanese government and the people of Taiwan on high alert. A joint effort by all stakeholders involved rigorous investigative efforts to perform contact tracing and ascertain patient's travel history effectively. However, heightened community spread of infection led to a raised alert for Taipei and New Taipei City to level 3. "This day would probably come sooner or later," said Daniel. The slow pace of vaccinations combined with more transmissible variants to create a perfect "window," allowed the island to experience a flare-up. It did not help, he said, that more people left their masks at home and failed to social distance. The Covid-19 end of life care ethical challenges encountered were numerous such as Covid-19 patients refusing to be intubated, disagreement between Covid patients and families on intubation, the legal procedures of signing do-not-resuscitation consent documents, hospital in-patients having no family members to accompany and assist … and died alone, difficult decisions and communication about intubation in aged patients, and restriction of family care, shared decision-making, limited resources.

A Work in Progress: End-of-Life Care in India

Dr Sumana Navin, an independent consultant on Organ Donation and Transplantation, explained that the barriers to end-of-life care and palliative care in India are multi-layered and not easy to dismantle. There is a complex mix of sociocultural and medical factors against the backdrop of the legal milieu that impacts the quality of death. In addition, there are disproportionate medical interventions for end-of-life patients and overcoming these challenges requires a nationwide movement. Palliative care in India is estimated to be less than 1%. The country has seen a rapid surge in chronic and life-limiting diseases. Advanced stages of cancer are presented in almost 70% of patients suffering from the disease, and there is a higher incidence of end-stage organ disease and dementia. In 2015, India was ranked 67 out of 80 countries on the quality-of-death index worldwide. Dr Navin cited reasons why religion and spirituality are essential considerations for palliative end-of-life care and explained the importance of community engagement in shaping policies and laws. Patients facing end-of-life care struggle with important spirituality issues such as the meaning of one's life and reason and pain for the suffering. She recommended that palliative care in India be improved through the legal framework for end-of-life care; the constitution should inform the framework of India and international conventions. Healthcare professionals must have a clearer understanding of palliative care, and it is an obligation of the healthcare system. Dr Navin emphasised the need for systematic and sustained public and community engagement in shaping policies and laws. She said that understanding terminally ill patients' social and religious backgrounds and family values are critical elements in the ethics discourse. It is paramount that legal reforms are patient-centred, focusing on healing and dying with dignity.

Value Conflicts and Uncertainties in End-of-Life Care in Multicultural Communities: A Kenyan African Perspective

Dr Lilian Omutoko is a Senior Lecturer in the University of Nairobi, Kenya. Dr Omutoko said ethical dilemmas at the end of life are challenging to healthcare workers on a daily basis. There are no clear-cut choices but rather multiple choices which are a result of multiple values and multiple faiths. Principlists argue that the ethical principles suffice in ethical decision making, while defenders of case-based approaches assume that moral reasoning culminates from moral intuitions. Both approaches do not recognize the existence of multicultural and religious traditions in multicultural societies. Multicultural communities exist all over the world by virtue of globalization and immigration. Africa is a good illustration of cultural pluralism. Despite the diversity of cultures, ethical decisions must be made during the provision of end-of-life care. In the African set up there is always the question as to who is the next of kin which affects decision making, while proclaimed faith of patients and families influence decisions made by health workers. Therefore, some of the ethical dilemmas in end-of-life care are with informed consent. How and where a patient dies is important. Withdrawal and withholding of life-sustaining treatment are often challenging decisions because no one wants to be blamed for neglect or death of their relative. Many families prefer home care, and they will opt for it because of its benefits to the patient and the family. But there are many cases of patients being taken to the hospital in the last twenty-four (24) hours because not many people know how to care for the dead except for the Muslims who know the religious rituals. In the backdrop of the discussion of cultural pluralism, values and uncertainties at the end-of-life care show that culture may not be shared which appeals for respect of respective values, tolerance and accommodating attitudes. Ethical issues at end-of-life care spell the importance of holistic clinical ethics committees that are culturally appropriate and responsive to palliative care needs, the committees will help in moral deliberations.

Plenary 5:
Ethical conflicts at the beginning of life

When is a human - human?

Prof Elizabeth Bukusi from the Kenya Medical Research Institute defined the concept of a human being from a legal, scientific and religious perspective in her talk entitled 'When is a human - human?' From a legal perspective, the definition of a human being is someone who possesses human rights. From a religious perspective, a human being is a composite of body and soul made in the image of God. Scientifically a biosocial being represents the highest level of development of all living organisms. However, controversies arise when the term 'person' is used to denote a definite moment in the life cycle of a human being. Prof Bukusi said that being human is balancing many extremes, and human morality should go beyond "doing the right thing." When does the unborn child become a person? The answer varies across different perspectives; from a religious perspective, a child becomes a person at conception; science believes that life starts at fertilisation, and culture dictates that life starts when one is self-conscious and independent. Different religions also pose different views.

Birth planning vs Therapeutic Abortions: Shared Decision Making & Foetal Anomalies

Dr Cynthia Coleman from Texas Children's Hospital and Women's Pavilion and the Baylor College of Medicine, USA, talked about 'birth planning vs therapeutic abortions: shared decision making and foetal anomalies. Between 2-3% per cent of pregnancies are affected by foetal anomalies. Approximately 21% of all infant deaths in the United States are due to foetal anomalies (4515 reported deaths in 2018). The WHO reports 295,000 annual deaths of infants less than 30 days old due to foetal anomalies. Cynthia provided a brief overview of treatment options, including foetal surgery interventions (a scarce and heroic resource), therapeutic abortion or termination of pregnancy for foetal anomalies, which is widely available and the most common treatment choice. Palliative options include natural death or comfort-focused longevity, curative/corrective options after birth and planned support for a life with a disability. Abortion is the most frequent choice. Dr Coleman said 84% of developed countries permit abortions for foetal anomalies after the second trimester; some require careful review of ethics clinical boards considering that viability is most pronounced at 22 to 24 weeks. Dr Coleman said there should be a distinction between an unwanted pregnancy and an undesired quality of life; therefore, the rationale for abortion is based on protective instincts and the pursuit of the child's best interest by the mother.

Prof Lut Geerts – Implementation of the South African Choice on TOP Act in the context of fetal anomalies diagnosed late in pregnancy

Prof Geerts from the Stellenbosch University, Cape Town, South Africa interpreted the intention of the Termination of Pregnancy (TOP) Act in the context of foetal anomalies diagnosed late in pregnancy. She said a multidisciplinary team of knowledgeable professionals is crucial to making decisions regarding late TOP. Accurate assessment of literature and consultation of relevant clinicians and allied health care professionals are essential to obtain the best possible opinion about the prognosis of the anomaly in individual cases. The prognosis for anomalies must be viewed within its social context – local context, current (and prospective), realistically available care and treatment. The prognosis of a condition is often worse when detected perinatally instead of postnatally. Therefore, the best evidence from the prenatal literature will guide the ultimate decision. When the severity of the outcome in the individual case cannot be determined accurately, the decision regarding late TOP will be based on the average or most common expected outcome and not on the rarer, worst (or best) case scenario.

Debate:

A thorny debate - conscientious objection by healthcare professionals

Stuart Rennie, an Associate Professor of Social Medicine at the University of North Carolina at Chapel Hill and Udo Schuklenk, Professor of Philosophy at Queen's University, Kingston and Research Chair in Bioethics debated a motion that "doctors in hospitals have no moral justification for demanding conscientious objection accommodation as far as the delivery of professional services within their scope of practice to eligible patients who request those services." The debate was chaired by Theresa Rossouw, a Professor of Immunology at the University of Pretoria.

Professor Rennie argued for compromise and a change to legal frameworks and policies in the many countries where conscientious refusal to treat by medical professionals is allowed, saying this was necessary to 'create room' for conscientious objection by healthcare professionals. He 'drew the line' at Schuklenk's contention that eliminating conscientious objection from medicine, mainly because it clashed with the central tenets of the Hippocratic Oath, was the only pragmatic way to go.

Professor Schuklenk argued that the 'ethics' underlying the accommodation of what he termed "a Conscientious Refuser in Modern Medicine" was fundamentally flawed when it came to the very raison d'etre for a person entering the study and practice of medicine. "The health care professional acknowledges that they have a professional obligation to provide patient care, yet they refuse to provide a service, not on the grounds of professional judgment, but grounds of individual conscience. The issue is not a conscientious objection, but conscientious refusal, because a professional could object to practice on the grounds of their conscience, but provide the service anyway, because they are professionally obliged to do so," he explained.

Rennie said that if access to abortion is a concern, it would be better to advocate for more abortion providers and clinics. Conscientious objection is generally not the major obstacle to abortion access for patients.

"On a compromise view, some conscientious objections should be rejected, and objectors should perform offending care. It's another case where conscientious objectors should bite the bullet," he conceded. However, measures should be taken to "reduce the potential for these dilemma-causing situations."

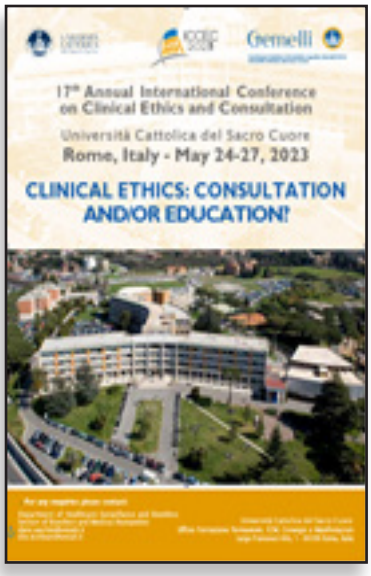
Rennie said conscientious objection was rooted in "a long cultural history, which did not make such beliefs correct. However, much of modern debate tended to discredit conscientious objection to assert an argument further. That's no surprise. It's a kind of a cultural proxy war".

Conference Gala Dinner

The conference dinner was held at the Hamm and Uys restaurant, Blaauwklippen in Stellenbosch. All COVID-19 protocols were observed in a well-ventilated area. Delegates were treated to a wide range of South African dishes. It was a great social and networking event for all our guests.

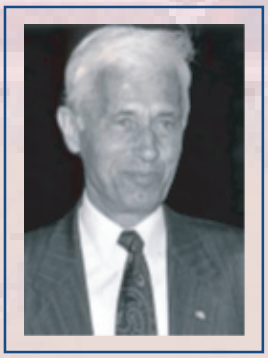
17th Annual International Conference on Clinical Ethics and Consultation

Rome, Italy – May 24-27, 2023



Hans Joachim Schwager Award for Clinical Ethics 2021

Professor Schwager was a pioneer in clinical ethics support in Germany and a member of the Board of Directors of the v. Bodelschwinghsche Stiftungen Bethel, the sponsor of the Hans Joachim Schwager Award. Sarosh Saleem was the recipient of the Hans Joachim Schwager Award for Clinical Ethics. She is an Assistant Professor, Bioethics from the Shalamar Medical & Dental College, Aga Khan University. The Award is valued at 5000 euros to encourage individuals and groups engaged in clinical ethics support to communicate their experiences, achievements, and challenges to a larger audience and to support clinical ethics practitioners who have successfully implemented ethical consultation in healthcare facilities. The award was presented by Dr Klaus Kobert, Vice President of the Jury.



Hans Joachim Schwager Award for Clinical Ethics 2023

The award aims at individuals or groups, who perform innovative or pioneer work in clinical ethics. As the implementation of a clinical ethics program often needs stamina and courage, the award is intended to encourage and support these initiatives. During the ICCEC 2023 in Rome, Italy, the Jury will present the Hans Joachim Schwager Award for the sixth time. Applications are welcome from individuals and groups with documented activities of implementation of clinical ethics. The application should include a written report of the activities in the field of clinical ethics and of challenges during the process. A description of how obstacles were mastered should complement the application. All written communications must be submitted in English. Applicants should send their application 10-20 (maximum) pages via e-mail (format pdf) to Klaus Kobert, MD, Evangelisches Klinikum Bethel - klaus.kobert@evkb.de

For more information, visit the websites: www.clinical-ethics.org and www.bethel.de | Deadline for application is **October 31st, 2022**.

Acknowledgments:

The 16th Annual International Conference on Clinical Ethics and Consultation would like to express its sincere appreciation to the following individuals, companies and institutions for making the event a huge success:.

Consultus: Conference organiser

Audio-visual services: Onscreen Presentations (Mo Jaffer)

Social Media marketing: Dr Karel Caals, National University of Singapore

Freelance Reporter: Chris Bateman

Expressions photography

Organising committee:
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