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BIOETHICS

Study guide

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Recommended by the CCMC of FSBEI HE ISMU MOH Russia as a study guide for foreign students, mastering educational programs of higher education by the educational program of the specialty of General Medicine for mastering the discipline “Bioethics” (Protocol No. 2 of 23.12.2020)

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The study guide considers theoretical aspects of bioethics in general, some of its most burning issues and their regulation, as well as bioethical problems in specific medical occupations, being aimed at development of certain general cultural, general professional and occupational competencies of students. The contents of the study guide will help students improve their reading, speaking and presentation skills. The theoretical information is presented as texts on three main sections of the course. For the purpose of mastering the studied material and self-control, situational and test tasks on the suggested topics are included.

The study guide is intended for 2nd-year foreign students, mastering educational programs of higher education by the educational program of the specialty of General Medicine for studying Bioethics as an academic discipline.
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>BCE / BC</td>
<td>Before Common Era / Before Christ</td>
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<tr>
<td>CE / AD</td>
<td>Common Era / Anno Domini</td>
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<tr>
<td>CIA</td>
<td>Central Intelligence Agency</td>
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<tr>
<td>CV</td>
<td>curriculum vitae</td>
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<tr>
<td>DNA</td>
<td>deoxyribonucleic acid</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
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<tr>
<td>FBI</td>
<td>Federal Bureau of Investigation</td>
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<tr>
<td>GCP</td>
<td>Good Clinical Practice</td>
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<tr>
<td>GLP</td>
<td>Good Laboratory Practice</td>
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<tr>
<td>GMO</td>
<td>genetically modified organism</td>
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<tr>
<td>HAART</td>
<td>highly active antiretroviral therapy</td>
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<tr>
<td>HGP</td>
<td>Human Genome Project</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>iPSC</td>
<td>induced pluripotent stem cells</td>
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<tr>
<td>KGB</td>
<td>Committee for State Security</td>
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<tr>
<td>MHC</td>
<td>major histocompatibility complex</td>
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<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<tr>
<td>RNA</td>
<td>ribonucleic acid</td>
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<tr>
<td>STI / STD</td>
<td>sexually transmitted infection / sexually transmitted disease</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>U.S. / USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>USSR</td>
<td>Union of Soviet Socialist Republics</td>
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<tr>
<td>WAS</td>
<td>World Association for Sexual Health</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WMA</td>
<td>World Medical Association</td>
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<tr>
<td>WPA</td>
<td>World Psychiatric Association</td>
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<td>WW I, WW II</td>
<td>World War I, World War II</td>
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INTRODUCTION

The purpose of teaching Bioethics to medical students is to let them master theoretical material and form general cultural, general professional and occupational competences via mastering forms of spiritual culture and specific features of bioethics as a philosophy and a science about human survival. This knowledge will let them give adequate assessment to moral relations emerging while performing professional activity, form an ability to single out, analyze and generalize the most significant relations and features of phenomena and processes belonging to the domain of bioethics, make correlations and compare facts in time and space on their own.

The suggested study guide is divided into three sections:
1. General Issues of Bioethics;
2. Bioethics and Medical Practice: Common Issues;
3. Special Issues of Bioethics.

Section 1 considers theoretical aspects of bioethics in general: its main paradigms, principles and rules, philosophical grounds, categories. Their study lays the foundation for further study of the discipline, since it presents and forms moral and ethical grounds of the medical profession.

Section 2 highlights some of the most burning issues of bioethics and their regulation: death, dying, medical experiments, and the role of ethics committees in correct conduction of research, both from ethical and medical standpoints, including ethical issues of HIV. The raised problems are related to a wide range of medical specialties, and many medical professionals come in touch with them, which is why their study is the cornerstone in formation of moral and ethical grounds of a medical worker.

Section 3 focuses on bioethical problems in specific medical occupations, covering bioethical issues in transplantology, genetics, psychiatry, sexology, oncology. Their study will help students learn specific bioethical features of some most dynamically developing medical specialties and see that, aside from common
bioethical grounds of medicine, any medical specialty has a number of pressing biomedical problems.

Each section of the study guide is divided into four blocks, touching upon certain aspects, issues and problems of bioethics in order to develop in students certain general cultural, general professional and occupational competences:

- the ability to perform abstract thinking, analysis, and synthesis;
- the ability to use the basics of philosophic knowledge to form a worldview position;
- the ability to act in unusual situations, readiness to bear social and ethical responsibility for one’s own decisions;
- readiness to work in a team, have a tolerant attitude to social, ethnic, professional and cultural differences;
- readiness to solve standard tasks in one’s professional activity using informational and bibliographic resources, medical and biological terminology, informational and communicative technologies, taking into account the basic requirements for information security;
- the ability to use the basics of economic and legal knowledge in one’s professional activity;
- the ability and readiness to implement ethical and deontological principles in one’s professional activity;
- the ability to conduct research work.

The first block “Reading skill development focus” contains the main topics of the discipline. A number of tasks for mastering the educational material are included. This block is aimed at developing the ability to correctly express one’s thought, separating the main information from the secondary one.

The next block “Presentation skill development focus” contains a list of topics for making presentations in order to control the process of mastering the presented material and training of information search skills. This block is aimed at developing
the ability to listen and hear the interlocutor’s arguments, define his / her position, and also argue one’s own.

The third block “Speaking skill development focus” contains situational (problem) tasks aimed at expressing one’s position, opinion, and analysis of the acquired knowledge by means of discussion. This block of the study guide is aimed at development of the speaking skill, determination and reasoned presentation of one’s own position in the form of dialogue (pair work) and polylogue (group work). The situational tasks (three for one topic) describe real incidents (cases) from different fields of medical practice. A physician does not only solve clinical tasks, but faces problems of moral choice of some action or another on a daily basis. To avoid a medical error, a physician should be able to make a proper decision, which requires special moral and ethical knowledge of him / her. Situational tasks are aimed at teaching a future medical specialist to use theoretical knowledge of the principles, values and rules of bioethics in practice.

The fourth block contains test tasks by means of which a student can check whether his / her image of Bioethics is complete enough. The block is focused on current control of mastering the material.

At the end of the study guide there is a list of recommended literature, solution patterns, keys to the tests, and an appendix “How to make a good presentation”, which provides practical tips for students who want to make substantial and effective presentations. Each time a student starts making reports and presentations, he / she is recommended to study this material and follow the suggested tips.

The study guide meets the requirements of the Federal State Educational Standards of Higher Education, the current work program of the discipline “Bioethics” and is intended for third-year foreign students mastering educational programs for specialists. It can be used both in class and for extra-curricular activities.
Section 1. GENERAL ISSUES OF BIOETHICS

1.1. Bioethics as a Science

Reading skill development focus
1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Concepts of Ethics, Bioethics, Deontology, Humanism

Ethics (Greek ἠθικόν, from Ancient Greek ἠθος “ethos, temper, custom”) is a philosophical discipline, which has morality as the subject of study.

Initially, the meaning of the word ethos was “a joint home and the rules generated by a joint home, the norms that unite the society, overcoming individualism and aggressiveness”. As a society develops, the study of conscience, good and evil, empathy, friendship, the meanings of life, self-sacrifice and so on, are added to this meaning. The concepts worked out by ethics are mercy, justice, friendship, solidarity, and others – they guide moral development of social institutions and relations.

In science, ethics is a field of knowledge, and morality is what it studies. The term “ethics” is sometimes also used to refer to the system of moral standards of a particular social group.

Bioethics (from Ancient Greek βίος “life” and ἠθική “behavior, actions”) is a doctrine of the moral side of human activity in medicine and biology.

The subject of bioethics is a systematic study of wildlife and human behavior in the light of moral principles and values. Bioethics is synthesis of life sciences and human health and has protection of life values in all its aspects as a goal. Bioethics is a science of survival of all living systems through the prism of universal ethics.
Bioethics is an interdisciplinary field of knowledge that arises at the intersection of philosophy, law, medicine, sociology, political science, demography, cultural studies, and religious studies. It explores moral aspects of a person’s attitude to life and death and includes the widest range of socio-economic, moral, ethical and legal problems of modern medicine.

Bioethics is a concept of moral principles of protecting a person and health of the population as a whole by protecting the quality of life, physical and mental integrity of a person and his human dignity. It studies the contradiction between people’s and community interests in the field of health and achievements in biology, medicine and pharmacy, which directly or indirectly can harm health and the quality of life. It combines the most diverse value systems: biological (physical existence, health, freedom from pain), social (equal opportunities to receive all types of medical services), environmental (awareness of the self-worth of nature, its uniqueness), personal (safety, self-esteem), etc.

The main idea of bioethics is that universal values should not be considered separately from biological facts. Since a human is part of the nature, he/she needs healthy food, fresh air, clean water, wild corners of nature. He/she cannot exist without animals, forests, rivers and soil, which are not only environmental resources, but also the main condition for survival of the humanity. Its goal is development of moral standards, requirements and principles, other mechanisms that ensure the use of scientific and technological achievements only for the benefit of a human and the nature.

Bioethics is an ethical response adequate to modern social conditions and to the most acute moral problems posed by the progress in medical science and biomedical technologies. The fundamental principles of bioethics constitute the theoretical basis for the new internationally recognized ethical standard of medical practice that has emerged in recent decades and is reflected in numerous international law documents, national laws, ethical codes and declarations of international and national medical associations.
In a narrow sense, the concept of bioethics denotes the whole range of ethical problems in interaction of a physician and a patient. Ambiguous situations that constantly arise in practical medicine as a result of the progress in biological science and medical knowledge requires constant discussion, both in the medical community and among the general public.

In a broad sense, the concept of bioethics refers to the study of social, environmental, medical and socio-legal problems relating not only to humans, but to any living organisms included in the ecosystems surrounding humans. In this sense, bioethics has a philosophical orientation and evaluates results of development of new technologies and ideas in medicine and biology in general.

Bioethics studies:
- ethical aspects of different medical specialties;
- ethical problems of human research;
- social issues related to health and demography policies;
- problems caused by human intervention in vital processes of other living creatures.

Bioethics addresses the following problems and issues:
- moral and legal regulation of medical activities and medical care;
- concepts of freedom, justice, responsibility in medicine;
- abortion;
- HIV/AIDS;
- criteria for human death detection;
- euthanasia;
- medical experiments and research;
- transplantology;
- cloning;
- genetics, genetic engineering;
- psychiatry;
- sexology and aspects of human sexuality;
• models of the “Medical worker – Patient” relationships, etc.

The main aspects of biomedical ethics as an interdisciplinary science are:

• *normative*, within the framework of which the specificity and “working capacity” of universal moral values in medicine are studied;

• *situational*, justifying the need for a moral choice and decision-making in various biomedical situations and incidents;

• *experimental*, involving extension of moral principles to biomedical research and their ethical expertise;

• *deontological*, regulating the functions and principles of the physician’s behavior in vertical (physician – patient) and horizontal (physician – physician) relationships;

• *institutional*, related to the need to solve social and professional health problems and the role of bioethics committees as special institutions in this process.

**Deontology** or **deontological ethics** (from Ancient Greek δέον “duty”) is the study of the problems of morality, a section of ethics.

While making an assessment of the perfect action, deontology is guided by its conformity or inconsistency with certain rules. It is also called *the ethics of duty or obligation*, or an ethical system based on the rules of behavior since they are the basis of the concept of duty. Deontology is a study of medicine’s duty, first of all of professional duty, standards of medical workers’ behavior.

The term “deontology” was introduced by Jeremy Bentham in the 19th century in his work “Deontology, or The science of morality” to designate the theory of morality as a science of morality. Subsequently, the science narrowed down to characterizing the problems of human duty, considering duty as an internal experience of coercion, given ethical values. In its modern specialized meaning, the term was introduced by Charlie Dunbar Broad in his book “Five Types of Ethical Theory”, which was published in 1930.

Deontology in medicine is specification of medical ethics in accordance with various specialties, with various parts of medical labor; it is a collective moral (spiritual
and practical) experience of medicine, a school of professionalism in medicine, the art of choosing the most optimal means for affirming medical humanism; this is the practical application of the principles and norms of medical ethics in order to maximize the amount of public utility and elimination of harmful effects of defective medical work. The provisions of medical deontology (norms, prohibitions, criteria, assessments) are prescribed to the medical worker in an imperative (mandatory) order.

Medical deontology is a more comprehensive concept than medical ethics, since it includes not only moral and ethical aspects of medical care, but also actions, work arrangement, improvement of knowledge and occupational skills of medical workers.

In addition to medical deontology, a separate branch is legal deontology. Today, deontology of legal professions – in the educational and regulatory aspects – is given special attention. In many countries, aspects of deontological ethics are legally enshrined (i.e. Code of Ethics of the National Police of France, Regulation on the Ethical Principles of the British Police Service, Ethics of the Federal Police of Germany, Code of Ethics of the United States Police, Code of Honor for rank and file officers of the internal affairs bodies of the Russian Federation).

At the international level, there are also legal deontological documents for a number of legal professions (i.e. the General Code of Rules for Lawyers of the European Community).

Medical deontology determines:

- moral aspects of the relationship between the medical worker and the patient and their specifics in various fields of medicine;
- moral aspects of the relationship between the medical worker and the patient’s loved ones;
- moral aspects of relationships between medical workers;
- moral aspects of professional medical errors and iatrogenesis;
- a patient’s rights and their regulation.

Modern deontology is organically included in the sphere of bioethics. Its problems are reflected in modern deontological codes adopted by medical communities of many countries.
Health should be a human right, and not a privilege for a limited circle of people who are able to afford it. Individuals should be regarded as equal in what is associated with their human qualities, dignity, freedom, individuality.

**Professional medical ethics** is a discipline which studies the norms of professional behavior of people working in the health care system. Its goal is to significantly deepen and update the norms and rules of a professional physician’s behavior.

There are three types of such norms:

- moral norms as an object of traditional medical ethics;
- norms of professional ethics: both collected in codes and those belonging to oral and written traditions associated with the medical profession;
- legal norms.

**Forensic medicine** studies the biological and medical contents of legal norms to develop prospects for their best interpretation, application and development.

Fields of bioethics:

1. General bioethics studies initial values and principles of medical ethics and documented sources of bioethics (international law, professional ethics, legislation);
2. Special bioethics analyzes the main problems considered in a general vein both in the medical and biological fields;
3. Clinical bioethics (bioethics of decisions) is based on the analysis of specific cases of medical and clinical practice, studying the values and ways of searching for an ethically correct line of behavior.

**Humanism** (from Latin *humanitas* “humanity”, *humanus* “human”, *homo* “human being”) is an ethical position in life which states that people have a right to determine the meaning and form of their life freely.

Humanism is not theistic and does not accept the “supernatural” vision of the real world. Humanism affirms the highest value of a person’s life, his/her right to self-determination and free expression of will.

The moral responsibility of a medical worker in the treatment and a response to gratitude for a successful outcome are of a different nature. If law and morality in
relation to a medical worker are a force of external influence on him/her, then moral
and ethical responsibility is the “inner voice” of a specialist talking about socio-cultural
upbringing. Sometimes a person can escape from the “punishing hand” of law, but it is
quite difficult to get away from the court of one’s own conscience. However, one
should not belittle the role and importance of medical law.

Still it is important to remember that law can only increase a specialist’s
responsibility when he/she is enriched with a philosophical and ethical content. In the
work of a medical specialist moral principles of humanism must be embodied in
specific behavioral norms, whose conscientious fulfillment will be a professional duty
and a matter of professional honor.

**Brief History of Bioethics**

History of bioethics counts more than three millennia. The most ancient source
which formulated requirements for a physician and his rights is considered to be the
*Code of Hammurabi*, the collection of laws related to the 18th century BCE.

Indian literature also regulates a physician’s behavior in such works as the
*Manus Code of Laws* (or the *Manusmṛiti*, about 2nd century BCE – 1st century CE) and
*Ayurveda* (Life Science, 9th – 3rd centuries BCE). There are three editions of *Ayurveda*
– the medical encyclopedia of antiquity. The most complete one belongs to doctor
Sushruta. One of the books of *Ayurveda* says what a physician should be, how he
should behave, how and what to tell the patient.

In ancient India, physicians swore an oath already in the middle of the 2nd
millennium BCE: a student undertook to honor his teacher up to personal sacrifice,
lead an ascetic lifestyle, put the patient’s needs above his personal interests, had to get
rid of all kinds of passions: hatred, self-interest, cunning; not to allow crimes, to keep
professional secrets.

For European medicine, the ethics of the ancient Greek physician Hippocrates
(about 460 – about 370 BCE) is of lasting importance. In his *Oath* Hippocrates defined
the fundamental principles of traditional medical ethics, many of which are relevant
today.
Abu al-Faraj, a physician and a writer who lived in the 13\textsuperscript{th} century, formulated the following appeal to the sick: “There are three of us – you, the disease and I; if you are with the disease, you will be two, I will be left alone – you will overcome me; if you are with me, there will be two of us, the disease will remain one – we will overcome it.” Along with the requirements for the physician’s personality, his human qualities (decency, honesty, kindness), great importance was attached to the need for constant self-improvement, because a bad physician can harm the patient, which is a gross violation of the moral standards of healing.

In the era of the Middle Ages and Renaissance, the moral guidelines of the medical profession were determined by Christian values – love for one’s neighbor, compassion, mercy. The famous Renaissance physician Paracelsus (1493–1541) taught his students: “The strength of the physician is in his heart; his work must be guided by God and illuminated by natural light and experience; the most important basis of medicine is love.” The Christian worldview set one of the most important moral principles of medicine – “Do good!”.

Medical ethics was further developed in the era of the New Age. At that time, the meaning of medicine in society was being rethought: the goal of medicine was then becoming not only individual, but also public health. Medical ethics was formalized as a system of detailed specific moral duties of a physician that regulate his/her professional activities. The works of the authors of that era, especially Thomas Percival (1740–1804), reflected many different aspects of internal professional relationships in medicine. He paid special attention to the requirements of etiquette in the relationship between physicians. As for the attitude towards patients, a physician acts as a philanthropist, who benefits them and receives corresponding appreciation from them. The physician should behave with patients “delicately, in the balanced, condescending and authoritative way.”

The first extensive discussion of bioethical problems took place in Nuremberg in 1946. This was due to medical experiments on people conducted by Nazi German physicians during World War II. At the Nuremberg trials, 23 German medical scientists were indicted. It was then that the first international document on bioethics was created.
in Nuremberg, the so-called “Nuremberg Code”, which regulates the conduct of scientific research and human experiments. The principles set forth in the Code were not requirements of the law, but moral standards.

An exceptional role in formation of the philosophical and analytical basis of bioethics belongs to Albert Schweitzer (1875–1965). In his ethics of *Reverence for Life* there is no division into a more and less valuable, higher and lower life. Considering every life form sacred and untouchable, he criticized anthropocentricity and expanded the biblical commandment “Thou shalt not kill” beyond the narrow limits of interhuman relations. His contribution to development of medical ethics is enormous and consists in creating a new mindset that includes the concept of environmental protection. A new thinking meant recognition of the responsibility of inhabitants of our planet for preservation and continuation of life on Earth. Survival is possible if a change in mentality is ahead of the pace of technological progress; if the gap between the rich and the poor decreases; if the cost of armaments decreases, and economic progress is not accompanied with destruction and degradation of the environment.

Bioethics is the science of laws, principles and rules for regulating the professional behavior of a medical worker. In the conditions of new medical technologies, they make it possible not only to use achievements of scientific and technological progress for the benefit of a person, but also to warn a medical practitioner and a medical scientist about inadmissibility of harming a person, his offspring, the world around him, forcing him to feel an involuntary “reverence for life”.

In the middle of the 20th century, a number of international organizations were formed – the WMA, the WHO, the UNESCO, the Council of Europe. Development of ethical documents regulating modern medical science and practice is among their goals.

In 1971, Van Rensselaer Potter’s book *Bioethics: Bridge to the Future* was published. The Potter concept is based on the idea that survival of the human civilization is impossible without a new interdisciplinary approach to the assessment of science and technology, which could integrate disconnected scientific worlds, especially natural science and humanitarian knowledge. This concept is based on the
concept of modern knowledge as syncretic, which, on the one hand, cannot further be considered in isolation from the existing biological facts that testify to the natural origin of a person and his/her needs, and on the other hand, must be transformed in such a way that it would be possible to combine cognitive goals and tasks of science with universal values.

Ethical values should not be considered separately from biological facts. A person is very dependent on vital biological needs. He/she is easily vulnerable in the world of “engineers, technologists and politicians” who have forgotten the simple truth: “if the plants dry out and die, and the animals cannot reproduce, then the person will soon become ill and die, being unable to continue his kind.”

Today, the total amount of human natural instincts is already insufficient to guarantee survival of the humanity in the form that would be approved of and accepted by each person living on Earth. If earlier the natural instincts and laws of survival stood guard over preservation of the human as a biological species, today they are being replaced by laws and ethical mechanisms of cultural adaptation and social selection. In conditions of minimizing the action of natural law, a person needs new approaches and methods for preserving and developing individual life, and scientists, physicians, psychologists, philosophers should develop new concepts of population and individual survival.

Decisions made by humanity on the basis of a single science approach, as well as forecasts that have exclusively scientific substantiation, often have a short-term nature and practically do not take into account interests and needs of future generations. As an example, Potter cites the history of a large-scale fight against malaria, which prevented numerous epidemics and contributed to the impressive reduction in child mortality in Africa in the 1960s. The “saved” children grew up, created their own families. In the context of the economic backwardness of African countries, this led to the emergence of a new circle of social problems – the need to provide the “saved” generation with work, housing, clothing, food. Another example is the story of thalidomide, a drug with a sedative effect. Being used by pregnant women, it was the reason for the birth of 10,000 children with severe impairment of physical development
and a subsequent disability. The detected teratogenic effect of thalidomide came as a surprise to scientists who did not suspect what dangers for human health such compounds could be fraught with.

The conclusion is obvious: knowledge can be dangerous, and science and technology can have consequences that are difficult to foresee unless the traditional way of thinking inherent in scientists and in the society as a whole is changed.

To get out of the vicious circle, when more and more new knowledge becomes a source of numerous dangers, it is necessary to separate such concepts as danger and unpredictability.

The danger of new knowledge arises in the process of its application. It can be eliminated with the help of more accurate scientific forecasts, while unpredictability has a total dimension and is associated with a certain way of thinking, theory and practice rationalization, as well as inaction, the absence of any special steps in order to change the situation.

The basis of unpredictability is the factor of chance, which is an important moment of not only biological, but also cultural evolution. The combination of order and randomness occurs daily in every person’s life who creates his/her own lifestyle, order and rules, which is very valuable for species as a whole due to uniqueness of each human. Due to dissimilarity of people and individually acquired habits, the humanity adapts to the environment well. In general, human behavior is characterized with the ordered disorder necessary for the evolution of culture.

The fight against unpredictability, randomness and disorder is possible, and it consists in laying down certain mechanisms that could guide random, unpredictable, often destructive, human behavior in the necessary direction, “channel”, streamline. One of such mechanisms is ethical principles and values, the ability to communicate and discuss ethical issues with other people.

**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

*Read Appendix “How to make a good presentation” before you start.*
1. Humanism as the ethics of civilized humanity and the substance of traditional ethics and bioethics.
2. Concept of bioethics (after V. R. Potter).
3. Philosophy of Reverence for Life (after A. Schweitzer).
4. Humanistic specificity of medical science and practice.
5. Main aspects of bioethics as an interdisciplinary science.
6. Contradictions of morality and law in bioethics.
7. Science ethics in the context of technogenic civilization.
9. Medical ethics from antiquity to the Middle Ages. Hippocrates model. Paracelsus model.
10. New time. Corporate class medical ethics of the 18th century.
12. Medicine under authoritarianism and totalitarianism.
14. Features of ethical problems in various areas of medical practice.

**Speaking skill development focus**

**Situational tasks**

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.
Situational task 1
A young man and a policeman were simultaneously taken to a small hospital. They injured each other in a criminal situation. The general health condition of the victims was approximately the same. The patients were of a different ethnic origin. The physicians, being of the same ethnic origin as the policeman, provided him with full medical assistance and, in fact, refused full medical assistance to the young man for no good reason, limiting him only with stopping external bleeding. The failure to provide medical assistance to the young man led to development of a life-threatening condition.

What violations were made by the physicians? Explain your opinion.

Situational task 2
Head physician: “I repeat once again for everyone – our clinic has its own unwritten labor code: a physician works as long as necessary for the patient. The beginning is at 9 a.m., the end is when all the work is done. Second, if a physician is not good, he/she must leave without intervention of the directorate and the union. It’s me who decides on the competence issue.”

Is the head physician right in his statements? Explain your opinion.

Situational task 3
“When they call you to visit the physician – you won’t be happy since there you will be especially struck by this prison mechanics of the physician. The physician’s look not only lacks concern, but even simple attention. He will not ask: “What are you complaining about?” because there are too many words, he will simply chop off: “Complaints?” If you talk too much about a disease, they will tear you off because it is so clear. A tooth? To extract. To treat? We don’t treat.” (A. Solzhenitsyn. The Gulag Archipelago).

What is the reason for the prison mechanics of the physician in relation to the patient? Explain your opinion.
Test tasks

Tick only one correct variant.

1. ETHICS IS A SCIENCE OF…
   1) relationships among living beings;
   2) the nature and meaning of moral relationships and principles;
   3) minimizing harm in human relationships;
   4) the ability to behave correctly in society.

2. THE RIGHT TO HEALTH CARE AND MEDICAL CARE IS RELATED TO THE GROUP OF…
   1) political rights;
   2) individual rights;
   3) social rights;
   4) economic rights.

3. THE MAIN GOAL OF THE PHYSICIAN’S PROFESSIONAL ACTIVITIES IS…
   1) saving and preserving human life;
   2) social trust in the profession of a physician;
   3) respect for colleagues;
   4) material benefit.

4. THE MAIN DISTINGUISHING FEATURE OF THE PHYSICIAN’S PROFESSIONAL ETHICS IS…
   1) the right to deviating behavior;
   2) a conscious choice of moral principles and rules of conduct;
   3) criminal liability for non-compliance with professional ethical standards;
   4) an unconditional need to subordinate personal interests to corporate ones;
   5) priority interests of the medical science over interests of a particular patient.
5. A PHYSICIAN HAS THE RIGHT TO MAKE A MEDICAL ERROR. THIS STATEMENT IS…
   1) true; we all make mistakes;
   2) false; a medical error is fraught with punishment;
   3) true; the one who does nothing is not mistaken;
   4) false; recognition of such a right is contrary to the principle of “Do no harm”.

6. BIOETHICS AND MEDICAL LAW SHOULD BE IN THE FOLLOWING RELATION TO EACH OTHER: …
   1) Both of them are independent from each other.
   2) Medical law is a priority.
   3) Bioethics is a priority.
   4) Bioethics is a criterion for correctness of medical law.

7. THE VALUE OF HUMAN LIFE IS DETERMINED BY…
   1) social status;
   2) age;
   3) nationality;
   4) Human life is priceless.

8. A PATIENT HAS THE RIGHT TO…
   1) directly familiarize with medical records;
   2) request copies of necessary medical documents;
   3) refuse medical intervention;
   4) all the rights mentioned above.

1) physiological, anatomical, biochemical;
2) emotional, economic, physical;
3) physical, socio-psychological, legal, moral;
4) There is no correct answer.

10. THE DETERMINING REGULATOR OF A PHYSICIAN’S DECISION TO SOLVE COMPLEX ETHICAL PROBLEMS IN HIS/HER PROFESSIONAL ACTIVITY COULD BE ANY OF THE MENTIONED HERE BUT…

1) international law;
2) secular ethics;
3) principles of professional ethics;
4) national law;
5) traditional religious morality;
6) personal benefit.
1.2. Principles and Rules of Bioethics

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Principles of Bioethics

Bioethics is an important point in philosophical knowledge. Development and formation of bioethics is due to the fact that both traditional and medical ethics have transformed and changed over time. This formation occurred primarily due to the fact that attention to human rights was increasing, and medical technologies continued to develop. Acute problems that could only be solved through legal means appeared.

The principles of bioethics are the following:
- do no harm (or nonmaleficence);
- do good (or beneficence);
- duty adherence;
- respect for human rights and dignity;
- respect for personal autonomy;
- equity.

1. “Do no harm” (or Nonmaleficence, Latin *Primum non nocere*) is the first bioethical principle proclaimed by Hippocrates and fixed in his *Oath*, also called the Hippocrates model. This commitment has become not only the main principle of all medical activity, but also the main model of the relationship between medical workers and patients, their relatives and friends. The Hippocrates oath reflects all spheres where a physician is involved and where he/she must not “do harm”:
   - a physical sphere – selection of proper treatment methods;
• socio-psychological and legal spheres – non-disclosure of medical confidentiality;
• a moral sphere – a physician must respect his/her teachers and colleagues.

A physician can sometimes harm his/her patient. But how can one differentiate between the types of damage caused by a medical professional? The following forms of harm are distinguished:
• harm due to a physician’s inaction, i.e. failure to help at the right time;
• a physician’s negligence, which is also harm as it can have serious consequences;
• damage caused by an unqualified physician, i.e. professional errors;
• damage caused by actions objectively necessary in a specific situation.

Causing damage of the first three types indicates professional incompetence of the medical worker, professional burnout, fatigue caused by irregular working hours due to a shortage of medical workers, and a varying degree of deformation of his/her morality.

Each visit to the physician carries a probability of causing any harm to the patient. Provision of medical care also includes procedures that cause physical harm in order to achieve the patient’s ultimate good – saving life, maintaining health. A visit to the physician requires time (and material costs) that a person could spend on something else. The physician recommends a certain mode of life, and this is a limitation of a person’s capabilities, freedom, especially with hospitalization.

Information on the disease prognosis can act as a source of harm. In this case, harm can be caused by both information concealment and by truthful communication thereof.

On the one hand, by deceiving someone, we thereby harm him/her, as we humiliate a person’s dignity. On the other hand, a person who has insufficient or incorrect information can inadvertently cause harm to oneself and others. In addition, truthful information without taking into account the patient’s emotional state can also harm, especially in case of a deadly disease diagnosis.
Harm to the patient can be caused by violation of medical confidentiality. Disclosure of confidential information (“medical confidentiality”), on the one hand, is punished in accordance with applicable law, and on the other hand, the law requires reporting a number of diseases to relevant health authorities.

Thus, observance of the “do no harm” principle is possible only if a health worker has formed moral beliefs and personality traits that meet the requirements of biomedical ethics. This principle captures the birth of professional medical ethics. It considers the problem of the relationship between the physician and the patient from the point of view of social guarantees and professional obligations of the medical community. The physician’s attitude gains the patient’s social trust.

2. “Do good” (or Beneficence) is the second important principle of bioethics, also called the Paracelsus model. It means that the physician’s actions should be aimed at the benefit of the patient. This principle was formulated by Paracelsus. It is aimed at avoiding harm that the physician can cause to the patient.

The “do good” principle is a form of interaction between a medical worker, a patient and his/her relatives when a moral relationship between them is one of the main elements of therapy. Taking into account the patient’s individual personality traits and establishment of a trusting relationship between the physician (and other medical personnel) and the patient is of paramount importance.

Benefit, charity, mercy are integral parts of the relationship between the medical worker and the patient in accordance with this principle. It focuses the attention of a medical worker on the need not only to avoid harm, but to take active steps to prevent and (or) correct it. The goal of medicine and healthcare is not just to avoid harm, but to ensure the patient’s good. This principle captures an emotional-mental relationship with the patient as part of the treatment process. It can also be referred to as paternalism – an emotional contact of the physician and the patient which can be compared with the relationship of a spiritual mentor and a novice.

3. Duty adherence is the third principle of bioethics, also called the deontological model. This principle appeared in medicine when physicians began to be
taught a professional duty. According to it, a medical worker must act strictly according to the prescribed bioethical norms and rules.

The requirements of a professional duty are rigorous for execution. In accordance with this principle, it becomes a professional duty for a medical worker to follow the “do no harm”, “do good” and other bioethical principles and standards. A violation of the requirements of a professional duty entails certain penalties (moral, administrative, legal).

4. **Respect for human rights and dignity** is a principle manifested in the following ethical rules: justice, truthfulness, confidentiality and informed consent.

This principle is based on recognition of a person as an unconditional value and involves a person’s free choice in relation to his/her life and health (the choice of a medical organization, a treating physician, treatment consent or refusal of it, etc.). A choice that the patient makes, no matter how it disagrees with the physician’s position, should determine the physician’s further actions. This principle is leading in bioethics as it allows the patient to realize his/her rights to the greatest extent in relation to one’s life and health.

5. **Respect for personal autonomy** is a principle which essentially sets forth a qualitatively new role that the patient begins to play in modern medicine. A person is recognized as an “autonomous personality” if he/she acts freely on the basis of rational understanding of his/her own good. Traditional medical paternalism instructed the physician to make decisions and act independently, ignoring the patient’s “ignorant” opinion of what his/her good is. Thus, the physician deprived the patient of the opportunity to be a person, the “master” of one’s own body, the “author” of one’s own biography. Such an attitude degrades a person’s dignity, puts one in the subordinate position, and often carries a threat to one’s vital interests.

The latter is especially true in commercially oriented healthcare, when any medical prescription (drug administration, making a diagnostic test, performing a treatment procedure) turns out to be a form of sale of a medical service. The “buyer” should be able to choose the “product”. Therefore, he/she must understand what, in fact, he/she needs in this situation (what is his/her good), and be able to independently
choose the right one from the proposed range of services. In other words, he/she must be recognized as an autonomous person. The situation in commercial medicine is only a special (albeit very revealing) case that demonstrates how important recognition of personal autonomy is.

On what basis can an independent rational choice of the patient be built if, in understanding of the biological foundations of the disease, he/she is entirely dependent on the physician who, among other things, may not agree with his colleagues? The fact is that treatment is not only an intervention in the body of a suffering person, but also a part of life (an episode of a biography) of both the physician and the patient, and their common part that they live interacting with each other. Therefore, the patient can quite rationally trust or distrust expert judgment of the physician, based on his/her previous experience. It is precisely on this that his/her right to choose a physician is enshrined in law.

If there is no personal experience with a particular physician or a medical organization, it can be obtained from other patients. This occurs through simple communication of patients who find themselves in the same ward or in one queue for an appointment with a physician. This kind of information can be obtained from numerous organizations that protect the rights of patients, or from insurance companies. A new, increasingly important source of information is the Internet. Through the Internet, people exchange opinions on the quality of service in various medical organizations (and even on the quality of work of specific physicians), prices for certain types of services, the situation in the wards, etc.

In other words, in the context of multivariance of treatment methods and ambiguity of expert opinions, the patient’s rational independent choice of his/her good is based on his/her critical ability to evaluate various sources of information, to distinguish a reliable opinion from advertising and self-promotion. In this choice, the patient realizes him/herself as an autonomous person.

Autonomy is a form of personal freedom when an individual commits actions in accordance with a decision freely chosen by him/her.

There are seven main aspects of autonomy:
• respect for the personality of the patient;
• providing the patient with psychological support;
• providing the patient with necessary information about the state of health and the proposed medical measures;
• the ability to choose from alternative options;
• the patient’s independence in decision-making;
• the patient’s ability to monitor the progress of research and treatment;
• the patient’s involvement in the process of providing him/her with medical care (“therapeutic cooperation”).

6. Equity as a principle can be formulated as follows: everyone should receive what is due to him/her. “Everyone” in this case can refer either to an individual person, or to a group of people distinguished for some reason. It will be fair to distribute social benefits among members of such a social group as low-income citizens, and it will be unfair to distribute it to everyone in a row. Unlike the principles considered earlier, this principle is intended to be used in situations when one’s assessments, decisions, and actions affect not just one person, but different people or different social groups. The principle of equity is not absolute, but relative. If, for example, in a situation with a donor organ transplant, it turns out that a patient who is taking a farther place on the waiting list is in a critical situation, one can compromise with obligations arising from the principle of equity and be guided by the principle of “do no harm”. However, the refusal to comply with the queue in such a case can be interpreted in the sense that we use the principle of equity, but we turn to the criterion of need and proceed from the degree of its severity.

The principle of equity at the physician–patient relationship level involves providing assistance to the patient regardless of his/her gender, age, racial and national origin, social and material status, political convictions and religion, personal preferences of the physician, etc. At the level of the healthcare system as a whole, it implies an equal access of all population groups to biomedical services and benefits, an access to pharmacological agents, protection of the most vulnerable segments of the
population. When distributing scarce healthcare resources, one has to turn to one criterion of equity or another: equality, consideration of individual needs, etc. Of course, none of them can be considered absolute and several criteria are often used to distribute limited medical resources.

In addition to the indicated principles, the following principles can also be noted:

- the principle of **respect for human dignity**, implying recognition of the self-worth of each person, including people who, due to their physical or mental state, do not have an ability to express their will themselves;
- the principle of **integrity**, focused on the physical and mental identity of the individual and prohibiting manipulation or destruction of this identity;
- the principle of **vulnerability**, characterizing fragility and finiteness of every life, and also requiring special protection and attention in relation to certain groups of the population (poor, illiterate, disabled people, children).

### Rules of Bioethics

The rules of bioethics are the following:

- informed consent;
- veracity;
- confidentiality;
- privacy protection.

1. **The informed consent rule** states that any medical manipulations should be carried out only with the patient’s voluntary and informed consent after the physician has provided him/her with the necessary information.

   The goal of obtaining informed consent is to agree on an optimal solution in all respects, to take into account both medical indications and the patient’s preferences. The physician gives professional advice on the most acceptable medical option, but the final choice remains with the patient. If the patient refuses the proposed option, the physician must either convince the patient or suggest trying an alternative method. A convincing patient’s disagreement is an absolute contraindication to any medical
action. The patient’s voluntary consent excludes coercion, deceit, forgery and other similar actions. Moreover, they are evaluated not only by morality, but also by law.

The physician is obliged to inform the patient about all possible methods of treatment, their goals, efficacy, costs, possible risks, and possible adverse reactions. The physician’s task is to convey the meaning of the proposed treatment to the patient. The physician must find clear words, taking into account the patient’s age and level of education. No intimidation or pressure on the patient must be performed.

It is the physician’s duty to inform the patient about:

- the nature and goals of the treatment proposed to the patient;
- a significant risk associated with it;
- possible alternative types of treatment.

Moreover, the concept of an alternative to the proposed treatment is central to the idea of informed consent. The physician gives advice on the most acceptable option from the medical point of view, but the patient makes the final decision based on his/her moral values. Thus, the physician treats the patient as a goal, and not as a means to achieve another goal, even if this goal is health.

When informing, special attention is also paid to the risk associated with treatment. The physician must address four aspects of risk: its nature, severity, a probability of its materialization, and suddenness of materialization. Voluntary informed consent is a crucial point in the decision-making process. Voluntariness of informed consent implies the non-use of coercion, deception, threats, etc. by the physician, when the patient makes a decision. In this regard, we can talk about expanding the scope of application of morality, moral assessments and requirements in relation to medical practice. It is a physician’s duty to be honest with patients.

In general, the informed consent rule could be violated in the following cases:

- with a child, since he/she is not considered an autonomous person, capable of a balanced and informed decision. All medical manipulations with the child should be carried out with informed consent of his/her parents or legal representatives;
• with a person recognized legally incompetent by the court and the medical commission. In such a case, informed consent of his/her guardians appointed by the court is required;
• with an unconscious patient. In such a case, the decision on treatment is made by a committee of physicians based on vital indications.

If the patient is capable of a rational and thoughtful choice, if he/she clearly and confidently expresses a decision in any form, it is a guide to action for the physician, but only if it does not contradict the law and his/her beliefs.

2. The veracity rule states that the patient and the medical worker should be truthful to each other, not hide or distort important circumstances related to health and treatment. It guarantees the patient’s right to truthful information about the diagnosis, prognosis and treatment methods. However, this general rule cannot be equally valid in all situations.

There are a number of questions that have not been given unambiguous answers yet:
• Can a physician soften or hide some information?
• Does the patient have a right to privacy?
• Is “false salvation” permissible?

Modern world practice shows how ambiguous the attitude of both physicians and patients is to absolutely truthful information about health. On the one hand, while telling the truth, the physician and the patient demonstrate mutual respect and trust. The physician formulates the diagnosis more accurately and replenishes practical experience, and the patient can give informed consent only by possessing truthful information. On the other hand, while telling the truth about a fatal disease, an unfavorable prognosis, an unsuccessful operation, etc., the physician must take into account the patient’s psychological state, the moment of conversation, the amount of truthful information. Ignoring such conditions makes the truth not only inappropriate, but also dangerous.

Patients are often aware of their diseases. The physician’s skill is to understand what is really important for the patient – to maintain, albeit an illusory, but hope, or
openly discuss their own experiences, fears and pain. The patient, surrounded with a wall of lies, omissions, hypocrisy, is left alone with the disease. His/her condition is aggravated by loneliness and grieve.

Many experts believe that a true story is possible if the truth does not cause even greater harm to the patient, does not deprive him/her of the last hope, and does not break his/her spirit and faith in recovery. If the physician decides to tell the patient the “bitter” truth, he/she must help the patient to accept and survive this truth, must morally support the patient until the last minute, talk about the disease and death, about hope and mutual support. After all, a patient’s death is not an easy test for a medical worker, who has a feeling of guilt and one’s own helplessness, although he/she did everything possible.

The veracity rule includes two main aspects:

- telling lies is prohibited;
- the listener has a right to receive a truthful message.

Faithfulness is a prerequisite for normal communication and social interaction. The balance of values cannot be predetermined a priori, in the form of a certain rule. However, it should always be borne in mind that the right to tell the truth is not unconditional, that privacy of another person is the most important legal norm and moral value in modern civilized societies.

3. **The confidentiality rule** states that information about the patient that he/she provides to the medical worker or the medical worker receives as a result of examination cannot be transferred to third parties without the patient’s permission.

The confidentiality rule, or preservation of medical confidentiality, allows to establish the most open, trusting relationship between the patient and the physician. In a conversation with the physician, the patient tells such details that he/she often hides from relatives and friends since he/she may be embarrassed by them. Preservation of medical confidentiality guarantees the patient peace and professional assistance.

The international code of medical ethics states that the physician must maintain absolute secrecy in everything that relates to patients who trust him/her. Information
about the fact of turning for medical care, one’s state of health, diagnosis, disease, and other information obtained during examination and treatment is medical secret.

Disclosure of medically confidential information is not allowed to people to whom it became known during training, performance of professional, official and other duties.

With the patient’s or his/her legal representative’s consent, it is allowed to transfer information constituting medical secret to other citizens, including officials, in the interests of examining and treating the patient, for conducting research, publishing in scientific literature, using this information in the educational process and for other purposes. In this case, a scientist must take care of providing secrecy of the patient’s personality.

Non-medical information about the patient or his/her relatives (personal information), which became known to the physician while performing his/her duties, should also be confidential. The effect of this rule is limited in the presence of a threat of infection spread, mass poisoning or damage, as well as if the physician suspects that the damage to the patient’s health was the result of criminal acts.

The confidentiality rule is the key to trust and frankness of communication, as well as social effectiveness of communication between the physician and the patient. It acts as a condition for protecting the patient’s social status, as well as his/her economic interests and personal autonomy. In the context of computerization, the value of the confidentiality rule requires special methods and procedures for its reliable implementation.

In many countries, provision with information constituting medical confidentiality without consent of the patient or his/her legal representative is allowed:

- for the purpose of examination and treatment of a patient who is not able to express his/her will due to his/her condition;
- if some highly contagious diseases are detected in the patient and if child abuse is suspected of;
- at the request of the bodies of inquiry and investigation, the prosecutor and the court in connection with an investigation or a trial.
The physician may only provide information related to the patient’s health status, i.e. the information recorded in the case history. The physician is not obliged to provide other information that became known in the process of providing the patient with medical care, unless he/she considers it necessary to prevent a serious crime (e.g. a terrorist act). The physician is not required to be an investigation agent, i.e. fulfill instructions of the investigation, obtaining information from the patient, no matter what considerations it is justified by. The physician is obliged to provide information only in relation to patients officially involved as defendants, witnesses or victims. The physician may only provide information to an official based on a formal written request in relation to a specific case. A gross error is communication of the patient’s information to the investigator and interrogator only on the basis of who he/she is. The physician must always inform the patient that medical confidentiality has been disclosed:

- in case of medical assistance to a minor to inform the parents or legal representatives;
- if there are grounds to believe that damage to the patient’s health has resulted from illegal actions.

The channels and methods for disclosing medical confidentiality are:

- an easy access to medical records, test results, sick leaves, certificates;
- information dissemination through computer systems;
- criminal negligence or talkativeness of medical personnel;
- availability of medical information to people who do not bear medical responsibility;
- information disclosure for personal gain;
- a conflict of interests, when the physician, in addition to the patient’s interests, is obligated to protect someone else’s interests (the employer, an insurance company).

4. **The privacy protection rule** states that the right to privacy, personal and family secrecy, protection of one’s honor and good name implies prohibition of any
form of arbitrary interference in private life on the part of the state, and also guarantees protection by the state against such interference by third parties.

Private life is a physical and spiritual sphere which is controlled by the individual him/herself, free from external influences, that is, the family and household sphere of the individual, the sphere of communication, attitude to religion, extra-curricular activities, hobbies and other areas of relations that the person him/herself does not want to make public if the law does not require it.

Personal and family secrets include secrecy of adoption, privacy of spouses, personal property and non-property relations existing in the family, and other information. The right to personal and family secrecy of a family member requires non-disclosure of relevant information and authority to dispose of relevant information at their own discretion or with consent of other family members.

In the process of a person’s life, various people legally receive information on certain aspects of other’s private life. Among them are physicians, lawyers, notaries, law enforcement officers, clergy, etc. That is why various requirements have been enshrined to keep secret information about the private life of citizens. For example, a notary is obliged to keep secret the information that became known to him/her in connection with implementation of professional activities.

The physician should not collect, accumulate and disseminate (transmit or sell) information regarding the patient’s private life without his/her consent. Elements of private life are the fact of going to the physician, information about the state of health, biological, psychological and other characteristics of the patient, treatment methods, habits, one’s lifestyle, etc. This rule protects the patient’s privacy from unauthorized intrusion of others – including physicians or scientists. Historically, it became relevant when broad areas of personal life (primarily, sexuality) ceased to be a subject of medical control in the early 1960s. Currently, the danger of criminal interference in one’s private life with the use of various kinds of personal information, encoded, stored on media and distributed on the Internet, is of particular importance.
**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

*Read Appendix “How to make a good presentation” before you start.*

1. Principle of “Do no harm” (Nonmaleficence principle).
2. Principle of “Do good” (Beneficence principle).
5. Principle of respect for personal autonomy.
7. Rule of informed consent.
8. Rule of veracity.
9. Rule of confidentiality.
10. Rule of privacy protection.
11. Principles and rules of bioethics on specific examples.
12. The patient’s right to informed consent in international and national codes of ethics.
13. Legislation on informed consent.
14. Patient’s right to information. Physician’s duty to inform the patient in an accessible form.

**Speaking skill development focus**

**Situational tasks**

1. *Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.*
2. *Using the information of the paragraph, answer the questions following them.*
3. *Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.*
4. *Compare the results of discussion with solution patterns.*
**Situational task 1**

Patient Kate, 27 years old, was treated at the clinic for systemic lupus erythematosus. According to a standard examination, a Wasserman reaction test was performed for her and was positive. Through the fault of the laboratory assistant and the nurse, the analysis results became known to the roommates who began to glance at the patient. The patient quarreled with her husband, thinking she had developed a severe mental reaction with exacerbation of symptoms of lupus erythematosus. It was very difficult for the attending physician to reassure the patient and her husband, explaining a possibility of specific positive Wasserman reactions with symptoms of lupus erythematosus.

What rule of bioethics was not respected by the laboratory assistant and the nurse? Explain your opinion.

**Situational task 2**

An obstetrician-gynecologist, working in a pharmaceutical company and receiving 20% of the drug cost if sold, prescribes an expensive multivitamin complex to all pregnant women in his district. At the same time, he “forgets” to talk about possible adverse reactions, such as frequent allergic reactions and early closure of a large fontanel in a child, and possible cheaper, but no less effective analogues.

What bioethical rules does the physician violate? Explain your opinion.

**Situational task 3**

In the ward there was a patient with obvious signs of a violent trauma. However, the patient insisted that she had fallen down. The physician, despite the patient’s requests, independently sent a telephone message to the police station stating that the patient stayed in the hospital with an injury of an unclear etiology. During the investigation, it turned out that her distant relative was living in the same apartment with the victim, and terrorized everyone living there. The patient, being in fear of him, was afraid to tell the truth. The result of the investigation was eviction of that person from the apartment and his further criminal prosecution.
What bioethical principle prompted the physician to act?

Test tasks

Tick several correct variants.

1. INTERVENTION IN THE FIELD OF HUMAN HEALTH SHOULD BE BASED ON…
   1) the patient’s free and informed consent;
   2) medical indications;
   3) rarity of the disease aspects and its cognitive value;
   4) requirements of the patient’s relatives;
   5) financial gain.

2. COORDINATION OF THE OPTIMAL SOLUTION IN ALL RESPECTS TAKING INTO ACCOUNT MEDICAL INDICATIONS AND THE PATIENT’S PREFERENCES IS THE GOAL OF THE RULE OF…
   1) veracity;
   2) privacy protection;
   3) confidentiality;
   4) informed consent.

3. DISCLOSURE OF PROFESSIONAL SECRETS BY THE PHYSICIAN WITHOUT THE PATIENT’S INFORMED CONSENT IS… (tick 2 correct variants)
   1) allowed only at the written request of law enforcement;
   2) allowed only at the request of close relatives;
   3) allowed only if there are grounds to believe that health damage was caused by unlawful actions;
   4) always unacceptable.
4. THE INFORMED CONSENT RULE COULD BE VIOLATED IN THE FOLLOWING CASES… (tick 3 correct variants)

1) with a child;
2) with an explosive, unbalanced personality;
3) with a person recognized by the court and the medical commission as legally incompetent;
4) with an unconscious patient;
5) with a person having a depressive, melancholy character.

5. THE TWO MAIN ASPECTS OF THE VERACITY RULE ARE… (tick 2 correct variants)

1) the presence of “lies for salvation”;
2) privacy of another person, which is the most important legal norm and moral value in modern civilized societies;
3) a prohibition to tell a lie;
4) the listener’s right to receive a truthful message;
5) the physician’s decision on what truth is the most necessary for the patient at this moment, given his/her personal qualities and condition.

6. THE PRIVACY PROTECTION RULE IS REFLECTED IN THE FOLLOWING STATEMENTS (tick 3 correct variants):

1) The information about the patient could be shared with relatives and close friends without his/her permission.
2) The information about the fact of seeking medical help, the state of health, the diagnosis and other information constitute physician – patient confidentiality.
3) Non-medical information about the patient or his/her relatives (personal information) should not be confidential and does not constitute physician – patient confidentiality.
4) If some highly contagious diseases are discovered in patients (syphilis, meningitis), as well as gunshot wounds, and in case child abuse is suspected, information could be provided without informed consent of the patient or his/her legal representatives.

5) The physician is not obliged to provide other information that became known during medical care provision, unless it is considered necessary to prevent a serious crime.

7. THE CHANNELS AND METHODS OF DISCLOSING PHYSICIAN – PATIENT CONFIDENTIALITY INCLUDE… (tick 4 correct variants)

1) information dissemination through computer systems;
2) a report on a clinical case at the conference without disclosing the patient’s data;
3) information disclosure for personal gain;
4) discussion of the patient’s clinical case at a consultation with another patient;
5) crime negligence or talkativeness of medical personnel;
6) an easy access to medical records, test results, sick leaves, certificates.

8. THE RULE THAT PROTECTS THE PATIENT’S PRIVACY FROM UNAUTHORIZED INTRUSION OF OTHERS IS THE…

1) confidentiality rule;
2) privacy protection rule;
3) veracity rule;
4) informed consent rule.

1) veracity rule;
2) informed consent rule;
3) confidentiality rule;
4) privacy protection rule.

10. RESPECT FOR PERSONAL AUTONOMY OF THE PATIENT BY THE ATTENDING PHYSICIAN INVOLVES…

1) keeping a secret about the patient’s state of health;
2) observance of the patient’s suffrage;
3) transfer of information about the nature of the patient’s diseases to his/her employers;
4) informing the patient about the state of health of his/her family members at their request.
1.3. General Aspects of “Medical Worker – Patient” Relationships

Reading skill development focus

1. Read the suggested text material.

2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Ethical Codes in Medicine

One of the oldest medical and ethical documents is the Hippocratic Oath. This oath was given by graduates of the famous school of Asclepiads, the founder of which was considered the god of medicine Asclepius. Its most famous graduate was the famous Hippocrates the Great of Kos.

The Hippocratic Oath is a document consecrating the medical life of medical schools of the Hippocrates times. Medical schools and medical associations (corporations) had already appeared. Entering a corporation, a physician had to behave accordingly: to refrain from all reprehensible actions and not to drop his dignity. The emergence of the Hippocratic Oath was caused by the need to dissociate the graduates from single physicians, charlatans, and to ensure public trust in physicians of a particular school.

The oaths that formulate moral standards of the physician’s behavior existed in Egypt before the Hippocratic Oath. The origin of the oath is much older than the life of Hippocrates: according to legend, the oath goes back to the direct descendants of Asclepius. It passed orally as a family tradition from generation to generation. The oath was first recorded by Hippocrates in Hellenistic Alexandria under Herophilus and Erasistratus and became a document from the 3rd century BCE. Since then, the text of the oath has been repeatedly translated into new languages, has been edited, significantly changing its meaning. Here is the text:
Hippocratic Oath

“I swear by Apollo Physician, by Asclepius, by Hygieia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture.

To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician’s oath, but to nobody else.

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.

Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I break it and forswear myself, may the opposite befall me.”

As we can see, turning to actual medical obligations, the authors put the patient’s lifestyle (mode) in the first place. From the very first steps, a young physician must learn the first law of medicine “Do no harm” and understand that the principle of equity must be adhered to steadily. Healing is defined not as a craft, but as an art where moral purity is needed and vices are unacceptable. Many prohibitions of the Oath turned into
legislative norms of most countries, threatening a modern physician with various, but always serious punishments, especially for disclosing medical secrets.

The *Hippocratic Oath* contains nine ethical principles or obligations:

1. obligations to teachers, colleagues and students;
2. the principle of non-harm;
3. obligations to assist the patient (the principle of mercy);
4. the principle of caring for the patient’s benefits and dominant interests;
5. the principle of respect for life and a negative attitude to euthanasia;
6. the principle of respect for life and a negative attitude towards abortion;
7. the obligation to refuse intimate relationships with patients;
8. a commitment to personal improvement;
9. medical confidentiality (the principle of confidentiality).

In some cases, the traditional *Hippocratic Oath* comes into conflict with requirements of part of society, including some medical workers. Moreover, some principles of the *Hippocratic Oath* today in many parts of the world do not have any power. The original version recorded by Hippocrates in the 3rd century BCE in the Ionian dialect of the ancient Greek language forbade a physician to promote abortion and suicide. Today, abortion and euthanasia in many countries of the world are completely ordinary and not condemned phenomena. For its time, the *Oath* was a great achievement setting a high moral standard.

In 1948, the General Assembly of the International Medical Association adopted the Declaration of Geneva, which in its essence is a modern version of the *Hippocratic Oath*. Here is its original text:

**Declaration of Geneva**

“At the time of being admitted as a member of the medical profession:
I solemnly pledge to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude that is their due;
I will practice my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets that are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;

My colleagues will be my sisters and brothers;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I will maintain the utmost respect for human life;

I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

I make these promises solemnly, freely and upon my honor.”

Later, in 1949, the Declaration of Geneva was included in the International Code of Medical Ethics. Here is the original text without the Declaration above:

<table>
<thead>
<tr>
<th>International Code of Medical Ethics</th>
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<tbody>
<tr>
<td><strong>“Duties of physicians in general</strong>**</td>
</tr>
<tr>
<td>A physician shall always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.</td>
</tr>
<tr>
<td>A physician shall respect a competent patient’s right to accept or refuse treatment.</td>
</tr>
<tr>
<td>A physician shall not allow his/her judgment to be influenced by personal profit or unfair discrimination.</td>
</tr>
<tr>
<td>A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.</td>
</tr>
<tr>
<td>A physician shall deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.</td>
</tr>
</tbody>
</table>
A physician shall not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.

A physician shall respect the rights and preferences of patients, colleagues, and other health professionals.

A physician shall recognize his/her important role in educating the public, but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.

A physician shall certify only that which he/she has personally verified.

A physician shall strive to use health care resources in the best way to benefit patients and their community.

A physician shall seek appropriate care and attention if he/she suffers from a mental or physical illness.

A physician shall respect the local and national codes of ethics.

Duties of physicians to patients

A physician shall always bear in mind the obligation to respect human life.

A physician shall act in the patient’s best interest when providing medical care.

A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician’s capacity, he/she should consult with or refer to another physician who has the necessary ability.

A physician shall respect a patient’s right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.

A physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.

A physician shall in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.
A physician shall not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

*Duties of physicians to colleagues*

A physician shall behave towards colleagues as he/she would have them behave towards him/her.

A physician shall not undermine the patient-physician relationship of colleagues in order to attract patients.

A physician shall, when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect the patient’s confidentiality and be confined to necessary information.

**Basic Models of “Medical Worker – Patient” Relationships**

There are four basic models of “Medical worker – Patient” relationships:

- paternalistic;
- technical;
- collegial;
- contract.

The **paternalistic model** (from Latin *paternus* “paternal”) is a traditional relationship form between the physician and the patient which dominated medicine until the middle of the 20th century. The physician took responsibility for the treatment outcome, and also decided to what extent the patient could be informed about the essence of the disease, the treatment mechanisms and its consequences. The patient was completely dependent on the actions of the physician. A physician, according to this model, is a professional in medicine and a “life expert” in general. The physician assumes moral superiority over the patient.

<table>
<thead>
<tr>
<th>Positive side</th>
<th>Negative side</th>
</tr>
</thead>
<tbody>
<tr>
<td>The principles of “Do good” and “Do no harm” work directly.</td>
<td>The patient is deprived of the right to autonomy.</td>
</tr>
</tbody>
</table>
The technical model, where the physician does not actually communicate with the patient, is a kind of the paternalistic model since the patient does not understand the readings of the equipment as much as the physician does. A physician is an applied scientist, inclined to be interested in facts, but not in ethical values.

<table>
<thead>
<tr>
<th>Positive side</th>
<th>Negative side</th>
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<tbody>
<tr>
<td>The physician has a desire to use the latest achievements of medical science in clinical practice.</td>
<td>The model follows the principle of “Treat the disease, not the patient” ignoring the mental and cultural dimensions of the disease.</td>
</tr>
</tbody>
</table>

The trend towards this model exists in the western countries, which is caused with complex standardization processes and technological breakthroughs. Interpretation of the obtained data requires a lot of knowledge from the physician, and the need to explain to the patient what is happening becomes more difficult due to the amount of data received. The physician acts as an expert. At the same time, he/she does not take into consideration the patient’s life problems.

The collegial model leads to an agreement between the physician and the patient to act together, combining their efforts, will and knowledge to fight the disease. The physician and the patient collaborate as colleagues in pursuit of common goals – maintaining health, healing the disease, alleviating the pain or suffering of the dying person. In this model, mutual trust plays a crucial role. The physician acts as a friend or a teacher, involving the patient in a dialogue to identify the best mode of action. He/she explains to the patient all possible treatment options apart from the most suitable one.

<table>
<thead>
<tr>
<th>Positive side</th>
<th>Negative side</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is maximum trust and responsibility from the both sides, an atmosphere of dialogue.</td>
<td>Ethnic, economic and value differences between people make the principle of common interests difficult to implement.</td>
</tr>
</tbody>
</table>

The contract model corresponds to real conditions best of all, since it is based on a contract or agreement: the relationship between the physician as a provider of
medical services and the patient as a client buying these services. This model avoids rejection of morality by the physician.

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<thead>
<tr>
<th>Positive side</th>
<th>Negative side</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is clear legal and medical certainty and regulation of services that define mutual obligations of the physician and the patient.</td>
<td>The role of values of the humanistic nature is belittled. However, the agreement implies respect for the principles of freedom, personal dignity, honesty, fulfillment of promises and justice.</td>
</tr>
</tbody>
</table>

Traditionally prevailing paternalism in medical practice gives way to the principle of cooperation. The moral value of autonomy was so high that a good deed of the physician against the will and desire of the patient has been considered unacceptable recently.

**Moral Problems and Conflicts in “Medical Worker – Patient” Relationships**

There are new moral problems in “Medical worker – Patient” relationships:

- **Depersonalization**, which is about a high degree of labor division in modern medicine leading to expansion of the circle of people the patient has to contact with, which is why direct communication and personal contact between the patient and the physician becomes problematic;

- **Commercialization**, which means that within the market form of healthcare organization physicians are producers and sellers of medical services, and patients are buyers, which leads to fundamental contradictions between physicians’ and patients’ interests;

- **Formalization**, which means that the basis of modern medical knowledge is the natural science approach to a person, absolutization of which leads to destruction of the patient’s whole perception as a unique personality, and the patient becomes an object for the physician to apply his/her knowledge and skills;

- **The patient’s skepticism** to the medical worker’s recommendations, which is about raising public awareness in the field of medicine, medical services and
pharmaceuticals advertising leading to formation of a tendency in the patient to self-medicate, distrust and doubt the correctness of the treatment prescribed by the physician, and turn to alternative medicine.

Any person who has ever had a misfortune to be in the role of a patient or was a patient’s relative can passionately and colorfully talk about his/her misadventures and unpleasant contacts with a medical staff. It should be emphasized that patients in many cases find their relationships with physicians unsatisfactory. Physicians often tend to be difficult to communicate with: they are unfriendly, do not correspond to the patient’s ideas and are not able to create a trusting relationship with patients.

The most common causes of conflict situations are:

1) insufficient attention to the patient due to the lack of interest or unreasonably low wages;

2) the lack of the patient’s informed consent for treatment;

3) the lack of coordination in the actions of physicians of different specializations, collegiality in drawing up a treatment plan;

4) incorrect medical records;

5) professional incompetence (unreasonable expansion or insufficient research);

6) characteristic features of the physician and the patient;

7) the patient’s unwillingness to spend money on treatment.

Some rules of interaction with the patient will help a physician to avoid unnecessary unpleasant situations:

1. Address the patient using his/her official full name.

2. Listen to the patient attentively.

3. Do not use difficult medical terms unless necessary.

4. Conduct a conversation at the level accessible to the patient.

5. Do not be a moralist.

Here are some errors in interaction with the patient:

1. Indifference and disinterest – they cause most complaints against medical personnel around the world.
2. Irresponsible instructions, heart-to-heart talks, phrases “Get ready!”, “Leave the childishness!”, “Behave like an adult!” etc. must be avoided.

3. Threats, no matter what form they have (even comic).

4. Inadequate advice like “Get married!”, “Divorce!” etc.

**Compliance** in medicine is voluntary compliance of the patient with the prescribed treatment mode. It is one of the cornerstones of modern medicine.

To achieve compliance, the process of communicating with the physician and medical competence are especially important. The physician should adequately present the information necessary for the patient so that it is understood by any patient, taking into account educational qualifications and the complexity level of the material.

In modern medicine, paternalism is changing to collaboration. However, not all physicians are supporters of this tactics, since it can complicate work of medical personnel. Many patients also do not want to take responsibility for making decisions. However, as Hippocrates said, “Some patients, despite doom awareness, recover only because they are confident in the skill of the physician.”

Here are five steps to turn a dispute with a patient into a productive collaboration:

1. Make a pause to define tactics of working with an objection.
2. Listen to all objections that the patient is ready to present.
3. Provide a psychological connection: give a calm explanation of the situation, its analysis.
5. Call for dispute solution.

The activities aimed at an increase in adherence to the prescribed therapy and compliance include:

- activities for the patient’s education;
- organizational activities (reminders, notes on the case history, etc.);
- psychological activities (counseling, behavioral therapy, multi-professional teams, etc.);
- technological activities (lids for reminder packages, dosage forms, telemonitoring, etc.);
• economic activities (monetary and non-monetary incentives);
• complex activities.

The patient can have a different attitude to his/her disease:
• Pedant patient – these are primarily elderly people: all questions are written, they seek to get full answers to their questions, regardless of the physician’s time.
• Correct patient – such a patient adequately perceives his/her condition, is sustained, remains calm, fulfills all the physician’s prescriptions and seeks adequate contact with the physician.
• Skeptic patient – such a patient does not trust one physician, seeks advice, consults with other physicians, changes them, requires medical tests to be repeated.
• Clever patient – such a patient speaks using ready-made diagnoses, reads medical literature, and doubts professionalism and competence of physicians.
• Optimistic patient – such a patient underestimates the severity of the disease, does not want to treat, and does not comply with prescriptions.
• Pessimistic patient – such a patient is sure that he/she has a serious disease, always overestimates the severity of his/her condition.
• Pragmatic patient – such a patient aims to maximize the benefits of the disease whether it is the quality of service, attention from relatives or a direct material benefit (a sick leave, compensations, etc.).

There are no patients with a pure variant. These variants are usually mixed in one person.

The priority of the patient’s interests in medical care provision is based on the following positions:
• compliance with ethical and moral standards, as well as a respectful and humane attitude of medical workers and other employees of a medical organization towards patients;
• provision of medical care to the patient complying with his/her physical condition and, if possible, cultural and religious traditions;
• organization of medical care for the patient with a rational use of his/her time;
• establishment of requirements for the design and placement of medical organizations, taking into account compliance with sanitary standards and providing patients with comfortable conditions in medical organizations;
• creation of conditions providing an opportunity to visit the patient and his/her stay with relatives in a medical organization, taking into account the patient’s condition, observance of the anti-epidemic regime and interests of other people in the medical organization.

**Patient’s Rights**

Patients in many countries have similar rights like:
• making a choice of a physician and a medical organization;
• prophylactics, diagnostics, treatment, medical rehabilitation in medical organizations in sanitary and hygienic conditions;
• obtaining advice from medical specialists;
• pain relief associated with the disease and (or) medical intervention using available methods and drugs;
• obtaining information about the rights and obligations, the state of health, a choice of people who may get information about the patient’s health;
• obtaining medical nutrition in case of being treated in a hospital;
• protection of information in accordance with medical confidentiality;
• refusal of medical intervention;
• compensation for harm caused to the patient’s health while providing with medical care;
• admission of a lawyer or a legal representative to protect the patient’s rights.

Modern medicine is not perfect and quite often there are situations when the patient refuses medical intervention to be provided. In many countries, the right to refuse medical intervention belongs to:
• the potential patient him/herself;
• one of the legal representatives of the potential patient.

Groups of people in relation to whom the refusal of medical intervention can be given by legal representatives are:
• minor patients under 15 years of age, as well as drug-dependent patients under 16 years of age;
• minor patients under 18 years of age in need of transplantation of human organs and tissues;
• legally recognized incompetent citizens who cannot independently express their will and refuse medical intervention;
• minor teenagers with drug addiction at the time of providing narcological assistance, as well as conducting an examination to determine the state of drug or other intoxication.

In medical practice, there are often situations when legal representatives sign a refusal of medical intervention, which subsequently can lead to the patient’s death. For example, due to religious beliefs or other reasons, situations arise when parents or other legal representatives sign a refusal of medical intervention. In order to avoid such situations, laws of many countries clearly define the criteria for signing a refusal by legal representatives. For example, legal representatives of incapacitated patients are required to notify the guardianship authorities about the refusal of medical intervention necessary to save the patient’s life. The information should be provided at the place of the patient’s residence the day after signing the refusal. In exceptional cases, the attending physician has a right to appeal to the court in order to protect the patient’s health and save his/her life, despite the decision of legal representatives.

Perfect health is an important indicator of human life, so people need to treat it carefully. But, unfortunately, it is not always possible without medical intervention. It’s good if a person has chosen a physician and they trust each other, but what if there is no way to make a voluntary decision? The laws of many countries set out situations where medical care is provided without the patient’s consent, that is, his/her refusal to
intervene is not allowed. Specific options are considered when medical services are provided without signing a voluntary consent. For example:

- the patient’s life is at high risk and emergency assistance is required, but it is impossible for the patient to express her/his will;
- emergency assistance without presence of legal representatives;
- in case of a disease that endangers the life and health of others;
- in case of a serious mental disorder;
- in relation to people who have committed crimes;
- during forensic psychiatric examination.

In such cases, a board of doctors or the physician him/herself may decide to provide medical care. If a meeting of a board of doctors is impossible, and the physician does not dare to take full responsibility, medical care may be provided without the patient’s consent by court order.

As for refusal of medical services, medical intervention is preceded by the patient’s voluntary consent to it. Despite the fact that a voluntary informed consent is signed at the first visit, the patient can refuse medical intervention at any of its stages. There are two forms of refusal:

- a complete refusal of any medical services;
- a partial refusal of a specific medical service.

The legislation is applied to both state budgetary medical organizations for free medical services and other medical organizations that carry out legal medical practice (private clinics, scientific organizations, etc.).

Each patient has a right to make independent decisions on a complete or partial refusal of medical care. In turn, the choice of a complete refusal, in fact, means termination of cooperation with the chosen medical organization, and this medical organization is usually not responsible for the patient’s life and health after it.

If the patient has decided to sign a refusal of medical intervention, the attending physician or another employee of the organization should provide the patient with detailed information about the consequences of the decision. A probable death of the
patient, possible complications, as well as other consequences, are to be set out in an understandable form indicated in a special document. When deciding to refuse medical care, the patient or his/her legal representatives bear all responsibility for a possible fatal outcome and other consequences.

After the patient having made a decision to refuse medical intervention, the medical organization draws up a document that is signed by the patient or his/her legal representative and an employee of the medical organization. A refusal is made out in writing and is attached to the patient’s medical records.

As for provision of medical services by private medical organizations, a potential patient enters into a contract for provision of paid medical services, which he/she can terminate at any time. The patient must pay all expenses of the medical organization that it incurred by the contract.

If the provided services fully satisfy the patient and the contract continues, at the end of the treatment all the documents are issued to the patient: the physician’s records on the state of health, a copy of the contract, statements about the quality of the paid services and the patient’s condition after them.

**Medical Errors**

**Medical error** is a conscientious error of the medical worker based on imperfection of modern science, ignorance or inability to use existing knowledge in practice.

Medical errors are divided into diagnostic, therapeutic, tactical, technical, organizational, and deontological.

The main causes of medical errors are:

- **objective**: imperfection of medical science and practice; relativity of medical knowledge; a probability of an atypical course of the disease in a particular patient caused by the features of the body; an insufficient supply of medical organizations with necessary diagnostic equipment, drugs, etc.;
- **subjective**: medical ignorance due to a lack of qualifications, a lack of experience and specifics of the medical worker’s thinking, i.e. individual abilities to
accumulate, understand, use medical knowledge; defective examination of the patient; rejection of the advice of a colleague or a board of doctors or, on the contrary, the physician’s desire to hide behind the authority of consultants, etc.

Prevention of medical errors is facilitated by the physician’s constant desire to increase the level of professional competence, an attentive and sensitive attitude to patients, moral reflection on difficult situations arising in medical practice.

**Iatrogeny** (from Greek ἰατρός “physician” and γενεά “generative”, meaning “brought forth by the healer”) is a term proposed in 1925 by the German psychiatrist Oswald Bumke to refer to psychogenic diseases that arise as a result of the physician’s careless attitude. However, in the 1970s, after the publication of the International Classification of Diseases (ICD), it acquired a slightly different meaning. Today it is any undesirable or adverse consequences of preventive, diagnostic and therapeutic interventions or procedures that lead to impaired body functions, restriction of a habitual activity, a disability or even death; complications of medical activities that developed as a result of both erroneous and correct actions of the physician. In other words, it is deterioration of the patient’s physical or emotional condition provoked by a medical worker unintentionally.

Iatrogenies can be classified as follows:

- a communicative iatrogeny, which develops on communication with a medical worker (an integral part of deontology);
  - a medication iatrogeny, which develops most often as a result of adverse drug effects, ranging from allergic reactions and shock to drug ulcers of the gastrointestinal tract and bleeding from it;
  - a manipulative iatrogeny, which develops due to abundance of invasive diagnostic methods and techniques (biopsy, endoscopy, etc.);
  - an anesthetic-resuscitative iatrogeny, which is related to complications that arise or are recorded in this field of medicine: cardiac arrest, respiratory arrest, brain damage, etc.
Egrotogeny is an adverse effect of some patients on others in the process of their communication. Egrotogenesis can cause the patient no less harm than iatrogenesis, since the patient often believes the other patient more than the physician.

Presentation skill development focus

Prepare a 10-minute presentation on a particular topic below.

Read Appendix “How to make a good presentation” before you start.

1. Basic models of relationships between the physician and the patient.
2. Physician’s professionalism and moral responsibility.
5. Medical diagnostics as a specific cognition process.
7. Patient’s competence and ability to understand information.
8. Information voluntariness and its violation (coercion, manipulation, persuasion).
9. Patient’s right to refuse any intrusion into the health sphere. Patient’s right to withdraw consent.
10. Legal and moral basis for provision with medical care in case of impossibility to obtain the patient’s informed consent.
11. Surrogate consent of an incompetent patient.
12. Obtaining informed consent from patients with limited competence.
13. Professional solidarity and mentoring in medicine.
14. Psychosomatic paradigm in medicine.
15. Intuition in medicine.
16. ICD-10: sections and diseases included in them. ICD-11: upcoming amendments.
Speaking skill development focus

Situational tasks

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.

2. Using the information of the paragraph, answer the questions following them.

3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.

4. Compare the results of discussion with solution patterns.

Situational task 1
A 44-year-old man was admitted to the surgical department with back pain. Six months later, he was discharged with severe brain damage. The tragedy occurred due to an error of a drunken anesthesiologist who gave him 10 times more soothing than necessary before the operation.

Was it a medical error, an accident, or a crime? Explain your opinion.

Situational task 2
A medical assistant, advising a patient with psoriasis, to the patient’s question: “How long will I suffer from this disease?” replied: “All your life!” The patient, who did not expect such an answer, was very upset because he had thought that his disease was easy to cure.

What bioethical principle did the medical assistant violate by giving a definitive conclusion on timing of the disease course? Was he obliged to explain to the patient in detail that his disease was chronic, difficult to treat, but with adequate therapy he could achieve stable remission?

Situational task 3
Three years ago, Alex had a surgery for transurethral resection of the prostate adenoma. The postoperative period was difficult, and six months later Alex developed
striction of the urinary canal, which required a second operation. The essence of the conflict is as follows: the patient claims that he has not been warned about possible consequences of the operation, otherwise he would not have agreed to it, and demands compensation for moral damage. The physicians are sure that before the operation the conversation with the patient has taken place, which is why they do not consider themselves guilty in this situation.

Why do you think the conflict arose between the physicians and the patient?

**Test tasks**

Tick only one correct variant.

1. THE PATIENT’S RIGHT TO REFUSE TREATMENT IS BASED ON…
   1) awareness of his/her limited financial opportunities;
   2) recognition of limited medical facilities;
   3) the right to a calm natural death;
   4) the patient’s desire.

2. THE TECHNICAL RELATIONSHIP MODEL PRINCIPLE IS…
   1) to benefit the patient and do no harm;
   2) to treat the disease, and not the patient;
   3) to create the maximum spirit of trust and responsibility from both sides.

3. THE RELATIONSHIP BETWEEN THE PHYSICIAN AS A HEALTH CARE PROVIDER AND THE PATIENT AS A CLIENT IS REFLECTED IN THE … MODEL.
   1) technical;
   2) contract;
   3) collegial;
   4) paternalistic.
4. COMPLIANCE IS …
   1) the patient’s voluntary following the prescribed treatment mode;
   2) the patient’s voluntary consent to experiments;
   3) the absence of the patient’s informed consent to treatment.

5. A MEDICAL ERROR IS …
   1) intentional improperly performed actions or inaction of the medical worker
      which entailed a deterioration in the patient’s health or his/her death;
   2) an action of the medical worker which entailed a deterioration in the patient’s
      health or his/her death as a result of negligence or low qualification;
   3) inaction of the medical worker which entailed a deterioration in the patient’s
      health or his/her death as a result of negligence or low qualification;
   4) unintentional improperly performed actions or inaction of the medical
      worker which entailed a deterioration in the patient’s health or his/her death.

6. A MEDICAL ERROR IS A RESULT OF THE PHYSICIAN’S ACTION DUE TO…
   1) negligence;
   2) bad luck;
   3) a conscientious error.

7. THE OBJECTIVE CAUSES OF MEDICAL ERRORS INCLUDE ALL OF THE
   MENTIONED BELOW BUT …
   1) imperfection of medical science and practice;
   2) a lack of diagnostic equipment;
   3) incomplete examination and research of the patient;
   4) relativity of medical knowledge.
8. THE SUBJECTIVE CAUSES OF MEDICAL ERRORS INCLUDE …
   1) relativity of medical knowledge;
   2) imperfection of medical science;
   3) a probability of an atypical course of the disease;
   4) a desire to hide behind the authority of consultants.

9. IATROGENY IS …
   1) adverse effects of medical interventions leading to organ dysfunction, a disability or even death;
   2) an unscientific idealistic view that the human is the center of the universe;
   3) a group of moral theories, where the criterion of moral evaluation is the result of behavior;
   4) the physician’s lack of knowledge of some disease.

10. A HUMAN RIGHTS ABUSE IS …
    1) intervention;
    2) deviation;
    3) marginalization;
    4) discrimination.
1.4. Philosophic Categories in Bioethics

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Basic Ethical Concepts

Anthropocentrism (from Greek ἄνθρωπος “human” and Latin centrum “center”) is an idealistic view where the human is the focus of the universe and the goal of all events taking place in the world.

Anthropocentrism is one of the most consistent expressions of the point of view of teleology, that is, ascribing non-natural, external goals to the world. In ancient philosophy, Socrates formulated anthropocentrism, later representatives of patristics, scholasticism and some philosophers of the New Age adhered to this view.

The American professor Lynn White singles out the Judeo-Christian tradition for the emergence of anthropocentrism, according to which everything is created for the human whom God chose to dominate the Earth.

Beginning in the Renaissance, the human in philosophy ceases to be considered involved in God. Events in science affecting the place of the human in the universe include mainly the heliocentric system of the world of Copernicus, which has shifted the focus from the human to the Sun, and the evolutionary theory of Charles Darwin, which has lowered the human from the top of the chain of being.

Anthropocentrism prescribes putting the phenomenon of the human at the head of all other lives. The value of a human life can only balance the value of another human life. In philosophy, anthropocentrism refers to concentration of philosophical research on human issues.
Anthropocentrism is opposed to the worldview of monotheistic religions (theocentrism that reigned in the Middle Ages), where God is the center of everything, and ancient philosophy (cosmocentrism), where the space is at the center of everything.

Consequentialism (from Latin consequens “consequence, conclusion, result”) is a group of moral theories where criterion of moral evaluation is the result (consequence) of behavior. From the consequentialist point of view, a morally legal act or omission is one that gives good results or consequences (including those consequences that arose in the course of achieving these results). The historical forms of consequentialism were eudemonism, hedonism, utilitarianism, and rational egoism.

In contrast, in deontology an assessment is made on the basis of correctness or incorrectness of behavior depending on the followed moral principles, on the motivation of the behavior itself, and not on the results of this behavior. Ethics of virtue determines the morality of an act focusing more on the moral qualities of the subject than on the consequences of its action or inaction.

These approaches to morality can lead to the same actions and assessments, as well as to different ones. For example, a consequentialist will not lie because a lie will lead to negative consequences. A deontologist will not lie because it is forbidden by moral precepts and rules, and a proponent of ethics of virtue will not lie because a lie is contrary to his/her virtuous essence, which he/she intends to protect.

However, the difference in approaches becomes apparent when good goals are not achieved by good means, and good intentions lead to negative consequences. Such contradictions are illustrated by well-known statements: “He who wills the end wills the means”, “The end crowns all”, “Hell is paved with good intentions”, “We wished our best, you know the rest”.

Ethical critics of consequentialism believe that consequentialism follows the maxim “The end crowns all” which argues that “if the end is very important, then any way to achieve it is acceptable”.

Utilitarianism (from Latin utilitas “benefit, gain”) is a field of ethics where the moral value of behavior or a deed is determined by its usefulness. The usefulness of an act means the integral pleasure or happiness received by all affected parties over the
duration period of the act consequences. Utilitarianism refers to a consequential group of ethical theories since it does not judge an act by itself, but by its results.

Utilitarianism is based on hedonism or eudemonism, i.e. value (axiological) teachings, according to which pleasure or happiness is the highest value. Strict definitions of pleasure and happiness remain a problem at the moment. The question remains whether these concepts are identical.

Utilitarianism evaluates the morality of any act solely by its consequences, that is, by whether it brings pleasure or suffering to anyone. The end justifies the means, and no means can be judged as immoral if they lead to a moral end. Utilitarianism does not divide people as a whole into moral and immoral, it just notes that some of their actions can lead to moral or immoral consequences.

In this regard, utilitarianism is opposed to deontological ethics and ethics of virtue, which evaluate, respectively, actions and ethical agents. Deontological ethics can declare an act moral or immoral in itself and proclaims the principle of “Do what seemed right, come what might”. Ethics of virtues assesses the morality of the personalities dividing everyone into “bad” and “good”. Utilitarianism stands radically out since the first it evaluates is not whether a person is good or bad, but whether a person feels good or bad.

For these reasons, utilitarians are skeptical of such concepts as duty, dignity, retribution, etc. From the utilitarianism point of view, any person, even the most immoral, deserves happiness. No one, even causing other people much suffering, deserves punishment simply for this fact itself. A person can be prosecuted only if it is necessary to prevent further antisocial acts (and only if the suffering of other creatures outweighs the pleasure received by the villain).

Hedonism (from Ancient Greek ἡδονή “pleasure”) is an axiological teaching where pleasure is the highest good and the meaning of life, the only terminal value (while all other values are instrumental for achieving pleasure). Hedonism is often equated with utilitarianism, but there is a difference that it is a purely axiological teaching: it claims what is a value, but does not prescribe people’s behavior. Hedonism is not a complete moral system, but a value basis. Utilitarianism is a consequentialist
ethical teaching that provides specific instructions for human behavior. It asserts that a correct society should be organized in a way that people’s actions bring maximum pleasure to each other and minimize suffering. Hedonism, in contrast to utilitarianism, allows a purely personal, selfish desire.

**Eudemonism** (from Greek ευδαιμονία “prosperity, bliss, happiness”) is an ethical teaching that recognizes the desire to achieve happiness as the criterion of morality and the basis of human behavior.

According to eudemonists, the highest good for the human is happiness. According to Aristotle, happiness is “what we always choose for its own sake and never for the sake of something else”. Among medieval thinkers, eudemonism was partly characteristic of the teachings of Thomas Aquinas and was reduced to the assertion that the highest happiness lies in the knowledge of God and the possibility of seeing him in the life to come.

Representatives of the hedonistic trend in eudemonism (Epicurus, Gassendi, La Mettrie, Voltaire, Holbach) identified happiness and pleasure. However, unlike hedonism, pleasure is directly dependent on human virtues. According to Epicurus, the highest kind of pleasures is not basic physical pleasures, but subtle spiritual ones. Happy is the one who has reached the state of complete serenity or ataraxia. One of the critics of eudemonism in ethics was Immanuel Kant, who believed that the motive for a truly moral act can only be duty, but not pursuit of happiness.

In Eastern philosophy, Buddhism with its postulate of getting rid of all suffering in order to achieve nirvana can be attributed to the eudemonistic teaching. According to Dalai Lama 14th, “the main goal of human life is happiness. It is obvious. Regardless of whether we are atheists or believers, Buddhists or Christians, we are all looking for something better in life. Thus, in my opinion, the main movement in our life is movement to happiness...”.

**Morality and Empathy**

Moral values are imperative and binding. The imperativeness of morality is expressed in the concept of “duty.”
Moral duty as a concept of ethics means morally reasoned coercion to action. Moral duty requires not coercion, but self-coercion. Duty is an internal impulse, the need to perform any action. Duty is a necessity; therefore, duty fulfillment puts a person before the need to give up his/her own choice. A duty carries a moral principle only if its fulfillment is voluntary. Moral duty is conscious and free submission to requirements of moral behavior. Following duty, we recognize the priority of a higher beginning than our own interests.

A person’s duty is divided into two types: empirical and moral. Empirical duty is parental, friendly, patriotic, professional, etc. Moral duty (universal) is selfless indiscriminate reverence for all living beings. Empirical duty may conflict with universal duty, for example, between corporatism as the principle of professional morality and universal morality.

Historically, the content of moral duty has changed. In pre-class society, there was “talion law” (retaliation equal in power to crime) meaning “measure for measure” or “crash for crash”. Talion law acted only in relation to another community. It did not imply individual duty and individual responsibility.

In early class society, talion law was replaced by the “golden rule of morality”: “Do unto others as you would have them do unto you”. Medieval Christian ethics considers the golden rule of morality in the context of the Sermon on the Mount: “So whatever you wish that men would do to you, do so to them; for this is the law and the prophets” (Matthew, 7:12). The duty dictated in this case is already a moral law. The golden rule of morality is an ethical paradigm inherent in all religions.

Immanuel Kant developed the idea of the golden rule. The categorical imperative imputes a person to act in such a way that a maxim (a short saying of a moral, ethical character; a rule of behavior a person is guided by in his/her actions) of his/her will could serve as the basis for universal legislation. This means that moral behavior is one that ensures harmony between people.

The human performing duty:

- fulfills its requirements without external coercion;
• refers to duty requirements in such a way as if he/she him/herself installed them;
• is convinced of correctness of the requirements;
• does it disinterestedly.

Moral duty of a person involves:
• contribution to the good of other people;
• resistance of the evil;
• virtue;
• prevention of inner perversity.

Moral duty is awareness of the need for what is prescribed by a moral ideal. It is wrong to understand duty as a form of public control over individual behavior. Morality is a system of mutual responsibilities. Moral duty in relations with other people is an attitude where a person is a goal and never a means. This statement is one of the formulations of the categorical imperative of Immanuel Kant. Moral duty is expressed in a disinterested, benevolent relationship to each other. A categorical imperative must act under any conditions. It is based on pure will, not affected by feelings. Duty is severe and requires a person to have a calm and consistent ministry.

Moral duty to oneself consists in never becoming a means in the wrong hands, not agreeing on bonded relationships, trying to be happy. A person should not forget about personal happiness because this allows one to fulfill moral duty to other people better.

**Moral choice** is a spiritual and practical situation of self-determination of a person in relation to principles, decisions and actions. Moral choice is when a person internally chooses a moral (good or evil) attitude and also acts in accordance with this choice. Moral choice is a choice of one’s attitude (good or evil) towards other people.

**Cynicism** (from Ancient Greek κυνισμός) is a defiantly scornful and contemptuous attitude to the norms of public morality, cultural values and ideas of decency, a negative, nihilistic attitude to generally accepted norms of morality, to official dogmas of the prevailing ideology. It is a behavior expressing conscious and
demonstrative disregard for certain moral values, a worldview that perceives ethical rituals as obstructing or excessive for solving practical problems, denying such motives of behavior as compassion, pity, shame, sympathy, and others as inappropriate to personal interest.

Cynicism in beliefs and behavior is characteristic of people who are ready to resort to any means to achieve their personal goals. It is also characteristic of people who are desperate to find a means against injustice and hypocrisy of society, to find a way out of their powerless position.

Speaking of political communication, cynicism is born in a situation when the audience, receiving political messages, is more likely to distrust them than to trust. In other words, the public is skeptical of what politicians say. In the public sphere, cynicism is difficult to measure – as a rule, this level is determined by contextual factors (environmental or personal factors).

The behavior, perceived by others as cynical, causes condemnation of society and is a factor provoking conflict.

Cynicism, in contrast to moral relativism (which gives an orientation to relativity of moral principles, their dependence on the subject and circumstances), sets the mind on intentional humiliation, deliberate simplification in interpretation of both one’s own motives and norms of behavior, as well as the motives of other people, the principle of devaluation of principles as such, whose entire sphere is perceived as “high, “transpersonal”.

Vulgar cynicism is a mocking and ironic attitude towards something that acts as “high” or “principled”, being mostly a characteristic of outsiders of social and cultural processes, socially and culturally weak groups.

**Pluralism** (from Latin pluralis “multiple”) is a philosophical position according to which there are many different equal, independent and irreducible foundations or forms of being (ontological pluralism), and therefore forms of knowledge and cognition methodologies (epistemological pluralism).

Political pluralism is a principle that promotes the existence of a diversity of political forces with competition between them for representation in the government.
It involves a legal conflict of interest, discussions between supporters of different points of view. Necessary but insufficient conditions for the existence of political pluralism are freedom of speech and freedom of the media, a multi-party system, political opposition, free elections, parliamentarism, and public organizations independent from the state.

Political pluralism uses the basic concepts of sociological pluralism on the equal rights of social development factors to substantiate the idea of a variety of political doctrines and practical actions for their implementation.

Amoralism is a principle of practical or ideological orientation, including a denial of moral principles and generally accepted norms of behavior in society, a nihilistic attitude to all moral norms and principles.

Morality (from Latin *moralitas*, the term was introduced by Cicero stemming from Latin *mores* “generally accepted traditions, unwritten rules”) is socially accepted ideas about good and bad, right and wrong, good and evil, as well as the totality of normal behavior arising from these ideas. Sometimes the term is used not in relation to the whole society, but to its part, e.g. Christian morality, bourgeois morality, etc.

There is a difference between morality and ethics. Ethics (also known as moral philosophy) is a branch of philosophy that studies moral issues. The word *ethics* is usually used as a synonym for the word *morality* and sometimes in a narrower sense – to denote moral principles and traditions of certain groups or individuals. Similarly, some ethical theories, especially deontology, distinguish ethics and morality, saying that “although human morality and ethics are ultimately reduced to the same thing, there is a tradition in which *morality* is used for systems like Immanuel Kant’s, based on the concept of duty, obligations and principles of behavior, while for the word *ethics* the approach is similar to Aristotelian practical reasoning based on the concept of virtue which avoids the separation of “moral” considerations from other practical considerations. Morality and ethics are often used as synonyms, but morality to a greater extent denotes views based on practice or teaching how to behave in personal relationships or in society, while ethics is more related to the system of principles, or to philosophy and their theoretical justification”. 

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**Empathy** (from Ancient Greek ἐν “in, at” and πάθος “passion, suffering”) is conscious sympathy with the current emotional state of another person without losing the feeling of the external origin of this experience. Accordingly, empath is a person with a developed ability for empathy.

The term *empathy* was coined by Edward Titchener in 1885. One of the first definitions of empathy was made in 1905 by Sigmund Freud: “We take into account the patient’s mental state, put ourselves in this state and try to understand it by comparing it with our own.”

Empathy and compassion in the medical profession are of great importance. The meaning of the term may vary slightly depending on the context. So, in medicine, empathy is mostly determined by “empathic listening”, in psychology it is an understanding of the emotional state of another person and demonstration of this understanding. For example, when interviewing a patient, a manifestation of empathy means, firstly, understanding his/her words, feelings and gestures, and secondly, it becomes clear to the patient that the physician is aware of his/her experiences. Thus, the emphasis is on the objective side of the process, and possession of the skill of empathy means the ability to collect information about thoughts and feelings of the patient. The purpose of such an empathic hearing is to make it clear to the patient that he/she is listened to, and to encourage him/her to express feelings more fully, allowing the physician to make a more complete picture.

The types of empathy include:

- emotional empathy, based on the mechanisms of projection and imitation of the motor and affective reactions of another person;
- cognitive empathy, based on intellectual processes (comparison, analogy, etc.);
- predictive empathy, based on a person’s ability to predict affective reactions of another person in specific situations.

Special types of empathy are sympathy and compassion.

- Sympathy is a person’s experience of the same emotional states that another person experiences through identification with him/her.
• Compassion is a formalized form of expression of one’s state regarding experiences of another person.

From the point of view of psychology, the ability to empathy is considered the norm. There are techniques for detecting the level of the ability to show empathy (high, normal, low) and even individual aspects of this ability. The range of empathy manifestation varies quite widely: from a light emotional response to complete immersion in the world of feelings of a communication partner. It is believed that empathy occurs due to an emotional response to perceived external, often almost imperceptible, manifestations of the other person’s emotional state – actions, speech, facial expressions, gestures, etc.

After twenty years of medical practice, the physician is better at treating patients than at the beginning of his/her career. Development of empathy, as well as the study of medicine, is to be improved throughout life. Empathy development is the result of constant daily practice, not a sudden burst of inspiration.

Presentation skill development focus

Prepare a 10-minute presentation on a particular topic below.
Read Appendix “How to make a good presentation” before you start.
1. Introduction of ethical criteria into science.
3. Specificity of religious and ethical thought in medical practice.
4. Personality in the situation of moral choice and moral conflict.
6. Functions of morality and ethics. Empathy and compassion.
7. Needs and interests, values and assessments, moral norms and rules.
Speaking skill development focus

Situational tasks

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.

2. Using the information of the paragraph, answer the questions following them.

3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.

4. Compare the results of discussion with solution patterns.

Situational task 1

“The body is entrusted to us, and our duty in relation to the body is that the human spirit, firstly, disciplines the body, and then takes care of it” (Immanuel Kant, a German philosopher).

Explain whether a person is the keeper or master of the body, according to the philosopher’s view.

Situational task 2

Different ethical approaches evaluate dependence of personal morality and moral actions in a different way. Explain the difference in evaluation approaches between deontological ethics, ethics of virtues and utilitarianism.

Situational task 3

There are two types of duty: empirical and moral. Explain the both types and give examples of how they can contradict each other.
Test tasks

Tick only one correct variant.

1. THE CONCEPT OF MEDICAL PROFESSIONALISM IMPLIES THE PRESENCE OF HIGH MORAL QUALITIES IN A PHYSICIAN AND ACQUIRED ETHICAL KNOWLEDGE. THIS STATEMENT …
   1) is true;
   2) is false;
   3) depends on the situation;
   4) There is no correct answer.

2. MORALITY IS …
   1) classified by culture according to the criterion of people’s “good-evil” relationships and morals;
   2) a set of scientific facts;
   3) a philosophical doctrine;
   4) strict compliance with written laws;
   5) a form of the “collective unconscious” which points to the due;
   6) an area of scientific knowledge regarding the universal laws of society development.

3. THE MAIN FUNCTION OF MORALITY IS …
   1) educational;
   2) social;
   3) prognostic;
   4) regulatory.

4. THE “GOLDEN RULE OF MORALITY” IS TO …
   1) show honor to elders;
   2) “do unto others as you would have them do unto you”;
   3) give “crash for crash”;
   4) respect opinions of others.
5. HUMANISM MEANS …
   1) sincerity;
   2) tolerance;
   3) kindness to humanity;
   4) nobility.

6. THE MORAL PRINCIPLE PRESCRIBING A DESIRE TO HELP OTHERS IS CALLED …
   1) an ambition;
   2) altruism;
   3) empathy;
   4) tolerance.

7. MORAL RELATIONS INVOLVE CONSIDERATION OF ANOTHER PERSON AS …
   1) an object one’s action is directed at;
   2) an equal person entitled to respect for dignity;
   3) people are different, the main thing is the goal achieved;
   4) it is a “dog-eat-dog world” since it is human nature.

8. DUTY IS PERFORMED BY VIRTUE OF …
   1) professional responsibilities;
   2) timely orders;
   3) conscience requirements and a moral ideal consequence;
   4) ideological justification of social progress;
   5) the boss order;
   6) mutual benefits;
   7) requirements of loved ones.
9. A CONSERVATIVE ETHICAL TRADITION IN BIOETHICS IS FORMED BY…
   1) hedonism;
   2) a traditional religious worldview;
   3) pragmatism;
   4) the ethics of Immanuel Kant;

10. THE IDEA OF JUSTICE IN MEDICINE IS IMPLEMENTED IN THE FORM OF…
   1) mercy of medical workers;
   2) a free care for a sick person;
   3) a high pay to medical workers;
   4) an equally high level of medical care for all people;
   5) all of the listed above.
Section 2. BIOETHICS AND MEDICAL PRACTICE: COMMON ISSUES

2.1. Ethics Committees. Medical Trials and Research

Reading skill development focus
1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Ethics Committee

Ethics committee is an independent body operating at the institutional, regional, national or supranational levels, consisting of people with scientific/medical education and without it, whose duties include ensuring protection of the rights, safety and well-being of research subjects and guaranteeing the public this protection through the review and approval of the clinical trial protocol, the acceptability of researchers, equipment, as well as methods and materials that are to be used in obtaining and documenting informed consent of the trial subjects.

The Declaration of Helsinki, developed by the World Medical Association (WMA), is a set of ethical principles for the medical community regarding research ethics and human experiments. Its first edition was adopted in 1964 in Helsinki, Finland, after which it underwent nine revisions. The declaration extends the principles first formulated in the Nuremberg Code, and applies these ideas directly to clinical research.

Like the Nuremberg Code, the Declaration of Helsinki makes informed consent the central document of ethical research activity, but allows the consent of the representative of the subject of research if the person is incapable (a minor or a person
with a physical or mental disability), because this person is unable to give informed consent.

The Declaration determines the acceptability of known and investigated methods of treatment, as well as principles of treating a patient with alternative methods. The concept of “special committee” was fixed in this Declaration for the first time in international practice.

Today, the ethics of biomedical experimentation and research is not a list of good wishes since there are structures and mechanisms that make it possible to enforce strict compliance with these standards. Ethics committees became a kind of “mechanism” for such control.

The principles of ethics committees include:

- independence;
- competence;
- openness;
- pluralism;
- objectivity;
- confidentiality.

Ethics committees carry out the functions of examination, counseling, recommendations, motivation, evaluation, orientation in moral and legal issues of clinical research. The specificity of ethical review is “ignoring” the purpose of the study as its priority. They work to ensure that all possible precautions and safety standards are guaranteed to patients.

An ethics committee should consist of a rational number of participants (members), and collectively have the qualifications and experience sufficient to assess correctly the scientific and ethical aspects of the proposed study.

Recommendations on the composition of an ethics committee:

- It must have at least five members.
- One member should not be related to any scientific field by nature of his/her activity.
• All members must be independent of the researcher and the sponsor.
• At least one member must be independent of the research center.
• The list of members and their qualifications should be documented.

According to international requirements (in particular, the Declaration of Helsinki), each scientific research protocol must undergo a preliminary ethical examination and obtain the approval of a relevant ethics committee.

The purpose of this examination is to ensure protection of the rights, safety, well-being and dignity of people participating in biomedical research and experiments as subjects.

Ethics committees existing in the world operate on two levels:
• national;
• regional (local).

The main practical work on ethical control of medical science and practice is carried out mostly at the regional level.

The verdict shall be issued for each document received by an ethics committee:
• a positive opinion;
• preliminary changes required to obtain a positive opinion;
• a negative opinion;
• all previously positive opinions are suspended.

There are two main models (types) of ethics committee functioning:
• the “American” model – ethics committees are vested with “prohibitive” powers;
  • the “European” model – ethics committees have “deliberative advisory” powers.

Ethics committees also implement a dialogue with the public, its education in the field of bioethics and advise governments and parliaments on medical ethics.

Documents for an ethical review:
• a trial protocol, which is a kind of instruction for physicians conducting the study. Researchers are required to follow the protocol strictly – this serves a guarantee
that the study is carried out correctly in all centers. Multicenter clinical trials are always carried out according to a single protocol. Failure to comply with the protocol may result in exclusion of the researcher / research center from the research program;

- a researcher brochure;
- an individual registration card, which is a document intended for entering all the information provided for in the protocol and to be transmitted to the sponsor for each subject of the study;
- the trial subject’s informed consent form, which is the patient’s voluntary consent to medical intervention, based on the information received in the understandable form from the medical worker about possible options of medical intervention, the proposed methods of diagnosis and treatment, and their health consequences. It should include: a provision that a scientific study is expected; clinical trial objectives; types of treatment (including placebo) and the likelihood of patients being randomly distributed between different types of treatment; description of the research procedures; responsibilities of the patients participating in the trial; a predictable risk, possible inconvenience; alternative treatment methods (advantages and disadvantages); compensation for damage to health; terms of payment to participants for participation in the study (if provided); possible costs of the subject during the study; provision on voluntary participation in the study; a possibility of refusing to participate in the study at any time without adverse consequences; confidentiality of information and a guarantee that the names of the study participants are not to be indicated when publishing results of the study; a possibility of conducting checks (subject to confidentiality) by representatives of official authorities; names and phone numbers of contact persons;
  - information on research qualifications;
  - a copy of trial subjects’ health insurance policy certificate;
  - researcher certificates confirming training in Good Clinical Practice (GCP) and/or Good Laboratory Practice (GLP).
Good clinical practice (GCP) is a standard for planning, organizing, conducting, monitoring, auditing, documenting clinical trials, and analyzing and presenting their results, which guarantees reliability and accuracy of the data and presented results, as well as protecting the rights, health and confidentiality of research subjects.

Researchers should always be ready to be quality checked on their work. Checks are divided into several types: monitoring, audit and inspection. Regular monitoring checks how ethical standards for conducting the research and trial protocol, as well as the quality of filling out the documentation, are followed. An audit is usually conducted only once, in the most important studies. The purpose of an audit is to verify the compliance with the GCP rules, the protocol and the local law. The duration of an audit depends on complexity of the study and may take several days. Inspection pursues the same goals, being carried out by official control and licensing authorities.

Brief History of Medical Trials

The creation of ethics committees and regulation of medical trials and research was preceded by a long and often tragic history.

The problem of moral regulation of medical trials arises when society, in principle, agrees with the very possibility of conducting scientific research on a person at any extent. The development of scientific medicine did without systematic research on humans for a long time. The main data were obtained by observation or by analogy with the method of vivisection of animals (conducting intravital surgical operations on the animal in order to study functions of the body (or extracted individual organs), the mechanisms of drug action, to develop methods of surgical treatment, or for educational purposes). A small number of descriptions of experiments on living people preserved in history relates mainly to studies conducted on oneself, one’s relatives or acquaintances. For example, Edward Anthony Jenner tested his method of vaccinating against smallpox on his own son and a neighboring boy, Jacques Ponto proved the efficacy of the serum from a viper bite, Roger Smith worked out a dose of curare which is not fatal to humans, Werner Forsman tested methods for diagnosing congenital heart
defects, Alain Bombard revealed the limits of possibilities for survival in extreme conditions, Emerich Ullmann tested the rabies vaccine, etc.

It started to change (albeit very slowly) from the second half of the 19th century, when medicine from a special kind of craft gradually turned into a state institution, which, in addition to providing assistance to specific patients, was entrusted with public health care. Establishment of a clinical institution, whose goals would combine treatment of patients, scientific research and training of medical students, was of significant importance. Thus, organizational foundations of a disciplined systematic medical research in humans were created. This process, which ended only after World War II, had an important consequence that the idea of the good in the work of a physician, including a physician-scientist, seems to be bifurcated. On the one hand, it is about the benefit of a particular patient, and on the other – about the benefit of society as a whole from acquisition of reliable scientific data. The contradiction of these two forms of the good determines the specificity of moral conflict in scientific research on human. The greater the threat society faces, the easier it is to authorize the sacrifice of an individual’s interests on the altar of science. Of course, in emergency situations, the spread of especially dangerous diseases (plague, smallpox, cholera), catastrophes, natural disasters or wars, such an ethics has its justification (though not unconditional).

Such measures as quarantine or sorting of the wounded on the battlefield or in the area of the earthquake epicenter are justified by the situation measures of compulsory restriction of civil rights and freedoms. Problems arise when the ethics of emergencies endures in peacetime situations. The most characteristic examples of violations of subjects’ rights are described precisely in relation to research in military medicine, as well as diseases that pose a social danger – sexually transmitted diseases, yellow fever, hepatitis, cancer, etc.

Development of medicine as a state institution and a medical science is closely connected with interests of the army and navy. In many countries, military departments have been the most significant source of funding for biomedical research.

At the same time, the ethos (a set of moral imperatives) of scientific research has changed – a research, which used to be primarily aimed at bringing a benefit to subjects
themselves, has now been carried out for the benefit of others, especially soldiers. At the same time, in a wartime emergency situation, no one required obtaining consent to involve people as subjects in the trial. One part of the war machine involved recruiting soldiers for service, and the other was a call to trials. The same principles were applied to both of them. In wartime, the desire to get the maximum benefit for the greatest number of people was a decisive argument in order to send a certain number of people to death so that others could live. The same ethics justified the use of mentally retarded or mentally ill patients in clinics as subjects.

The Nuremberg trials of the 1st Military Tribunal (1946–1947) revealed facts of medical trials on humans, monstrous in their cruelty and scope, when a huge number of prisoners of concentration camps, mainly of the non-German origin, were used for scientific research and medical trials. These “studies” and “experiments” have become an integral part of the concept of “crime against humanity”. During the trial, many documents were collected, including protocols on conducting trials on people in order to study the effect of hypothermia on the human body, effects of poisons. Millions of people were specially infected with diseases that were of interest to “experimenters”, and “with minimal time and effort”, methods for treating and achieving immunity to malaria, infectious jaundice, and typhus were investigated. Experiments on sterilization, regeneration of bones, muscles, the nerve tissue, bone transplants, experiments on separation of twins, on homosexuals, experiments with hypothermia, mustard gas, sulfanilamide, sea water and its effect on the body, with pressure drops, became known to the whole world. After reviewing the facts of Nazi medical trials by a military tribunal, their results were recognized as insignificant and useless, since they did not bring any practical benefit.

Numerous facts of the involuntary use of military personnel and the civilian population as subjects (moreover, with a threat to their life and health) took place in the 1950s in the USA and the USSR in connection with programs to study the effect of radiation on the human body. Research on “special tools” was systematically conducted in humans in the laboratories of the KGB and the CIA.
The three following cases are most characteristic. Patients at the Willow Brook Center for Mentally Retarded People in New York were infected with hepatitis virus in order to study the pathogenesis of the disease and develop a vaccine against it. In another New York hospital, scientists injected live cell cultures of cancer cells into senile patients to study the mechanisms of the immunological response. For 40 years, the American National Center for Infectious Diseases Research had been investigating the pathogenesis of secondary syphilis using a control group of untreated African-American patients. Moreover, the subjects were attracted to the trial under the pretext of providing them with help, which in reality did not happen even when penicillin became an affordable means for treatment.

Another well-known trial on the use of a liquid form of sulfonamide, including ethylene glycol as a solvent, brought to death of 110 children.

The catastrophe took place with thalidomide, the result of which was the birth of children with a congenital developmental anomaly – phocomelia – “seal limbs”. Many children born with phocomelia died, but today there are about 10,000 patients with deformities of the limbs, auricles, heart defects, etc.

In all the mentioned cases, as well as in similar ones, the researchers justified their actions by social significance of obtaining new knowledge about the pathogenesis of dangerous diseases in order to develop methods for combating them. The right to attract, in their opinion, “inferior” individuals whose lives had no value and could be sacrificed for the common good was especially noted. This view was common in the academic community. At the Nuremberg Tribunal Nazi physicians referred to it in order to justify their actions in cruel trials on prisoners.

Scandals around the United States (and to a somewhat lesser extent the countries of Western Europe) around the facts of involuntary use of people as subjects in biomedical trials contributed to the fact that long before the events were described, developed ethical standards for conducting trials on humans had been in demand. A gradual, uneven process in different countries and different fields of medicine has begun, and the process of creating social technologies for the ethical and legal regulation of human trials is currently far from being complete.
A reference to business interests is important because it allows one to notice the threat to development of ethical control principles from rapidly expanding commercialization of research in this area. The objectivity of research funded by pharmaceutical and biotech companies is highly suspect. Practically no negative results are published.

The main ideological sources for the development of ethical standards for medical trials on humans were the texts of the 1947 Nuremberg Code of Ethics and the 1964 Declaration of Helsinki.

The WMA Declaration of Helsinki formed the basis for all subsequent recommendations and legislative acts defining human rights and ethical obligations that physicians assume in conducting clinical trials. The principles set forth in the Declaration of Helsinki are advisory provisions, but they do not exempt physicians from criminal and civil liability under national law. All the main documents based on the Declaration of Helsinki which are developed by authoritative international organizations should be reflected in national legislation, which, in turn, should provide for the possibility of independent public control over observance of human rights in planning and conduct of clinical trials, because clinical trials in humans are a cardinal type of scientific activity, since it is impossible to obtain and select new, more effective and safer drugs, as well as to “cleanse” medicine of obsolete inefficient drugs without them.

The WMA Declaration of Helsinki in the section “Basic Principles” says: “The research protocol must be submitted for consideration, comment, guidance and approval to a research ethics committee before the study begins. This committee must be independent of the researcher, the sponsor and any other undue influence. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration. The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the
committee, especially information about any serious adverse events. No change to the protocol may be made without consideration and approval by the committee.”

The International Convention on Civil and Political Rights states that no one shall be subjected to torture, cruelty, inhumane or inferior treatment, or punishment. In particular, no one may be subjected to medical or scientific trials without freely given consent.

**Ethical Aspects of Medical Trials and Research**

Today, human biomedical research continues to be a necessary form of the existence of medicine and healthcare. The scope of research involving humans is rapidly and steadily expanding.

Groups of research (trials) in medicine include:

- biomedical trials studying the reaction and changes in the state of the body of healthy people under the influence of certain external factors. They have no direct relationship to treatment of diseases;
- clinical trials conducted in treatment of diseases. They are conducted according to clear rules that exclude points that could distort the result.

Different trials related to a particular research group (biomedical or clinical) can be attributed to the following types:

- preventive trials conducted to find the best ways to prevent a disease in people who have never suffered from it, or to prevent relapse in patients. In such trials, drugs, vaccines, vitamins, minerals, changes in lifestyle can be studied;
- screening trials conducted to find the best way to detect certain diseases or conditions;
- diagnostic tests made to find the best way to diagnose a particular disease or condition;
- therapeutic trials conducted to examine the efficacy and safety of experimental drugs, new drug combinations, or new methods in surgery or radiation therapy;
- quality of life research conducted to explore ways to improve the quality of life of patients with chronic diseases;
- enhanced access programs involving the use of an experimental drug in patients with serious or life-threatening diseases that cannot be included in a clinical trial because they do not meet the inclusion criteria. Typically, such programs involve patients for whom there are no effective methods of treatment or those who have tried all standard, well-known methods of treatment which did not help.

The main problem questions of medical research bioethics are the following:
1. Are human clinical trials acceptable? If so, what should be the limitations and conditions for their conduct?
2. What should be considered an experiment in the clinics?
3. How to reduce the potential risk for volunteers and to ensure their confidentiality?
4. How to test genetic drugs in healthy volunteers?
5. How to avoid abuse in research?
6. How to organize research, taking into account peculiarities of the legislation and social conditions of different countries, as well as to observe and protect the rights of those who participated in them?

The basic principles of medical research (trials) are as follows:
1. Trials should be carried out by a qualified personnel under the supervision of an experienced physician. In all cases, the responsibility lies with the physician, but not the patient, despite the informed consent given by the patient.
2. In any trials involving people as subjects, each participant should be appropriately informed of the goals, methods, expected benefits, risks and inconveniences associated with participation in the trial.
3. Participants must be informed that they have the right to abstain from participation in the trial and that they can withdraw their consent and refuse to continue the trial at any time after it began.
4. Biomedical trials involving people as subjects cannot be carried out legally if the risk to the subject of a trial is disproportionately high compared with the importance of its objectives.

5. In any biomedical trial, the life and health of subjects is always above the interests of science and society.

6. The plan and method of carrying out a trial must be clearly formulated in the protocol. The protocol must be approved of by an independent ethics committee. The researcher must provide current information to the ethics committee, especially about any adverse effects.

7. It is forbidden to conduct clinical trials on a common basis among people belonging to vulnerable categories of the population (a special procedure for regulation is applied here).

Vulnerable categories of the population include:

- Children. Before conducting a trial, for example, of a new drug on children, it is necessary to conduct previous clinical trials on adults with the same pathology and obtain informed consent of the parents; clinical trials of drugs for minors without their parents’ consent are prohibited. When conducting clinical trials on children, it is forbidden to convince the parents and the child so that they could decide to participate in the trial using financial or other material mechanisms. It is prohibited to involve children in orphanages and correctional institutions in trials, and it is also necessary to limit drastically participation of children from dysfunctional families (where parents are alcoholics, drug addicts, unemployed, and many times convicted). Moreover, according to the Declaration of Helsinki, the child’s consent must be obtained in addition to the parents’ permission. Diagnostics, treatment methods and drugs that are not approved for use, but are being considered in the established manner, can be used for treatment of people under the age of 15 years only with an immediate threat to their lives.

- Pregnant women. Clinical trials of drugs on pregnant women are prohibited unless these are drugs intended for pregnant women and when the risk of harm to the pregnant woman and the fetus is completely eliminated.
• People with mental disabilities. Clinical trials of drugs intended only for treatment of mental diseases are allowed in some countries if they are carried out with written consent of the legal representatives of these individuals.

• Prisoners. It is forbidden to conduct clinical trials of drugs on people serving sentences in places of liberty deprivation, as well as on people held in pre-trial detention centers, without their written informed consent.

Other vulnerable groups include:

• economically or educationally insolvent individuals;
• military personnel;
• medical workers and members of their families;
• students of educational organizations with medicine as major.

Trials on people who have no legal basis to consent to their participation in research can only be carried out if a specific written permission is obtained from proxies, and if the subject him-/herself does not object to this, and if the expected results of the trial suggest a direct beneficial effect on health of the test subject. It is not recommended to conduct trials on patients deemed incompetent, when similar trials can be carried out with comparable effectiveness on individuals who can give their consent to this.

When deciding to participate in a trial:

1. The patient should be able to ask the researcher all the questions, get answers and have enough time to make a decision.

2. The choice to participate in clinical trials or not is a personal decision of the patient made without coercion.

3. The patient can discuss the received information with a physician, family members and friends, and consult with a lawyer if necessary.

Clinical trials have the following disadvantages (risks):

• physical and psychological damage, adverse reactions can occur;
• treatment can be ineffective;
• a research program (protocol) can take a lot of time (visits to a research center, treatment);
  • dosing modes can be more complex than with standard treatment.
Participating in a clinical trial, a person can:
• gain access to new types of treatment which are not available to other members of the society;
• have professional medical care in leading medical organizations and from leading specialists, additional diagnostic methods, examinations;
• help other patients;
• contribute to global progress.

Recently, the role of medical trials has also increased in connection with introduction of evidence-based medicine principles in practical public health, the main of which is adoption of specific clinical decisions for treating a patient not only based on the physician’s personal experience, but on strictly proven scientific data from controlled trials. However, despite the fact that the conduct of trials is necessary at the final stage of a specific study, their conduct is unsafe and does not pass unnoticed for those individuals who serve as material for them. Any trial carries a greater or a lesser risk element for the patient. The very nature of the relationship between the researcher and the subject is such that their goals are significantly different. If for the physician the acquisition of new knowledge is paramount, for the patient, of course, it is improvement of the state of health.

Responsibility of the researcher implies the following:

1. The duty of the physician participating in a medical trial is to protect the life, health, privacy and dignity of the subject.
2. A medical trial on humans should be consistent with generally accepted scientific principles.
3. Responsibility for the test subject should always rest with a person with appropriate medical qualifications and never with the test subject.
4. Each medical trial project involving humans must be preceded by a thorough assessment of predictable risks.

5. Physicians must stop any trial when it is discovered that the risk exceeds the expected benefits.

6. Public access to all trial plans must be provided.

7. Subjects must be voluntary and informed participants in a trial project.

8. The physician must obtain informed consent from the subject, given without coercion.

9. When publishing trial results, researchers are required to maintain accuracy of the results.

**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

*Read Appendix “How to make a good presentation” before you start.*


2. Institutional means of ethical control of biomedical research and trials (ethics committees).


4. Basic principles of scientific experiments and clinical trials. Documents regulating medical and biological trials.

5. History of medical trials and research.

6. Medical abuse of Nazi Germany and militaristic Japan.

7. Inhuman use of medicine in the 20th century in different countries aside from Germany and Japan.

**Speaking skill development focus**

*Situational tasks*

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.

3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.

4. Compare the results of discussion with solution patterns.

**Situational task 1**

The German philosopher Immanuel Kant wrote: “An animal is just a means for a specific purpose. This specific purpose is a human”. If animals are just a means, then should animals have an ethical attitude towards them, e.g. in a laboratory experiment?

**Situational task 2**

The Russian physician Vikenty Veresaev wrote: “The organisms of animals and humans are too different, and you cannot infer from the first to the second without an error”.

What did he warn about?

**Situational task 3**

Kate Dimanche, a general practitioner in a small provincial US town, was approached by a large pharmaceutical company with a proposal to participate in clinical trials of a new non-steroidal anti-inflammatory drug for treatment of osteoarthritis. She was offered a certain amount of money for each patient who would participate in the trials. A company representative assured her that the test project had passed all the necessary formalities, including permission from an ethics committee. Ms. Dimanche had never participated in trials before. She was glad of the opportunity and the prospect of additional earnings and agreed without clarifying the scientific or ethical sides of the research.

Is she right to give a quick consent to participate in clinical trials?
Test tasks

Tick several correct variants.

1. MEDICAL TRIAL ETHICS REQUIRES ENTIRE EXPLANATION OF THE EXPERIMENT ESSENCE TO ITS PARTICIPANTS. ASSESS THE STATEMENT.

   1) It is true.
   2) It is false.
   3) It depends on trial/research methodology.
   4) It depends on the physician’s opinion.

2. THE TRIAL PARTICIPANT CAN MISLEAD OR WITHHOLD INFORMATION WHILE COLLECTING DATA ABOUT HIM/HER. ASSESS THE STATEMENT.

   1) It is true.
   2) It is false.
   3) Only if the information is secret.
   4) It depends on the participant’s opinion.

3. THE DUTIES OF AN ETHICS COMMITTEE, AMONG OTHERS, INCLUDE …

   1) ensuring protection of the rights, safety and well-being of research subjects and guaranteeing the public this protection;
   2) analysis of violations of rights and working conditions of research participants;
   3) development of standards for provision of qualified legal assistance;
   4) bringing the basic requirements of the law to all participants in the process.

4. THE MAIN DOCUMENT REGULATING RESEARCH ETHICS IN ACCORDANCE WITH THE HELSINKI DECLARATION IS THE …

   1) Nuremberg Code;
   2) Hippocratic Oath;
   3) informed consent;
   4) national law.
5. PARTICIPANTS CAN REFUSE A MEDICAL TRIAL OR RESEARCH …
   1) during coordination of the trial stages;
   2) before the trial;
   3) It is false. They cannot refuse it;
   4) any time after its start.

6. VULNERABLE GROUPS IN MEDICAL TRIALS / RESEARCH INCLUDE (tick 3 correct variants): …
   1) children;
   2) prisoners;
   3) government officials;
   4) students of medical educational organizations.

7. THE RESEARCHER IS OBLIGED TO WARN … ABOUT CHANGES IN THE MEDICAL TRIAL / RESEARCH.
   1) only its subjects;
   2) no one; it is enough that the researcher knows;
   3) assistants;
   4) all the sides participating in the trial / research

8. AN INABILITY TO FAMILIARIZE WITH THE FULL PICTURE OF THE TRIAL / RESEARCH …
   1) strengthens the researcher’s responsibility;
   2) makes the trial or research impossible;
   3) removes all responsibility from the researcher;
   4) encourages the subjects to stop participating in the trial / research.
9. CONCEALMENT AND DECEPTION CAN BE NECESSARY ACCORDING TO THE TRIAL / RESEARCH METHODOLOGY. ASSESS THE STATEMENT.

1) It is true.
2) It is false.
3) It is sometimes true.
4) It is true only if the subjects agree to it.

10. AN ADVERSE OUTCOME OF THE TRIAL / RESEARCH AND ITS EFFECT ON THE SUBJECT IS EVALUATED BY …

1) the researcher;
2) the subjects;
3) a special commission;
4) the researcher’s colleagues and students.
2.2. Ethical Issues of HIV

**Reading skill development focus**

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

**General Facts about HIV**

**Human Immunodeficiency Virus** (HIV) is a slowly progressing infectious disease which infects the immune system, and the body becomes highly susceptible to opportunistic infections and tumors, which ultimately lead to the patient’s death. A HIV vaccine does not currently exist.

In 1981, the first three scientific articles appeared about unusual cases of pneumocystis pneumonia and Kaposi’s sarcoma in men who had sex with men. Prior to this, the both diseases had been rare and characteristic of completely different groups of patients: Kaposi’s sarcoma mainly affected elderly men of the Mediterranean origin, and pneumocystis pneumonia – patients with leukemia after intensive chemotherapy. The occurrence of these diseases, indicating a severe immunodeficiency state, was observed for the first time in young people who were not included in the corresponding risk groups. Later they found the same symptoms among drug users with hemophilia A and Haitians.

The HIV was independently discovered in 1983 in two laboratories: in the Pasteur Institute (France) under the supervision of Luc Montagnier and in the National Cancer Institute (USA) under the leadership of Robert Gallo. The results of studies when a new retrovirus was first isolated from the tissues of patients with AIDS symptoms were published on May 20, 1983 in the journal *Science*. In 1986, it was discovered that the viruses discovered in 1983 by French and American researchers are genetically identical. In 2008, Luc Montagnier, Harald zur Hausen and Françoise
Barré-Sinoussi were awarded the Nobel Prize in Physiology or Medicine “for the discovery of the human immunodeficiency virus”.

The virus can be transmitted through direct contact of a damaged mucous membrane or damaged skin of a healthy person with biological fluids of an infected person: blood, pre-seeded fluid (secreted throughout the entire sexual intercourse), sperm, vaginal secretion and breast milk. Virus transmission can occur during unprotected anal, vaginal or oral sex.

Intact skin is an effective barrier to infection, as there are no cells in the skin that can be infected with HIV. A successful infection requires direct contact with the circulatory system or with cell membranes of mucous membranes. Mucous membranes of the genitals and rectum often receive minor damage during intercourse, through which the virus can enter the bloodstream. Such damage more often occurs in the presence of sexually transmitted diseases, e.g. in patients with herpes. Infection is also possible with an intact mucous membrane, since the latter contains a significant number of dendritic cells (including Langerhans’ cells), which can play the role of “carriers” of viral particles to lymph nodes. Therefore, unprotected anal sex is a particularly dangerous form of sexual intercourse for the host partner, since this form causes the greatest number of minor and major injuries.

Virus transmission is more likely to occur with the use of infected needles and syringes (especially by drug users), as well as with a blood transfusion, e.g. if a medical personnel violates established procedures for checking donor blood. Virus transmission can also occur between the mother and the child during pregnancy, delivery (infection through the mother’s blood) and breastfeeding (both from an infected mother to a healthy baby through breast milk, and from an infected baby to a healthy mother through biting her breast during feeding).

Infection can also occur with the use of donor sperm, donated breast milk from a HIV-infected donor, as well as through medical instruments for parenteral interventions, medical devices contaminated with HIV and not processed in accordance with the requirements of regulatory documents.
It can also take place during tattooing, cosmetic, manicure and pedicure procedures with non-sterile instruments.

Spouses and sexual partners should be aware if their partner has HIV. A condom is the best remedy for all forms of sexual activity.

There are many legends around HIV transmission, so let’s focus on how HIV is not transmitted. The virus is not airborne. It cannot be transmitted either by the household route, through contact with intact skin, through insect bites, tears and saliva (due to the fact that the concentration of HIV virions in these fluids is lower than the infectious dose, and also because saliva is an aggressive environment that destroys HIV virions with its enzymes).

Besides, HIV is not transmitted:

- with friendly kisses, handshakes, hugs;
- through sweat or tears;
- when using common dishes or bedding;
- when sharing a bath and / or a toilet;
- when using a telephone, sports equipment;
- when coughing and sneezing;
- through animals or insect bites;
- in public transport.

The following stages of HIV infection are distinguished:

1) the incubation stage (the window period), lasting from the moment of infection to the emergence of detectable antibodies to HIV, from 2 weeks to 1 year (in people with weakened immunity from 2 weeks to 6 months);

2) the stage of primary manifestations (the acute phase), lasting up to 1 month from the moment of infection;

3) the subclinical stage (chronic HIV), developing after the acute phase ends, when the “equilibrium” is established between the rate of virus propagation and the immune response, and then for many months and years (up to 8-10 years). The use of highly active antiretroviral therapy (HAART) can extend this stage for decades. At this
stage, HIV-infected patients can infect other people even when using HAART, although treatment significantly reduces the likelihood of infection;

4) the stage of deuteropathy (*recrudescence*), lasting for 1-2 years, when inhibition of cellular immunity begins;

5) the final stage, which is the terminal stage of HIV infection (*AIDS*). In the absence of treatment, it lasts up to 3 years, on average for 1-2 years. At this stage, opportunistic infections and tumors are generalized. The life expectancy in the absence of HAART is less than 1 year.

The factors that reduce transition of HIV infection to AIDS are the mature and senile age, co-infection with other viral diseases, poor nutrition, stress, genetic characteristics. The factors that delay AIDS development are the use of highly active antiretroviral therapy, treatment of recrudescence diseases, compliance with recommendations of the attending physician, proper nutrition, a healthy lifestyle (smoking cessation), genetic features.

HIV remains one of the main problems of global public health: today it has claimed more than 32 million human lives. In 2018, 770,000 people died from HIV-related causes worldwide.

At the end of 2018, there were approximately 37.9 million people with HIV in the world, and 1.7 million people became infected with HIV in 2018.

62 % of adults and 54 % of children with HIV worldwide received antiretroviral therapy in 2018.

The most affected region is Africa with 25.7 million people living with HIV in 2018. Africa also accounts for nearly two-thirds of the total global number of new HIV infections (*see Picture 1 and Table 1)*.

It is estimated that currently only 79 % of people with HIV know about their status. In 2018, 23.3 million people with HIV received antiretroviral therapy globally.

Between 2000 and 2018, the number of new HIV infections decreased by 37 %, and the HIV-related mortality rates decreased by 45 %, and thanks to HAART, 13.6 million lives were saved over the same period.
Picture 1. HIV/AIDS prevalence world map in 2009 according to UNAIDS data\textsuperscript{1}

This achievement was the result of large-scale efforts under national HIV programs with the support of civil society and a wide range of development partners.

**Table 1.** List of countries by HIV/AIDS adult prevalence rate, 2016 (%)

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<thead>
<tr>
<th>#</th>
<th>Country</th>
<th>%</th>
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<tbody>
<tr>
<td>1.</td>
<td>Eswatini</td>
<td>27.2</td>
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<tr>
<td>2.</td>
<td>Lesotho</td>
<td>25.0</td>
</tr>
<tr>
<td>3.</td>
<td>Botswana</td>
<td>21.9</td>
</tr>
<tr>
<td>4.</td>
<td>South Africa</td>
<td>18.9</td>
</tr>
<tr>
<td>5.</td>
<td>Namibia</td>
<td>13.8</td>
</tr>
<tr>
<td>6.</td>
<td>Zimbabwe</td>
<td>13.5</td>
</tr>
<tr>
<td>7.</td>
<td>Zambia</td>
<td>12.4</td>
</tr>
<tr>
<td>8.</td>
<td>Mozambique</td>
<td>12.3</td>
</tr>
<tr>
<td>9.</td>
<td>Malawi</td>
<td>9.2</td>
</tr>
<tr>
<td>10.</td>
<td>Uganda</td>
<td>6.5</td>
</tr>
</tbody>
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framework of specialized medical care programs. The trusting atmosphere creates a more sincere and stable relationship between the patient and the medical worker. The patient will be more open to discussing characteristics of their behavior related to HIV infection.

People seeking HIV-related care (such as voluntary counseling and screening, treatment for STIs) may be in severe psychological stress and fear reprimand from the family or the public if they are HIV-positive. In such situations, the quality of the patient’s communication with the medical worker is of particular importance. Medical specialists should not make evaluative judgments regarding the patient’s behavior and individual actions. They must keep information secret about the patient, carefully listen and encourage the patient, give accurate answers to questions and provide a patient with comprehensive support.

People living with HIV often face the inability to use health services due to bias from those who provide these services. Fear of stigma and discrimination creates additional barriers to getting help. The strategy used to solve these problems involves formation of the skills that infected people need to assert their rights.

A medical worker contacting with a HIV patient and his/her relatives should be able to acquire and interpret the information necessary to determine the patient’s health status, as well as be able to prioritize the patient’s problems.

This means that a medical worker must be able to conduct a comprehensive survey of the patient and his/her relatives, or the people caring for him/her; assess the patient’s mental state; determine his/her needs, goals and values; formulate the patient’s medical, psychological and social problems based on the available information. A medical worker should be able to understand and evaluate the priorities for the patient’s psychological state and thus establish effective relationships with the patient and demonstrate ethical behavioral communication skills in the process of interacting with the patient and his/her relatives, ensuring partnerships based on respect for the individual. The physician must have skills to ensure the patient’s commitment to treatment, be able to motivate the patient to overcome the disease.
One of the most important tasks of a physician and a clinical psychologist working with HIV-positive patients is to develop a commitment to antiretroviral therapy (HAART) and the ability to inform the patient and motivate him/her to make decisions regarding a continuous use of drugs that sometimes cause a subjectively difficult physical and mental state due to possible adverse effects. At the same time, both the physician and the patient should understand that any deviation from the treatment mode, even the most insignificant, can cross out all efforts for previous treatment and provoke a relapse of the disease.

There comes a moment when palliative medical care for a HIV-positive patient comes first, designed to alleviate the patient’s condition and psychologically support him/her and his/her loved ones. Then the coordination aspects of communication within the framework of palliative medical care come to the fore. Here they are:

1. Engage others. Encourage others to support the patient in setting goals and making plans for the future.
2. Encourage others to take care of the patient and his/her family.
3. Encourage others to find resources for self-regulation in the patient and find them yourself. Include the patient in support groups.

In addition to the coordination aspects, it is necessary to follow the clinical aspects of communication in a hospital:

1. Strengthen clinical, psychological, and social assessment.
2. Clarify the goals and objectives of patient care.
3. Discuss and agree on all aspects related to the patient.
4. Review your treatment plan as often as necessary.

The specific aspects of health workers’ communication must also be considered when providing palliative medical care for HIV patients:

1. Identify the causes and facts of the patient’s anxiety.
2. Assess the clinical condition of the patient.
3. Assess how well the patient has adapted to the treatment.
4. Share the information on risk factors of deterioration in the patient’s condition.
5. Provide clinicians with information for diagnosis and treatment plans.
7. Keep registration and medical records.
8. Add the patient’s training.
9. Interact with your immediate social environment, organize and strengthen this interaction.
10. Discuss plans and goals of patient care, reach agreement with the patient and his/her relatives on this.

A particular aspect is communication with family members of a HIV-positive patient:
1. Provide them with consent and support.
2. Discuss help objectives.
3. Discuss a joint care plan of the patient.
4. From time to time return to discussing plans and seek a joint agreement during discussion.

People want to be informed honestly about bad news, but at the same time they expect sensitivity from the physician. It is very important for them to be perceived as individuals. Both patients and relatives believe that physicians should talk with them about death, but at the same time take into account their condition and choose the right moment for conversation.

Each patient has a need for information about his/her health status. When working with HIV-positive patients, it is difficult for the physician to report unpleasant news about changes in the state of health and treatment problems, and it is difficult for the patient to learn about it. However, the physician has to do this regularly. It is important to study the experience of other physicians in solving this problem, to develop a technology for reporting on hard news, and to investigate consequences of such messages in different contexts.
Ethics of HIV Testing

Considering aspects of HIV testing, there are two types of it: voluntary and mandatory.

In voluntary anonymous testing, the patient is registered under the number. In this case, the indication of demographic information (age, gender) is permissible, but neither the name nor the address of the subject is recorded in the medical documents. During voluntary confidential testing, information about the patient’s personality is reflected in medical documents. However, the patient must be provided with guarantees of information non-disclosure.

HIV testing should certainly be accompanied with patient counseling both before and after testing. Adequately informing the patient sometimes becomes the best psychotherapy. Depending on the individual psychological characteristics of each patient, it is advisable to inform the patient that the medical literature has repeatedly reported cases where regular sexual activity with a HIV-positive partner for many years did not lead to infection; what test results are false positive; that a positive result does not mean HIV; that medicine knows cases where HIV has not developed in “HIV-positives” for more than 10 years, etc. The grossest violation of professional ethics will be informing the patient without competent counseling about a positive test result that has yet to be confirmed in the reanalysis. Patients are finally informed of the test results only after confirmation of the positive test results. This is done in order to avoid tragic cases similar to the one that occurred in Riga, the capital of Latvia, in 1991, when the couple, having learned about the positive test result of one of them, committed suicide, and in posthumous studies of the fact HIV infection was not found.

In many countries, the following contingents are required to be tested for HIV:

1) donors of blood, blood plasma, sperm and other biological fluids, tissues, organs, as well as pregnant women, including in case of abortion and placental blood sampling for biological production;

2) physicians, paramedical and junior medical personnel of healthcare organizations engaged in direct examination, diagnosis, treatment, maintenance, as
well as forensic examination and other work with people infected with HIV who have
direct contact with them;

3) physicians, paramedical and junior medical personnel of laboratories that
conduct examination for HIV infection and study blood and biological materials
obtained from people infected with HIV;

4) scientists, specialists, employees and workers of research organizations,
enterprises (manufactures) for production of medical immunobiological preparations,
and other organizations whose work is related to HIV-containing material;

5) medical workers in hospitals (departments) of the surgical profile;

6) people who are called up for military service, enter military service under a
contract and military educational organizations (military training centers, military
departments, military training faculties).

Many foreign experts believe that the practice of mandatory HIV testing not only
violates human rights, but also appears to be ineffective as a barrier to the spread of the
epidemic, and therefore its use should be quite limited. The WHO does not support the
practice of mandatory testing either.

Today, many rapid HIV tests are available. They are known as the “on-site test”,
“the patient’s bedside test” and the “simplified rapid test”. Most of these tests allow to
get the result in 15-30 minutes. Such rapid tests are useful when the result needs to be
obtained quickly, e.g. in the emergency room, before an urgent surgery, a delivery or
after an accidental needle injury. The main problem with the use of rapid tests is the
need to advise the patient on testing and obtain consent to test conduction.

There are currently two main types of rapid tests: saliva and blood. A saliva test
is performed as follows: a device with an absorbent plate is taken out of the bag (it is
important not to touch the absorbent plate), and a special bottle with a liquid is opened.
The absorbent plate is placed above the teeth on the outside of the gums and is drawn
on the outer surface of the upper and lower gums, without touching the surface of the
cheeks and tongue. Then the plate is placed in a special bottle with a liquid so that it
could touch the bottom of the bottle. The result is read after 20 minutes. If the result is
negative, a red-violet line appears opposite the triangle with the letter “C”, but there is
no line opposite the triangle with the letter “T”. If the result is preliminary positive, two red-violet lines appear: one opposite the letter “C”, the other opposite the letter “T”. The result is invalid when the lines do not appear at all, or when they are located outside the zones of the triangles.

A blood test is performed in a similar way: a small pillow of the ring finger is punctured, blood is dripping, and lines also appear opposite the indicators in 20 minutes: one means “Not infected”, two mean “Infected”.

Tests are sold in some pharmacies, but it is specifically advised to find out exactly where they are sold. They are also distributed free of charge by public organizations involved in HIV prevention.

HIV-test results mean the following.

A positive result can mean that:

• HIV is present in the human body;
• the body has developed antibodies against HIV;
• it is not an indicator of human health;
• a person can infect another person.

A negative result can mean that:

• HIV antibodies have not been detected in the blood;
• there may be no HIV infection;
• HIV antibodies are produced on average 2-3 months after the moment of infection (the “window” period).

An uncertain result can mean that:

• it is impossible to determine the test result with certainty;
• repeated HIV testing is needed in 2-3 weeks.

After the test, the physician’s actions should be the following:

• Only the result of the final test result must be reported to the patient.
• Clearly explain to the patient what the result means.
• If necessary, repeat the test and clearly and truthfully explain to the patient why this is necessary.
Inform the patient that with strict adherence to the testing methodology, the possibility of obtaining false results is minimal.

**Highly Active Antiretroviral Therapy Adherence**

*Highly active antiretroviral therapy* (HAART) is a method of treating HIV infection, which consists in taking several antiviral drugs. Thanks to the effective action of therapy, HIV-positive people can lead a normal life. The effect of HAART is that a HIV-positive person reaches zero viral load, as a result of which the quality and duration of life is practically no different from HIV-negative people. HAART also allows HIV-positive parents to conceive and give birth to a healthy baby in the natural way. The most modern treatment options have practically no adverse reactions, are safe for humans and consist in taking one tablet per day or one injection in one or two months.

The therapy goals are:

1. **Virological** – to stop the virus reproduction in the body. Its indicator is a decrease in the viral load in 4 weeks by more than 10 times, to less than 20-50 copies / ml in 16-24 weeks, keeping it at this level for as long as possible.

2. **Immunological** – to restore the state of the immune system. When the viral load decreases sharply, the body gets an opportunity to restore the number of CD4+ lymphocytes gradually and, accordingly, an adequate immune response.

3. **Clinical** – to increase the duration and quality of life of a HIV-positive patient. Taking therapy in most cases saves a person from AIDS development, which means occurrence of diseases that could worsen the patient’s life and even lead to death. Since the number of viruses in the blood and tissues decreases sharply, unprotected sexual intercourse becomes less dangerous, and, therefore, an opportunity to conceive a child appears.

The main problem with HIV suppressing is its high mutagenicity – the ability to vary its RNA and thus produce viable mutations even under adverse conditions. The basis of HAART is the method of using several drugs at the same time to suppress various stages of virus development. The drug combination consists of two, three or
four components. The virus can develop resistance to a particular drug if it is taken irregularly or in insufficient doses.

The therapy requires strict adherence to the administration schedule (at a specific hour or at the predetermined time before or after a meal). The patient cannot skip drug doses, cannot take reduced or increased doses in case of skipping. All this creates a big burden on a HIV-positive patient, therefore, before starting therapy, the administration mode is discussed with the physician, and the drug composition can be adjusted.

In many countries, costs of HIV-infected patients’ treatment are paid from the state budget. Such drugs are given free of charge to patients who, for medical reasons, need to take HAART in specialized medical organizations (AIDS centers, infectious diseases hospitals). However, not all patients in need of treatment can receive drugs due to insufficient funding and high prices in different countries, as well as for complexity of the procurement process. Such drugs usually do not go on free sale.

**Occupational Risks of HIV Infection**

Occupations of the highest risk to get infected with HIV are:

- a paramedical staff;
- procedural, guard and operating nurses;
- operating surgeons, obstetrician-gynecologists, emergency doctors, pathologists;
- a junior medical staff.

The risk of HIV infection depends on the following factors:

- the patient’s HIV status and the disease stage;
- the patient’s receiving HAART;
- the degree of tool contamination with an infectious material;
- the type of the tool that caused an injury;
- the degree of the skin integrity and mucous membrane violation upon the injury;
- treatment of the wound surface after the injury;
• timeliness of postexposure chemoprophylaxis of HIV infection with antiretroviral drugs.

The most common emergency situations occur:
• while taking blood samples from the vein;
• during intravenous injection and blood transfusion;
• while putting the cap on the used needle;
• while transferring HIV-contaminated fluids from a syringe to a glass tube;
• while cleaning the workplace;
• during a hand-to-hand transfer of sharp surgical instruments;
• during a hazardous tissue suturing technique.

Common HIV emergency situation rules are the following:

1. Each patient should be considered a potential source of infection, regardless of the status, age and gender.
2. Hospitals should have all necessary equipment and means for disinfection of the laboratory equipment.
3. If the virus is suspected, a set of measures is taken to identify and suppress the spread of the disease.
4. An extraordinary investigation is under way with a view to further warning.
5. An emergency situation with HIV infection is recorded in a special journal.
6. Health care providers should carefully observe measures to prevent HIV infection.
7. Medical workers with injuries (wounds on the hands, exudative skin lesions) are suspended from medical care of patients and contact with their care items.

**HIV-Phobia. Stigmatization and Discrimination of HIV-Positive Patients**

The diagnosis is made, and the patient is left alone with it. The first person who knows about the diagnosis is a medical worker, and the length and quality of life with HIV depends on how the patient receives the information about the disease, in what form and how the post-test counseling is conducted.
**HIV-phobia** is a socio-psychological phenomenon characterized with an irrational, unaccountable, or even obsessive fear of infection, an incurable painful disease, HIV-related social ostracism and death.

The inevitable reaction of most people to the word “HIV” is fear. It could be a fear of infection, dying, death, powerlessness of medicine and society as a whole, unable to counter HIV with anything effective. One of the paradoxical manifestations of HIV-phobia is an unconscious desire of people to “forget” about the threat, to turn their back on it. This is manifested both in irresponsible, constantly threatening infection behavior, and in underestimating the problem on the part of state bodies.

In the minds of HIV-positive patients themselves, the fear of discrimination and stigmatization by society is in the foreground. Preserving medical confidentiality in cases of HIV infection is of great importance.

When dealing with HIV-positive patients, the physician has to deal not only with the clinical reality, but also with the myths and prejudices associated with this disease, the spread of which is largely due to ignorance of a large part of the population. The prohibition of any discrimination is a norm of international law, contained in many documents adopted by various international organizations.

In the first documents adopted by the WHO, the WMA and other organizations in connection with the growing HIV pandemic, one of the central places was taken by a specially highlighted requirement not to discriminate HIV-positive people, as well as people representing “risk groups”, as discrimination against people living with HIV not only violates human rights, but also undermines fundamental public health principles. It can provoke a feeling of revenge in an infected person, which can turn into a deliberate spread of the infection. The refusal of physicians and other representatives of the medical profession to provide assistance to HIV-positive people is the most serious problem from the point of view of medical ethics.

Along with the denial of assistance to HIV-positive patients, a gross violation of professional medical ethics is disclosure of the appropriate diagnosis. There are many examples where this kind of behavior of medical workers initiated discrimination, ostracism, and even direct violence against HIV-positive patients.
**Stigmatization** (from Greek στίγμα “marking, labeling”) is hanging social labels, linking any negative quality with an individual person or a lot of people, although this connection is absent or not proven; one of the forms of human alienation. It is an integral part of many prejudices. HIV is often viewed negatively, and social attitudes can harm infected people or those who are suspected of being infected.

Discrimination is determined mainly by legal and human rights. When a person loses his/her job due to a negative subtext or perception of HIV, this is obvious discrimination.

General types of stigmas are:
- physical defects: various kinds of physical abnormalities;
- individual traits, lifestyle: a criminal record, drug abuse, various sexual practices, a job loss, suicide attempts, and even a radical political position;
- congenital stigmas: a race, ethnicity and religion, which can be inherited and reach all members of the family.

There are also:
- external stigmas: domination, oppression, the use of force and control, aggression, categorization, accusation, punishment, condemnation, exclusion, ridicule, resentment, avoidance – an intolerant attitude towards people different from others;
- inner stigmas: feelings of shame, fear, anxiety, depression, inferiority complex, a personal guilt.

Stigmas are linked to discrimination.

**Discrimination** (from Latin discriminatio “distinguish”) is a negative attitude, bias, violence, injustice and depriving people of certain rights and privileges because of their belonging to a particular social group.

Stigmatization causes discrimination, which, in turn, causes an internal stigma, which, being encouraged, reinforces stigmatization, thus creating a vicious circle. Here are the most typical situations:

1. People think that AIDS is scary because they were born in a society that was panicky afraid of AIDS.
2. People who do not know enough about HIV and its effects on the body associate it with very poor health and a terrible frightening change in the appearance.

3. HIV is an infection, and everyone is traditionally afraid of infections; ignorance of the real ways of HIV transmission contributes to fear and isolation.

4. People associate HIV-positive people with those who even before the HIV epidemic were stigmatized in society: people who do various sexual practices, drug users, sex workers. In the eyes of ignoramuses, HIV infection looks like a disease of “bad people”, like a “punishment for bad behavior”.

5. HIV touches on the topic of sex, which is largely taboo and associated with various moral restrictions, fears, vices, guilt, etc.

6. HIV mostly affects people who are most often discriminated in society: women, adolescents, men who have sex with men, drug users, etc.

7. Many people think that if they do not use injecting drugs and do not practice random sex, it means that “they are not like that” and HIV cannot touch them, and only risk groups are to blame for the spread of HIV. Today the HIV epidemic affects the entire population and has long gone beyond the risk group, spreading rapidly among the so-called wealthy segments of the population.

Stigmatization and discrimination may take place:

- at work;
- in police and other agencies;
- in the media;
- in communities;
- in the healthcare system, etc.

All this leads to social exclusion of HIV-positive people. The language is the key to stigmatization. Powerful metaphors are used to reinforce and legitimize it. This connects HIV with death, horror, shame, punishment, etc. It can make life unbearable for those who live with HIV.

Stigmatization can cause people who have undergone it to be reluctant to take tests, can make them change their behavior, abandon preventive measures, and lead to poor quality care and discrimination. For example, a woman may not want to bottle a
baby if she thinks it will brand her as HIV-positive. Families, friends, and colleagues of HIV-infected people often become victims of stigmatization and discrimination.

Support for those affected by HIV includes the following activities:

- support groups;
- work aimed at overcoming fears;
- counseling;
- conflict resolution;
- dissemination of educational information adapted for the target audiences (e.g. medical workers);
- giving a word to HIV-positive people;
- encouraging formation of a supportive atmosphere through communication;
- protecting the rights of HIV-positive people.

To overcome discrimination and stigmatization, people have to know about:

- what is HIV;
- HIV transmission routes;
- the social, economic and age status of HIV-positive people;
- safe behavior;
- the ways to get protected against HIV.

**HIV Denialism**

Proponents of the HIV denialism movement believe that HIV is a grandiose scam, which is based primarily on commercial interests of many influential structures and people.

HIV denialists say that:

- the existence of HIV is not clearly proven;
- HIV has gone beyond the risk groups, which is not characteristic for infections;
- HIV drugs are expensive on purpose, and their use is accompanied with adverse reactions, which also contributes to development of serious diseases.
The scientific community does not accept the views of participants in the HIV-denialism movement and considers them pseudoscientific.

The question of whether to be treated or not is everyone’s personal choice. But HIV denialists endanger other people urging them to abandon HAART.

Denial is a normal period for anyone who is experiencing a serious illness. But HIV-positive patients, succumbing to the ideology of denialists, prolongate this period.

The problem is aggravated by indifference or aggression of medical workers, the lack of an individual approach to the patient, as well as a psychological support system for people.

The groups most vulnerable to HIV denialism include:

- pregnant women and young parents not treating their HIV-positive children;
- HIV-positive people who do not want to put up with the diagnosis.

The main cause of the problem is a low level of public awareness about the etiology of the disease, its transmission and treatment methods.

The *Continuum* is a magazine published by an activist group of HIV denialists. Published from 1992 to 2001, it was closed due to the fact that the chief editors of the magazine died of HIV-related diseases.

**Protection of HIV-Positive People’s Rights**

Many countries guarantee every citizen protection against any form of discrimination caused by the presence of any disease. A physician’s refusal to provide medical care is usually a criminal offense.

Dismissal from work, refusal to give an employment, refusal to enroll in educational organizations and to admit to organizations providing medical care, as well as restrictions of other rights and legitimate interests of HIV-positive people, including residence restriction, because of their status are not allowed. Similarly, other rights and legitimate interests of HIV-positive people’s family members must be protected.

Many countries take the following obligations on protection of HIV-positive people’s rights:
• regular public information about available measures to prevent HIV infection;
  • epidemiological surveillance of the HIV infection spread;
  • production of means for prevention, diagnosis and treatment of HIV infection, as well as monitoring the safety of drugs, biological fluids and tissues used for diagnostic, therapeutic and scientific purposes;
  • available medical examination for detection of HIV infection, including anonymous one, with prior and subsequent counseling and ensuring the safety of such medical examination for both the examined person and the person conducting it;
  • free provision with all types of qualified and specialized medical care to HIV-infected people, including drug administration during treatment on both the outpatient and inpatient basis, as well as their free transportation to and from the place of treatment;

When applying for a job, a person is not required to inform about the HIV-positive status in the application form or in the CV; he/she has a right to inform about it or not. At the interview, it is also not necessary to talk about the diagnosis. The employer has no right to ask about it. If the interest in this issue is shown, it is devoid of a legal basis. However, for workers in certain professions, medical examinations are required. It should be borne in mind that the requirement to undergo a HIV test is usually illegal. Some people with HIV have problems finding a job.

HIV infection is a specific disease when an infected person begins to avoid others, while others avoid too close contacts with him/her as well. The spread of HIV infection has led to public prejudice against HIV-positive people. A big error is stereotypical perception of all HIV-positive people as a homogeneous group. It is unacceptable to discriminate and stigmatize them.

Today it is becoming increasingly apparent that socio-psychological assistance to HIV-infected people also solves other tasks, e.g. prevention of drug addiction and the HIV infection spread.

Unfortunately, not every medical organization that has HIV-positive patients has a full-time psychologist, so physicians have to take on these functions in addition to
treatment and observation. Implementation of recommendations for medical workers dealing with HIV-positive patients does not require any special knowledge or wise methods from the health care provider. Sometimes it is enough just to have a simple human communication with simple human compassion, avoiding callousness, a critical assessment of the patient’s behavior, without waiting for possible gratitude in response.

It is important to make it clear to patients with such an attitude that they remain people, full members of the society, and owners of human dignity.

**Presentation skill development focus**

Prepare a 10-minute presentation on a particular topic below. Read Appendix “How to make a good presentation” before you start.

3. HIV denialism.
5. Voluntary and mandatory testing for HIV. Pre-exposure prophylaxis (PrEP).
6. Refusal of medical care for HIV-positive patients in the light of history and modern bioethical requirements.

**Speaking skill development focus**

**Situational tasks**

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.
**Situational task 1**

Patient Anthony was admitted to the Department of Maxillofacial Surgery with a diagnosis of a fracture of the zygomatic orbital complex on the left. The results of the HIV test were positive. The physician informed the patients in the ward that their neighbor was HIV-positive so that they should use personal hygiene products individually, did not use ointments and drops of this patient, since there is a tendency among patients to use each other’s drugs and medications.

What bioethical rule was violated by the physician, and which one led his/her actions?

**Situational task 2**

The patient was admitted to the ophthalmology department with signs of inflammation of the left eye of the unclear etiology. A detailed examination of the patient for chronic diseases revealed HIV. The patient was informed about his diagnosis and offered treatment in a specialized hospital. However, the patient rejected treatment. Taking into consideration the patient’s inadequacy to his condition, his family was informed about the diagnosis.

What bioethical rule guides physicians in their relationships with this HIV-positive patient?

**Situational task 3**

A HIV-positive patient asks the physician not to disclose the diagnosis to his partner.

What should the physician do in this case?
Test tasks

Tick only one correct variant.

1. HIV IS …
   1) a slowly progressing infectious disease which infects the immune system, and the body becomes highly susceptible to opportunistic infections and tumors, which ultimately lead to the patient’s death;
   2) a slowly progressing disease of the bacteriological nature;
   3) an acute human immunodeficiency virus infectious disease;
   4) a progressing infectious airborne disease.

2. AFTER THE PATIENT PASSED HIV TESTING, THE MEDICAL WORKER MUST…
   1) advise the patient on all necessary questions about HIV;
   2) report on the patient’s HIV status to his/her family, work place, and police;
   3) discuss this patient with the medical organization staff;
   4) not explain anything to the patient, give out the test results and send the patient to another medical organization.

3. A HIV-POSITIVE PERSON SHOULD …
   1) not disclose his/her HIV-positive status to anyone;
   2) change the places of residence and work;
   3) report that he/she is HIV-positive to his/her partner;
   4) inform about it his/her relatives and friends, at work, in the police.

4. THE RULES FOR TAKING HIGHLY ACTIVE ANTIRETROVIRAL THERAPY INCLUDE …
   1) an increase in the drug dose in case of therapy skipping;
   2) strict adherence to the drug mode;
   3) a necessity to take drugs;
   4) a necessity to take drugs for all close relatives of a HIV-positive patient.
5. MEDICAL CONFIDENTIALITY REGARDING A HIV-POSITIVE PATIENT MEANS THAT THE INFORMATION ABOUT HIS/HER STATUS …

1) must not be disclosed to anyone;
2) could be distributed among others;
3) should be used as incriminating evidence on the patient;
4) could be kept secret or not (which depends on the physician’s decision).

6. THE PHYSICIAN’S REFUSAL TO PROVIDE MEDICAL CARE TO A HIV-POSITIVE PATIENT …

1) depends on the physician’s attitude towards HIV-positive people;
2) is considered the norm by society and law;
3) is a criminal offense;
4) should be encouraged by the administration of the medical organization.

7. HIV-RELATED STIGMA AND DISCRIMINATION …

1) are considered the norm in society;
2) are interrelated and lead to violations of HIV-positive people’s rights;
3) should be taken for granted by HIV-positive people;
4) should be encouraged by the state and legislated.

8. HIV-PHOBIA IS …

1) fear of infection, excruciating an incurable disease, death from HIV;
2) fear of medical manipulations;
3) fear of queues, crowds;
4) fear of contracting the infection in medical facilities.
9. THE MEASURES AIMED AT OVERCOMING HIV-PHOBIA INCLUDE …
   1) isolation of HIV-positive people from others;
   2) dissemination of educational information about HIV among the population;
   3) encouraging dissemination of information on the HIV-status of people;
   4) hiding any information about HIV from the public.

10. THE MAIN CAUSE OF HIV DENIALISM IS …
   1) expensive antiretroviral therapy as conspiracy of pharmaceutical companies;
   2) distrust of the population in the information received from the WHO;
   3) a low level of public awareness of the HIV etiology, transmission modes and
treatment;
   4) neglect of HIV-positive patients and aversion to them by medical workers.
2.3. Bioethical Aspects of Death

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Concepts of Death in History

Death is termination, a complete stop of biological and physiological processes of the body; irreversible destruction and/or dysfunction of critical irreplaceable systems of the body (neither now, nor in the future) by artificial, biological, chemical or electronic-technical systems (i.e. the brain is irreplaceable).

Thanatology (from Greek θάνατος “death”) is a branch of medicine that studies the state of the body at the final stage of a pathological process, the dynamics and mechanisms of dying, the causes of death, clinical, biochemical and morphological manifestations of the gradual body cessation. The phenomena most often causing death are aging, malnutrition, an illness, suicide, homicide and accidents.

Death has always carried an imprint of mystery and mysticism. Unpredictability, inevitability, unexpectedness and sometimes insignificance of the causes leading to death took the very concept of death beyond the limits of human perception. Death is an existential problem, and the attitude towards it is largely predetermined by culture. In traditional cultures, death is an important moment in life. The experience of death is reproduced in all ancient rituals and initiations, it is described by ancient cultural artifacts.

The theme of death is central to the myths of all nations. Myths about the origin of death among all peoples are subject to general laws:

1. Firstly, people did not die before, and then somehow they lost this ability.
2. Secondly, the idea of a precedent is applied: one person died, and after that all people started to die.

3. Thirdly, this is an idea of punishment: death is seen as a punishment for misconduct, an error, disobedience.

The most frequently repeated image is death as a victim and an exchange. “Death among savages is a subject of mutual exchange between ancestors and living people and does not form a gap, but an exchange of reciprocal gifts.”

In Christianity, death is a punishment for the original sin. At the same time, Christ died voluntarily, making a ransom sacrifice that freed humanity from the original sin (“trampling down death by death”). Most religions view life as a preparation for death. “The institution of death, as well as the institutions of afterlife and immortality, are late gains of political rationalism of the priestly castes and churches; it is on the management of this imaginary sphere of death that they build their power.” An individual realized his/her loneliness in the face of death only in the 16th century (the Reformation period). Until this time, the attitude towards death was of a folkloric and cheerful nature.

The most important religious idea is the idea of immortality of the soul, which is trying to fight death. In the ratio of these two concepts, the biggest paradox of the human existence is concluded: a person knows that he/she will certainly die, but he/she lives as if he/she was immortal. The idea of immortality is very close to a human and is associated with characteristics of the psyche. A person has an idea of the past and future, but psychologically a human is in the eternal present. Interpretation of the meaning of death, its sacred nature is one of the main merits of religious thinking.

Death is the most important moment in a person’s life, when a person sums up moral results of the entire path, and carries out deep self-knowledge. At this moment moral enlightenment and insight can come.

Many creations of humanity acquire value and meaning in the face of death – art, philosophy, music, love. Everything passes, thereby acquiring its price.

Death can be natural and artificial, it can be glorious and shameful, meaningless and in the name of something. Ancient Greeks dreamed of a glorious death, of a feat
in the name of a great goal. World religions exploit death as much as possible, “blackmailing” death and eternal torment, promising salvation to all parishioners. In Buddhism, the main task of bodhisattvas is to die correctly, that is, extinction of all vital functions, the loss of one’s own identity and merging with the highest absolute – nirvana – is the highest goal. The life of a Christian is preparation for eternal posthumous immortality. In Christianity, natural death in the family circle, with confession and communion is valued. A human is not alone, he/she says goodbye to the family, talks to God. Death remains within the framework of the ritual.

Death cannot be seen as the opposite of life. Death is not the absence of life, but its end, completion. Therefore, death is not opposed by life, but by birth. This is a completely natural process of transition from the living state to the inanimate one. Living and nonliving, survival and non-survival are two sides of the single nature surrounding us.

Death can be defined as a common property of all living things. One of the founders of thanatology Marie François Xavier Bichat said that life is “a combination of phenomena that oppose death”. Friedrich Engels wrote that “Life is a mode of existence of protein bodies, and this way of existence consists in the constant updating of their chemical constituents through nutrition and excretion,” and further formulated the following thesis: “To live is to die.”

As for the study of death, the Soviet academician Vladimir Negovsky wrote in his Essays on Resuscitation that “... the course of natural science stopped for a while before studying death. For centuries, this phenomenon has been so complex and incomprehensible that it seemed to be beyond human cognition. And only gradually accumulating timid and at the beginning rather elementary attempts to revive a person and random successes at the same time destroyed this unknowable wall, which makes death a “thing in itself”.”

The end of the 19th and especially the 20th century brought radical changes to the problem of death. Death ceased to bear the imprint of mysticism, but its mystery remained. Death, being the natural conclusion to a lifetime, has become the same object of scientific research as life itself.
One of the founders of experimental pathology, who was at the forefront of thanatology, the famous French physician and physiologist Claude Bernard wrote in *An Introduction to the Study of Experimental Medicine*: “...To know how animal and human organisms live, it is needed to see how many of them die, because the mechanisms of life can be revealed and discovered only by knowledge of the mechanisms of death.”

The change in the scientific attitude towards death, reduction of death to a natural physiological process that requires qualified physiological analysis and study, was perhaps most clearly manifested in the statement of the Russian physiologist Ivan Pavlov: “...What a vast and fruitful field would be revealed for physiological research if right after the illness or due to imminent death, the experimenter, with full knowledge of the matter, was looking for a way to defeat the one and the other.”

The problem of death has received new coverage in the context of biomedical ethics. Moreover, it has become a key problem which has formed the basis of many other ethical problems, first of all, the understanding of human, the meaning of life, the criteria of living and nonliving. The most complex and controversial issues of medical ethics related to the problem of death are euthanasia, abortion, organ transplantation, etc.

The French historian Philippe Ariès, analyzing the origin of mass ideas about death in Europe, identifies five stages in the development of ideas about it in his book *The Hour of Our Death*:

1. From archaic times until the 11th century – “a normal thing” (“the tame death”). The idea is that all people will someday die; death is an ordinary, inevitable phenomenon that does not cause much fear. The dead were regarded as asleep (“deceased”) “until the end of time.” Cemeteries were not only places of burial, but also places of life (a place of gatherings, meetings, etc.).

2. Since the 12th century – “the death of the self”. This idea of death appeared under the influence of growth of individual consciousness and adoption of the idea of the Last Judgment in society between the 11th and 13th centuries. The value of the rituals associated with the near-death state and burial increases. The proximity of the living
and the dead ceases – cemeteries are taken out of the city limits (the territory of the living). At the same time, death is actively expressed in art.

3. In the age of Enlightenment – “remote and imminent death”. Death is presented as something wild, unbridled. This is a reaction to the loss of protection mechanisms from the nature.

4. In the era of Romanticism – “the death of the other”. Another person’s death is more difficult to experience than the proximity of one’s own death. The phenomenon of death is being aesthetized.

5. In the 20th century – “the invisible death”. There is a fear of the very mention of death, this topic becomes forbidden. There is a reduction in the duration of the rituals associated with death (funeral, mourning). People try to give the corpses of the dead a look similar to the living.

The phenomenon of death serves a powerful source of morality, giving rise to feelings of compassion, sadness, conscience, pity, mercy. Awareness of mortality and related spiritual quests are inherent to human only. The very essence of morality is made up of feelings arising from experiencing the threat of death of a loved one. The most important commandment, “Thou shalt not kill”, is the prohibition of death as the worst thing that a person can do in relation to another person. Morality owes its origin to death in the sense that moral standards have grown in the struggle against the entropy of death, they contribute to life and collective survival.

Moral Meaning and Biosocial Significance of Death

Today, the phenomenon of death is increasingly being included in the field of specific scientific knowledge. The dominant importance is acquired by biomedical research carried out with involvement of a wide arsenal of natural-science cognitive means. The study of death as a holistic phenomenon involves development of philosophical, psychological, sociological, cultural approaches.

In the context of biological research, death is considered the most important evolutionary mechanism providing the effect of natural selection, a kind of “payment” for the possibility of development and a complication of the organization. The vital
activity of any biological object involves a simultaneous course of the processes of creation and destruction. The biological meaning of death of elements and subsystems (whether cells, organisms, species) is acquired only in relation to a holistic biosystem. Therefore, if a “partial death” (e.g. cell death) is a condition for growth and development of the human body, then a complete death of a person is a condition for continued existence of supra-organism formations, primarily the species of *Homo sapiens*.

The course of human life, like the life of all other creatures, is genetically programmed from birth to death. Although the average life expectancy has almost doubled and is growing further over the past hundred years in developed industrial countries due to the success of medicine, the maximum life expectancy has remained almost unchanged (reaching the so-called “biblical limit”). We have changed the survival curve so that almost any of us has a chance, bypassing childhood and maturity, to live to 70. However, even in developed countries only 1 out of 10,000 people lives up to 90 years. Like other species, our species has a fixed lifespan.

We know little about the causes of the aging process in a multi-cellular organism. Aging, which has been most studied in mammals, can be defined as changes that accumulate in the body over time and bring it closer to death (slowing down the repair and regeneration processes, reducing the effectiveness and activity of the immune, nervous and endocrine systems, etc.). However, it is difficult to find out what the cause is and what the only symptoms of aging are. One of the causes of aging is accumulation of mutations in all cells of the body, but this cannot be applied to all species. Attempts to find the only cause of aging fail.

Each species is characterized with certain life expectancy, which can vary under the influence of selection. There is evidence that one finch lived in captivity for 26 years. In the end, a small bird died of the old age. In nature, however, there is no such a thing as old finches. Birds and small mammals do not age simply because they do not live long. With almost 50% annual mortality in the population, no one can count on life longer than a few years. Everyone is dying young.
Biology considers life not as a linear, but as a cyclic structure, as a series of changes, or as a life cycle. For each definite point of this cycle there is a definite probability of an individual’s death, and the degree of this probability increases as one moves around the circle. At 70 years, a person is almost three times more likely to die next year than at 30, and almost five times more than at 10. This is what is called aging. Our social planning largely depends on awareness of the likelihood of such an outcome. Thus, the process of dying is not limited to the old age, but begins with the beginning of the life cycle, acting along its entire length and passing through a series of recognizable and describable stages.

The search for the meaning of life is connected with the task of understanding death. Traditional culture, starting with ancient myths, tried to give death a symbolic and a sacred meaning. In the Old Testament, an opinion appeared that death makes sense of life. This opinion was first expressed in Ecclesiastes: “vanity of vanities; all is vanity”, both old and young, rich and poor, healthy and sick, wise and stupid – everyone is subject to death, it equals everyone, leaving nothing behind it. Everything is destroyed by time, and death is its symbol. The struggle with time and death is an important dimension of culture.

The meaning of death is the creation of conditions for development, enrichment of life, since species, clan, social progress is possible only in the form of a constant change of generations of individuals – temporary and real personifiers of generic properties and relationships.

**Stages of Dying and Criteria of Death**

The stages of death (stages of dying) are groups into which the process of death of an animal or a human organism can be conditionally divided.

The onset of death is always preceded by terminal conditions – preagony, agony, and clinical death – which on the whole can take different time, lasting from several minutes to hours and even days.

- Preagony is a reflex defensive reaction of the body with a function of “pain reduction” before death, usually caused by severe or very painful damage to the organs
and systems of the body and is almost always associated with the corresponding psychological state. It is accompanied with a complete or partial loss of consciousness, a loss of pain sensitivity. In preagony, a violation of the central nervous system functions, a decrease in the blood pressure and centralization of the blood circulation occur. Breathing is disturbed, it becomes shallow, irregular, but possibly frequent. The lack of ventilation leads to a lack of oxygen in the tissues, but the main type of metabolism remains oxidative. The duration of preagony can be different: it can be completely absent (e.g. with severe mechanical damage to the heart), and it can persist for a long time if the body is able to somehow compensate for the inhibition of the vital functions (e.g. with a blood loss). Without therapeutic measures, the process of dying often progresses, and preagony is then replaced with a terminal pause, which is characterized by the fact that after being rapid breathing suddenly stops completely. Transient periods of asystole (a cessation of the cardiac activity with disappearance of bioelectric activity) lasting for 1-2 to 10-15 seconds are also detected.

- Agony is an attempt to use the last remaining opportunities to save life by the body in conditions of inhibition of the functions of vital organs. At the beginning of agony, the pressure increases, the heart rate is restored, strong respiratory movements begin (but the lungs are almost not ventilated – the respiratory muscles responsible for both inhalation and exhalation are contracting simultaneously). Consciousness can be restored for a short time. The duration of agony is usually short, no more than 5-6 minutes (in some cases, up to half an hour). Then, the blood pressure reduces, heart contractions stop, breathing stops, and clinical death occurs.

- Stage I (clinical death) is the initial stage of death. The respiratory and cardiac activity cease, the brain ceases to respond to stimuli – all external signs of the body’s activity disappear. Clinical death under normal conditions lasts an average of 6-10 minutes, depending on the physical condition of the body at the time of death and the causes of death themselves. Modern medicine is able to reanimate the body at this stage of death, but if resuscitation is not successful or has not been carried out, stage II begins.
- Stage II (biological death) is the middle of the body dying process. It represents an almost complete cessation of physiological processes in cells and tissues. Biological death begins in the interval between 3 and 14 minutes and ends within several hours. Modern medicine is not able to revive the body at this stage of death.

While in traditional culture and medicine the main principle of the attitude towards death was to fight against it, biomedical ethics attempted to rehabilitate death, to revise the unambiguously negative attitude towards it, when something more terrible, which is worse than death, is indicated. First of all, the question arose about the definition of death and its exact criteria.

Until recently, physicians have associated death with cardiac arrest, cessation of respiration, and other body functions, i.e. the death of the whole organism was identified with the death of one organ. At the end of the 20th century, special devices have been spread in practical medicine to replace the heart, kidneys, lungs, and be capable of supporting life for a long time. So, for example, in 1971 Karen Quindley (USA) at the age of 21 became a victim of a car accident, fell into coma and was in it for 10 years. After the trial, which qualified her condition as irreversible, it was decided to turn off all equipment, allowing her to die.

Due to the fact that the phenomenon of a “delayed death” arose, it was necessary to change the criteria of life and death.

1. One of the conclusions of modern medicine is that the death of one organ does not mean the death of the whole body. In the early 1980s a universally valid definition of human death as a result of brain death was developed in line with biomedical ethics. The brain integrates the work of other organs and is responsible for the work of consciousness.

2. Death is considered today not an instantaneous event, but progress consisting of several stages: cessation of breathing and the heartbeat, cessation of the brain activity, destruction of body cells.

3. Death and dying should be distinguished from each other. Speaking about the fear of death, we often mean the fear of dying, pain and suffering. The following paradox arose in modern medicine: it cannot prevent the fact of death, but it can support
the process of dying for a long time, i.e. to keep a person in the state between life and death.

4. Philosophical analysis of this state made it possible to reconsider many traditional ideas about life and death, and also to reevaluate some of the old religious views. Considering the problem of death, we again turn to the question of what it means to be a person, to be an individual.

5. Biomedical ethics raised the question of the need to provide a person with autonomy in resolving the most important issue – the attitude to a person’s own death. Thus the concept of “the right to death” was introduced (although it is far from being universally recognized).

Philosophers did not initiate revision of traditional notions of death, and they did not put forward new criteria for death and life. All these questions came from medical practice. However, inclusion of philosophers in these problems led to their more detailed consideration. For example, the stage of dying, previously unknown for philosophy, as well as death as a process, was then more precisely characterized by philosophy. Philosophical analysis made it possible to reconsider many traditional ideas about life and death. Philosophers demanded a search for a more adequate criterion for death than brain death. Such criteria as an ability to communicate, an ability to respond, a response to pain were proposed. The most important problem posed by philosophy in the new conditions sounds like: What does it mean to be a person, to be an individual? When we talk about a person, we do not mean a biological life, digestion and the heartbeat. The right to death just speaks of the fear of “plant existence” that degrades human dignity. Not death, but this existence is considered the worst that can happen to a person – this is the loss of oneself, the loss of one’s own dignity. The main question is: What is human life? Is life or the absence of suffering the highest value? While there is no biosocial definition of life, another issue that requires new solutions is the question: What is death? If death is understood as the death of one organ, there can be no question of prolonging the life of many people. If death is seen as getting rid of unnecessary suffering in the irreversible process of dying, the problem takes the form of a choice between a painful and long death and an easy
and quick death. If a person’s death is determined only in connection with brain death, many patients have to be euthanized. In addition, this problem is associated with the other – the problem of organ transplantation, which is considered further.

**Brain death** is a condition when the brain is dead while the appearance of life is artificially maintained with the help of resuscitation measures, providing for the cardiac function, blood circulation and respiratory activity. Currently, “brain death” is understood as a pathological condition associated with total necrosis of the brain, as well as the first cervical segments of the spinal cord, while the cardiac activity and gas exchange are maintained with continuous mechanical lung ventilation.

Brain death can develop due to many causes, including brain injury, intoxication, cerebral edema, etc.

The actual synonym for brain death is the concept of “irreversible coma”, the treatment of which is pointless. A patient whose brain death has been ascertained is actually a “living corpse”. It is not the same as apallic syndrome.

The ethical and organizational principles for the diagnosis of brain death are:

1) the principle of a unified approach to the definition of “brain death”, regardless of whether organs are subsequently to be taken for transplantation. It is realized in the patient’s right to an uninterested statement of death, i.e. to diagnose brain death without taking into account the possibility of further transplantation;

2) the principle of collegiality – mandatory participation in the diagnosis process of several physicians (at least three);

3) the principle of organizational and financial independence of teams that diagnose brain death, remove organs and make transplantations.

In many countries, determination of the time of a person’s death and termination of resuscitation measures lie within the following simplified scheme:

1. The moment of a person’s death is the moment of death of a person’s brain or biological death (irreversible death of a person).

2. Brain death occurs with complete and irreversible cessation of all its functions, recorded with a working heart and mechanical ventilation.
3. The diagnosis of brain death is established by a council of physicians in the medical organization where the patient is located. This council should include an anesthetist-resuscitator and a neurologist with experience in the specialty for at least five years. It cannot include specialists involved in removal and transplantation of organs and (or) tissues.

4. A person’s biological death is pronounced on the basis of the presence of early and (or) late cadaveric changes.

5. Biological death is pronounced by a medical professional.

6. Resuscitation measures are terminated if they are recognized absolutely hopeless, namely:
   - when pronouncing a person’s death on the basis of brain death, including the ineffective use of all the resuscitation measures aimed at maintaining life;
   - with ineffectiveness of resuscitation measures aimed at restoring vital functions, within no less than 30 minutes;
   - in the absence of a newborn’s heartbeat after 10 minutes from the beginning of resuscitation measures (artificial lung ventilation, heart massage, drug administration).

7. Resuscitation measures are not carried out:
   - in the state of clinical death with progression of incurable diseases or with incurable consequences of an acute injury incompatible with life;
   - in the presence of signs of biological death.

Rules for Communicating with a Dying Person

An incurable disease inevitably brings closer the reality of death. It significantly changes a person’s life, and often leads to the emergence of “personality growth” signs.

All these changes indicate an increase in the sensitivity of a terminally ill person, which makes specific requirements for those who are close to this person: relatives, physicians, psychologists. The patient asks important questions like “Will I die soon?”. Great responsibility is required in talking with the patient about death. First of all, it is necessary to advise to put things in order (last desires, a testament, etc.). A physician
should not have to tell the patient directly about the upcoming death: “Everyone should be prepared for the worst, especially those who are seriously ill”.

Some people think that the patient should be told the whole truth, while others emphasize the need for caring for a seriously ill patient and not telling anything about the impending death. Somebody else can think that they should behave as the patient wants.

There is no universal formula or phrase which is suitable in all cases and under any circumstances. An incurable disease inevitably brings the reality of death. It significantly changes a person’s life. What happens when death approaches?

To some extent, the answer to the question can be received in conversations with patients:

- Life priorities are re-evaluated: all sorts of little things lose their meaning.
- A feeling of liberation arises: what is not wanted is not being done.
- The force of obligation (“I’m obliged”, “it’s necessary”, etc.) is gone.
- A momentary sensation of life is amplified.
- The importance of elementary life events is exacerbated (changing of the seasons, raining, a leaf fall, etc.).
- Communication with the loved ones becomes deeper.
- The fear of rejection is reduced, the desire to take risks increases.

There are some important principles to consider when working with a dying person:

1. People die alone quite often. The well-known philosophical dictum “A human always dies alone” is often understood too literally and justifies others a protective fence from a dying person. But the fear of death and pain become even stronger if a person is left alone. A dying person must not be treated as already dead. This person must be visited and communicated with.

2. Complaints of a dying person should be listened to carefully, and so should his/her needs be satisfied.
3. Efforts of all those around a dying person must be directed for his/her benefit. Dealing with a dying person, one should avoid superficial optimism, which causes suspicion and mistrust.

4. Dying people rather prefer to talk than listen to visitors.

5. The speech of a dying person is often symbolic. For its better understanding, it is necessary to decipher the meaning of the symbols used. The patient’s gestures, stories and shared memories are usually indicative.

6. One should not interpret a dying person only as an object of care and compassion. Often, people with the best intentions try to decide what is best for a dying person. However, excessive assumption of responsibility reduces the patient’s range of independence. Instead, the person should be listened to, allowed to participate in decisions about treatment, visitors, etc.

7. Staying with a dying person requires simple human responsiveness to be shown.

8. People who communicate with a dying person and his/her loved ones also need a substantial help. It is important for physicians to overcome humiliation of professional dignity. This feeling is quite common among physicians for whom a patient’s death in a certain sense is a professional catastrophe.

**Presentation skill development focus**

Prepare a 10-minute presentation on a particular topic below.

Read Appendix “How to make a good presentation” before you start.


2. Concepts of death and dying in various cultural and philosophical traditions.

3. Rules of communication with incurable and dying patients.

4. Fear of death and its elimination as a moral and psychotherapeutic task.

5. Patient’s right to the truth about the last diagnosis.


8. Criteria of death and moral paradigms of understanding the personality.
9. Rights to death, suicide and murder: concepts, similarities and differences.

**Speaking skill development focus**

**Situational tasks**

1. **Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.**
2. **Using the information of the paragraph, answer the questions following them.**
3. **Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.**
4. **Compare the results of discussion with solution patterns.**

**Situational task 1**

The American bioethicist D. Callahan states: “An adequate healthcare system must satisfy the needs of people to prevent premature death, but at the same time it must set the limit for an individual’s desire to extend life to a very old age at a huge cost”.

What bioethical values are involved in the controversial attitude of D. Callahan? Do you think he is right?

**Situational task 2**

At the moment, deceased people are subjects to mandatory autopsy.

What moral basis does this practice have?

**Situational task 3**

A nurse had to inject a patient with an intravenous solution of bromine. Taking a bottle of a colorless liquid from a medical cabinet, where bromine was usually
located, and not paying attention to the label, she made an injection. The patient started cramping immediately after the injection. Despite the measures taken, the patient died an hour later. It turned out that instead of bromine, the nurse had injected 10 ml of tetracaine hydrochloride.

What was the nature of the nurse’s actions which predetermined the patient’s death: economic, political, moral, psychological, religious, legal? Explain your opinion.

**Test tasks**

*Tick only one correct variant.*

1. DEATH IS …

   1) termination, a complete stop of biological and physiological processes of the body, irreversible destruction and/or dysfunction of critical irreplaceable systems of the body;
   2) a condition characterized with sharp reduction or the absence of reaction to external stimuli, diminished or completely missing reflexes, a violation of the respiratory depth and frequency, a change in the vascular tone, an increased or slowed heart rate;
   3) a condition characterized with activation of compensatory mechanisms aimed at combating extinction of the vital forces of the body;
   4) a condition developing in response to extreme stimuli and accompanied with a progressive violation of the vital functions of the nervous system, blood circulation, respiration, metabolism.
2. THANATOLOGY IS …

1) a science that studies the laws of death and revitalization of the body in order to develop the most effective methods for prevention and restoration of extinct or freshly extinct vital functions of the body;

2) a science that studies the state of the body at the final stage of a pathological process, the dynamics and mechanisms of dying, causes of death, clinical, biochemical and morphological manifestations of the gradual body cessation;

3) a science that studies the methods of protecting the body from an operating injury and its consequences, as well as from pathological disorders caused directly by a surgical disease, by controlling the vital body functions during surgery and in the postoperative period;

4) a science that studies pathological processes and diseases with the help of scientific, mainly microscopic, research of changes that occur in the cells and tissues of the body, organs and organ systems.

3. THE MAIN CRITERION FOR HUMAN DEATH IN MODERN MEDICINE IS …

1) respiratory arrest;

2) a lack of the brain electrophysiological activity;

3) palpitations;

4) the cardiorespiratory criterion.

4. THE USE OF RESUSCITATION EQUIPMENT FOR A PATIENT IN A CRITICAL CONDITION IS …

1) abuse of therapeutic agents;

2) implementation of the principle of “struggle for human life to the end”;

3) a sign of a specialist’s low qualification;

4) a lack of moral and ethical culture in a physician.
5. THE PRINCIPLE OF COLLEGIALITY DURING DIAGNOSING BRAIN DEATH IS …
   1) disinterested death pronouncement (i.e. diagnosis without taking into account a possibility of further transplantation);
   2) organizational and financial independence of teams diagnosing brain death, organ harvesting and transplantation;
   3) mandatory participation in the diagnosis process of minimum three physicians;
   4) that brain death cannot be diagnosed without consent of the patient’s relatives.

6. LIFE EXPECTANCY IN MOST DEVELOPED COUNTRIES OVER THE PAST 150 YEARS …
   1) has not changed;
   2) almost doubled and grows further;
   3) first doubled and then started to decline;
   4) declines all the time.

7. THE PHENOMENA MOST OFTEN CAUSING DEATH INCLUDE …
   1) bad relationships with others, aggressiveness;
   2) bad luck, apathy;
   3) poor memory, forgetfulness;
   4) malnutrition, aging.

8. AGING IS …
   1) changes that get accumulated in the body and bring it closer to death;
   2) the process of transition from life to death, when there is accumulation of changes in the body structures and transition of the human body to a qualitatively new state – transformation into a corpse;
   3) the condition of the body, expressed in a violation of its normal functioning, life expectancy and its ability to maintain homeostasis;
   4) changes based on increasing hypoxia of all tissues (primarily the brain), acidosis and intoxication with metabolic products.
9. AWARENESS OF MORTALITY AND RELATED SPIRITUAL QUESTS ARE INHERENT TO …

1) human only;
2) all living organisms on Earth;
3) all animals;
4) all plants.

10. THE IDEAS OF DEATH INHERENT IN PEOPLE TODAY, ACCORDING TO THE FRENCH HISTORIAN PHILIPPE ARIÈS, ARE CALLED …

1) “the death of the self”;
2) “the invisible death”;
3) “the death of the other”;
4) “remote and imminent death”.

2.4. Bioethical Issues of Euthanasia

Reading skill development focus
1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Euthanasia: Concept and Types

Euthanasia (from Greek εὖ “good” or “well” and θάνατος “death”, literally “good death”) is satisfaction of the patient’s request for death acceleration by any action or means, including termination of artificial measures to maintain life. This is a practice of ending the life of a person suffering from an incurable disease, experiencing an unbearable suffering.

Euthanasia has been known since ancient times. In Sparta babies born weak or sick were killed. Some ancient tribes had a custom of killing or leaving unattended old people who became a burden for their families. For the first time in the 20th century, euthanasia was officially introduced in Nazi Germany. Hitler’s decree of 1939 stated: “to expand the powers of the appointed ... physicians, for humane reasons, terminally ill patients would be provided with a “good death” in case of a critical assessment of their disease state”. During implementation of this order, with the help of lethal injections and asphyxiating gas, about 100,000 people (mainly with mental disorders) were killed.

Euthanasia is a very complex and contradictory phenomenon from the moral and ethical points of view.

From the standpoint of the principle “Do no harm”, the following questions are asked: What is less evil, less harm to the patient? Is it life extension, but one that is accompanied with excruciating pains? Or a quick and painless death, after which there is no return?
From the point of view of the principle “Do good”, the following questions are asked: What is the benefit for a hopelessly ill patient who is experiencing incurable pain and suffering? Is it the maximum life extension? Or compliance with his/her will to accelerate death by euthanasia?

There are no unambiguous answers to these questions that satisfy all parties. This is why euthanasia is regulated by law.

There are two types of euthanasia distinguished by the role of the physician:

1) passive euthanasia, which means intentional termination of maintenance therapy by physicians;

2) active euthanasia, which means drug administration to the dying person or performing other actions that entail a quick and painless death.

Also, there are two types of euthanasia by the role of the patient:

1) voluntary euthanasia, which is performed at the patient’s request or with his/her prior consent (e.g. in the United States it is common practice to express one’s will in case of an irreversible coma in advance and in a legally valid form);

2) involuntary euthanasia, which is carried out without the patient’s consent, usually in the unconscious state. It is made by decision of his/her relatives, guardians, etc.

Type combinations lead to moral dilemmas:

- active involuntary euthanasia is similar to a murder;
- active voluntary euthanasia attracts attention from the point of view of moral justification;
- passive voluntary euthanasia is problematic from the physical point of view;
- passive involuntary euthanasia causes moral indignation, as serious as active involuntary one, although it is almost invulnerable from the legal point of view.

**Assisted suicide** is a suicide committed with the help of the physician. The physician knowingly and intentionally provides the patient with the knowledge or tools (or both) needed to commit suicide, including counseling on lethal doses of some drugs, prescribing their lethal doses, or providing with such drugs.
Assisted suicide is often confused with euthanasia. With euthanasia, the physician independently manages the tool that leads to death – usually a lethal drug. With assisted suicide, it is necessary that a person in the right mind should voluntarily express the desire to die and ask for a drug dose that would stop his/her life. A distinctive aspect is that the procedure of assisted suicide requires that the patient should administer the drug on his/her own.

The Netherlands became a pioneer in legalizing voluntary euthanasia. In 1984, the country’s Supreme Court declared voluntary euthanasia acceptable. On April 1, 2002, all types of euthanasia became legal in the Netherlands. Thus, the Netherlands became the first country to enshrine the human right to death constitutionally. For this, it is necessary that the patient should express such a desire, be terminally ill, mentally sane, experience severe pain, and the attending physician should have consulted with other physicians regarding the patient’s condition. Thus, terminally ill people have the right to choose between having treatment or refusing from it.

To date, all forms of euthanasia are legal in the Netherlands, Belgium, Luxembourg, Canada, Colombia, and in the state of Western Australia.

Passive euthanasia is legal in the USA, Chile, Argentina, Uruguay, the United Kingdom, Ireland, France, Spain, Portugal, Italy, Sweden, Finland, Israel, India, South Korea, Australia, and in some states of Mexico.

Assisted suicide is legal in some states of the USA, in Switzerland, in Germany, and in the Australian state of Victoria.

In many countries, euthanasia is expressly prohibited: Russia, Ukraine, Belarus, China, Brazil, Poland, Albania, Turkey, Iran, Iraq, Mongolia, Kazakhstan, Uzbekistan, Kyrgyzstan, Tajikistan, Egypt, Sudan, South Sudan, Ethiopia, Nigeria, South Africa, Syria, Jordan, Botswana, Angola, Kenya, Tanzania, The Gambia, Thailand, Vietnam, Myanmar, Indonesia, Malaysia, Zambia, Zimbabwe, Papua New Guinea, Guyana, Cuba, Peru, The Bahamas, Ghana, Cameroon, Malawi, Rwanda, Uganda, Oman, Yemen, Sri Lanka, Cambodia, Brunei, Pakistan, etc.

In other countries, euthanasia is not allowed (it can be said that it is prohibited, because its use is equal to aiding in murder) (see Picture 2).
Picture 2. Legality of euthanasia in the world, 2020²

Arguments For and Against Euthanasia

The reality today is that euthanasia is used almost throughout the world, regardless of whether it is legal or not. The question is the price, moral standards of the physician, the degree of punishment and corruption of the healthcare system. It should be remembered that the use of euthanasia may be qualified as a murder. Passive euthanasia may be qualified as a failure to help the patient. The physician is obliged to alleviate suffering of the dying person in all accessible and legal ways, and any cases of killing seriously ill patients at their request can be qualified as a murder by their relatives or friends.

Despite the fact that euthanasia is prohibited in many countries, healthcare organizations receive a huge number of letters from hopeless patients. Unable to tolerate the disease adequately, they demand that physicians should be allowed to relieve their suffering. For example, the Russian oncologist Vladimir Denisov says: “We can only alleviate the patient’s suffering with nothing but drugs. In such circumstances, prohibition of euthanasia is a manifestation of unhealthy humanism.” At the same time, the Russian Academician Yuri Lopukhin claims: “We must fight to the end, the condition of a hopelessly ill patient can improve, while the attitude that it is more humane to kill the patient will demoralize the physician.”

A well-known supporter of euthanasia, the American physician Jack Kevorkian helped terminate the lives of more than 130 hopelessly ill people and received the nickname “Doctor Death” for his work. In 1989, he built the so-called “suicide machine” (“Mercitron”, as he called it), which delivers a lethal dose of analgesics and toxic drugs to the patient’s blood.

Today, people suffer, e.g. from cancer, much more than in the past, because undoubted progress has been made in the fight against cancer, which has led to the fact that now a person does not die at the early stages of the disease, as it was before, and even in cases where treatment does not lead to recovery or remission, it reaches the point in disease progress that was fundamentally unattainable in the past.

Allowing physicians to help patients with euthanasia inevitably leads to tragic and immoral cases. An error diagnosis, an unexpected recovery, dishonesty of
physicians since they are the same people with all their inherent flaws and defects – all lead to life count errors.

“I often see people being forced into euthanasia by relatives exhausted by expectation of the inevitable end and having lost patience,” says Frank Kurselman, a psychiatrist from Amsterdam, talking about a woman whose relatives gathered in Amsterdam in connection with upcoming euthanasia. One relative came from abroad. When the patient hesitated in the last minutes, the family members told her: “Well, come on, she came from such a distance!” Instead of doing everything to comply with the patient’s true will (and save her life), the physician euthanized her.

Depression accompanies an incurable disease and often complicates its course. As soon as the patient throws off depression, requests for euthanasia are gone.

All the churches condemn euthanasia. For example, the 1980 Declaration on Euthanasia of the Roman Catholic Church, states: “...no one is permitted to ask for this act of killing, either for him- or herself, or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action.” It does not start a polemic against euthanasia solely from the standpoint of faith since life is the highest value for all who are guided by common sense and seek objective truth.

The Russian experts on Ethics A. Gusseinov and R. Apresian cite a number of general cross arguments for and against euthanasia regarding its fundamental admissibility or inadmissibility (see Table 2).

<table>
<thead>
<tr>
<th>For</th>
<th>Against</th>
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<tr>
<td>Life is good only when, in general, pleasures prevail over suffering, positive emotions over negative ones.</td>
<td>A choice is made not between life-suffering and life-good, but between life in the form of suffering and the absence of life in any form.</td>
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Life can be considered good as long as it has a human form, exists in the field of culture, moral relations and rationality. Within the framework of a worldview that recognizes life as the highest good and value, euthanasia is unacceptable.

Maintaining life at the stage of dying requires large financial costs. This argument should be taken into account within practical decisions, but not when it comes to moral justification of the act of euthanasia itself.

**Presentation skill development focus**

Prepare a 10-minute presentation on a particular topic below. Read Appendix “How to make a good presentation” before you start.

1. Euthanasia and its types. Attitudes towards euthanasia in society.
2. Legislation on the problem of euthanasia.
3. Ethical problems of prolonging the patient’s life.
4. Subjects of responsibility and law for decision making.
5. Social analysis of suicide.

**Speaking skill development focus**

**Situational tasks**

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.
Situational task 1

An incurable patient, 72 years old, suffering from colorectal cancer, repeatedly asked the physician to speed up the death onset. The patient’s relatives promised the physician a reward for the euthanasia procedure. The physician refused to perform the euthanasia act himself, but consulted the patient’s son on the administration route and the dose of poison. In the physician’s absence, the patient was given a lethal dose of insulin with his consent.

Was it euthanasia? If yes, what type of euthanasia was it? Explain your opinion.

Situational task 2

In court, a man was convicted of the murder of his paralyzed mother. Caring for her and finding out from physicians that they could not cure his mother, he suggested that her torment should be stopped. Allegedly securing her consent, he tried to strangle her with his hands, but, not reaching death, he inflicted several wounds on her chest with a knife. At the trial, declaring that he knew about euthanasia, he decided to use it out of compassion. Although the court did not recognize this motive as a mitigating circumstance, journalists discussed its possibility in the media.

Is it possible to recognize the man’s actions as euthanasia? Explain.

Situational task 3

A 19-year-old man suffered from thermal burns of the face and the respiratory tract, had his hands amputated, and was completely blind. The prescribed treatment did not help. His mother was a physician. While caring for him she constantly experienced torment from helplessness since painkillers did not help, and her son overwhelmed her with requests to help him pass away because life had become unbearable for him. The mother finally had been persuaded, wrote a testament, gave her son a fatal injection and drank a handful of sleeping pills for suicide. She was rescued and then a criminal case for premeditated murder was opened, since euthanasia is prohibited in the country under review. After the investigation, referring to a mental disorder being found out, the case was discontinued.
Is it possible to treat the mother’s actions as euthanasia? Explain.

Test tasks

Tick only one correct variant.

1. THE TERM “EUTHANASIA” LITERALLY MEANS …
   1) “good death”;
   2) the physician’s actions aimed at ending the patient’s life;
   3) actions of the medical personnel aimed at ending the patient’s life;
   4) death acceleration at the request of a gravely ill patient with an incurable disease.

2. THE MEANING OF THE WORD “EUTHANASIA” INCLUDES SUCH CONCEPTS AS …
   1) calm and easy death;
   2) means for death;
   3) death actions;
   4) all mentioned above.

3. THE TYPES OF EUTHANASIA DO NOT INCLUDE … ONES.
   1) active;
   2) involuntary;
   3) physical;
   4) passive

4. ACTIVE EUTHANASIA DIFFERS FROM PASSIVE ONE BY …
   1) the priority of the physician’s decision before the patient’s one to terminate the patient’s life;
   2) intentional or deliberate life deprivation;
   3) the physician’s active intervention in the process of life termination at the patient’s request;
   4) the absence of the patient’s consent or request for death.
5. THE TERM “PASSIVE EUTHANASIA” MEANS …
   1) the physician’s actions aimed at prolonging the patient’s life;
   2) the physician’s actions aimed at terminating the patient’s life;
   3) the physician’s refusal from any measures aimed at prolonging the patient’s life;
   4) intentional interruption of the patient’s life at the request of his/her relatives.

6. IN THE COUNTRIES WHERE ONLY PASSIVE EUTHANASIA IS LEGAL …
   1) it is possible at the family request;
   2) it can be requested in oral form;
   3) it is possible for patients with mental disorders;
   4) the patient must be competent while requesting for it.

7. IN THE COUNTRIES WHERE VOLUNTARY EUTHANASIA IS LEGAL, IT IS…
   1) carried out at the patient’s request;
   2) carried out at the relatives’ request;
   3) carried out without the patient’s consent;
   4) There is no correct answer.

8. ASSISTED SUICIDE IS …
   1) a suicide committed with the physician’s help;
   2) deliberate interruption of the patient’s life at the request of his/her relatives;
   3) the physician’s actions aimed at prolonging the patient’s life;
   4) death acceleration at the request of a gravely ill patient with an incurable disease.
9. CHOOSE THE CORRECT STATEMENT: “…”.

1) Voluntary euthanasia is carried out without the patient’s consent.
2) Passive euthanasia is introduction of drugs to a dying patient or other actions that entail quick and painless death.
3) Euthanasia is relief of near-death suffering of terminally ill people, the killing being agreed upon with physicians.
4) Active euthanasia is intentional termination of maintenance therapy by physicians.

10. INADMISSIBILITY OF EUTHANASIA IS DETERMINED WITH …

1) a violation of the principle “Do no harm”;
2) a possibility of a diagnostic error;
3) a lack of necessary equipment;
4) inadequate experience of the medical personnel.
2.5. Bioethical Issues of Abortion

Reading skill development focus
1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Abortion: Concept and Classifications

Abortion (from Latin abortus “miscarriage”) is artificial termination of pregnancy. According to modern medical standards, an abortion can be made at a period of up to 22 weeks of pregnancy or, if the gestational age is unknown, with the fetal weight of up to 400 g. Abortions can be classified on several grounds:

1. By intent:
   • Miscarriage (or a pregnancy loss) is a spontaneous abortion in the first 22 weeks. Depending on pregnancy termination, there can be an early (up to 12 weeks) and a late (from 12 to 22 weeks) miscarriage.
   • Artificial abortion is intentional termination of pregnancy up to 22 weeks.

2. By safety:
   • Safe abortion is carried out with participation of a qualified specialist (a physician, a nurse, etc.) using approved and recommended methods and made in a medical organization.
   • Unsafe abortion is made by a person without medical education or without necessary training, in unsanitary conditions, or by a woman herself.

Unsafe abortions result in approximately 70,000 female deaths and about 5 million disabilities per year worldwide. With safe abortion, the risk of complications is significantly lower than with unsafe one. Safe abortion methods also vary in the likelihood of complications. In addition, the likelihood of complications depends on
the quality of the procedure and pregnancy duration. Legal abortions in developed countries are among the safest procedures in modern medical practice.

According to the WHO, in countries where women have an access to safe abortion, the probability of death due to abortion with modern methods does not exceed 1 per 100,000 interventions. For comparison, in countries that do not provide women with an access to safe abortion, the probability of dying from early abortion complications is 0.9–3.5 per 1000 interventions. Of 500,000 women of the childbearing age dying from pregnancy-related causes, 15 % of cases are deaths from complications of unsafe abortion every year, with 98 % of deaths occurring in developing countries.

Unsafe abortions also include the so-called “folk” methods. In the history of humanity, various plants have been used to terminate pregnancy: tansy, mint, etc. The use of herbal remedies for abortion can lead to serious, including fatal, adverse reactions, such as multiple organ failure, and is not recommended by physicians. Sometimes women try to cause a miscarriage with the help of injuries of the abdominal cavity, self-medication, introduction of sharp objects, and other means into the uterine cavity. These methods are used in countries where abortion is prohibited or inaccessible. Their use leads to a high level of complications and mortality among women.

3. By methods:

By methods of abortion, pregnancy termination can be divided into surgical (or instrumental) and medical. Surgical methods involve extraction of the fetus with special tools, but not necessarily including surgery. Medical or pharmaceutical abortion is provocation of spontaneous abortion with drugs.

- Medical abortion is performed at up to 9-12 weeks of pregnancy, depending on the recommendations and norms in a particular country. This method belongs to safe methods of abortion and is recommended by the WHO with a gestational age of up to 9 weeks. There are also schemes for medical abortion for the second trimester of pregnancy. The patient can receive drugs for medical abortion only from the attending physician and takes them in her/his presence. Free sale of drugs for medical abortion is prohibited.
Medical abortion leads to complete abortion in 95–98% of women. In other cases, the abortion is completed by vacuum aspiration. In addition to incomplete abortion, the following complications can occur with medical abortion: an increased blood loss and bleeding (with the probability of 0.3–2.6%), haematometra (blood accumulation in the uterine cavity, with the probability of 2–4%). For their treatment, hemostatic and antispasmodic drugs are used, with the therapy duration of 1-5 days.

- Surgical abortion is carried out only by specially trained medical personnel in medical organizations with medical instruments. The main instrumental methods of abortion are vacuum aspiration (“mini-abortion”), dilation and curettage (acute curettage) and dilation and evacuation. The choice of a method depends on the pregnancy duration and on the capabilities of a particular medical organization.

Vacuum aspiration, along with medical abortion, is a safe method of abortion according to the WHO, recommended as the main method of abortion for pregnancy of up to 12 weeks. In manual vacuum aspiration, a syringe is inserted into the uterine cavity with a flexible plastic tube (cannula) at the end. Through this tube, the ovum is sucked. With electric vacuum aspiration, the ovum is sucked out with electric vacuum suction. Vacuum aspiration leads to a complete abortion in 95–100% of cases. This is a non-traumatic method that eliminates the risk of uterine perforation, endometrial damage and other complications that are possible with dilatation and curettage. According to the WHO, the frequency of serious complications to be treated in a hospital after vacuum aspiration is 0.1%.

Dilation and curettage is a surgical procedure when the physician first dilates the cervical canal (dilatation) and then curettes the walls of the uterus using a curette (curettage). Dilation of the cervix can be carried out with special surgical dilators or by taking special medications. Before the procedure, a woman must be anesthetized and given sedatives. The WHO considers it to be a less safe method and recommends resorting to it only in extreme cases.

Dilation and evacuation is an abortion method that is used in the second trimester of pregnancy. The WHO recommends it as the safest method of abortion at this period. However, abortion in the second trimester is generally more dangerous and
more likely to lead to complications than abortion at the earlier period. The procedure of dilatation and evacuation begins with expansion of the cervix, which can take from several hours to 1 day. After that, an electric vacuum suction is used to remove the fetus. In some cases, this is enough for a complete abortion. In other cases, surgical instruments are used to complete the procedure.

*Artificial birth* is an abortion method used at the later stages (starting from the second trimester of pregnancy) and is artificial stimulation of childbirth.

4. By therapeutic grounds:
   - up to 12 weeks – at the woman’s request in the countries where it is legal;
   - up to 22 weeks – for social reasons in the countries where it is legal;
   - without a term – for medical reasons.

**Ethical Positions on the Issue of Abortion**

In the modern world, the permissibility of abortion and its limits is a hotly debated issue due to religious, ethical, medical, social and legal aspects. In some countries (e.g. the USA, Poland), this problem became so acute that it caused a split and a fierce confrontation in society.

The first moral issue that causes controversy is whether an existing human life is interrupted during abortion. Opponents of abortion speak about a “conceived child”, “an unborn baby”, “a child in the mother’s womb”. Many believers regard abortion as killing a person, albeit at an early stage of its development. According to proponents of the right to abortion, an embryo cannot be considered a child from the legal, social, or biological point of view.

The second debatable moral issue concerns the priority of the interests of the embryo over the interests of the woman, or vice versa. Opponents of abortion put the embryo’s right to life on a par with the woman’s rights. Proponents of the right to abortion give priority to the woman’s right to personal integrity and freedom to dispose of her own body.

Participants in these debates are divided into two main camps, which call themselves proponents of the choice, or the pro-choice movement (emphasizing the
right of a woman to pregnancy termination), and the life-protection (or pro-life) movement (emphasizing the right of an embryo or a fetus to be born).

Historically, abortion, along with infanticide, was considered in the context of family planning, selection of children by sex, control of the population, and property rights of the head of the family. Issues of the rights of a prospective mother, as well as the rights of a prospective child, were rarely taken into account. Sometimes questions about abortion morality, pregnancy prevention and children abandonment were raised, although basically all of these measures were not prohibited by law. Then, as today, such discussions often dealt with questions about human nature, the soul existence, the moment of life beginning and the human personality origin.

Current discussions about whether an embryo or a fetus is a human are complicated by the current legal status of children. According to modern legal norms, children are not full citizens until they reach adulthood, when they acquire the fullness of civil rights and obligations. At the same time, starting from the 19th century, children are considered as individuals within the framework of legislation on crimes against the individual. From the legal point of view, if the fetus is a person, this person is in very specific conditions, since it exists inside the body of another person and, as a rule, cannot be the object of any direct action on the part of another person. For jurisprudence, this circumstance creates great problems in recognizing the fetus as a person.

Many of the concepts used in the controversy surrounding the problem of abortion are considered examples of political framing – the use of emotionally loaded words in order to make one’s own position convincing and discredit the position of opponents.

*Position of proponents of abortion prohibition (the pro-life movement)*

The main argument for the prohibition of abortion according to the pro-life movement is that the embryo is a human being. This thesis is confirmed by citing such facts as the presence of a separate unique genome in the embryo and various physical traits that, in the process of fetal development, make the embryo more and more
physically resembling a person (e.g. the presence of limbs, eyes, ears, fingers, etc.). Recognizing the human embryo, abortion opponents equate abortion to killing.

One of the clarifications of the thesis that the embryo or the fetus is a human being is the assertion that it experiences pain during abortion. In support of this thesis, the propaganda film “Silent Scream” is often cited, which shows a number of ultrasound images of the fetus during the gestational age of 12 weeks in the course of abortion. The pictures are commented by the gynecologist and staunch opponent of abortion Bernard Nathanson. According to his interpretation of the images, the fetus twitches in fear, trying to dodge surgical instruments and screaming in pain.

Modern scientific evidence indicates that the fetus is not able to experience pain until at least the 24th week of development: it does not have nerve endings in the cerebral cortex, which most modern experts recognize as a necessary, albeit insufficient, condition for sensitivity to pain. The question of when exactly after the 24th week the fetus begins to feel pain remains not fully resolved today. Studies of susceptibility of the fetus to pain are difficult for many reasons – in particular, as with other speechless research objects, if there is a reaction to a stimulus, it is not always possible to determine the nature of such a reaction (i.e. whether it is a response to pain or purely a reflex).

Proponents of abortion prohibition indicate that a man and a woman are potentially responsible for having a sexual intercourse, which may result in pregnancy, since the reliability of any contraceptive is not 100%. In other words, from the point of view of abortion opponents, people who want to get rid of an unwanted pregnancy solve the problem that has arisen through their fault, at the expense of the unborn child, who, unlike themselves, is not guilty of the situation.

The anti-abortion movement has close ties with various churches and religious organizations. Abortion opponents often cite religious positions and statements of religious leaders, in particular, that abortion is a sin.

**Position of proponents of the right to abortion (the pro-choice movement)**

The main argument of proponents of the right to abortion is that no one, except the woman herself, should control her body, her fate and life. All this is included in the
list of rights guaranteed by the constitutions of many countries. In most legislative systems, a person is vested with constitutional rights from birth, not from conception, which gives a higher legal status to the woman than to the embryo. The woman has more rights to be considered a person from the moral point of view, since she, unlike the embryo, has consciousness, is able to think, feel, hope and dream.

Proponents of the right to abortion believe that the final decision on abortion can be made only by a pregnant woman, not by her partner, relatives or government organizations, since it is a woman who bears the risks associated with health and life during pregnancy, and in case of a child’s birth, she does the main work on his/her upbringing.

The question of whether the embryo is a human is not a key issue for abortion proponents. They note that women have abortions regardless of dominant views in society or their own individual views, therefore, the task of society and the state is to provide them with an access to safe abortion. According to proponents of the right to abortion, the issue of the embryo’s status is a matter of a subjective opinion. In particular, they indicate that some women perceive the embryo as a child from the moment of conception, and women for whom pregnancy is undesirable feel horror and disgust. These two opposite reactions, like all intermediate ones, are normal and natural feelings.

At the same time, objecting to abortion opponents, proponents of the right to abortion cite a number of arguments against considering the embryo to be a human. For example, they note that one of the most important parameters which differs an embryo from a born person is its dependence on a particular woman, since it is inside her body. Meanwhile, even if one recognizes that the embryo has the right to life, it never includes the right to use the body of another person. From the point of view of proponents of the right to abortion, just as the state cannot force people to become organ or blood donors, it just cannot force a woman to save an embryo’s life, risking her own health and life during gestation and childbirth.

Proponents of the right to abortion do not agree with the assertion that life begins from the moment of conception. In their opinion, this thesis is unscientific and is the
only one of the existing religious beliefs, which can be the principle of individuals, but cannot be used as an element of politics in multi-confessional secular states. They also believe that from the scientific (biological and evolutionary) point of view, a fertilized ovum is not a fundamentally new step in the development of life on Earth and that only one tiny step separates it from independent germ cells (male and female), which already carry a unique genetic potential of a new person.

From the point of view of proponents of the right to abortion, sexual contact does not imply an automatic consent to a possible pregnancy, because people have the right to have sex not for childbirth. In addition, sexual contact is not always voluntary. The widespread prevalence of sexual violence is, in the opinion of proponents of the right to abortion, a serious argument for giving women an access to abortion.

Proponents of the right to abortion indicate that the prohibition of abortion does not lead to a decrease in their number. They note that the key role in a woman’s decision to have an abortion is played not by moral convictions, but by practical considerations: the presence of a permanent partner and his willingness to care for the child, the woman’s reliable sources of income, the availability of kindergartens and other social guarantees. If legal and safe abortion is unavailable, women resort to criminal or folk abortion methods, which lead to an increase in health complications and maternal mortality. This view is supported by scientific evidence. For example, in the USSR, after the abortion ban in 1936, the number of abortions did not decrease, but continued to grow, while by the 1950s, the proportion of deaths from abortions exceeded 70% of all maternal deaths.

Proponents of the right to abortion also point out that prohibiting or restricting an access to abortion does not affect fertility. This view is also supported by scientific evidence. As demographic studies show, the number of abortions depends on the availability of contraception and sexual and reproductive literacy of the population (the ability to use contraception correctly). Fertility depends on such indicators as urbanization, educational attainment, and economic stability. It is these independent laws that lead to the fact that the birth and abortion rates also change independently of each other. For example, in Poland, after the abortion ban in the early 1990s, the birth
rate did not increase, but decreased, while in Russia the birth rate also declined, although the number of abortions for the same two decades decreased without any legal prohibitions from 1990 to 2018 by 8 times.

Ignoring the woman’s rights leads to a massive “epidemic” increase in the number of abortions, which under adverse conditions of the “underground” cripple and take a huge number of lives.

The woman’s right to control her body won its place in European culture with difficulty. An expansion of medical indications for abortion gradually took place. In the first half of the 19th century, the concept of “social reasons” came into attention. As a result, the civilized world comes to recognize the woman’s right to be completely autonomous in deciding whether to terminate her pregnancy or not.

A significant place in the controversy surrounding the problem of abortion is the question of whether abortion affects mental health. In most scientific publications, the WHO recommendations for obstetrician-gynecologists suggest that a vast majority of women undergo abortion without consequences for the psyche. A number of studies indicate that the percentage of mental disorders among women who have had an abortion is significantly higher than among women who have given birth or who have not become pregnant. It should be borne in mind though that these results do not imply a causal relationship between abortion and mental disorders, but may reflect consequences of pre-existing conditions for the disease. A number of researchers and organizations consider the issue of the existence of such a connection not fully understood. Researchers claiming that there is a high risk of psychiatric hospitalization after abortion indicate that mental health effects may occur not immediately, but after a long time after abortion.

Ethical Approaches to the Issue of Abortion

Today, among all the points of view around the abortion problem, there are three main approaches which generalize all of them. They are conservative, moderate and liberal.
1. Conservative approach. This is an extreme anti-abortion position, which does not recognize any exceptions, no circumstances justifying abortion. Abortion, according to it, is unacceptable, even if pregnancy and childbirth are life-threatening for the mother, e.g. with a heart disease, a kidney disease, etc. Abortion is unacceptable even if the pregnancy came as a result of rape. The argument is that the child is not guilty in either case, and should not suffer. No one has the right to decide whose life is worth saving (the value of life and the right to life are the same for both the mother and the child). The physician, according to this position, should organize treatment in such a way that it would be possible to save both of them: the mother and the child. No one can kill an innocent creature that did not have a conscious intention to kill the mother and is not involved in the circumstances of conception, which means that it does not bear any responsibility for them, and even more so – it does not deserve such a punishment as deprivation of life.

The conservative point of view is based on moral values of religious culture. Abortion is condemned by the three main religions – Christianity, Islam and Judaism – and is considered a form of murder. In the religions of the East and other parts of the world, as well as in the latest religious movements, positions in relation to this issue are less defined.

2. Moderate approach. It tries to combine the elements of the both points of view and avoid undesirable conclusions that can be drawn from them. At its core is a softened anti-abortion position – abortion is unacceptable, but it could be allowed as an exception in cases where there are medical contraindications or when pregnancy comes from rape. Exceptions are justified by the need to take into account the desires and interests of the mother. In the first case, with medical contraindications, the mother’s right to life (and health) is violated. In the second, with rape, there is no voluntary consent of the woman.

3. Liberal approach. Current legislation that legalizes abortion is based on the liberal point of view. The liberal justification for abortion is based on two principles. The first is the woman’s right to control her body. The second is the denial of the personal status of the fetus.
From the first principle it follows that abortion is seen as a purely personal, intimate problem, which concerns only women, and no one should intervene. The full right of a woman to be completely autonomous in deciding to terminate a pregnancy is recognized regardless of the reasons, which can be either medical or social. Abortion is just one of medical operations.

The second principle, which is that the fetus is not a human, has the following arguments:

a) Even if the fetus is a human being, there is a huge difference between it and a human. The same is for a plant: the difference between seeds, sprouts and grown plants is large. It is clear that an acorn and an oak are not the same thing.

b) The embryo therefore needs the mother biologically and socially, because it is not independent, not autonomous, cannot develop outside the mother’s body and must exist within her for 9 (or around so) months. This means that the act of birth determines exactly the moment when a new being becomes autonomous.

From this position, only birth is recognized as the beginning of a person’s life, and before that, the embryo is part of the mother’s body.

Based on this, the judgment “the right of a woman to abortion” turns into the judgment “the right of the body to own the body” or “the right of the body to control the function of the body”, and the decision on abortion is a result of taking into account certain interests, a balance of life circumstances, but not a moral act.

Abortions in many countries are part of the health insurance system, performed both in state and private medical organizations (see Picture 3). In these countries every woman has the right to independently decide on the issue of motherhood. Abortion should be made only in organizations that have received a license for a specified type of activity, by specially trained physicians. Artificial pregnancy termination carried out by a person who does not have higher medical education of the appropriate profile is punished.

There is a gradual increase in the average age of women making an abortion, which is attributed to increased popularity of contraception in the younger generation.
Picture 3. Abortion laws in the world, 2020

According to the provision of the WMA Declaration of Oslo, enshrined in many national laws, a physician can refuse to conduct an abortion if this is contrary to his/her personal convictions, except when it is required for medical reasons, or when it is impossible to replace a physician. In case of his/her refusal, a physician must give the patient over to another physician.

**Presentation skill development focus**

Prepare a 10-minute presentation on a particular topic below.

Read Appendix “How to make a good presentation” before you start.

2. Social consequences of the abortion ban and its impact on women’s health. A pregnant woman’s right to autonomy.
4. Historical, social, moral, legal and religious aspects of human reproduction.

**Speaking skill development focus**

**Situational tasks**

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.
**Situational task 1**

A three-day-old baby fell asleep forever due to a generous dose of phenobarbital prescribed by the medical staff on duty in the neonatal pathology department for sleeping without shouting at night.

What inalienable human right and bioethical principle have been violated in this case?

**Situational task 2**

In a small village, a 19-year-old girl was raped. The victim of sexual violence did not inform anyone except her parents and a physician. She came to the physician having a 6-week pregnancy with a request to have an abortion at home in order to avoid publicity. The physician refused performing abortion at home. The victim became depressed and committed suicide. Parents accused the physician of predisposing her to committing suicide, and, when the physician gave details of the circumstances to the law enforcement authorities in the interrogation process, of medical confidentiality disclosure.

From the legal point of view, was the physician right when she refused:

a) performing abortion at home, and  
b) when “reported the details” during interrogation?

**Situational task 3**

In Japan, a young couple requested a correction of their fetus. After getting married, a husband had been found out muscular dystrophy – an incurable disease that gradually causes weakness of the entire muscular system of the body. The couple terminated the pregnancy after a medical test which showed that the fetus had inherited the father’s disease.

What evidence was taken into account to conduct abortion: personal, social, or medical? Explain your opinion.
Test tasks

Tick only one correct variant.

1. ABORTION IS ALLOWED AT A WOMAN’S REQUEST IN MOST COUNTRIES…
   1) at any time during pregnancy;
   2) until the end of the second trimester of pregnancy;
   3) up to 12 weeks of gestation;
   4) up to 4 weeks of gestation.

2. ABORTION IS ALLOWED FOR MEDICAL REASONS …
   1) until the end of the second trimester of pregnancy;
   2) up to 12 weeks of gestation;
   3) up to 4 weeks of gestation;
   4) at any time during pregnancy.

3. SAFE ABORTION IS CONDUCTED BY …
   1) a woman without assistance;
   2) a physician in antiseptic conditions;
   3) a physician in an appropriate medical organization;
   4) a woman with the help of a nurse.

4. AN ARGUMENT NOT RELATED TO THE POSITION OF THE PRO-LIFE MOVEMENT IS: …
   1) Abortion is a sin.
   2) The rights of the embryo and the woman are equal.
   3) Only a pregnant woman can make an abortion decision.
   4) A man and a woman are responsible for having sex.
5. THE CONSERVATIVE APPROACH TO ABORTION CONTAINS, AMONG OTHERS, THE FOLLOWING ARGUMENT:

1) Only a child’s birth is recognized as the beginning of a person’s life; until that, an embryo is part of the mother’s body.
2) Exceptions are justified by the need to consider the mother’s desires and interests.
3) The value of life and the right to life for both a mother and a child are the same.
4) A woman has a right to control her body.

6. THE MODERATE APPROACH TO ABORTION IS …

1) denial of the personal status of the fetus;
2) based on a softened anti-abortion position;
3) a woman’s right to control her body;
4) the value of life is the same for both a mother and a child.

7. THE BASIS FOR ADMISSIBILITY OF ABORTION WITH THE LIBERAL APPROACH IS …

1) denial of the personal status of the fetus;
2) a child’s rights;
3) privacy;
4) the existence of a medical operation to terminate pregnancy.
8. A NEGATIVE ATTITUDE TO ABORTION IN THE TRADITIONAL CHRISTIAN MORAL SYSTEM IS DETERMINED BY ALL OF THE FOLLOWING BELOW, EXCEPT…

1) violations of the commandment “Thou shalt not kill”;
2) a failure to obey the commandment of love;
3) teachings on relocation of souls (metempsychosis);
4) irreducibility of a personality to human properties of the psychophysical nature.

9. IN CHRISTIAN ETHICS, ABORTION AS A NECESSARY MEASURE IS PERMISSIBLE SINCE …

1) life destruction becomes a murder only after a child’s birth;
2) an embryo is initially doomed to death in case with ectopic pregnancy;
3) it’s better to take the embryo’s life instead of “producing poverty”;
4) failure children sometimes become criminals.

10. THE PHYSICIAN HAS A RIGHT TO REFUSE PERFORMING ABORTION DUE TO HIS/HER MORAL BELIEFS. THE STATEMENT IS …

1) true, but in this case a physician must transfer the patient to another physician who can do it;
2) true in any case;
3) false;
4) difficult to give an unambiguous answer.
Section 3. SPECIAL ISSUES OF BIOETHICS

3.1. Bioethical Issues in Transplantology

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Transplantology: Concept and Types

Medicine is a developing system where transplantology is one of the most promising “growth zones”. Transplantology develops the latest medical technologies of the highest category of complexity, which then find wide application in other areas of practical medicine.

Transplantology is a branch of medicine that studies problems of organ transplantation (in particular, of the kidneys, liver, heart), as well as prospects for creating artificial organs.

Transplantation is replacement of tissues and/or organs that are absent or damaged by a pathological process, with one’s own tissues or organs, or those taken from another organism.

Transplant types are classified by source of organs and tissues:

1. Autotransplantation, or autologous transplantation, takes place when the transplant recipient is the donor himself. For example, skin autotransplantation from undamaged sites to the burnt ones is often used for severe burns. Autotransplantation of the bone marrow or hematopoietic stem cells after high-dose antitumor chemotherapy is widely used in leukemia, with lymphomas and chemosensitive malignant tumors.
Recent advances in cleansing of the intercellular matrix from cells using the process called decellularization have allowed researchers to recreate organs for autotransplantation using their own iPSCs (induced pluripotent stem cells) of the patient’s cells by plating them on a substrate from the intercellular matrix obtained from an allograft or by 3D bioprinting.

2. **Allotransplantation** is a transplant of organs and tissues from another individual of the same biological species; the transplant donor for a human is another human body. There are such types of allotransplantation as:
   - closely related allotransplantation, when the transplant donor is a close genetic relative of the first line of kinship;
   - remote related allotransplantation, when the donor is a distant genetic relative of the second or third lines of kinship;
   - unrelated allotransplantation, when the donor is a stranger who is not genetically related to the recipient at all.

To date, allotransplantation is the predominant type of kidney, liver, heart and lung transplantation, and the case with more than half of bone marrow transplants.

The current state of the allotransplantation technology does not allow organ transplantation from a spontaneous donor to a spontaneous recipient. It is unlikely that this will be possible ever in the future due to the fact that the human immune system works this way. Hopes of transplantologists today are associated not with improvement of allotransplantation technologies, but with development of the technique of therapeutic organ cloning, which in the future should allow for complete homologous transplantation for all patients.

For successful organ allotransplantation, in order for an organ to take root and be functional in the recipient’s organism, both the recipient and the donor must match the so-called antigens of the major histocompatibility complex (MHC), or at least match at least five of the six main antigens. A mismatch in two antigens does not exclude a possibility of transplantation in principle, but greatly increases the likelihood of transplant rejection. A mismatch in three or more antigens excludes a possibility of transplantation from the given donor to the given recipient.
Allotransplantation, even if there is a perfectly compatible and a closely related donor (six out of six antigens coincided), also requires a high degree of immunosuppression of the recipient’s body in order to suppress possible transplant rejection and ensure its survival. With incomplete coincidence or with unrelated transplantation, the requirements for the level of immunosuppression provided are even higher.

3. **Isotransplantation** is a type of transplantation when there is biological compatibility of the donor and the recipient (e.g. transplantation from one identical twin to the other).

4. **Xenotransplantation** (from Greek ξένος “foreign” or “strange”), or interspecific transplantation, is transplantation of organs, tissues and / or cellular organoids from the organism of one biological species into the body or part of the body of another biological species.

One of the first xenotransplantation experiments was carried out at the end of the 19th century by the French physiologist Charles Edouard Brown-Séquard, and at the beginning of the 20th century by the French-Russian surgeon Serge Voronoff. In 1984, a baboon heart transplant was carried out on an American infant named Baby Fae (Stephanie Fae Beauclair). The baboon’s heart was used because there was no time to find a suitable human heart. It was supposed to subsequently replace it with a human one. However, the girl died due to rejection in 21 days.

Xenotransplantation remains impossible at the current level of transplantology. Even with very strong immunosuppression of the recipient’s organism, the pig’s xenograft does not survive in the human body as a result of the super-acute rejection reaction, accompanied with massive hemolysis, agglutination of red blood cells and platelets, and multiple vascular thrombosis of the transplanted xeno-organ.

It should be noted in general that the greatest obstacle to transplantation is rejection of transplanted tissue organs by the host immune system. This leads to an increase in activity and intensity of the immune response from the host organism. Therefore, success of transplantation is ensured by suppression of immunity, which leads to a decrease in viability of the body.
Main Bioethical Problems in Transplantology

The main bioethical problems with transplantation of human organs and tissues are the following:

1) inadmissibility of the donor organs’ sale (the problem of commercialization);
2) ethical and social aspects of the problem with compensation to the living donor who donated an organ;
3) a high cost of organ transplant operations and the issue of social justice in healthcare;
4) problems associated with the key stages of transplant technology:
   • pronouncement of a person’s death according to the criteria for brain death;
   • removal (collection) of organs and/or tissues from a corpse and a living donor;
   • distribution of organs and/or tissues to recipients.

The issue of equitable distribution of scarce health care resources is one of the most pressing moral issues. However, there is no doubt that the departmental mechanism for distributing scarce resources, which is closed to public control, does not contribute to the public understanding of the need, from the point of view of prospects for development of medicine, of priority funding for transplant programs. In order to achieve public confidence and informed consent to recognize certain redistribution of resources in favor of transplantology development, an interested public dialogue and openness to public control of departmental mechanisms for their distribution are necessary. Organ transplantation not only saves hundreds of thousands of patients from death, but also provides them with a high quality of life. However, this raises a number of difficult moral problems. Bioethical issues of transplantology differ significantly, depending on whether it is a problem of organ harvesting for transplantation in a living person or from a dead person’s body.

The types of organ and / or tissue sources for transplantation are as follows:

• cadaveric donorship (75–90 % of cases);
• living donors;
Moral problems in obtaining organs from living donors. Organ transplantation from a living donor carries a serious risk. Firstly, this is a risk associated with a surgical operation itself, which for any patient is always a strong psychophysiological trauma. The literature describes cases of serious complications during and after kidney removal from a donor (including death). Secondly, having lost one of the paired organs or part of an unpaired organ, the donor becomes more vulnerable to adverse effects, which is fraught with development of various forms of pathology. Obtaining an organ or part of it from a donor is obviously a retreat in relation to the donor from one of the fundamental ethical principles of medicine “Do no harm”. A surgeon who takes an organ or a tissue from a donor deliberately injures him/her and puts his/her life and bodily well-being at considerable risk. To minimize damage to the donor’s health, free treatment, including drug therapy, is legally approved. Therefore, in reality, after discharge from the hospital where the organ was taken, the donor has a serious chance to be left alone with his/her problems, directly or indirectly due to the removal of the organ or part of it. There is a conflict of two bioethical principles: “Do good” and “Do no harm”. The law prohibits organ transplantation if it is known a priori that it will bring to an irreversible disorder in the donor’s health.

The right to sacrifice in favor of a loved one is widely recognized. It implies the presence of the donor’s free will to perform a noble deed. At the same time, moral standards do not remain neutral with regard to the goodwill of this free will. From the ethical point of view, donorship should be a voluntary, consciously committed and disinterested (altruistic) sacrifice. Volunteering is possible in the absence of coercion to donorship, based on clan, administrative, financial or other dependence. Altruism involves exclusion of a commercial transaction, that is, a sale, in the relationship between the donor and the recipient. The awareness of sacrifice should be based on information provided by the physician about a possible risk in relation to the health status and social well-being (working capacity) of the potential donor, as well as about
chances for success for the prospective recipient. From this point of view, donors cannot be incapacitated citizens who, due to their age or state of intellectual ability, are not able to make a decision consciously. Currently, in all countries of the world, the practice of transplanting organs and tissues from a living donor to only closely related recipient is adopted for ensuring the principles of voluntariness and altruism. Today, however, a possibility of allowing transplants not only to closely related people, but under the supervision of authorized independent bodies, is being discussed. It poses a serious threat that it can lead to donorship commercialization, even extortion of organs and tissues, a danger that will be extremely difficult to cope with. With closely related transplants, moral problems can also arise. When transplanting organs and tissues, the rule of informed consent is especially important.

Moral problems of organ transplantation from a corpse. From the secular point of view, a person’s death does not interrupt effectiveness of his/her will in relation to what belongs to him/her. The will is a special form of expression, which extends beyond the line separating a person’s life from death. It is also recognized that any act of abuse of the body of the deceased is a reprehensible act that offends his/her memory. In other words, for both religious and secular consciousness, a dead body has a special moral status and involves certain rules of treatment.

Brief History of Transplantology

The founder of experimental transplantation of vital organs (in particular, the heart) is the French surgeon Alexis Carrel, who was awarded the Nobel Prize for this in 1912. He conducted research on organ transplantation in experiment, their conservation and the technique of applying vascular anastomoses. He developed the basic principles of preservation of the donor organ and its perfusion.

The first organ transplantation from person to person was performed by the Soviet and Ukrainian scientist Yuri Voronoi in 1933 in Kherson. One of the founders of Russian transplantology is the Soviet Russian scientist Vladimir Demikhov, who in 1951 developed transplantation of a donor heart to a dog in detail. On December 3, 1967, Christiaan Barnard, a surgeon from South Africa, having undergone a
preliminary internship with Demikhov, as well as in a number of world surgical clinics, successfully transplanted a heart transplant to a person in Cape Town (South Africa) for the first time in the world. Barnard considered Demikhov his teacher, visited his laboratory twice. However, unlike Barnard, who gained world fame, Demikhov died in poverty in an old one-bedroom apartment. Since then, more than 40 thousand such operations have already been done. In the USSR, the first heart transplant was performed in 1968 by the chief surgeon of the Soviet Army Alexander Vishnevsky, and the first successful transplant was made by an outstanding surgeon, academician of the Russian Academy of Sciences Valery Shumakov in 1987. Currently, the Institute of Transplantology and Artificial Organs in Moscow is named after him. This is the leading organization of the Russian Federation in the field of clinical and experimental transplantology.

The first successful kidney transplant was performed in 1954 between two identical twin brothers by a group of physicians led by the American surgeon Joseph Murray. He continued his research and made it possible to get a kidney transplant from an unrelated donor, and also examined the properties of immunosuppressants and the rejection mechanism. The first liver transplant was made in 1956 by the American surgeon Thomas Starzl. A lung transplant was first carried out in 1963 by Dr. James Hardy at the University of Mississippi clinic, but the patient died a few days after the operation. Joel Cooper succeeded in transplantation of one lung in 1983, and in 1986 he successfully transplanted two lungs.

In 2005, a unique face transplant surgery was performed in Amiens (France) by a team of physicians led by Dr. Jean-Michel Dubernard. The tissues required for transplantation were taken from a dead donor. The operation was subjected to Isabelle Dinouard, 38 years old, who was bitten by her own dog on the lower part of the face. The damage to the face was extremely severe: the woman lost her nose, lips and chin, and could hardly eat and talk. Currently, Isabelle Dinouard speaks with obvious effort, her lower part of the face remains inactive, but now she does not stand out in the street crowd in general.
The record holder for life expectancy with a donor organ was the American Tony Housman, who lived after heart transplantation for 30 years and died of cancer.

**Types of Legal Regulation of Organ and Tissue Retrieval**

There are three types of legal regulation of organ and tissue retrieval from a deceased person:

- presumed refusal;
- presumed consent;
- routine retrieval.

1. **Presumed refusal** is recognition of a person’s initial refusal with any actions. If a person agrees to commit alleged actions, then he/she must express consent in the established form. For organ retrieval for transplantation, explicit consent is required from the donor while he/she is alive (either an organ donor card, or a driver’s license mark), or consent is obtained from a person’s relatives after death. A potential donor’s consent in the form of a lifetime order or family members’ consent after his/her death is used in the United States, the Netherlands, Canada and other countries. In this case, it is assumed that the absence of expressed consent is tantamount to denial. The approach is based on the individual’s fundamental right to self-determination and autonomy. A person should be able to manage his/her life and body, including – within reasonable limits – even after death. At the same time, it does not contradict the public interest in obtaining organs and tissues for transplants.

2. **Presumed consent** is implied as people do not express their refusal explicitly throughout their lives. It is recognition of a person’s initial consent to any action. If a person does not agree to commit alleged actions, then he/she must express refusal in the established form. The mechanism for presumed consent is laid down in the current Russian and other countries’ laws on transplantology. Although a special permit for organ retrieval after death is not requested, consent is assumed. It provides the right to refuse both by the person in advance and by one’s relatives after his/her death.

3. **Routine retrieval** was carried out in the USSR. Its basis is prevailing prevention, according to which the authorities, at their discretion, can dispose of the
body of a deceased person. In particular, they give health services the authority to perform an autopsy, to retrieve organs for scientific and other manipulations, and to use physiological fluids and tissues of the corpse for a variety of purposes. The body of a deceased person in this case is interpreted as state property and physicians can use it in the public interest. Here utilitarian ethics is fully implemented. Routine retrieval of organs for transplantation also affects the moral values of the family of the deceased. The tradition which prescribes to the relatives of the deceased his/her worthy burial as a moral duty goes back centuries. At the same time, inviolability of the remains and respect for them are strictly mandatory. Manipulations with the body of the deceased without the family’s permission can be perceived by many people as their personal insult and moral damage.

Summing up, it should be noted that the concept of brain death was developed in neurology regardless of the goals and needs of transplantology. However, it was precisely for transplantologists that this concept opened up tremendous opportunities that were not available with traditional pulmonary-cardiac death criteria. Therefore it is no coincidence that it was precisely in connection with development of transplantology that this problem was subjected to comprehensive discussion from the ethical and legal points of view. Among them, the central place is taken by the problem of reliability of the brain death diagnosis. It almost entirely falls within the professional competence of neurologists and becomes a moral problem when it comes to trusting the population in the reliability and quality of the practical use of these procedures before deciding on retrieval of organs for transplantation. A lack of awareness of the population about the measures taken by public health authorities to ensure reliability of the procedures for brain death diagnosis creates favorable conditions for unfounded accusations, rumors and, in general, undermines public confidence in activities of physicians in the field of transplantology. The most important principle that protects the procedures for brain death diagnosis from the influence of selfish interests of “procurers” of organs, and thereby ensures their reliability, is organizational and financial independence of medical organizations, involved in the diagnosis and collection of organs, from transplantologists.
Laws of many countries state that the objects of transplantation can be the heart, lung, kidney, liver, bone marrow and other organs and (or) tissues. Laws usually do not apply to organs, their parts and tissues, related to the process of human reproduction, including reproductive tissues (ovum, sperm, ovaries, testicles or embryos), as well as blood and its components.

Retrieval of organs or tissues from a corpse is not allowed for transplantation if the healthcare organization was informed at the time of retrieval that during his/her life the person, relatives or legal representatives expressed their refusal of retrieval of organs or tissues for transplantation after death.

Retrieval of organs or tissues is not allowed for transplantation from a living donor who has not reached the age of 18 (a bone marrow transplantation case is the exception) or has been recognized as legally incompetent.

Retrieval organs or tissues is not allowed for transplantation if they belong to a person suffering from a disease that poses a danger to the life and health of the recipient.

Retrieval organs or tissues is not allowed for transplantation from people who are in official or other dependence on the recipient.

Coercion of a living donor to consent to retrieval of organs or tissues entails criminal liability.

Forcing a person into retrieval of organs or tissues for transplantation, committed with the use of violence or with a threat of its use, is punishable.

Retrieval of organs or tissues for transplantation from a living donor can be carried out only in the interests of the recipient’s health and in the absence of organs or tissues suitable for transplantation from a corpse or an alternative treatment method, the effectiveness of which is comparable with the efficiency of organ or tissues transplantation.

Retrieval of organs or tissues for transplantation from a living donor is allowed to the recipient if:

- the donor is warned of possible complications for his/her health in connection with the upcoming surgical intervention to retrieve organs or tissues;
• the donor freely and knowingly has expressed his/her consent to the retrieval of organs or tissues in writing;

• the donor has undergone a comprehensive medical examination and there is a conclusion by a council of medical specialists on the possibility of retrieving organs or tissues for transplantation.

Retrieval of organs from a living donor is allowed if he/she is in a genetic relationship with the recipient (bone marrow transplantation is the exception).

The donor can be both a living person and a corpse. Retrieval of such organs as the heart, liver and stomach can be carried out only when the biological death of the donor occurs. In this case, there should be no obvious refusal of the donor’s relatives.

**Bioethical Principles in Transplantology**

The main bioethical principles of human organ or tissue transplantation are the following:

1. Human organs and tissues cannot be considered as objects of purchase and sale.

2. A transplant from a living donor can be based only on voluntary self-sacrifice in order to save the life of another person.

3. The potential donor should be fully informed about the possible consequences of organ explantation on his/her health.

4. Explantation that directly threatens the donor’s life is not morally acceptable.

5. It is unacceptable to shorten the life of one person, including through abandonment of life-supporting procedures, in order to extend the life of another.

6. The most common practice is to remove an organ from people who have just passed away. An ambiguity in determining the moment of death should be eliminated.

7. The conditions for an ethically correct brain death diagnosis include: the principle of a unified approach to brain death diagnosis, the principle of collegiality and the principle of financial and organizational independence of teams.

8. The priority of distribution of donor organs should not be determined by identifying the benefits of individual groups and special funding.
9. In distribution of donor organs, three criteria are taken into account: immunological compatibility of the donor-recipient pair, severity of the recipient’s condition, and the queue.

10. It is morally unacceptable to use the most unprotected people and those in extreme situations: homeless people, patients in psychiatric clinics, children, residents of developing countries.

Purchase and sale of human organs is strictly condemned. Trade in organs and tissues is prohibited by laws of many countries. Monetary exploitation of both patients who need donor material and donors who donate their organs for money is unacceptable.

The trend towards commercialization has its objective reasons due to a shortage of organs for transplantation, forcing patients to search for extraordinary sources of donor organs. What is the moral evil of organ commercializing? First of all, the human body is transformed into a commodity-thing, equated through the purchase and sale mechanism to other things, thereby destroying its special social status. Through the corporeality of human, one’s personal potentialities and aspirations are realized in a variety of different forms. Therefore, manipulations with the body are nothing more than forms of influence on the personality. The transformation of the body into a thing and a commodity depersonalizes a person, causes moral damage. The permission to trade organs and tissues will increase social injustice; the rich will literally survive at the expense of the poor. This newest form of human exploitation by human is capable of destabilizing social life to a large extent. It should be noted that in fact commercialization of the human body has already begun, since blood, sperm, and oocytes can be sold and bought. Therefore, from the point of view of supporters of market mechanisms in harvesting organs for transplantation, the only question is to put the really emerging market of human organs from living donors (and from corpses) on a solid legal basis. To avoid such negative consequences, society should either go through legalization of organ trade from living donors (which is hardly acceptable), or develop a set of measures that can:

- effectively control the ban on commercialization;
• reduce the pressure of objective factors by improving the financing of transplantology programs, creating national systems for procuring and distributing cadaveric organs for transplantation;

• strengthen the mechanisms of social protection of the population.

As a “third” way, some authors propose replacing the organ purchase and sale mechanism with a mechanism of material compensation for organ donation.

In addition to ethical principles, there are also legal ones. The legal principles of transplantation of human organs are regulated by articles from the Council of Europe Convention on Human Rights and Biomedicine. Some of them are:

1. Removal of organs or tissues from a living donor for their transplantation can be carried out solely for the purpose of treating the recipient, as well as in the absence of an appropriate organ or a tissue. Explicit consent must be obtained.

2. An incapable person cannot be a donor, except as a donor of regenerating tissues (e.g. if the recipient is the donor’s brother or sister).

3. The human body and its parts should not be a source of financial gain as such.

4. The seized part of the human body can be used only for the purpose it was seized for.

The positions in relation to organ and tissue transplantation are as follows.

• The conservative position states that even such a fundamental goal as saving human life requires the observance of many conditions, including the observance of freedom and voluntariness. The transplantation practice by its disproportionate ethical orientations unprecedentedly increases the social danger of error.

• The liberal position is reduced to justification and propaganda of transplantation as a new direction in medicine. The extension of transplantation practice is associated with overcoming the system of rituals and attitudes towards death. The success of transplantology is possible only in conditions of a “developed and prepared public opinion”.

The problem of deficiency of donor organs has at least several solutions:
• propaganda of organ donorship after a person’s death with his/her lifetime consent;
• creation and use of artificial organs;
• xenotransplantation;
• cloning of organs and tissues.
All of them have their own moral and ethical problems that need to be addressed.

Presentation skill development focus

Prepare a 10-minute presentation on a particular topic below.
Read Appendix “How to make a good presentation” before you start.
1. Moral problems of obtaining organs from a living donor and from a corpse.
4. Problems of development and cultivation of artificial organs and tissues.
5. Stem cells and fetal tissues in transplantation: bioethical aspects.
6. Concept of victim voluntariness. Right to integrity. Patient’s right to withdraw consent.
7. History of scientific transplantation.

Speaking skill development focus

Situational tasks

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.
Situational task 1
In the morgue, physicians harvested eyeballs, pituitary glands, and sometimes other tissues from corpses and sold them to clinics and drug companies. Are the actions of physicians legal? Explain your opinion.

Situational task 2
In the hospital, a man died from injuries sustained during a traffic accident. His relatives demanded that the head physician should prohibit autopsy. However, a forensic expert started making autopsy against the will of the patient’s relatives, on the basis of the investigator’s resolution. Finding it out, the patient’s relatives burst into the morgue and forcefully prevented the autopsy. The physician who opened the corpse called the police and wrote a statement on bringing responsibility to those responsible for disorganizing the work of the medical organization.

Were the rights of the patient’s relatives violated? Explain your opinion.

Situational task 3
A 40-year-old woman died in an accident. Should her family be asked for permission to make a corneal transplant? Explain your opinion.

Test tasks
Tick several correct variants.
1. ALLOTRANSPLANTATION IS A TRANSPLANT FROM …
   1) animal to human;
   2) human to human;
   3) human to animal;
   4) plant to human.
2. THE PRINCIPLE OF “DO NO HARM” IN TRANSPLANTOLOGY IS VIOLATED REGARDING THE …
   1) donor;
   2) recipient;
   3) physician;
   4) patient’s relatives.

3. THE PRINCIPLE OF “DO GOOD” IS IMPLEMENTED IN TRANSPLANTOLOGY REGARDING THE …
   1) donor’s relatives;
   2) recipient;
   3) donor;
   4) physician.

4. PRESUMED CONSENT IS CHARACTERIZED WITH …
   1) a lack of moral and legal restrictions;
   2) the condition of the donor’s consent expressed and legally registered during lifetime;
   3) the condition of consent of the donor’s relatives;
   4) freedom of interests of science and society.

5. THE FOLLOWING CRITERIA ARE TAKEN INTO ACCOUNT WITH DISTRIBUTION OF DONOR ORGANS AND/OR TISSUES (tick 3 correct variants):…
   1) immunological compatibility of the donor-recipient pair;
   2) the nationality;
   3) the recipient’s social status;
   4) severity of the recipient’s condition;
   5) the queue;
   6) financing.
6. THE MAIN REASON FOR COMMERCIALIZATION OF TRANSPLANTOLOGY IS …
   1) greed for profit, self-interest;
   2) poor education;
   3) a deficiency of donor organs;
   4) country economic backwardness.

7. THE PROBLEM OF COMMERCIALIZATION IN TRANSPLANTOLOGY SUGGESTS INADMISSIBILITY OF (tick 2 correct variants) …
   1) determining the recipient by social status;
   2) human organ and/or tissue sale;
   3) organ harvesting from persons with mental disorders;
   4) organ transplantation from persons under the age of 18.

8. THE BIOETHICAL PRINCIPLES OF TRANSPLANTOLOGY, AMONG OTHERS, INCLUDE …
   1) buy-sell objects;
   2) reduction of a person’s life expectancy;
   3) The use of the most unprotected contingents of people and those in extreme situations as donors is morally not permitted.

9. THE RIGHT TO SACRIFICE IS …
   1) the recipient’s right to choose a donor;
   2) connected with xenotransplantology;
   3) voluntary altruistic sacrifice;
   4) promotion of organ donation.
10. POSSIBLE SOLUTIONS TO THE PROBLEM OF ORGAN DONORSHIP

INCLUDE (*tick 4 correct variants)*:

1) xenotransplantation;
2) allotransplantation;
3) cloning;
4) creation of artificial organs;
5) promotion of organ donorship after the death of a person with lifetime consent;
6) cash compensation for donors.
3.2. Bioethical Issues in Genetics

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Genetics: Concept and Brief History

Genetics (from Greek γενητωσ “generative”, “descending from someone”) is a branch of biology that studies genes, genetic variations and heredity in organisms. Depending on the object of study, it is classified into genetics of plants, animals, microorganisms, humans, etc. Depending on the methods used in other disciplines, there is molecular genetics, environmental genetics, etc. Ideas and methods of genetics play an important role in medicine, agriculture, microbiological industry, as well as in genetic engineering.

Medical genetics is a system of knowledge about the role of genetic factors in human pathology and a system of methods for diagnosis, treatment and prevention of a hereditary pathology in a broad sense. It studies the role of heredity in human pathology, transmission patterns of hereditary diseases from generation to generation, develops methods for diagnosis, prevention and treatment of hereditary diseases, including those ones with a hereditary predisposition.

Modern genetics, and especially human genetics, is one of the most rapidly developing areas of scientific knowledge. Many of its achievements find their practical applications very quickly, in particular, in the field of medicine and healthcare. The statements of those who believe that in future biology and medicine will increasingly rely on the foundation of genetics are not devoid of well-known grounds. Such rapid progress of medical genetics is inevitably accompanied with constant emergence of ever new moral and legal problems. Some of them, e.g. those associated with a
possibility of obtaining genetically identical copies (clones) of living or already dead people, attract the attention of the broadest sections of society. Others, perhaps no less important and acute, are discussed mainly among specialists.

**Clinical genetics** is an applied section of medical genetics that studies hereditary diseases and methods for their prevention, diagnosis and treatment.

Initially, genetics studied general laws of heredity and variability only on the basis of phenotypic data. Understanding the mechanisms of heredity, that is, the role of genes as elementary carriers of hereditary information, the chromosome theory of heredity, etc., has become possible with application of cytology, molecular biology, and other related disciplines to the problem of heredity. Genes are specially marked regions of DNA or RNA – molecules where all genetic information is encoded.

History of genetics starts in 1865 and is briefly associated with the monk Gregor Mendel, who studied plant hybridization at the Augustinian monastery in Brno (the present-day Czech Republic), published at a meeting of the local society of natural scientists the results of studies on the inheritance of traits when crossing peas (*Experiments on Plant Hybridization* being published in works of the society in 1866). Mendel showed that some hereditary inclinations do not mix, but are transmitted from parents to descendants in the form of discrete (isolated) units. The laws of inheritance formulated by him later received the name of Mendel’s laws (or Mendel’s principles). During his lifetime, his works were little known and critically perceived (the results of experiments on another plant, a four o’clock flower (*Mirabilis jalapa*), at first glance, did not confirm the revealed patterns, which critics of his observations used very willingly).

At the beginning of the 20\textsuperscript{th} century, the work of Mendel again attracted attention in connection with the studies of Carl Correns, Erich von Tschermak and Hugo de Vries on plant hybridization, which confirmed the main conclusions on independent inheritance of characters and on numerical relationships in the “splitting” of characters in the offspring.

Soon, the English naturalist William Bateson introduced the name of a new scientific discipline – genetics (in 1905 in a private letter and in 1906 in public).
An important contribution to development of genetics was the chromosome theory of heredity, developed, first of all, thanks to the efforts of the American geneticist Thomas Hunt Morgan, his students and employees who chose the fruit fly *Drosophila melanogaster* as the object of their research. The study of the laws of linked inheritance made it possible, by analyzing the results of crosses, to compile location maps of genes in “linkage groups” and to compare linkage groups with chromosomes (1910–1913).

The era of molecular genetics begins with works appeared in the 1940s–1950s that proved the leading role of DNA in transmission of hereditary information. The most important steps included decoding the DNA structure, the triplet code, description of the mechanisms of protein biosynthesis, detection of restriction enzymes, and DNA sequencing.

Inheritance was originally studied in a wide range of organisms, but scientists began to specialize in genetics of specific species. Model organisms are those that have already accumulated a lot of scientific data and are easily contained in laboratory conditions. Model organisms were chosen in part due to their convenience — a short generation time (a fast generation change) and a possibility of genetic manipulations. As a result, some species have become major in genetic research.

The term “congenital disease” means that some pathology has been present in a human since his/her birth. It can be a consequence of both a “breakdown” of genes and a result of exposure of the developing fetus to unfavorable factors during pregnancy or a trauma during delivery.

The term “hereditary disease” implies that the cause of the violation lies in the structural change in hereditary information of human cells. It depends on a specific disease whether it will possibly be inherited or not.

Genetic diseases are not as rare as it was previously considered:

1. 2–3 % of all pregnancies result in the birth of a child with serious hereditary diseases or congenital abnormalities that cause a disability, mental retardation or early death.
2. By the age of 25, 50–70 of 1000 live-born individuals have diseases with a significant genetic component.

3. More than 25% of patients in children’s clinics have a hereditary pathology.

4. More than 50% of children incapable of learning have genetic disorders (see Picture 4 and Table 3).

The groups of hereditary diseases include:
- monogenic diseases;
- chromosomal diseases;
- diseases with an inherited predisposition (multifactorial diseases);
- genetic diseases of somatic cells;
- diseases of genetic incompatibility between the mother and the fetus.

![Diagram](Picture 4.png)

**Picture 4. Debut age of hereditary diseases**

### Bioethical Problems and Principles in Medical Genetics

Medical genetics has the following bioethical problems:

- Hereditary diseases concern not only the individual suffering from them. These diseases are transmitted to descendants, so the problems that arise are fundamentally familial, generic in nature.
• There is a dramatic gap between the success of the diagnosis of hereditary diseases and the ability to treat them (as practice shows, a vast majority of people at risk for hereditary diseases do not want to be diagnosed, as they do not want to know their future since they are not able to change it).

• Future generations are the main object of attention, while the material costs are borne by the current generation.

Table 3. Contribution of hereditary and congenital diseases to infant and child mortality in developed countries (approximate figures)\(^5\)

<table>
<thead>
<tr>
<th>Main causes of death before the age of 1 year</th>
<th>(\approx) Death rate, (%)</th>
<th>Main causes of death at the age of 1-4 years</th>
<th>(\approx) Death rate, (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>perinatal factors</td>
<td>28</td>
<td>accidents</td>
<td>31</td>
</tr>
<tr>
<td>hereditary and congenital diseases</td>
<td>25</td>
<td>hereditary and congenital diseases</td>
<td>23</td>
</tr>
<tr>
<td>sudden death syndrome</td>
<td>22</td>
<td>tumors</td>
<td>16</td>
</tr>
<tr>
<td>infections</td>
<td>9</td>
<td>infections</td>
<td>11</td>
</tr>
<tr>
<td>others</td>
<td>6</td>
<td>others</td>
<td>6</td>
</tr>
</tbody>
</table>

Traditional medical ethics is focused primarily on the relationship between two individuals – the physician and the patient. One of the main features of bioethical problems in medical genetics is that it is associated with the fact that hereditary diseases (although they occur in individuals) are transmitted to descendants as a result of reproductive processes. The problems studied in medical genetics are generic, and not just individual, as is the case with conventional diseases. Another feature of medical genetics, which also manifests itself in specifics of bioethical problems, is that there is more or less successful treatment only for a very small number of hereditary diseases. Mostly, it is limited to measures for prevention and diagnosis of these diseases. The latter circumstance determines such specific problems as ethics of diagnosing a particular pathological condition, if there is no sufficiently effective method for its

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treatment. There are great doubts as to whether a person wants to know his/her fate without being able to avoid it.

The specificity of bioethical problems in medical genetics also lies in the fact that the subject of genetic practice is mainly concerned with health of unborn children – future generations. Therefore, as a form of medical care, medical genetics can develop only in such a social situation where both individuals and society as a whole recognize responsibility for the health of not only living fellow citizens, but also those who have yet to be born. The recognition of this responsibility makes us think about the problem of justice in relation to distribution of public resources between the generation of those already living and those who will replace them.

Bioethical principles of medical genetics were formulated in 1997 in the WHO program on human genetics. They include:

1. Equitable distribution of public resources allocated to genetic service in favor of those most in need.
2. Voluntary participation of people in all medical genetic procedures, including testing and treatment. The exclusion of any coercion by the state, society, physicians.
3. Prevention of discrimination based on genetic information in employment, insurance or training.
4. Joint work with representatives of other professions to provide all types of medical and social assistance to patients suffering from hereditary diseases and families.
5. The use of a clear, accessible language when communicating with a patient.
6. Providing patients with necessary and supportive care on a regular basis.

**Cloning and Related Bioethical Problems**

**Cloning** is an emergence in a natural way or a receipt of several genetically identical organisms through asexual (including vegetative) reproduction; obtaining several identical copies of hereditary molecules (molecular cloning); biotechnological
methods used to artificially produce clones of organisms, cells or molecules. **Clone** is a group of genetically identical organisms or cells.

The term “cloning” came from Ancient Greek κλών (“twig”, “sprig”, “offspring”). It began to be used for a group of plants (e.g. fruit trees) obtained from a single producer plant in a vegetative (non-seed) way. These descendant plants exactly repeated the qualities of their ancestor and served as the basis for breeding of a new variety (if their properties were useful for gardening). Later, not only the whole such group was called a clone, but also each individual plant in it (except the first), and the receipt of such descendants was called cloning. Over time, the meaning of the term expanded and began to be used when growing bacteria cultures.

Advances in biology have shown that in plants and bacteria, the similarity of the descendants with the producer organism is due to the genetic identity of all members of the clone. Then the term “cloning” began to be used to mean production of any lines of organisms that are identical to this and are its descendants.

Later, the name “cloning” was transferred to the very technology of producing identical organisms, known as nuclear substitution, and then to all organisms also obtained by this technology, from the first tadpoles to the Dolly sheep.

In the late 1990s, implying the possibility to use the same technology for obtaining genetically identical human individuals, the term “human cloning” appeared. The term has ceased to be in the scientific community, it was picked up by the media, cinema, literature, computer game manufacturers. It entered the language as a common word, no longer having the special meaning that it had about a hundred years ago.

There are several types of cloning:

1. Reproductive cloning allows one to get clones with predetermined traits based on the use of cloned genetic material.
2. Therapeutic cloning allows to get donor organs based on one’s own stem cells. These organs are not rejected by the body.
3. Molecular cloning is cloning of DNA molecules (including genes, gene fragments, gene sets, DNA sequences containing no genes), in other words, production of a large number of identical DNA molecules using living organisms.
4. Natural cloning is widespread in various complex organisms. In plants, natural cloning occurs with various methods of vegetative propagation. In animals, cloning occurs during ameiotic parthenogenesis and various forms of polyembryony. Among vertebrates, there are clonal breeding species of lizards consisting of parthenogenetic females alone. In humans, natural clones are monozygotic twins. In some species of armadillos, normally from four to nine monozygotic twins are born. Clonal propagation is widespread among crustaceans and insects.

As for therapeutic cloning, it uses the process known as transplantation of somatic cell nuclei (replacing the cell nucleus, research cloning and cloning of an embryo), consisting in removing an egg (oocyte) from which the nucleus was removed, and replacing this nucleus with DNA of another organism. After many mitotic divisions, this cell forms a blastocyst (the early stage of the embryo, consisting of approximately 100 cells) whose DNA is almost identical to the primary organism.

The purpose of this procedure is to obtain stem cells that are genetically compatible with the donor organism. For example, embryonic stem cells can be obtained from DNA of a patient with Parkinson’s disease, which can be used to treat it, and they will not be rejected by the patient’s immune system.

Therapeutic human cloning suggests that embryo development stops during the period of 14 days, and the embryo itself is used as a product for stem cells.

Lawmakers in many countries fear that legalizing therapeutic cloning will lead to its transition to the reproductive variant. However, in some countries (e.g. in the UK) therapeutic cloning is permitted.

Stem cells obtained through therapeutic cloning are used to treat many diseases. In addition, a number of methods with their use are currently under development (treatment of certain types of blindness, spinal cord injuries, Parkinson’s disease, etc.).

This method often causes controversy in the scientific community. The term describing the created blastocyst is being debated. Some believe that it is incorrect to call it a blastocyst or an embryo, since it was not created by fertilization, but others argue that under appropriate conditions, a fetus can develop from it, and, ultimately, a child – it is therefore more appropriate to call the result an embryo up to them.
The potential for applying therapeutic cloning in the medical field is enormous. Some opponents of therapeutic cloning are opposed to the fact that this procedure uses human embryos, while destroying them. To others, it seems that such an approach instrumentalizes human life or that it would be difficult to allow therapeutic cloning without allowing reproductive cloning.

In many countries, therapeutic cloning is prohibited, although laws are constantly debated and amended.

**Human cloning** is a predicted methodology consisting in creation of an embryo and the subsequent cultivation of people from the embryo that have the genotype of an individual, existing or previously existing. Contrary to a common misconception, a clone, as a rule, is not a complete copy of the original, since only the genotype is copied during cloning, while the phenotype is not.

Moreover, even with development under the same conditions, cloned organisms will not be completely identical, since there are random deviations in development. This proves the example of natural human clones – monozygotic twins, which usually develop in very similar conditions. Parents and friends can distinguish them by the location of moles, slight differences in their facial features, voice and other signs. They do not have identical branching of blood vessels, and their papillary lines are far from being completely identical. Although the concordance of many characters (including those related to intelligence and character traits) in monozygotic twins is usually much higher than in dizygotic twins, it is far from being always 100%.

**Technological difficulties and limitations.** The most fundamental limitation is the impossibility of repeating consciousness, which means that the complete identity of individuals, as shown in some films, is impossible, but only a conditional identity, the measure and border of which is still to be investigated. The inability to achieve 100 % purity of experience leads to some non-identity of clones. For this reason, the practical value of cloning is reduced.

**Socio-ethical aspect.** Fears are raised by such moments as a large percentage of failures during cloning and the associated possibility of emergence of inferior people.
The issues of fatherhood, motherhood, inheritance, marriage and many others are included here as well.

*Ethical and religious aspect.* From the point of view of the main world religions (Christianity, Islam, Buddhism), human cloning is either a problematic act or an act that goes beyond the scope of dogma and requires theologians to clearly substantiate a particular position. The key point which most of all causes rejection from the point of view of religion is the purpose of cloning – artificial creation of life in an unnatural way, which is an attempt to remake the mechanisms, from the point of view of religion, created by God. Another important negative point is creation of a person just for immediate killing during therapeutic cloning.

*Biosafety.* The issues of biological safety of human cloning, in particular, long-term unpredictability of genetic changes, are discussed. In some countries, the use of these technologies in relation to humans is officially prohibited (the USA, France, Germany, Japan, Russia, etc.). The only international act prohibiting human cloning is the Additional Protocol No. 168 to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings of 1998.

A new phobia called *bionalism* has formed. It refers to the fear of cloned people, of their possible superiority in physical, moral and spiritual development.

Artificial cloning of animals and plants is a new type of human activity which arose at the end of the 20th and the beginning of the 21st centuries, consisting in reproducing old and creating new biological organisms related to the study of the genome, involving interference in its structure, aimed (except for scientific) to solve many practical problems.

Exact reproduction of an animal or a plant in both natural and artificial cloning is impossible. In any case, the new organism will differ from the maternal one due to somatic mutations, epigenetic changes in the hereditary material, environmental influences on the phenotype, and random deviations that occur during ontogenesis.
One of the first successful cloning of a mammal (a house mouse) was carried out by Soviet researchers in 1986. They used the electroporation method to fuse the enucleated zygote and mouse embryo cells with the nucleus.

A significant contribution to solving this problem was made by a Scottish team of researchers. In 1996, their research results on the successful birth of lambs as a result of transplantation of nuclei derived from sheep fetal fibroblasts into enucleated oocytes were published. In its final form, the problem of animal cloning was solved by a group of the British embryologist Ian Wilmut in 1996, when a sheep named Dolly was born – the first mammal obtained from the nucleus of an adult somatic cell. Its own oocyte nucleus was replaced by a cell nucleus from a culture of breast epithelial cells of an adult lactating sheep.

Subsequently, successful experiments were conducted on cloning of various mammals using nuclei taken from adult somatic animal cells (of a mouse, a goat, a pig, a cow, etc.), as well as taken from dead animals frozen for several years. The advent of the animal cloning technology aroused not only great scientific interest, but also attracted the attention of large businesses in many countries. In general, the animal cloning technology is still under development. A large number of organisms obtained in this way exhibit various pathologies leading to intrauterine death or death immediately after birth, although every 5th embryo survived cloning of sheep in 2007 (in case with Dolly, 277 embryos were needed).

In 2004, Americans began commercial cloning of cats, and in 2008, South Korean customs officers began training seven puppies cloned from somatic cages of the best Korean search dog of the Canadian Labrador Retriever breed. According to South Korean scientists, 90% of cloned puppies meet the requirements for working at customs, while only less than 30% of ordinary puppies pass professional suitability tests.

China has already commercially produced animal cloning for medical research.

The most successful of the methods of cloning higher animals is the method of “nuclear transfer” which was used to clone the Dolly sheep in the UK. Dolly lived
enough to call the experiment successful. According to scientists, this technique is the best of what we have today to begin direct development of human cloning techniques.

A brief history of animal cloning has the following chronology:

- 1970 – successful frog cloning;
- 1985 – bony fish cloning;
- 1986 – the first mouse cloning from embryonic cells in the USSR;
- 1996 – the Dolly sheep cloning from adult animal cells;
- 1998 – the first cow cloning;
- 1999 – the first goat cloning;
- 2001 – the first cat cloning;
- 2002 – the first rabbit cloning;
- 2003 – the first bull, mule, deer cloning;
- 2004 – the first commercial cat cloning;
- 2005 – the first dog cloning (an Afghan Hound);
- 2006 – the first ferret cloning;
- 2007 – the second dog cloning;
- 2008 – the third dog cloning (a Labrador named Chase by state order), which gave a start to commercial dog cloning;
- 2009 – the first camel cloning;
- 2011 – cloning of eight coyote puppies;
- 2018 – cloning of two cynomolgus monkeys;

**Eugenics and Related Bioethical Problems**

**Eugenics** (from Ancient Greek εὖ “good” and γενήσ “come into being, growing”) is a doctrine of selection in relation to humans, as well as ways to improve its hereditary properties. The doctrine was intended to combat the phenomena of degeneration in the human gene pool.

This doctrine in its modern sense originated in England. Its leader was Francis Galton – a cousin of Charles Darwin. For the first time this term was used in his book
“Inquiries into Human Faculty and Its Development”, published in 1883. Galton intended to make eugenics, which, in his opinion, affirmed the right of the Anglo-Saxon race to world domination, as “a part of national consciousness, like a new religion.” He put forward the theory of the hereditary origin of inclinations, abilities and talents. The author argued that conscience, dignity and other manifestations of the human higher psyche are biologically predetermined.

Eugenics was widely popular in the first decades of the 20th century, but later became associated with Nazi Germany, that is why its reputation was significantly damaged. In the post-war period, eugenics fell in line with Nazi crimes, such as racial hygiene, Nazi experiments on people and destruction of “unwanted” social groups. However, there were a number of regional and national governments that supported eugenic programs until the 1970s.

In modern science, many problems of eugenics, especially the fight against hereditary diseases, are solved within the framework of human genetics.

There are “positive” and “negative” eugenics, although the line between them is arbitrary.

The goal of positive eugenics is to promote reproduction of people with signs that are considered valuable to society (the absence of hereditary diseases, good physical development and high intelligence).

The purpose of negative eugenics is to stop reproduction of people with hereditary defects, or those who are considered racially, physically or mentally inferior in a particular society.

According to the Soviet and Ukrainian geneticist Sergey Gershenzon, in connection with rapid development of genetics in general and genomics in particular, eugenics has lost its meaning as an independent science: “Now eugenics is the past, moreover, very tarnished. And the goals set before eugenics by its founders and not achieved by it have passed completely into jurisdiction of medical genetics, which is rapidly and successfully moving forward.”
Due to the halo created after Nazi Germany leader Adolf Hitler’s activity in this field, practically no one dares to call the policy of encouraging propagation of more intelligent, healthy citizens as eugenics.

The discussion around eugenics is quite heated. There are pros and cons.

According to the pros, it is assumed that the so-called genetic burden grows in developed countries. This could be a result of preservation of the so-called “low-viable individuals” (e.g. when pregnant women are transferred to the “conservation” mode). In the natural process of pregnancy, part of the resulting mutational disorders are screened out due to miscarriages; and with artificial maintenance of such a pregnancy, preservation of a negative factor (that is, causing the very natural rejection) also occurs. The second reason for the growth of genetic burden is development of medicine, which allows people with significant congenital genetic diseases to reach the reproductive age. These diseases were previously an obstacle to transmission of defective genetic material to future generations. A way to reduce genetic burden, in addition to abortion, is preventive counseling of parents based on the results of analyses in medical genetic centers. Eugenic principles today are partially implemented in recommendations for a desirable and an unwanted pregnancy – so far, such assessments are based on a survey or biotesting of only a small category of people included in the so-called “risk groups”.

According to the cons, firstly, inheritance of many traits that are considered in modern society as negative (drunkenness, drug addiction, etc.) and positive (a high IQ, good health, etc.) is poorly studied. Secondly, people suffering from congenital somatic defects (weak immunity, poor physical development) may possess intellectual qualities that are valuable to the society.

**Prenatal diagnostics** is a comprehensive diagnostics to detect pathology at the stage of fetal development. It allows detecting more than 98% of fetuses with Down syndrome (trisomy 21), around 99.9% with Edwards syndrome (trisomy 18), around 99.9% with Patau syndrome (trisomy 13), more than 40% of heart development disorders, etc. If the fetus has a disease, the parents carefully consider the possibilities of modern medicine and their own possibilities for rehabilitation of the child with the help of a medical consultant. As a result, the family decides on the child’s fate and
decides whether to continue bearing or terminate the pregnancy. Paternity determination in early pregnancy, as well as fetal sex determination, also refers to prenatal diagnostics.

Thus, prenatal diagnostics is a genetic diagnosis at the stage of intrauterine development in order to identify the existing genetic pathology or a genetic predisposition to future diseases that significantly change the quality of human life. It inevitably entails a discussion of the advisability to continue the pregnancy. In this case, the bioethical problem is the right to take the life of a potential person who has a “level of health” that is inappropriate to the norm. Abortion here becomes a means of ridding parents of worries about the life and health of an initially sick child.

Human Genome Project and Related Bioethical Problems

The Human Genome Project (HGP) is an international research project whose main goal originally was to determine the sequence of nucleotides that make up DNA and to identify 20,000 – 25,000 genes in the human genome. This project is called the largest international collaboration ever held in biology. It became the basis for the international project Genome Project-write.

The project began in 1990 under the leadership of the American biologist James Watson under the auspices of the US National Institutes of Health. In 2000, a working draft of the genome structure was released, followed by the full genome in 2003. However, even today, an additional analysis of some sites has not been completed yet. A private company Celera Genomics launched a similar parallel project, completed somewhat earlier than the international one. The bulk of the sequencing was performed at universities and research centers in the USA, Canada and the UK. In addition to the obvious fundamental significance, determination of the structure of human genes is an important step for development of new drugs and other aspects of healthcare.

Although the goal of the human genome decoding project is to understand the structure of the human genome, the project is also focused on several other organisms, including bacteria, insects, and mammals.
Initially, it was planned to determine the sequence of more than three billion nucleotides contained in the haploid human genome. Then several groups announced an attempt to expand the task to sequencing of the diploid human genome.

The genome of any individual organism (excluding identical twins and cloned animals) is unique; therefore, sequence determination of the human genome should in principle include sequencing of numerous variations of each gene. However, the task of the Human Genome Project was not to determine the sequence of all DNA located in human cells. Some heterochromatin regions (a total of about 8%) remain unsequenced to this day.

The US National Center for Biotechnology Information (and its partner organizations in Europe and Japan) stores genomic sequences in the database known as GenBank, along with sequences of the known and hypothetical genes and proteins. Computer programs were developed for data analysis, because the data themselves are almost impossible to interpret without such programs.

The process of identifying the boundaries of genes and other motifs in unprocessed DNA sequences is called a genome annotation and belongs to the field of bioinformatics.

Another goal of the Human Genome Project is to study the bioethical, legal, and social consequences of genome decoding. It is important to research these issues and find the most suitable solutions before they become the basis for disagreement and political problems.

All people have unique genomic sequences. Therefore, the data published by the Human Genome Project do not contain the exact genome sequence for each individual person. This is a combined genome of a small number of anonymous donors. The resulting genomic sequence is the basis for future work on identifying differences between individuals.

Among concerns related to this project is the idea of a “genetic passport”, which will indicate whether this person carries a mutation which is harmful to health. It is assumed that this information will be confidential, but no one can guarantee that there will be no information leakage, as well as no experiments on transgenosis, creation of
organisms with genes transplanted from other species, and the spread of such “chimeras” in the environment will not take place.

**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

Read Appendix “How to make a good presentation” before you start.

1. Specificity of moral problems and legal aspects in genetics.
2. Eugenics. Social and moral consequences of eugenic attempts to improve the gene pool.
7. Moral problems in implementation of the *Human Genome Project*.
8. GMOs and fear of them.

**Speaking skill development focus**

*Situational tasks*

1. *Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.*
2. *Using the information of the paragraph, answer the questions following them.*
3. *Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.*
4. *Compare the results of discussion with solution patterns.*
**Situational task 1**

Modern medicine allows one to detect the presence of the Huntington’s chorea disease gene at the end of the 1st trimester of intrauterine development. It means that in 40 or 50 years after birth, a person will be struck by this ailment. Sometimes this disease manifests itself in adolescence.

Is it bioethically correct not to warn the parents about this?

**Situational task 2**

In 1975, Anne Drossart, a girlfriend of the famous French actor Yves Montand, gave birth to a daughter named Aurora, and in 14 years tried to get him to recognize his paternity. Mr. Montand, however, vehemently denied this. However, three years after his death, the court, impressed by the external similarities between Yves and Aurora, recognized the fact of his paternity. But his family appealed against this decision. A genetic expertise of Montand’s remains in 1998 proved that Aurora was not his daughter.

Is paternity always a prerequisite for genetic similarity?

**Situational task 3**

Genetically modified potatoes have been created. They can be developed further with introduction of human protein.

Does it mean that by consuming such potatoes a person becomes a cannibal?

**Test tasks**

*Tick several correct variants.*

1. HUMAN CLONING IS …
   1) allowed without restrictions;
   2) allowed with some restrictions;
   3) prohibited;
   4) not prohibited.
2. MORAL AND ETHICAL PROBLEMS OF MEDICAL GENETICS (DIAGNOSIS, TREATMENT, PREVENTION, AND PROGNOSIS) ARE NOT RELATED TO …
   1) the patient only;
   2) interests of the patient’s family and relatives;
   3) well-being of descendants and health of future generations;
   4) previous generations.

3. THE NON-DIRECTIVE NATURE OF GENETIC CARE DOES NOT INCLUDE…
   1) objective information presentation;
   2) information on the probabilistic nature of genetic counseling data;
   3) “competent influence” on the patient’s choice and decision-making.

4. GENE THERAPY SHOULD BE CARRIED OUT …
   1) for medicinal purposes only;
   2) for medical and moral preparation and an increased care for the unborn child;
   3) for creating a society of healthy people;
   4) in order to change the genome of the patient’s heirs, i.e. to conduct gene therapy of germ cells.

5. GENETIC PROGNOSTIC TESTING DETECTS A PERSON’S …
   1) genetic predisposition or susceptibility to any disease;
   2) social danger;
   3) creative or business insolvency;
   4) response to medication therapy.
6. GENETIC PROGNOSTIC TESTING IS PERFORMED …

1) in order to create a perfect society through artificial selection;
2) for medical research purposes only;
3) for artificial selection of the population;
4) both for medical and moral preparation and an increased care for the unborn child, and in order to clarify the clinical diagnosis;
5) in order to create favorable social conditions for people with increased intellectual abilities.

7. BIONALISM IS …

1) fear of the future;
2) fear of human clones;
3) complete denial of everything;
4) showing interest in cloned people.

8. EUGENICS IS …

1) a study about the state of the body at the final stage of a pathological process;
2) a study of selection in relation to humans, as well as ways to improve their hereditary properties;
3) a study about hereditary properties of the organism;
4) a study about the diagnosis and treatment of congenital diseases.

9. PRENATAL DIAGNOSTICS INCLUDES (tick 2 correct variants) …

1) clinical assessment;
2) fetal sex determination;
3) pathology detection at the stage of fetal development;
4) pathology detection at the stage of pregnancy planning.
10. REPRODUCTIVE CLONING ALLOWS ONE TO …

1) get clones by vegetative propagation and is characterized with production of a large number of identical DNA molecules using living organisms;
2) receive donor organs based on one’s own stem cells;
3) get clones with predetermined traits based on the use of cloned genetic material;
4) get clones by vegetative propagation.
3.3. Bioethical Issues in Psychiatry

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Concept of Psychiatry

Psychiatry (from Ancient Greek ψυχή “soul” and ἰατρεία “treatment”) is a branch of clinical medicine that studies mental disorders through the prism of methodology of medicine, methods for their diagnosis, prevention and treatment. This term also means the totality of state and accredited non-state organizations, in some countries eligible for involuntary isolation of individuals representing a potential danger to themselves or others.

The definition of psychiatry proposed by the German psychiatrist Wilhelm Griesinger (1845) was widely recognized as a study of recognition and treatment of mental disorders. According to some modern authors, this definition contains the most essential features of this medical discipline, precisely formulates the tasks facing psychiatry, stating that recognition means not only diagnosis, but also the study of the etiology, pathogenesis, course and outcome of mental disorders. The treatment, in addition to the therapy itself, includes the organization of psychiatric care, prevention, rehabilitation and social aspects of psychiatry.

Of all medical disciplines, psychiatry is most concerned with the person as a whole, taking into account biological, mental, spiritual and social components. The specificity of mental disorders is their duration. Mental disorders last for years, and sometimes for the whole life, unlike somatic diseases which are usually often an episode in the patient’s life. In connection with features of psychiatry, some social problems arise, e.g. employment of a person who has had an attack, improvement of
housing conditions, normalization of family relations, relationships with people around. Most bioethical problems of modern medicine are especially acute in psychiatry. First of all, this is the principle of voluntary treatment, the principle of “Do no harm” in psychiatry, which could be associated with insufficiently justified coercive measures in provision of psychiatric care. There could also be insufficiently substantiated social restrictions and prohibitions on patients, their stigmatization in society, violation of confidentiality, unacceptable interference with patients’ privacy. Hospitalization in a psychiatric hospital in some cases can harm the patient, and a long stay in the inpatient hospital sometimes leads to hospitalization, characterized with a break in family and/or social ties, etc.

According to one of the common definitions, a mental disorder is, in a broad sense, a state of mind that is different from the normal, healthy one (although jurisprudence, psychiatry, and psychology give more specific definitions).

Many researchers speak of the fundamental impossibility to give an exact definition of “normal behavior”, since in different cultures and historical situations the criteria of the mental norm differ.

The equation of the concepts of “mental disorder” and “mental illness” is criticized, since it is difficult to apply the main criteria for the disease in psychiatry: the biological criterion involves the presence of a bodily pathology; the medical criterion is used to assess the quality of life and the threat to life; and the social criterion deals with impaired human social functioning. It is often only assumed that certain mental disorders are based on impaired bodily functioning. In this regard, in the ICD-10, the term “mental disorder” is already used instead of the terms “mental illness” or “mental disease”.

There is no single agreed definition of the opposite concepts “disease – health” and “norm – pathology” in psychiatry.

Psychiatry is divided into general and special. While special psychiatry studies individual diseases, general psychopathology, or rather, general psychiatry, studies general laws of a mental disorder. Typical psychopathological conditions can occur with different diseases; therefore, they have a common meaning. General psychiatry is
based on generalization of all the changes that arise during certain mental disorders. In particular, pathopsychology is sometimes included in general psychiatry, in addition to general psychopathology. Special psychiatry is sometimes called special psychopathology. Signs (symptoms) of mental disorders are the subject of psychiatric semiotics. Manifestations, symptoms of a mental disorder, the biological nature of those pathological changes in the body that lead to mental disorders are studied by clinical psychiatry.

Modern psychiatry studies the etiology, pathogenesis, clinic, diagnosis, treatment, prevention, rehabilitation, and examination methods of mental disorders. In turn, examination in psychiatry is divided into: forensic psychiatric, military psychiatric and medical social psychiatric.

Manifestations of mental disorders bear the imprint of the socio-cultural environment where the person was brought up. Therefore, the same mental disorder in different societies and cultures can manifest itself in different ways. In cultural and social strata, where mental disorders do not find understanding and support from others, somatization or the somatic orientation of such disorders increases. For example, in China, major depression is more often somatized (patients complain of impaired functions of internal organs), while in the USA and Europe it is more often characterized as apathy, a loss of energy and emotions.

The ICD-10 describes this kind of disorders in the Mental and Behavioral Disorders section. It includes:

- organic, including symptomatic, mental disorders;
- mental and behavioral disorders due to the use of psychoactive substances;
- schizophrenia, schizotypal and delusional disorders;
- mood (affective) disorders;
- neurotic, stress-related and somatoform disorders;
- behavioral syndromes associated with physiological disturbances and physical factors;
- disorders of adult personality and behavior;
• mental retardation;
• disorders of psychological development;
• behavioral and emotional disorders with the onset usually occurring in childhood and adolescence;
• unspecified mental disorders.

**Basics of Bioethical Regulation in Psychiatry**

In the field of psychiatry there are a lot of bioethical issues and dilemmas. For example, keeping medical secrets in psychiatry is extremely important, but the requirement of professional ethics and the law not to disclose professional secrets can become a very difficult ethical dilemma. For example, should the wife of a schizophrenic patient be informed of her husband’s diagnosis? Are healthcare providers required to be truthful to her? What corresponds to the well-being of the patient: whether should the wife know the truth about the diagnosis and prognosis of her husband’s disorder, or should this truth be rather hidden from her? Like with any other clinical discipline, the problem of abuse is relevant in psychiatry.

It is important to emphasize that the content of the principles and many norms of modern ethics in psychiatry is internationally recognized. Such documents as the 1991 UN Code *The protection of persons with mental illness and the improvement of mental health care*, the *Hawaiian Declaration* adopted in 1977 and revised in 1983 by the World Psychiatric Association (WPA), etc., determine the minimum ethical standards in the work of each psychiatrist. The *WMA Geneva Declaration* (1948) instructs every physician not to allow any discrimination against patients.

The WPA is an international organization founded in 1950 and uniting psychiatric associations of different countries. It participates in improving the quality of specialist training and setting ethical, scientific and therapeutic standards in the field of psychiatry. Its goals are:

• to expand knowledge and skills necessary for working in the field of mental health and in assisting the mentally ill;
• to improve care for the mentally ill;
• to prevent mental disorders;
• to maintain mental health;
• to protect the rights of the mentally ill;
• to promote development and observance of the highest ethical standards in mental healthcare, training and research;
• to promote development of the highest quality standards in psychiatric care, training and research, as well as compliance with such standards;
• to promote non-discrimination (equality) in assisting the mentally ill;
• to protect the rights of psychiatrists.

Damage from Psychiatric Practice and Bioethics

Laws of many countries define necessary and sufficient conditions that allow hospitalization of certain categories of patients suffering from mental disorders without their voluntary consent. Firstly, these are psychopathological conditions, usually defined as severe mental disorders. Secondly, there are cases when examination or treatment of the patient is possible only in a specialized hospital. Thirdly, the patient’s condition must have at least one of the three following characteristics:

1. The patient poses an immediate danger to him-/herself and others.
2. The patient is helpless, that is, unable to independently satisfy his/her basic vital needs.
3. The patient’s mental state excludes leaving him/her without psychiatric help, otherwise it will cause significant harm to his/her health.

The modern approach to involuntary treatment of people with mental disorders was outlined in 1954, when the WHO expert committee on mental health determined hospitalization of socially dangerous people with mental disorders through court as humiliating for them and their relatives. The legislation governing involuntary treatment, which existed in many countries at that time, copied the criminal justice model.
The damage from psychiatric practice can be of the following types:

1. Coercion. Coercive measures in psychiatry lead from harmless situations of involuntary examination by a psychiatrist (e.g. in some cases of expert examination of disability) to forced drug administration or feeding.

2. Social restrictions (bans). They are related, first of all, to the performance by people with mental disorders at certain types of professional activity and at activities that are not professional, but associated with a source of increased danger.

3. Alienation. As a rule, it is inherent in the attitude of modern society towards people suffering from mental disorders. Having contacts with a psychiatrist or staying in a psychiatric hospital (or “registered” in the dispensary), psychiatric diagnoses that have become known to others – all this becomes “labels” in assessments of ordinary people, stigmatizing people with mental disorders, degrading their human dignity, creating emotional isolation around them, conducive to their discrimination and exploitation.

4. Moral damage. Caused to people with mental disorders by physicians or a medical staff, it arises from a violation of professional ethical standards by medical workers: confidentiality, truthfulness, non-interference in personal life, etc. In particular, in the psychotherapeutic work, the psychiatrist should not forget about the danger of harming the patient by imposing one’s own beliefs and values on him/her.

5. The harm that accompanies the use of invasive and treatment methods with adverse reactions. In the history of treatment of mental disorders there are a variety of pages, including the so-called “mechanized psychotherapy” of German psychiatrists of the first half of the 19th century. Particularly noteworthy are the agents that cause pain: plaster bandages, cauterization with iron, or even just the use of a whip. The use of “mechanized methods”, psychosurgery methods, “shock” methods for treatment of mental disorders and the subsequent abandonment of such therapy or a significant narrowing of indications for it once again confirmed the urgency of the “Do no harm” ethical principle in psychiatry. It must be remembered that the modern practice of using psychotropic drugs is often accompanied with very serious adverse reactions: impaired motor activity, a gait disorder, etc.
In accordance with the principle of “Do no harm”, a moral choice in such conditions should be a “choice of the lesser evil”. The practical effect of this principle in the work of a psychiatrist is differentiated depending on the clinical picture of the disease and, most importantly, on the severity of the patient’s condition. But at the same time, the physician’s actions must fully comply with the law.

When considering the ethical principle of “Do no harm” in psychiatry, the problem of abuse by physicians and a medical staff arises with particular acuity. The main normative act of medical ethics regarding abuse in psychiatry is the WMA Hawaiian Declaration.

Abuse in psychiatry can have many different aspects. The most serious of them are associated with a psychiatric diagnosis. From the bioethical point of view, it is necessary to clearly distinguish between two groups of erroneous medical diagnoses of this kind. The first group is diagnostic medical errors, understood as “conscientious errors”. The second group are cases when erroneous diagnostic conclusions of psychiatrists not only incorrectly reflect the state of patients’ mental health, but are also necessarily caused by non-medical factors.

The moral responsibility of psychiatrists in such situations is determined by the measure of their responsibility for the fate of their patients, as well as by responsibility for prestige of their profession. The diagnosis of a mental disorder cannot be based on discrepancy of a person’s views and beliefs with those accepted in society.

After adoption of the WMA Hawaiian Declaration, both international and national ethical and legal documents of many countries contain specific provisions and norms prohibiting the use of psychiatric drugs for non-medical purposes under the guise of treatment (in particular, to punish people with mental disorders, or in the interests of others people).

The most important factor determining prevention of abuse in psychiatry is professional independence of the psychiatrist. The problem of professional independence of a physician has both moral and ethical, as well as social (including legal) dimensions.
Principles of Mental Care Delivery in Bioethics

Privacy in psychiatry also has many features. In the context of stigmatization of people with mental disorders that continues in modern society, the requirement of the strictest observance of medical confidentiality by physicians and a medical staff when providing psychiatric care is especially urgent.

Moral and ethical conflicts associated with the need to preserve medical confidentiality when providing mental care are filled with genuine drama. For example: psychiatrists have hidden from the patient’s wife that her husband suffers from an endogenous mental disorder. In 10 years (during this time the second child was born in the family), when the progression of the disease convinced the woman how seriously ill her husband was, she wrote a letter to an outside physician (as a response to his popular book about psychiatry): “...And so recently he was again admitted to the hospital. This time it was hard to fool me. Physicians confirmed that this was not neurasthenia, but a real mental disorder (I was not told which one). What came out of the holy lies of physicians? I do not want to live. It’s scary to recognize, but I want the death of my husband or mine... If I had been honestly told at the age of 26, I would have divorced with my husband and arranged my fate... I want to say that your “holy lie” is still being revealed. Now I say: damn you with your lies!” This case is characterized by the fact that here is a genuine, vital moral dilemma – any decision by a physician, on the one hand, can be justified with an appropriate moral norm, but at the same time, any choice will be vulnerable from the moral and ethical points of view.

Ethical decisions in psychiatry play a greater role than in other medical disciplines. This specificity of the psychiatrist’s activities is due to the following features of his/her work:

- No one except psychiatrists is faced with the need to assess the state of the human psyche in order to make an opinion on depriving a patient of freedom for his/her safety.

- The boundaries of the psychiatrist’s activities are blurred since there are no clear guidelines where his/her duties begin and where they end.
• To date, there is no common understanding of what constitutes a mental disorder.

The principle of informed consent is cross-cutting for bioethics in general. In psychiatry, obtaining the patient’s consent for any intervention in the field of his/her health (hospitalization, prescribing research or some kind of treatment) has the following aspects:

• receiving information in an accessible form and taking into account the mental state, the nature of the patient’s mental disorder;
• prior consent before starting treatment (with the exception of cases provided for by law);
• the patient’s right to refuse treatment (with the exception of cases provided for by law).

The legal side of obtaining informed consent for psychiatric treatment distinguishes this discipline from a number of other clinical disciplines. Firstly, in psychiatry, the patient’s consent to treatment must necessarily be in writing. Secondly, the physician must provide a person suffering from a mental disorder with information about possible treatment, including alternative variants, the duration of the recommended treatment, as well as with information about pain, possible risks, adverse reactions and expected results in an accessible form, taking into account his/her mental state and the nature of the mental disorder. The consent for incompetent patients (minors under 15 years of age and individuals legally recognized as incompetent) is given by their legal representatives. If the diagnosis does not cause categorical rejection or expressed negative emotions in the patient, the physician may discuss the issue with the patient. When discussing another issue very important for the patient – the treatment duration – the physician should be truthful with the patient.

Professional bioethics in psychiatry has the following norms:

1. The main goal of the psychiatrist’s professional activity is to provide mental help to everyone who needs it, as well as to promote and protect the mental health of the population.
2. The professional competence of the psychiatrist (special knowledge and the art of healing) is a prerequisite for psychiatric activity.

3. The psychiatrist is not entitled to violate the physician’s ancient ethical commandment “Do no harm!”

4. Any abuse of the knowledge and the physician’s position by the psychiatrist is incompatible with professional ethics.

5. The moral obligation of the psychiatrist is to respect freedom and independence of the patient’s personality, honor and dignity, and to take care of rights and legitimate interests of the patient.

6. The psychiatrist should strive to establish therapeutic compliance with the patient based on mutual agreement, trust, truthfulness and mutual responsibility.

7. The psychiatrist must respect the patient’s right to accept or refuse the offered mental care after providing him/her with necessary information.

8. Without permission of the patient or his/her legal representative, the psychiatrist is not entitled to disclose information obtained during examination and treatment of the patient and constituting medical secret, including the very fact of providing a person with mental care.

9. When conducting scientific research or testing new medical methods and means with participation of patients, the admissibility limits and the conditions for their implementation must be predetermined.

10. The moral right and duty of the psychiatrist is to uphold professional independence.

11. In relations with colleagues, the main ethical grounds are honesty, fairness, decency, respect for their knowledge and experience, as well as willingness to transfer their professional knowledge and experience.

12. When providing mental care to a patient, the psychiatrist does not have a moral right to conclude property transactions with the patient, use his/her work for personal purposes, or enter into an intimate relationship using the physician’s position or the patient’s mental insolvency.
Incompatibility of Political (Punitive) and Independent Psychiatry

Political psychiatry, or punitive psychiatry, is abuse of a psychiatric diagnosis, treatment and isolation in order to limit the fundamental human rights of certain individuals or groups in society.

Cases of psychiatry abuse are observed in many countries, cultures, and political systems. Abuse of psychiatry is the deliberate infliction of moral, physical or other damage to a person by applying medical measures that are not necessary.

The goals of punitive psychiatry include:
- deprivation of legal capacity or infringement of rights on the basis of a false diagnosis;
- establishment of compulsory medical supervision;
- hospitalization of mentally healthy people (or not so healthy, but not requiring hospitalization), the use of clinics as places of detention;
- administration of medical procedures to healthy people, including painful, dangerous or crippling ones (psychotropic drugs, brain electroshock, lobotomy, etc.);
- deliberate harm to physical and mental health (“driving a person crazy”);
- falsification of death causes with the help of a false diagnosis.

The use of psychiatry for political purposes may be due to such factors as:
- a totalitarian political regime (the desire for complete state control over all aspects of human life);
- psychiatry is forced to serve two multidirectional principles: treatment of the mentally ill and psychiatric repression of people who show political or ideological dissent;
- a lack of legal basis, a lack of proper legislative regulation of mental care, a declarative nature or the absence of legislative acts regulating provision with mental care;
- a lack of extra-departmental control over psychiatrists’ activities and the right to judicial appeal in the field of mental care;
extremely difficult conditions in psychiatric hospitals leading to
dehumanization of the medical personnel;

- low appropriateness of treatment measures: the use of drugs with severe adverse reactions and poorly substantiated treatment methods;
- peculiarities of psychiatrists’ thinking in a totalitarian state, where the sign of equality is put between actual mental anomalies and asocial forms of behavior; a deliberate interpretation of dissent as a psychiatric problem;
- a lack of a unified methodological approach to solving diagnostic and expert issues, a lack of standardized diagnostic criteria;
- a lack of attention of psychiatric medical workers to ethical issues of forensic psychiatry.

Punitive psychiatry was quite spread in the past. Here are some brightest examples:

1. Germany. Abuse of psychiatry for political purposes was an integral part of the crimes committed under the Nazi regime in Germany in relation to both mentally ill and healthy people. Political abuses of psychiatry include mass sterilization (which affected 300,000 people) and massacres of patients in Nazi Germany.

2. USA. In the 19th century, some American psychiatrists sought to diagnose black slaves with the so-called “drapetomania” – an alleged mental disorder (which does not exist in reality) that prompted slaves to flee, and dysesthesia (a “perversion of sensitivity”) – a “disease” (which does not exist in reality) that prompted to break, destroy results of labor, refuse to work, caused disobedience, insolence in them. These were the sociopolitical circumstances when one social group dominated the other and determined the situation when activists of the subordinate group were considered “sick” and “in need of treatment”. Clennon Washington King Sr., an Afro-American pastor and a teacher who tried to enroll in vain at a university exclusively for whites in Mississippi and thereby to overcome the racial barrier, was sent to a psychiatric organization by police in 1958 under the pretext of his potential danger. After a stay in a psychiatric clinic, a commission of 27 physicians found him mentally healthy. The term “protest-like psychosis” was used in psychiatric literature in the 1960s in the
United States to designate as insane African Americans who were members of the civil rights movement. It was a way to pathologize civil protest. With the FBI filing, many representatives of the social movement were diagnosed with schizophrenia.

3. China. Since the 1950s, psychiatry in China has been actively used for political purposes for several decades. Many political and religious dissidents were forcibly placed in psychiatric hospitals. Extensive documentary evidence shows that during the period of the “Cultural revolution” (1966–1976), political abuses of psychiatry became widespread. During that period, under an extremely harsh and repressive regime, abuse of psychiatry for political purposes reached its peak. Articles of Chinese psychiatrists of that time used the diagnoses of “political mania” and “paranoid schizophrenia” in relation to political dissidents. It has been argued that people engaged in “anti-state activities” most often suffer from delusions of persecution, delusions of attitude or delusions of greatness within the framework of paranoid schizophrenia. Since 1987, the so-called Ankang hospitals began to be created in China. These are special type psychiatric hospitals designed to contain offenders recognized as insane. Arrested political dissidents and other categories of people inconvenient for the state were often considered as the most “serious and dangerous” category of all allegedly mentally ill offenders and were the first candidates for placement in such organizations.

4. USSR. The practice of Soviet authorities’ struggle against dissidents and human rights activists that consisted in abuse of a psychiatric diagnosis, treatment and isolation, took place throughout the history of the Soviet Union. A psychiatric diagnosis allowed authorities to avoid a public trial of dissidents by sending them to psychiatric hospitals without trial and for an indefinite period. In addition, the declaration of dissidents as mentally ill people allowed authorities to evade the issue of political prisoners.

At the same time, another problem appeared in the Soviet Union – the so-called acquittal psychiatry, that is:

- recognition of the real or an imaginary criminal as insane when the case falls apart in court, or when it is inconvenient to bring the case to court for any reason;
• simulation of a mental disorder as a way to escape punishment.

Simulation to avoid criminal punishment is common because forensic psychiatry is open to corruption. In some cases, influential criminals “buy” a false diagnosis in order to avoid prolonged imprisonment. Cases of this got distribution both in the Soviet and post-Soviet periods.

During Perestroika (1980s Reformation), the Soviet press published many articles criticizing the practice of hospitalizing criminals who pretended to be psychiatric. According to the data published in the USSR Meditsinskaya Gazeta, bribery in the USSR led to the system by which criminals got an opportunity to avoid punishment by being hospitalized in psychiatric hospitals. This system led to the release of especially dangerous criminals in 2-3 years.

In the post-Soviet era, the opinion became widespread in the professional community that there was nothing wrong with forced hospitalization of dissidents since being placed in the hospital, they were supposedly saved from being sent to camps. Russian authorities are sometimes accused of returning to the practice of using punitive psychiatry against dissidents.

**Psychology, Psychiatry, Psychotherapy: Common and Different Features**

Psychology is a science that studies the laws of emergence, development and functioning of the psyche and mental activity of a person and groups of people. It combines the humanitarian and natural-science approaches. The object of psychology is a combination of various carriers of mental phenomena, the main of which are behavior, activity, relationships between people in large and small social groups.

Psychology objectives are:

• to study and understand the essence of mental phenomena;
• to study managing them;
• to use the acquired knowledge to improve the effectiveness of various branches of practice;
• to develop the theoretical basis for practice of psychological service.
Psychology has a connection with both natural sciences and the humanities. The connection of psychology with natural sciences is based on the biological nature of a human. However, the peculiarity of a person is that a human is a social being whose mental phenomena are largely socially determined. For this reason, psychology is usually attributed to humanities. A distinctive feature of psychology is the coincidence of the object and the subject of cognition, that is, the need to use reflection as a tool for research.

**Psychiatry** is a medical science and a clinical specialty devoted to the diagnosis, prevention, and treatment of mental disorders. These include various maladaptations related to mood, behavior, cognition, and perceptions. The initial psychiatric assessment of a person typically begins with a case history and mental status examination. Physical examinations and psychological tests can be conducted. On occasion, different techniques are used. Mental disorders are often diagnosed in accordance with clinical concepts listed in diagnostic manuals, such as the ICD, edited and used by the WHO and the widely used *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA).

**Psychotherapy** is a system of therapeutic effects on the psyche and through the psyche on the human body. It is often defined as an activity aimed at saving a person from various problems (emotional, personal, social, etc.). This is usually carried out by the psychotherapist by establishing a deep personal contact with the patient (often through conversations and discussions), as well as using various techniques.

Psychotherapy is also a branch of medicine. Psychotherapy is a combination of methods of non-physiological, non-drug treatment of mental disorders, when the patient’s psyche is affected psychologically. As a rule, psychotherapy is not used to treat the most serious mental disorders, such as schizophrenia. For example, with the help of psychotherapy, a patient can try to cure from obsessive hand washing or the fear of spiders. The use of psychotherapy does not exclude drug treatment. A psychotherapist, for instance, can not only treat agoraphobia (an unmotivated fear of open spaces) with the help of systematic desensitization (which is a psychotherapeutic method), but also prescribe tranquilizers to the patient to reduce the general level of
anxiety. The main problem of psychotherapy is the dominance of scientifically unjustified methods of influencing the psyche.

The concept of psychotherapy should be distinguished from both psychiatry and psychology. Psychotherapy can be a variety or an integral part of psychiatric treatment, but psychiatric treatment is often not limited to it (or, in some cases, e.g. with acute psychosis, it can generally be reduced only to medical treatment). A psychologist can also be a psychotherapist (after taking special courses and getting the appropriate qualifications).

Psychology and psychiatry agreed on the common object of study – the psyche, but they have different historical preconditions in determining their goals.

The psychologist faces the task of bringing to the client the need to listen to the internal state, understand the essence of the problem and make an independent decision to get out of a particular situation. Psychiatry is a branch of clinical medicine, having mental disorders in the field of study. Psychiatry deals with treatment and provision of preventive care for patients, including isolation of people with mental disorders who violate social norms and have deviations in behavior. Psychologists examine the soul of a person, and psychiatry puts forward the utilitarian goal of curing a mental disorder first of all, while theoretical understanding is carried out along the way.

**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

*Read Appendix “How to make a good presentation” before you start.*

1. Ethical and legal regulation in the field of psychiatry.
2. Depressive disorders in psychiatry: causes and consequences.
3. Psychology, psychiatry and psychotherapy: common and different features.
4. Political and independent psychiatry: reasons for their incompatibility.
5. History of psychiatry in connection to morality.
6. Psychoanalysis.
Speaking skill development focus

Situational tasks

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.

2. Using the information of the paragraph, answer the questions following them.

3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.

4. Compare the results of discussion with solution patterns.

Situational task 1

Student Peter, who had previously been treated for symptoms of cruelty and paranoid ideas, told the therapist that he intended to kill a student. He did not call her name, but based on the information he provided, she could be identified as Mary. The campus police were notified of that, but Mary’s family were not. Peter was detained by the campus police and then released because the police considered him to be in his right mind. Mary returned after the holidays, and Peter killed her. Mary’s family sued the university and the therapist for failing to take appropriate measures, which, according to Mary’s parents, should have included a warning to them about the danger that threatens their daughter.

What principle of bioethics is affected in this situation and what bioethical contradiction should a court decision resolve?

Situational task 2

Mark was diagnosed with manic-depressive psychosis with a predominance of the depressive phase. Initially, lithium treatment improved his condition, but after examination in the clinic, manic and suicidal tendencies revealed. It was difficult to involve him in the conversation; he was constantly talking about a black demon which sucked vitality from his brain. He was advised to go to the hospital, but he refused, claiming that the hospital would strangle him because harmful gases were released
from the cancer department. The physician talked to his sister and then negotiated Mark’s compulsory treatment.

Was there a restriction on the patient’s rights in that case?

**Situational task 3**

A deputy chief physician of the clinic (a gynecologist by specialty) demanded that a clinic employee, a psychiatrist, should provide him with lists of all young patients who were registered by her. The psychiatrist refused to comply with this order, saying that such information can only be transmitted with the patients’ consent. A conflict arose, and the psychiatrist was threatened with dismissal and other troubles. However, she did not change her mind.

Was the psychiatrist right by not obeying the deputy chief physician?

**Test tasks**

Tick only one correct variant.

1. **A BRANCH OF CLINICAL MEDICINE THAT STUDIES MENTAL DISORDERS THROUGH THE PRISM OF METHODOLOGY OF MEDICINE, METHODS FOR THEIR DIAGNOSIS, PREVENTION AND TREATMENT IS CALLED…**
   1) medical psychology;
   2) psychiatry;
   3) social psychology;
   4) psychotherapy.

2. **THE INTERNATIONAL CLASSIFICATION OF DISEASES OF THE 10TH REVISION USES THE TERM …**
   1) mental illness;
   2) mental trauma;
   3) mental malady;
   4) mental disorder.
3. A SPECIFIC FEATURE OF MENTAL DISORDERS IS …

1) their short course;
2) their duration;
3) a lack of special drugs for therapy;
4) There is no specificity.

4. DAMAGE FROM PSYCHIATRIC PRACTICE DOES NOT INCLUDE …

1) enforcement;
2) social restrictions;
3) moral harm caused to patients with mental disorders by physicians or the medical staff of a psychiatric organization;
4) positive dynamics in treatment of a mental disorder.

5. THE PRINCIPLE OF INFORMED CONSENT IN PSYCHIATRY DOES NOT INCLUDE THE PATIENT’S …

1) obtaining information in an accessible form, taking into account his/her mental state and the nature of the mental disorder;
2) prior consent before starting treatment (except for cases provided for by law);
3) right to refuse treatment in any case;
4) relatives’ prior consent before starting treatment (except for cases provided for by law).

6. THE MODEL OF “MEDICAL WORKER – PATIENT” INTERACTION IN PSYCHIATRY IS …

1) authoritarian;
2) based on the principle of informed consent;
3) The both variants are correct.
7. THE MAIN INTERNATIONAL BIOETHICAL DOCUMENT IN THE FIELD OF PSYCHIATRY IS THE …
   1) Hawaiian Declaration;
   2) Geneva Declaration;
   3) Code of Professional Ethics for a Psychiatrist;
   4) Constitution of a Psychiatrist.

8. ABUSE OF A PSYCHIATRIC DIAGNOSIS, TREATMENT AND ISOLATION IN ORDER TO LIMIT THE FUNDAMENTAL HUMAN RIGHTS OF CERTAIN INDIVIDUALS OR GROUPS IN SOCIETY IS CALLED …
   1) psychotherapy;
   2) psychiatry;
   3) psychology;
   4) political psychiatry.

9. RECOGNITION OF THE REAL OR AN IMAGINARY CRIMINAL AS INSANE WHEN THE CASE FALLS APART IN COURT, OR WHEN IT IS INCONVENIENT TO BRING THE CASE TO COURT FOR ANY REASON; SIMULATION OF A MENTAL DISORDER AS A WAY TO GET AWAY FROM PUNISHMENT IS CALLED …
   1) prison psychiatry;
   2) acquittal psychiatry;
   3) punitive psychiatry;
   4) psychotherapy.

10. “NORMAL BEHAVIOR” IN PSYCHIATRY IS …
    1) There is no exact definition of this term;
    2) a correct behavior;
    3) a behavior in the absence of health problems;
    4) None of the variants fits.
3.4. Bioethical Issues in Sexology

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Sexology: Concept and Areas of Research

Sexology is a science that studies all manifestations of human sexuality, including both attempts to characterize normal sexuality and the study of variability of sexual practices, including the so-called paraphilia (or sexual deviation).

Modern sexology is a multidisciplinary field of research that uses methods of a number of related disciplines: biology, medicine, psychology, statistics, epidemiology, pedagogy, sociology, anthropology, and sometimes forensics. It studies development of sexuality and sexual contact, including the technique of sexual intercourse and disorders of the genital area.

In the 1980s, sexology held a strong place among medical disciplines. Its formation was due to two main factors. Firstly, it was development of medical knowledge – physiology of the reproductive systems, psychoanalytic medicine, endocrinology and neuroendocrinology, medical genetics. Secondly, they were fundamental changes in the moral and ideological orientations of European culture of the last century. The Polish sexologist Kazimierz Imieliński writes: “A prolonged rejection of human sexuality and its understanding as ‘something obscene’ hindered the study of this sphere of human life, and also led to the emergence of numerous erroneous views, prejudices and fictitious judgments.”

European history has experienced two sexual revolutions (the periods of human sexuality reappraisal): the first – in the era of the Roman Empire collapse, the second – in the second half of the 20th century.
The transition from “rejection” and “oppression” of sexuality to its “liberation” is not only a condition for the emergence and existence of sexology, but also one of its theoretical foundations. The basic principle of modern sexology – the principle of individual differences – is based on recognition of the “normative” boundaries of sexual behavior relativity. The American biologist Alfred Kinsey, on the basis of an enormous factual material, stated the existence of a wide range of individual manifestations of human sexuality: “Normal human development is characterized, in particular, with a variety of individual ways of achieving sexual pleasure, and its paths are diverse not only with respect to manifestations, but also with respect to influences of numerous factors that are not always realized by human.”

In the framework of modern sexology, a physician, who is within the boundaries of the traditional regulatory model, often becomes a source of iatrogenic injuries. A patient with atypical sexuality is doomed to neurotic disorders: intolerance of the public opinion to other sexual behavior, reproducing the system of prohibitions, multiplies suffering associated with sexuality.

The state of modern sexology indicates that the problem of the norm and pathology of human sexuality at the level of medical practice is directly related to the moral and ideological context of culture. Overcoming its resistance, medical knowledge is trying to change the meaning of human sexuality.

The problem of sexuality liberation cannot be regarded only as a medical problem. Sexuality is one of the physiological systems of human life support. But its difference from other life-supporting functions – digestion, cardiovascular activity, respiratory apparatus, etc. – lies in the fact that it is directly woven into moral relations of almost any society. Moreover, there is a close relationship and interdependence between sexuality and morality, which depend on both the moral, mental, physiological health of a person and the well-being of a culture as a whole.

Modern sexual liberalism is characterized with a new understanding of sexuality as a means of maintaining health, with the emphasis on the sexual function as an independent subject of medical knowledge.
Sexology of the late 20th – early 21st century fundamentally divides ethical and social norms and human sexual behavior.

It should be noted that sexology is a descriptive, not a prescriptive discipline. It tries to document certain aspects of reality, but not to prescribe what behavior is appropriate, ethical, or moral. Sexology has often become a subject of conflict between its supporters, as well as those who believe that sexology encroaches on the sacred foundations of human life, or those who dispute, from the philosophical point of view, sexologists’ claims for objectivity and an empirical methodology.

There are several relatively independent areas of research in sexology:

- normal sexology, studying the biological, anatomical, physiological, psychological and social aspects of a person’s sexual behavior, which is not a deviation from the norm from the medical point of view;
- clinical (medical) sexology, engaged in prevention, diagnosis and treatment of health disorders associated with sexual behavior;
- ethnocultural sexology, exploring historical and cultural differences in the image and stereotypes of sexual behavior, in other issues related to gender differences that are available to different peoples at different time periods;
- forensic and criminal sexology, summarizing those aspects of knowledge about sexual behavior that could be useful in investigation and prevention of sexual crimes and crimes against public morality;
- family studies, studying sexual relationships within the family, particulars of performing parental roles depending on gender, etc.

Ethics of Sexology in Connection with Human Sexuality and Behavior

Ethics of sexology is a category of ethics about a wide range of forms of human sexual behavior. In general terms, problems of sexual ethics can be organized related to:

- consent, the institution and aspects of marriage (fidelity, premarital and illegitimate acts);
• gender differences;
• issues of how gender and power are manifested through sexual behavior;
• issues of individual health care concerns;
• fertility and health issues;
• issues of how individuals interact with society;
• issues of encounters due to sexual behavior.

In countries where public health is considered a public concern, there is also an issue of how sex affects the health of individuals. In such circumstances, where there are health impacts resulting from certain sexual activities, there is an issue of whether individuals have an ethical responsibility to the public at large for their behavior. Such concerns might involve regular periodic testing for sexually transmitted diseases, disclosure of infection with sexually transmitted diseases, the responsibility for taking safer sex precautions, ethics of sex without using contraception, leading to an increased level of unplanned pregnancies, and just what an amount of personal care an individual needs to take in order to meet his/her requisite contribution to general health of a nation’s citizens.

**Human sexuality** is a combination of biological, psychophysiological and emotional reactions, experiences and actions of a person associated with manifestation and satisfaction of sexual desire. It is an inborn need and function of the human body, similar to the processes of respiration, digestion, etc. A person is born with a certain physiological sexual potential, and later sexuality is formed already within the framework of individual life experience. In general, human sexuality is due to the integrated interaction of biological, mental and sociocultural factors (the definition is given by the Russian forensic physician Gennady Deryagin).

Human sexuality includes a wide range of behaviors and processes, physiological, psychological, social, cultural, political, spiritual or religious aspects of sex, as well as human sexual behavior. Sexuality, like other aspects of human behavior, is both biological and social in nature: some characteristics of sexuality are laid down genetically, others are formed in the process of socialization.
The Russian sexologist Igor Kon identifies several components of human sexuality:

- **Biological sex** is a set of characteristics, such as sex chromosomes, sex hormones, sex cells, external and internal genital organs, secondary sexual characteristics.

- **Gender identity** is a sense of belonging to a particular gender (i.e. a social gender), not necessarily coinciding with the biological gender. Sex started to be separated from gender in 1970s, when due to many scientific research it became clear that gender manifestations differ in different cultures and civilizations, changing in the course of history. They are not a consequence of some special “female” and “male” device of the brain, as it was previously thought, but are due to the structure of society. Gender identity is one of many human identities, such as national, professional, political, subcultural. It is defined as a feeling of belonging to a particular social group, but it is more pronounced. Most people define their gender identities as male or female, and they match their sex, which is called cisgender. Transgender is a mismatch between a person’s gender identity and the sex registered at birth. It also happens that a person feels strange (or does not feel fully his/her own) both the male and female gender, and determines his/her identity in some other way. Such identities are collectively called “non-binary”, which shows that they are beyond the framework of the traditional gender-binary system. Gender manifestation of people with female and male identities can also vary widely. If their manifestations go far enough beyond what is generally accepted for their gender, this is called gender non-conformity. Non-conformity is usually limited to gender manifestation, but does not imply a mismatch between gender identity and other parameters of gender or sex.

- **Gender social role** is a set of social norms that determine the expected behavior of a representative of a gender or sex. This behavior in society, consistent with the cultural norms of the given society, prescribing one or another “typically masculine” or “typically feminine” behavior, is often a source of gender stereotypes and prejudices about typical masculine and feminine behavior, such as a woman being the hearth keeper, and a man being the earner and leader. From sociology and
ethnography it is known that gender roles (i.e. a set of expected behavior patterns for a man or a woman) are distributed in different societies not equally, but depending on their economic development and social structure. Psychology, however, suggests that far not all the mental properties of men and women depend on their gender.

- **Sexual orientation** is an emotional, romantic and sensual attraction to people of the opposite sex (heterosexual orientation), of the both sexes (bisexual orientation) or their sex (homosexual orientation). Sometimes asexuality is also added here (the definition or self-determination of people who are not sexually attracted) and can be considered a kind of sexual orientation, although in fact it is its absence. None of the well-known sexual orientations is a mental disorder, all are normal forms of human sexuality. Although not a single theory about the cause of sexual orientation is widespread, scientists prefer biologically based theories.

- **Sexual identity** is identification of oneself with people who have one or another sexual orientation, awareness of oneself as a person of a certain orientation. Sexual orientation is different from sexual behavior. A person may or may not show his/her sexual orientation in one’s sexual behavior, support or imitate sexual behavior that does not correspond to his/her real sexual orientation. It should be noted that different sexual behavior is characteristic not only for human, but also for many species of animals (i.e. goats, cats, dogs, elephants, lions, penguins, dolphins, swans, hyenas, monkeys, whales, etc.). No sexual identity is considered deviant or pathological, regardless of its coincidence or mismatch with the true sexual orientation of the individual. Today it is believed that a psychotherapist or a sexologist should help an individual bring one’s sexual identity in line with his/her true sexual orientation only if their mismatch causes psychological discomfort for the individual, sexual orientation dysphoria (as, e.g. with a heterosexual who mistakenly considers him-/herself a homosexual due to the prison experience).

**Human sexual behavior** is a combination of mental reactions, attitudes and actions associated with manifestation and satisfaction of a person’s sexual desire. Sexual behavior is one of the forms of interaction of individuals which represents practical realization of human sexuality, being one of the options for social behavior.
Although human sexual behavior is closely related to the reproductive function, unlike sexual behavior of animals, it is determined by social development of a particular person. Therefore, human sexual behavior is relatively autonomous from its reproductive function.

Most societies have laws that prescribe certain restrictions on sexual behavior. Sexuality is changing from culture to culture, from region to region, and is constantly changing throughout the history of humanity.

Sexuality is a driving force of a person’s social activity, as it is aimed at achieving not only sexual satisfaction, but also at a socio-psychological state referred to as “happiness”, improving the quality of life. Sex-related experiences determine the choice of a particular behavior even in situations which are obviously not related to sexual contacts in the narrow sense.

Sexuality is a factor that encourages people to live together and work, being a driving force for rapprochement and unification of people, one of the main components of family life.

Sexuality performs different functions in people’s lives. Anthropologists, gynecologists, psychiatrists, psychologists, sociologists distinguish various functions. From the socio-psychological point of view, two main functions could be distinguished: the function of procreation and the function of enjoyment. When considering this phenomenon in the biological and anthropological aspect, the function of procreation can be considered the primary function of sexuality. The heterosexual intercourse provides reproduction of the genus. However, only a very small number of sexual acts serve this purpose today. In some marriages, production of children is not a goal at all, in others it is limited by contraceptives to only a few acts. If there were no other functions, it would be impossible to explain the purpose and causes of more than 99 % of sexual intercourse in humans while the function of enjoyment explains it.

Sex life, due to its intimacy, mystery and innermost feelings, like no other area of human functioning since ancient times, is surrounded with various kinds of myths, fictions and fantasies. If any person, and even a medical worker, is asked what is sexual
health, the answers will be very different and, nevertheless, very far from the true understanding of this concept.

**Sexual Health, Paraphilia and Sexual Education in Connection with Bioethics**

Sexual health is one of the recognized components of human health in medicine. The foundations of sexual health are laid back in the embryonic period of development, when sex differentiation occurs, but in the future it depends not only on biological, but on psychological and social factors, individual and general sexual culture, on motivation of sexual behavior, on satisfaction of unconscious impulses and adaptation of partners at all levels of interaction.

The current working definition of sexual health has been formulated through technical advice on sexual health in 2002 under the auspices of the WHO. Some aspects of sexual health were clarified by UNESCO in 2018 as part of development of recommendations on sexuality education.

**Sexual health** is understood not simply as the absence of a disease, but as the state of somatic, emotional, intellectual and social well-being in relation to sexuality. Sexual health implies a positive and respectful attitude to sexuality and sexual relations, the ability to lead a satisfying sex life, the absence of coercion, discrimination and violence. Achieving and maintaining sexual health is associated with realization of the inherent sexual rights of people (according to the WHO and UNESCO).

The World Association for Sexual Health (WAS) is an international organization that brings together representatives of the sexological community and sexologists. At its 13th Congress in 1997, it adopted the Declaration of Sexual Rights, which includes in particular such rights as the right to sexual independence, integrity and physical security, inviolability of private sexual life, sexual equality, a free and responsible reproductive choice, research-based information on sexuality, comprehensive sexuality education, reproductive health, etc.

**Paraphilia** (from Greek παρά “beside” and φιλία “love”, “friendship”) are such forms of sexual behavior that do not correspond to the sexual norm accepted in society. Since there are a lot of ideas about the sexual norm (each society has a specific sexual
norm at a certain historical period), it is impossible to list all types of behavior that were or are considered deviating. The attribution of a particular type of sexual behavior to paraphilia is very problematic and can vary at different periods in the history of humanity as a whole and in different cultures in particular. Paraphilia should be distinguished from unusual sexual preferences, which from the medical point of view are not considered unhealthy, but can be considered unacceptable in society.

The main groups of paraphilia are described in the ICD-10 in group F65 of diagnoses. The ICD-10 classifies disorders of sexual preference, including paraphilias, as follows: fetishism, fetishistic transvestism, exhibitionism, voyeurism, paedophilia, sadomasochism, multiple disorders of sexual preference, other disorders of sexual preference, an unspecified disorder of sexual preference.

The ICD-11, which comes into effect in 2022, classifies paraphilic disorders as follows: exhibitionistic disorder, voyeuristic disorder, paedophilic disorder, coercive sexual sadism disorder, frotteuristic disorder, etc.

Sexual education is a problem that is quite acute and controversial in almost all countries of the world. It raises such complex issues as sexuality of adolescents, sex before marriage, the use of birth control, etc.

**Sexual education** is a complex of medical, psychological, moral knowledge and concepts about human sexuality, including anatomical and physiological characteristics, reproduction, reproductive health, sexually transmitted diseases, contraceptives, emotional aspects of sexuality and relationships with a partner.

Sexual education could be formal (taught by professionals within the school, medical center, social welfare center, social family planning center, etc.) and informal (received from peers, the media, parents, etc.).

In different countries, different age groups receive a different set of information that could be classified as comprehensive sexuality education (which includes most of the aspects listed above) and abstinence-limited sex education (which promotes abstinence from sexual life before marriage and does not provide information on contraceptives, conception, and methods of fighting sexually transmitted infections).
Some people are unshakably convinced that any sexual information perverts adolescents, increases their sexual activity, increases the number of premarital relationships, pregnancies, etc. Others assert that once sexual education is introduced, all the problems of teenage and adult sexuality will disappear.

In many countries, sexual education has long existed, and its experience unconditionally dispels both irrational fears and exaggerated expectations. Some teachers and parents fear that sexual education may encourage children to have early sex. These fears are baseless. The Russian sexologist Igor Kon wrote that:

1. Adolescents who have undergone a systematic course of sexual education know more about sexuality, and their knowledge is more reliable.
2. This does not remove the problems and difficulties of psychosexual development, but facilitates resolution of conflicts arising from this.
3. Knowledge facilitates understanding and tolerance of other people’s views and behavior, which is very valuable both personally and publicly.
4. If the course of sexual education includes information about contraception and is taught early enough, it dramatically reduces the number of teenage pregnancies and abortions.

People who have received good sexual education in early adolescence, live better and pass on their knowledge and skills to their children, which reduces tension between parents and children.

There are many prejudices associated with sexuality in society. Unfortunately, these prejudices are supported by physicians due to their extremely low knowledge in the field of sexology, because until now in many countries medical students are not taught sexology and sexopathology.

Sexual education can provide more open and honest relations between men and women, which, in turn, will lead to weakening of sexual aggression, debunking many legends and myths about sex, and loosening up primitive stereotypes that have developed in this area of human life.
Transgender Transitioning and Bioethics

Transgender is a mismatch of gender identity or gender manifestation of a person with a sex registered at birth. Transgender per se is not a disease or a disorder. Transgender people are those who change or seek to change the parameters of their sex or gender based on their gender identity.

Transgenderism is often confused and mixed with sexual orientation. Sometimes it can be heard that transgenders go to “sex change” ostensibly in order to make their intimate relationships heterosexual after it. Although such a practice does exist, e.g. in Iran, it is essentially repressive in nature, since homosexuality is severely punished there. In general, gender identity and sexual orientation are unrelated things, and transgender people can be heterosexuals, homosexuals, asexuals, etc., just like cisgender ones.

Transgender people often experience severe psychological discomfort from inadequacy of their self-awareness of social expectations. Such discomfort can lead to serious consequences, up to depression and suicide. The best solution to this problem is often transgender transitioning. In many cases, the main or a serious additional cause of severe stress for transgender people is discrimination and rejection by surrounding people and society as a whole.

Transgender transitioning is a process of bringing the gender role and body of a transgender person into line with his/her gender identity. Transgender transitioning may include socialization in a new gender role, medical procedures for gender correction, a change of passport name and legal gender. From the point of view of modern medicine, transgender transitioning is the only effective way to overcome gender incongruence, that is, the state of transgenderism, when a person cannot fully accept his/her gender status as a male or a female. In this case, the amount of changes is determined in each case by the needs of a particular person.

Not all people who make or need transgender transitioning feel being representatives of the sex opposite to that attributed at birth.
In many countries, transgender transitioning is complicated by transphobia, which is widespread among ordinary people, as well as among psychologists and physicians.

Transgender transitioning may (or may not) include such steps performed in a general case in any sequence:

1. Social adaptation (resocialization) is a process which usually implies a change in gender manifestation and a social gender role. For example, a person begins to talk about him-/herself in a different sex and is called by a different name in accordance with gender identity, changes a clothing style, begins (or ceases) to use makeup, changes a sphere of activity, etc.

2. Legal recognition of gender is a change of the gender marker and name in identification documents: the passport, birth certificate, driver license, diplomas, bank cards, etc. This stage is very important if the transgender needs to recognize gender identity in any official interactions: getting a job, traveling, renting a house, opening a bank account, etc. In all situations surrounding people will look at documents and perceive a person by default in accordance with the gender that is indicated in them.

3. Hormone replacement therapy is the stage most affecting the appearance and, accordingly, the way a person is perceived by others. So, intake of female hormones (usually in combination with suppression of male ones) leads to the fact that a person begins to be read as a woman by default. The period for which noticeable changes occur usually takes from several months to a couple of years. However, in order to maintain the body in this state, hormones must be taken further on, because one’s own body does not produce them.

4. Surgical intervention is far from being the main and right stage for everyone since in recent years, the movement to abolish the requirement of forced sterilization (castration), which still remains mandatory in many countries for the legal recognition of gender, has gained momentum.

Also, as part of transitioning, operations that are not related to the genitals are sometimes performed. For trans-females, this can be a complex of operations to feminize the face, changing the shape of the nose, chin, eyebrows, etc., as well as
chondrolaryngoplasty (removal of the laryngeal prominence), often in combination with surgery on the vocal cords. In trans-males, these are, respectively, masculinization of the face, as well as liposuction (removal of fat deposits).

It is impossible though to get through transitioning:

- a change in the chromosome set: in trans-males it remains XX, and in trans-females – XY (unless they are intersex);
- gonads of the desired sex.

In different countries, an access to medical sex correction is determined by law. For example, in Russia, the diagnosis of transsexualism is required. It is made by a psychiatrist after observation, which can last from one month to two years. Then a special board of physicians (usually consisting of a psychiatrist, a psychologist, and a sexologist) issues a referral for medical sex correction and a change of documents. Transgender people report that they lack qualified medical care. Many also face prejudice and humiliation from physicians. All procedures for medical sex correction in Russia are paid for from patients’ own funds. The situation for transgender people is further complicated by the fact that due to discrimination at their workplace, many lose their jobs or cannot find new ones.

The Russian law provides a possibility of changing a person’s name and passport sex by a medical document confirming the fact of a “sex change”, which is issued by a medical board or obtained in court. In case of a successful change of the name and passport sex, a transgender person receives a new birth certificate and, accordingly, an opportunity to change other documents.

Presentation skill development focus

Prepare a 10-minute presentation on a particular topic below.
Read Appendix “How to make a good presentation” before you start.

3. Sexual culture in different countries.
4. Sexology in the context of culture.
5. Ethics in sexology. Sexual health.
7. Social aspects of sexology. Sexism.

**Speaking skill development focus**

**Situational tasks**

1. Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.
2. Using the information of the paragraph, answer the questions following them.
3. Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.
4. Compare the results of discussion with solution patterns.

**Situational task 1**

A 23-year-old young man came to see a therapist to receive a referral to a sexologist. During the conversation, the therapist became aware that the young man had non-standard sexuality. This information caused a fit of rage in the therapist: he began to insult the patient because of his sexuality, shouted that it was wrong. The patient did not receive a referral to a sexologist and had to go to another physician.

What principles of bioethics did the therapist violate? How was the therapist supposed to behave?

**Situational task 2**

At the physician’s office, a male physician, after listening to a female patient, started to harass her during medical examination. The patient rejected the physician’s harassment and went out.

Was the physician’s behavior adequate?
Situational task 3

Among physicians, especially neurologists, there was a tradition of examining patients completely naked. However, such an examination, in particular, if a male physician examines a female, causes a number of understandable problems. Patients were often accused of a sexual nature against physicians; therefore, doctors “secured” themselves by examining a patient in the presence of his/her close relatives (after Z. Freud).

What was the ethical inconsistency of this problem?

Test tasks

Tick several correct variants.

1. ETHICS IN SEXOLOGY STUDIES, AMONG OTHER ISSUES, THE FOLLOWING PROBLEMS (tick 2 correct variants):
   1) fertility and health issues;
   2) sexual development issues;
   3) gender differences;
   4) problems of the quality of sexual relations between people.

2. ACTIVE DEVELOPMENT OF MEDICAL SEXOLOGY TODAY IS ASSOCIATED WITH:
   1) transformation of moral and philosophy;
   2) development of the pharmaceutical industry;
   3) scientific and technological revolution;
   4) a wide spread of diseases related to the human sexual function;
   5) all of the listed factors.
3. EUROPEAN HISTORY HAS EXPERIENCED THE FOLLOWING NUMBER OF SEXUAL REVOLUTIONS (THE PERIODS OF HUMAN SEXUALITY REAPPRAISAL): …

1) two: the first – in the era of the Roman Empire collapse, the second – in the second half of the 20th century;
2) one, related to the emergence of medical sexology in the second half of the 20th century;
3) one, related to formation of Christian culture in the first centuries of European history.

4. HUMAN SEXUALITY IMPLIES …

1) the totality of mental and emotional reactions of a person associated with manifestation and satisfaction of sexual desire;
2) a set of rules to be followed;
3) attractiveness and behavior aimed at attracting attention;
4) a set of external human data.

5. THE TOTALITY OF MENTAL REACTIONS, ATTITUDES AND ACTIONS ASSOCIATED WITH MANIFESTATION AND SATISFACTION OF A PERSON’S SEXUAL DESIRE IS CALLED …

1) human sexual behavior;
2) sexual orientation;
3) human sensuality;
4) human depravity.

6. SEXUAL HEALTH IS …

1) the absence of painful changes in the body;
2) a state of somatic, emotional and social well-being in relation to sexuality;
3) ending a relationship between two people;
4) a desire to satisfy one’s sexual needs.
7. SEXUAL HEALTH IS AIMED, AMONG OTHERS, AT THE ABSENCE OF (*tick 2 correct variants*) …
   1) violence;
   2) discrimination;
   3) eroticism;
   4) love.

8. SEXUAL DEVIATIONS ARE ALSO CALLED …
   1) aberration;
   2) paraphilia;
   3) mutation;
   4) maladaptation.

9. SEXUAL DEVIATIONS, INCLUDED, AMONG OTHERS, IN THE ICD-10, ARE (*tick 3 correct variants*) …
   1) fetishism;
   2) homophobia;
   3) pedophilia;
   4) psychopathy;
   5) voyeurism.

10. SEXUAL EDUCATION TAUGHT BY PROFESSIONALS IS CALLED …
    1) formal;
    2) informal;
    3) comprehensive;
    4) abstinence-limited.
3.5. Bioethical Issues in Oncology

Reading skill development focus

1. Read the suggested text material.
2. Make sure you master the main issues of the paragraph:
   a) make a plan of the paragraph;
   b) write out key words of the paragraph;
   c) inform your groupmates about the meaning of each key word.

Concept of Oncology

Oncology (from Greek ὄγκος “burden, volume, mass”, “barb”) is a section of medicine that studies benign and malignant tumors, the mechanisms and patterns of their emergence and development, methods of their prevention, diagnosis and treatment.

Oncological diseases represent an extensive and heterogeneous class of diseases. Oncological diseases are systemic, affecting all organs and systems of a person. There are many forms and variants of the cancer course. Although patients often perceive an oncological diagnosis as a sentence, but far not all even malignant tumors lead to death. Modern studies have shown that every person has cancer cells that die and resolve under the influence of the antitumor immunity system.

Oncology is a special field of medicine where both high professional training of a physician and the ability to contact a patient who is mentally injured by, as patients consider, a deadly disease, are equally important. Therefore, the ability to gain trust of the patient is an indispensable component of successful treatment. The uncertainty of the etiology of malignant tumors raises doubts in people about possibilities of medicine. In response to a question about the origin of cancer, an oncologist cannot always give a clear, unambiguous answer, and this situation gives rise to various speculations among the population, and creates the basis for trust in various “healers”.

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Features of Interaction with an Oncology Patient

An important feature of bioethics in working with oncology patients is the need to fight against the widespread opinion about incurability of malignant neoplasms. Nowadays, almost no widespread disease causes such a horror and despair in people as cancer. Patients with clinical manifestations of oncological diseases at the first stages try to explain their feelings with random causes. They expect that the pain will pass, they prefer to be treated with home remedies. A smaller portion of patients quickly panics and immediately consults a physician.

After the first visit to the physician, the psychological situation changes. The patient’s mood depends on the impression that the physician has made. Patients have a hope that their fears are in vain, and the disease can be cured with conventional medications.

The period of stay in the hospital is associated with mental oppression, patients worry that they are in the oncology dispensary, and in this case, the oncologist’s personal contact with the patient is the key to a safe background for treatment.

The patient’s refusal of treatment and surgery is still a frequent phenomenon, indicating a lack of understanding by physicians of bioethical tasks in oncology. The patient’s refusal to have an operation on the basis of misinformation made for false reasons negates bioethical principles that place the patient’s interests above anything else.

Conducting a conversation with patients having cancer requires implementation of certain rules. Until the diagnosis is morphologically confirmed, no statements should be made about the nature of the disease and its timing to either the relatives, or the patient. An oncologist is not the “first contact” physician with the patient. Usually, the patient first goes to the therapeutist, surgeon, etc.

When providing medical services to cancer patients, physicians, depending on the typical features, often fall into two extremes. This can be unjustified optimism on the one hand, and intimidation and a sharply pessimistic attitude towards a possible disease outcome on the other. Unjustified optimism leads to the fact that in 1–2 years the physician who promised a complete recovery remains face to face with the patient’s
orphaned family and has to answer them first of all because they do not attribute the
death of their relative to the neglect of the disease, but to the lack of skill of the
physician.

The most authoritative physician should talk, well prepared not only by medical,
but also by life experience for solving complex bioethical problems.

Oncology patients are characterized by attempts to consult with many physicians
in different organizations. At the same time, they are driven by a natural and
understandable desire to overcome fear, perhaps find an error in the diagnosis and hear
a suggestion of less stressful, gentler treatment. At the same time, many patients
carefully hide from both the consultant and their attending physician the facts of
contacting another physician, being afraid to offend their physician. The attending
physician makes a bioethical error if at least he/she makes the patient understand
his/her resentment of mistrust.

From the bioethical point of view, the normal situation is participation of a
physician in all consultations. In this case the patient will have no reason to seek advice
from other physicians.

The greatest bioethical difficulties are encountered in assisting patients having
cancer of the 4th clinical group. Their therapists and oncologists attend them.

Oncological patients are tormented by a number of negative emotions: fear,
anxiety and, as a result, psychosomatic disorders – depression and mania, which an
experienced physician can cope with, knowing the phases of psychological processing
of the situation in the behavior of patients with malignant tumors, and being able to
determine the type of the patient’s higher nervous activity.

According to the famous Swiss-American psychiatrist Elisabeth Kübler-Ross,
the following phases of psychological processing of the situation in the behavior of
patients with malignant tumors are distinguished: unwillingness to know the truth –
Principles of Communication with Oncology Patients

The physician should adhere to the following important principles of communication that will help achieve the goal without injuring either his/her own psyche or the patient’s one:

1. Try not to aggravate the patient’s emotional trauma caused by the disease.
2. It is important to see primarily a person, a personality in each patient. Do not suppress, do not rise above, be thinner and more intelligent.
3. Mental characteristics, the level of intelligence, the character and life experience of patients are different (as of all people). The patient may have an opinion. The patient’s vision of the situation is likely to be different. Try to understand it, show respect for the patient’s point of view, and delicately correct it, without humiliating the patient’s dignity.
4. Do not forget that cancer is perceived as a threat to life in everyone’s mind. Therefore, bad news changes a person’s idea of the future abruptly and suddenly, causes a variety of mental reactions: from “denial” to aggression. Take this as a defense reaction, and try to gently translate the conversation into a positive channel.
5. The physician should not be sure that he/she can fully understand and realize the feelings and thoughts of a cancer patient. Do not judge, think positively.
6. Do not kill hope, but remember that “false optimism” also kills it.

The question of rational informing the patient about the true diagnosis should be approached individually. In each case, the physician chooses the only correct line of behavior. This is determined by the nature and stage of the disease, the psychological characteristics of the patient, his/her age, profession, attitude to the proposed methods of research and treatment, the patient’s social environment and socio-cultural affiliation, the country and the norms, traditions and settings of the medical organization, as well as by the level of the physician’s professional knowledge.

Every patient with a malignant tumor has the right to treatment. This situation is often underestimated, especially in situations when the patient is at the late stages of tumor development. Moreover, it is sometimes mistakenly believed that it is impossible
to help the patient. Meanwhile, it is at this time that the patient, more than ever, needs a sympathetic attitude towards him/her, effective medical measures.

Starting from the initial examination period, a cancer patient may experience severe emotional stress manifested by signs of anxiety, fear, and depression. In this state, various behaviors are possible, including inappropriate reactions: denial of the disease, refusal of treatment up to aggressive or suicidal moods. However, even being externally calm, the patient may experience fear at the thought of the disease, but tries to hide it from others. Hidden negative emotions of the patient often pass by the attention of an untrained physician. An inattentive and superficial attitude, arrogance and rudeness aggravate the patient’s experiences, worsening the course of the disease.

A number of patients refuse treatment which could be associated with a fear of the upcoming operation, a disbelief in the possibility of cure, the idea of a possibility of healing with herbs or home remedies. If an elderly patient fears for the outcome of the operation due to a concomitant pathology, past diseases or previous negative experience of surgical interventions, physicians explain that before solving the issue of surgery, an appropriate examination and treatment will be carried out. Young patients are frightened by the crippling nature of the operation (e.g. organ removal). In such cases, the physician informs about a possibility of reconstructive surgery, prosthetics.

A number of patients who recognize or suggest a malignant tumor refuse treatment, consider the disease incurable. In an interview, the patient is explained that the final diagnosis will be made only after a histological study. If cancer is actually detected, then, if at the early stage, when a complete cure is possible, and refusal of treatment will lead to a loss of time and the spread of the process, a possibility of cure will become doubtful.

Refusal of therapy can be associated with well-being of the patient, when a tumor was detected by chance against the background of full health. This is due to the fact that malignant neoplasms often, especially at the early stages, are asymptomatic, the general state of health does not suffer, and sometimes patients inadequately assess their condition. In such a situation, the patient hopes for an error in the diagnosis and does not believe in the need for treatment (a negative reaction). Severity of the situation is
explained to such patients, speaking of the tumor as an assumption, and only in an emergency situation about the presence of a tumor detected at an early, treatable stage. The patient’s refusal of treatment is considered one of the indicators of work organization in a medical organization.

Patients with advanced forms of malignant tumors are subject to palliative medical treatment.

The relationship of the physician with relatives and colleagues of the patient is the subject of special discussion. Here, psychological aspects play a role, as well as property, material and a number of other factors that are sometimes impossible to weigh at a time. At the same time, the patient’s interests come to the fore. No matter how busy the attending physician is, he/she must find the time to talk with the patient’s relatives, especially with a far-reaching process. The question is about the life of their loved one, it is a serious psychological trauma for them. Anxiety, an excessive care for the patient, less often – an inadequate reaction, some alienation, and restraint is typical for them. The next of kin should be correctly informed about the true diagnosis and the version, which should be followed in a conversation with the patient, as well as about the risk of surgical interventions and the prognosis. However, there are exceptions to this rule, especially when talking with the husband or wife, and sometimes with the patient’s children. For example, a number of women, agreeing to an ovariectomy, do not want the husband to be informed about the details of the operation. Such an intervention is considered a medical secret. In some cases, patients ask physicians not to talk about the severity of their condition to relatives, trying to protect the elderly or sick family members from the experience. Thus, this issue is resolved only after a thorough analysis of the patient’s relationship with those around him/her.

Relatives often ask questions about a possible life expectancy of the patient, especially in the presence of distant metastases. Specific dates are undesirable. The exact answer in such a situation is difficult for the relatives to perceive, and a natural error in one direction or another drops the physician’s credibility. The physician should be ready to answer questions about the volume of surgery, life quality. With the exception of relatives and the patient’s closest people, the physician does not have the
right to disclose information about the cancer patient. Notification of the patient’s acquaintances and colleagues about everything that concerns the patient violates the law on medical confidentiality. Care should be taken regarding telephone conversations with relatives, since the physician does not know who is on the other end of the wire. In such cases, they offer a personal meeting.

**Presentation skill development focus**

*Prepare a 10-minute presentation on a particular topic below.*

*Read Appendix “How to make a good presentation” before you start.*

1. Ethical aspects of communication with an oncology patient.

**Speaking skill development focus**

**Situational tasks**

1. *Read the tasks below describing real cases from medical practice or connected with philosophic problems of bioethics.*
2. *Using the information of the paragraph, answer the questions following them.*
3. *Discuss the principles, values and rules of bioethics touched upon in the situational tasks with your groupmates. Try to sound clear and persuasive in expressing your viewpoint in pair or group work.*
4. *Compare the results of discussion with solution patterns.*

**Situational task 1**

At a hospital appointment, an otorhinolaryngologist detects a laryngeal tumor in the patient at an early stage, but does not inform him about it, fearing for his mental state. He gives the patient a referral to an oncological clinic, but the patient postpones a visit to the oncologist for a long time, citing the lack of time. As a result, the patient was taken to the hospital emergency room by an ambulance team with the diagnosis: “Stenosis of the larynx, 3rd grade. Laryngeal cancer, esophageal germination”.

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What rule of bioethics was violated by the otorhinolaryngologist?

**Situational task 2**

A patient suffered from an inoperable form of pancreatic cancer. It was necessary to report the diagnosis to the patient first, and then, with his informed consent, to the relatives. The patient, being in the hospital and learning about his diagnosis, committed suicide. The physician who reported the diagnosis to the patient received a reprimand from the administration (the basis of the reprimand was that the physician had not found a psychological approach to the patient).

What rule of bioethics requires a special approach to informing and using communicative skills?

**Situational task 3**

The woman underwent a routine examination in the clinic. Soon the physician called her home, but since the woman was not at home at that moment, the further conversation took place with her mother. When asked who was calling and for what reason the daughter was needed, the physician told her that he was calling from the clinic and only wanted to report that she had a malignant tumor.

Did the physician violate the confidentiality rule in this case?

**Test tasks**

*Tick several correct variants.*

1. **ONCOLOGY IS …**
   1) a pathological process, represented with a newly formed tissue, where changes in the genetic apparatus of cells lead to dysregulation of their growth and differentiation;
   2) a section of medicine and biology that studies patterns of emergence, development and outcome of pathological processes; features and nature of dynamic changes in physiological functions in various pathological conditions of the body;
3) a section of theoretical and practical medicine that studies the state of the body at the final stage of a pathological process, the dynamics and mechanisms of dying, immediate causes of death, clinical, biochemical and morphological manifestations of a gradual cessation of the body;
4) a section of medicine that studies benign and malignant tumors, mechanisms and patterns of their emergence and development, methods of their prevention, diagnosis and treatment.

2. THE KEY TO FAVORABLE TREATMENT BACKGROUND OF THE ONCOLOGY PATIENT IS …
   1) maximum remoteness of the physician and the patient;
   2) a personal contact of the physician and the patient;
   3) the patient’s ignorance of the diagnosis;
   4) a lack of the patient’s desire to be treated.

3. UNTIL THE ONCOLOGICAL DIAGNOSIS IS MORPHOLOGICALLY CONFIRMED …
   1) it is necessary to tell everything about the nature of the disease and the process of its development to the patient;
   2) the physician should conduct a conversation with the patient’s relatives about the disease and its timing;
   3) no statements should be made about the nature of the disease and its timing to either the patient’s relatives or the patient him-/herself;
   4) the physician immediately needs to adjust the patient for an unfavorable outcome.
4. WHEN INFORMING THE PATIENT ABOUT THE ONCOLOGICAL DIAGNOSIS, IT IS IMPORTANT TO CONSIDER *(tick 2 correct variants)* …

1) the nature and the stage of the disease;
2) psychological characteristics of the patient;
3) the relationship of the patient with his/her relatives;
4) the patient’s financial security.

5. THE CORRECT ORDER OF THE PHASES OF PSYCHOLOGICAL PROCESSING OF THE SITUATION BY CANCER PATIENTS IS …

1) unwillingness to learn the truth – indignation – anger – “a deal with fate” – depression – a new hope – humility;
2) indignation – anger – depression – unwillingness to learn the truth – humility – “a deal with fate” – a new hope;
3) unwillingness to learn the truth – anger – indignation – “a deal with fate” – depression – humility – a new hope;
4) a new hope – humility – depression – “a deal with fate” – indignation – anger – unwillingness to learn the truth.

6. TREATMENT OF PATIENTS WITH ADVANCED FORMS OF MALIGNANT TUMORS IS …

1) palliative medical;
2) surgical;
3) radiation therapy;
4) chemotherapy.

7. IN A HEALTHY PERSON, CANCER CELLS …

1) never propagate;
2) propagate regularly;
3) are airborne into the body;
4) They are available in every person from birth.
8. ONCOLOGY PATIENTS OFTEN REFUSE OPERATIONS DUE TO (tick 2 correct variants) …
   1) family problems;
   2) different fears;
   3) a disbelief in the possibility of cure;
   4) political beliefs.

9. A MALIGNANT TUMOR …
   1) affects only one organ and never metastasizes;
   2) always causes mental disorders;
   3) inevitably leads to death;
   4) There is no correct answer.

10. ONE OF THE RULES FOR COMMUNICATING WITH ONCOLOGY PATIENTS IS …
    1) not to kill hope, but remember that “false optimism” also kills it.
    2) to think pessimistically because cancer is an incurable disease.
    3) not to tell the patient about the diagnosis, since this contributes to better treatment results;
    4) to be convinced that the patient is an ordinary person, not versed in medical matters, and cannot have an opinion.
Section 1. GENERAL ISSUES OF BIOETHICS

1.1. Bioethics as a Science

Situational task 1

Any patients, regardless of their gender, racial and ethnic origin, as well as other non-medical factors, including a financial situation, should receive good medical assistance. In the situation where the victims’ conditions were approximately the same, the choice of priority for provision of medical care to the patients was determined by the ethnic factor. From the legal point of view, there is a violation of the law – a failure to provide medical care in full.

Situational task 2

No. Here is the authoritarian model of relations between the leader and subordinates. The working conditions of the physician, shown in the situation, will inevitably lead a specialist to burnout syndrome. A physician, like any other specialist, should be able to restore physical, mental, sociocultural qualities. Professional services should not conflict with the physician’s right to an appropriate schedule of work and rest. All these issues are not only ethical, but also legal.

Situational task 3

It is due to “embeddedness” of the medical profession in the prison system on the one hand, and, on the other, to the attitude of free citizens to prisoners. Here, the patient-prisoner is perceived only as a labor force, bonded. There is a contradiction between bioethical principles and real medicine practiced in the incarceration system.

1.2. Principles and Rules of Bioethics

Situational task 1

The confidentiality rule was violated.
Situational task 2
The informed consent rule and the veracity rule are violated.

Situational task 3
The principle of equity prompted the physician to act.

1.3. General Aspects of “Medical Worker – Patient” Relationships

Situational task 1
It was a crime, since a grievous harm had been done due to negligence. There is a causal relationship between the anesthesiologist’s actions and the grievous harm. The responsibility comes under the law.

Situational task 2
The principle of “Do no harm” was violated. Yes, he was.

Situational task 3
The conflict arose because the information provided to the patient by the physicians and the patient’s informed consent to the operation were not documented. To avoid such a situation, the physician must obtain the written informed consent (or refusal) of the patient to medical intervention.

1.4. Philosophic Categories in Bioethics

Situational task 1
In these words of Kant, a person acts as the keeper and master of his/her body. The German philosopher Immanuel Kant clearly expressed his ethical (rigorism) and religious (Protestantism) position regarding the problem of “human and his body”.

Situational task 2
Deontological ethics can declare an act moral or immoral in itself and proclaims the principle of “do what seemed right, come what might”. The ethics of virtues
assesses the morality of personalities dividing everyone into “bad” and “good”. Utilitarianism states that the end justifies the means, and no means can be judged as immoral if they lead to a moral end. Utilitarianism does not divide people as a whole into moral and immoral, it just notes that some of their actions can lead to moral or immoral consequences.

Situational task 3

Empirical duty is parental, friendly, patriotic, professional, etc. Moral (universal) duty is selfless indiscriminate reverence for all living beings. Empirical duty may conflict with moral duty, e.g. between corporatism as the principle of professional morality and universal morality. Then students are expected to give examples extending this statement.

Section 2. BIOETHICS AND MEDICAL PRACTICE: COMMON ISSUES

2.1. Ethics Committees. Medical Trials and Research

Situational task 1

Yes. Ethical standards governing the attitude of researchers to test animals are presented in a number of international ethical documents. The Helsinki Declaration requires experimenters to take care of welfare of the animals used for research. The International Guidelines for Biomedical Research with Animals (1984) require laboratory experimenters to use animals in “the minimum necessary to obtain scientifically based results”, to “properly care for the animals”, to minimize their inconvenience, suffering, and pain. The pain inflicted “must be accompanied by the necessary sedative, analgesic or anesthetic measures”. The animals that suffer a severe fatal or chronic pain, or become crippled, should be euthanized without serious consequences.

Situational task 2

Vikenty Veresaev warned that it is unacceptable to transfer results of laboratory tests on animals directly to clinical ones and use them to treat a human. This is a
remainder of the fate of freak babies born of women who once took thalidomide, which had undergone positive testing on animals. But, as it turned out later, there was a small animal in New Zealand, on which the thalidomide test yielded a negative result. The proximity of the animal and human organisms does not mean their physiological and biochemical identity.

**Situational task 3**

No. Such a quick consent to participate in the trial is unacceptable. She should have verified herself that the research was in the interest of her patients. She should have got familiarized with the research protocol, its compliance with ethical standards and the approval of an ethics committee. If there were any doubts about an ability to assess the project herself, she needed to seek advice from colleagues. An expected monetary reward should not be higher than interests of her patients.

### 2.2. Ethical Issues of HIV

**Situational task 1**

The confidentiality rule was violated. The physician was led by the veracity rule. In that situation the confidentiality rule should have prevailed. The physician should have kept secret the patient’s HIV-positive status and advised the patient not to share his/her ointments, drops and personal hygiene products with other patients.

**Situational task 2**

It is the veracity rule. However, this example is inconsistent, because physicians may bear responsibility under the confidentiality rule. Before deciding to disclose medical confidentiality to the family, it is necessary to clearly weigh the pros and cons: the patient’s condition, his attitude, legal capacity, etc.

**Situational task 3**

The physician should talk with the patient to identify his contacts. The patient must be reminded of legal liability for HIV infection of the partner: punishment for
another person at risk of contracting HIV, as well as for actually contracting it. If there is any reason to believe that the patient will not inform his partner about his HIV-positive status and will practice unprotected sex, then the physician can inform the patient’s partner about this. If there are no such grounds, it is not necessary, since the patient himself takes responsibility for his actions.

2.3. Bioethical Aspects of Death

*Situational task 1*

In his statement, the American bioethicist D. Callahan contrasts utilitarian (material) values with ethical ones. The author is wrong when stating that health care, which puts a limit on a person’s life, is “adequate” for reasons of cost savings. Such “adequate” healthcare is contrary to the traditions and principles of bioethics. But it should be noted that D. Callahan raised a serious problem – the problem of equitable distribution of medical resources. Proponents of euthanasia, for example, indicate inappropriateness of spending money on hopeless patients. But there is a danger of a “slippery slope”: an imperceptible transition in the practice of euthanasia from patients of the advanced age to patients with other indications.

*Situational task 2*

This practice is morally based on mercy due to the clarity and accuracy of the fatal diagnosis.

*Situational task 3*

The action is of the psychological, moral and legal nature. It is psychological because there is a lack of the nurse’s attention to her actions. It is moral because there is a decrease in the nurse’s moral responsibility for her actions. It is legal because there is the nurse’s guilt manifested as negligence.
2.4. Bioethical Issues of Euthanasia

*Situational task 1*

Yes, it was. This type of euthanasia is assisted suicide. The physician acted as a consultant (assistant) who prompted or prescribed the drug and the administration route.

*Situational task 2*

No, this is a murder. The conditions for euthanasia are: the patient’s request (if possible, in writing); hopelessness of the condition; compassion as a person’s motive for conducting euthanasia; euthanasia should be conducted by a medical worker. All these conditions were absent in the man’s actions.

*Situational task 3*

Yes, this is active euthanasia. There is a persistent request of the patient, his suffering and hopelessness of the condition, a painless death, the motive of the mother’s actions is compassion, the young man’s mother is a physician. Criminal proceedings were instituted against the mother since euthanasia is prohibited in the country under review.

2.5. Bioethical Issues of Abortion

*Situational task 1*

The principle of “Do no harm” and the right to life have been violated.

*Situational task 2*

The physician was right when she refused to perform a criminal abortion since abortion must be carried out in a hospital or at any other suitable medical facility. However, it would have been better if she had spoken with the patient and tried to persuade her to do it in hospital conditions. As for the second question, the physician is obliged to give information to the inquiry bodies upon their written request.
Situational task 3

Medical. An incurable disease inherited by the embryo is a medical indication for abortion.

Section 3. SPECIAL ISSUES OF BIOETHICS

3.1. Bioethical Issues in Transplantology

Situational task 1

Harvesting of organs and tissues from a corpse is allowed if a ban has not been received from a person’s relatives by the time of harvesting or if it is expressed in a person’s lifetime will. There is nothing illegal in the actions of physicians in this part. However, purchase and sale of organs and tissues is prohibited and entails criminal liability. In this part, the actions of physicians are illegal.

Situational task 2

The actions of the forensic expert are legal since he performed autopsy on the basis of the investigator’s resolution.

Situational task 3

Harvesting of organs or tissues from the corpse is not allowed if at the time of removal the medical organization was informed that during life the person or his/her close relatives or legal representatives declared their disagreement with removal of organs or tissues for transplantation after death. Since there was no explicit prohibition in this case, a transplant is allowed.

3.2. Bioethical Issues in Genetics

Situational task 1

The patient (both a single woman and a married couple) is entitled to information about the fetal health status. But it is unlikely that an average couple (or a single woman) will ask the question about Huntington’s chorea. Since the disease can manifest itself in 40 or 50 years after birth, it is possible that during this time effective
means of treatment will be worked out. Therefore, it will be bioethically correct not to inform the parents of a possible disease.

Situational task 2
No. Paternity or maternity can have a legal nature, i.e. adoption, artificial insemination by non-parent gametes, etc. In this case, a genetic expertise refuted the claims of Aurora Drossart to the right to be a daughter of a famous French actor.

Situational task 3
No. Genetically modified potatoes remain potatoes. Any protein is nothing more than a set of amino acids in a certain sequence. Human protein is not identical to a human as a whole and as a person.

3.3. Bioethical Issues in Psychiatry

Situational task 1
The principle of confidentiality is affected. A court in the United States would have resolved this contradiction between a physician’s duty to keep medical secrets and the expected threat to Mary’s life, based on the use of a warning as a legal method of protecting the victim. In Russia, however, the law leaves the borders of confidentiality blurred, which deprives the society of an opportunity to violence prevention. It seems appropriate and moral following the letter of law. Failure to inform about the patient’s painful fantasies, about a crime mentally prepared by him cannot be recognized as complicity in the crime in view of the absence of a sign of joint action. However, this issue in Russia remains on the conscience of the physician.

Situational task 2
Yes, but it was legitimate because a patient’s hospitalization in a psychiatric hospital without his/her consent or consent of his legal representatives is allowed in cases of a direct threat to the patient himself or to others.
**Situational task 3**

Yes, she was right. The requirement of the deputy head physician was illegal, since it is possible to transmit information constituting a medical secret to others, including officials, only with the patient’s consent.

### 3.4. Bioethical Issues in Sexology

**Situational task 1**

The principle of “Do no harm” was violated, since the therapist insulted the patient. The principle of “Do good” was violated, because the therapist did harm to the patient. The principle of “Duty adherence” was violated, because the physician’s duty rejects such a behavior. The principle of respect for human rights and dignity was violated, since the therapist showed disrespect to the patient. The principle of respect for personal autonomy was violated, because the therapist rudely interfered in the patient’s private life. The equity principle was violated, because the therapist showed his prejudice to the patient. He was supposed to listen to the patient, to make a quick examination of his health condition, to ask for reasons to receive a referral to a sexologist and give this referral if it was really necessary. The therapist should not have shown any negative attitude towards the patient.

**Situational task 2**

No. A physician should not harass his/her patients since it is bioethically incorrect. Ethics in sexology states that relations between the physician and the patient should be of the non-violent nature. Such a behavior may lead to serious criminal prosecution.

**Situational task 3**

The ethical inconsistency was that at Freud’s time, a complete examination of the patient was required. A physician was confronted with shyness of patients and their fear that a complete examination was not medically justified, being only an expression of sexual interest on the part of the physician. In many respects, this tradition has not
been preserved today. Although propaedeutics prescribes the patient’s examination by systems, a narrow examination is often conducted, depending on the physician’s specialization or the patient’s complaints.

3.5. Bioethical Issues in Oncology

Situational task 1
The veracity rule was violated.

Situational task 2
The veracity rule requires that the physician should take a special approach to the patient when communicating topics that are especially acute for the patient.

Situational task 3
Yes, because the physician is obliged to communicate the diagnosis to the patient in a delicate form in case of a poor prognosis. In this case, there was no delicate form: the diagnosis was communicated without a personal meeting, by telephone and openly. An unfavorable diagnosis can be reported to the patient’s family members if the patient has not forbidden informing them, but the form itself was unacceptable.
KEYS TO THE TEST TASKS

Section 1. GENERAL ISSUES OF BIOETHICS

1.1. Bioethics as a Science

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1.2. Principles and Rules of Bioethics

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1.3. General Aspects of “Medical Worker – Patient” Relationships

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1.4. Philosphic Categories in Bioethics

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Section 2. BIOETHICS AND MEDICAL PRACTICE: COMMON ISSUES

2.1. Ethics Committees, Medical Trials and Research

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2.2. Ethical Issues of HIV

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2.3. Bioethical Aspects of Death

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2.4. Bioethical Issues of Euthanasia

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2.5. Bioethical Issues of Abortion

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Section 3. SPECIAL ISSUES OF BIOETHICS

3.1. Bioethical Issues in Transplantology

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3.2. Bioethical Issues in Genetics

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3.3. Bioethical Issues in Psychiatry

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<td>10 - 1</td>
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3.4. Bioethical Issues in Sexology

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<th>9 - 1, 3, 5</th>
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</thead>
<tbody>
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<tr>
<td>2</td>
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<td>4 - 1</td>
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<td>10 - 1</td>
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3.5. Bioethical Issues in Oncology

<table>
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<td>6–1</td>
<td>8–2, 3</td>
<td>10–1</td>
</tr>
</tbody>
</table>
RECOMMENDED LITERATURE

Main literature

Additional literature
Appendix

How to make a good presentation

Before you start making a presentation, please consider the following tips. They will help you prepare a substantial and effective presentation, regardless of an academic discipline.

1. The style remains the same during the whole presentation. Avoid styles that will distract the audience from the presentation itself.
2. Auxiliary information (control buttons) should not prevail over basic information (text, pictures, etc.).
3. It is recommended to use no more than three colors on one slide: one for the background, one for headings, one for the text. Use contrasting colors for the background and the text. Pay attention to the color of the hyperlinks.
4. You should not use animation effects too much. They should not distract the audience from the content of the information on the slide.
5. Conciseness and brevity of the presentation is achieved with short abstracts, dates, names, and terms. Do not overload the slide with textual information. Do not use solid text blocks.
6. Each slide should have a title. Headlines should attract the attention of the audience.
7. If there is a drawing on the slide, the inscription should be placed under it.
8. Fonts: for headers – 40 and more, for basic information – 24 and more.
   The text should be clearly visible. Use one of the following fonts: Arial, Verdana, Tahoma, Comic Sans MS. You cannot mix different types of fonts in the same presentation.
9. Bold, italicized or underlined words should be used to highlight the information on the slide.
10. The presentation volume should not be less than 8–10 slides.
11. The presentation structure is recommended to be the following:
    the 1st slide: title page – subject, author, logo;
the 2nd slide: contents;
subsequent slides – information related to the topic;
the penultimate slide: general conclusions;
the last slide – a list of references and the sources used.

12. To ensure clarity, you can use illustrations, tables, charts, etc. Distortion of illustration proportions is unacceptable.

When you give a presentation, remember that you speak to the audience. The presenter should make his / her information interesting and useful for the audience.

After you have prepared a presentation, it is recommended that you reviewed the tips again to make sure that you have made a good use of all of them.
Zavialov Andrei Vladimirovich
Antipina Olga Vladimirovna

BIOETHICS

Study guide