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Чекаліна Наталія Ігорівна
Петров Євген Євгенович

**МЕДИЧНА ЕТИКА І ДЕОНТОЛОГІЯ
В МЕДИЧНІЙ ПРАКТИЦІ**

*Навчальний посібник
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МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
ДЕРЖАВНА УСТАНОВА «ЦЕНТРАЛЬНИЙ МЕТОДИЧНИЙ
КАБІНЕТ З ВИЩОЇ ОСВІТИ МОЗ УКРАЇНИ»
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«УКРАЇНСЬКА МЕДИЧНА СТОМАТОЛОГІЧНА АКАДЕМІЯ»

**Н.І. Чекаліна, Є.Є. Петров**

# МЕДИЧНА ЕТИКА І ДЕОНТОЛОГІЯ У КЛІНІЧНІЙ ПРАКТИЦІ

*Навчальний посібник*

**Poltava – 2015**

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Рекомендовано Державною установою «Центральним методичним кабінетом з вищої медичної освіти МОЗ України» (лист від 24.12.2014 № 23-01-9/276) як навчальний посібник для студентів, лікарів-інтернів, курсантів, практикуючих лікарів.

**Рецензенти:**
Д.мед.н., професор **Свинцицький Анатолій Станіславович**, заваідувач кафедри внутрішньої медицини № 3 Національного медичного університету ім. М.О. Богомольця, м. Київ.

Д.мед.н., професор **Волошин Олександр Іванович,** професор кафедри пропедевтики внутрішніх хвороб Буковинського державного медичного університету.

**Чекаліна Н.И., Петров Є.Є.**
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У навчальному посібнику наведені основні морально-етичні принципи професійної діяльності лікаря. Розглянуті моделі стосунків між лікарем та хворим, питання морального вибору, правової відповідальності лікаря. Велику увагу приділено правилам проведення медичних досліджень, біоетиці.

Навчальний посібник призначений для самостійної підготовки до практичних занять, перш за все, студентів, які навчаються англійською мовою, проте може бути корисним магістрам, аспірантам, лікарям-інтернам, курсантам, практикуючим лікарям, викладачам.

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HIGHER STATE EDUCATIONAL ESTABLISHMENT OF UKRAINE
„UKRAINIAN MEDICAL STOMATOLOGICAL ACADEMY"

**N. Chekalina, Ye. Petrov**

# MEDICAL ETHICS AND DEONTOLOGY IN CLINICAL PRACTICE

*The textbook for students*

**Poltava – 2015**

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Recommend by Public institution "Central Methodological Office for Higher Medical Education of Ministry of Health of Ukraine" (letter from 24.12.2014, No 23-01-9/276) as a textbook for students, intern-doctors, trainees, medical practitioners.

**Review:**
Doctor of Science (Medicine), professor **Svintsytsky A.S.**, Head of the Internal Medicine Department No 3 of National Medical University named after O.O. Bogomolets, Kiyv.

Doctor of Science (Medicine), professor **Voloshin O.S.,** professor of the Propaedeutics to Internal Diseases Department of Bukovinian State Medical University.

**Chekalina N., Petrov Ye.**
Medical ethics and deontology in clinical practice [Text]: textbook for students / N.Chekalina, Ye. Petrov; HSSEU "UMSA". – Poltava. – 2015. – 152 p.

The textbook for students contains information about moral and ethical postulates in the relationship of the doctor and the patient, the solution of complex problems associated with moral choice, with respect of the patient's rights, ethics in relationships in the medical team. A large section is devoted to medical errors, rules of clinical trials, issues of bioethics.

The textbook for students is recommended for students who are learning English, but can also be useful to masters, residents, intern-doctors, trainees, medical practitioners and teachers.

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## PREFACE

Formation of moral and ethical and psychological postulates in the relationship of the doctor and the patient, the solution of complex problems associated with moral choice, with respect of the patient's rights, ethics in relationships in the medical team – these and many other questions of the day is an urgent problem, especially in conditions of the development of scientific and technical progress, when the patient's personality, his inner world becomes especially important in the medical process.

Formation outlook of young doctors on the principles of humanity and bring such important qualities as compassion, kindness, responsibility is essential in the learning process.

The introduction of new medical technologies such as assisted reproduction, gene therapy, and life support, leads to the faced of the doctors with new choices and dilemmas.

There are questions, tests of different difficulty levels, situational tasks in all subjects in the manual. A large section is devoted to medical errors, the main issue of medical law that allows young people to focus on the necessity of deep responsibility of the doctor at all stages of the medical process. The main attention paid to rules of clinical trials, the issues of bioethics, the characteristics of medical ethics and deontology.

The textbook for students is designed primarily for students who are learning English, but can also be useful to masters, residents, graduate students, intern-doctors, trainees, medical practitioners and teachers.

Associate professor N.Chekalina
Associate professor Ye. Petrov

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**TOPIC 1. Medical ethics and deontology: their definition, status and legal maintenance in a modern society.**

**Medical Deontology -** is professional ethics of medical workers and principles of behavior of medical personnel, directed toward maximum benefit of treatment.

Medical deontology includes problems of observing medical ***confidentiality***, the problem of ***the extent of the medical worker's responsibility*** for the ***life and health of the patient***, and problems of ***relationships of medical workers to each other***. In accordance with medical deontology, in relation to the patient, the medical worker must evince maximum attention and apply all his knowledge in order to restore the patient to health or bring relief to him in his sufferings; he must convey to the patient only information about his health that will be ***beneficial*** to him and ***establish contact between the patient and the physician***. He must avoid in the presence of the patient conversations and discussions with colleagues, personnel, and with the patient himself concerning his illness, which sometimes produce the development of ***iatrogenic diseases***.

**Medical ethics** (Latin ethica, from Greek ethice – *teaching of morals*), or **medical deontology** (Greek deon – '*duty' or 'obligation'*)

The term 'DEONTOLOGY' has been in wide use in the medical literature over past years) is ***a set of ethical standards and principles of behaviour of medical workers while executing their professional duties.***

According to modern conceptions, medical ethics include the following aspects:

*Scientific* - the section of medical science studying ethical and moral aspects of medical workers' activity;

*Practical* – the area of medical practice the tasks of which

are the formation and application of ethical standards and rules of the professional medical activities.

The medical ethics studies and defines the solution of various problems of inter-personal mutual relations in three basic directions:

- *medical worker – patient,*
- *medical worker – relatives of the patient,*
- *medical worker – medical worker.*

Such qualities as **compassion**, **kindness**, **keenness** and **responsiveness**, **care and attentive attitude to the patient** should be inherent in any worker of medical sphere.

It was Ibn Sina who had already demanded a special approach to the patient: "*You should know that every separate person possesses the special nature inherent in him personally. It seldom happens, or it is absolutely impossible, that somebody would have the nature identical with his*". The great importance has also a word, which means not only a culture of speech, but also the tact, skill to cheer the patient up and not to harm him with a careless statement.

A special importance in the medical profession have such universal human norms of intercourse as ability to respect and listen attentively to the interlocutor, to show interest in the contents of the conversation and opinion of the patient, as well as the correct and accessible construction of speech.

No less importance has the tidy external look of the medical personnel: ***clean dressing gown and cap, accurate replaceable footwear, well-groomed hands with shortly cut nails***, etc. In the ancient Indian medicine physician used to tell to his disciples: "*You now leave your passions, anger, greed, madness, vanity, pride, envy, roughness, buffoonery, falsity, laziness and any vicious behavior. From now on, you will have your hair and your nails shortly cut, wear red clothes, conduct a pure life*". It is necessary to remember always, that to the physician it is inadmissible to use perfumery and cosmetic means without any measure. Strong and pungent smells can cause undesirable reactions: from nervous irritation of the patient and various displays of allergy up to a sharp attack of bronchial asthma.



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PRIMUM NON NOCERE (Latin) - FIRST, DO NO HARM – this maxim is the main ethical principle in medicine.

The moral responsibility of medical worker means his observance to all the principles of medical ethics. Wrong diagnostics, treatment, behaviour of doctor and representatives of middle-ranking and junior medical personnel may lead to physical and moral sufferings of patients. Such actions of medical worker, as disclosure of medical secret, refusal to give medical aid, infringement of personal life's inviolability and so forth are inadmissible.

The care of patients assumes, among other, the need to observe to certain rules of the intercourse with him. It is important to give the patient the maximum of attention, to calm him, to explain the necessity to observe the regimen and to take medicines regularly, as well as to convince him of a possibility of recovering or improvement of his condition. It is necessary to observe greater caution during conversations with patients, especially those suffering from oncological diseases, who should not be informed of the true diagnosis. These days, the statement of the great physician of the antiquity, the father of medicine Hippocrates, "Surround the sick man with love and reasonable consolation, but, the main thing, leave him in ignorance of what threatens him", still has not lost its importance. Yet, in some countries they do inform patients of the seriousness of their including of a probable lethal outcome (Latin letalis - lethal), in this proceeding from social and economic reasons. Thus, in the USA the patient even has the right to bring a suit against the doctor who had hidden from him the diagnosis of a cancer tumour.

**Iatrogenic diseases**

Infringement of deontological principles of the intercourse with patients may lead to the development in them of the so-called iatrogenic diseases (Greek - iatros – 'physician', genes – 'generated', 'arising'). An iatrogenic disease (iatrogeny) is the pathological state of patient caused by careless statements or acts of physician or another medical worker which create in patient the idea that some disease is present in his organism or of its special

graveness. Inadequate, hurting verbal contacts, harmful for patient, may lead to various psychogenic iatrogenies.

Yet, as early as 300 years ago, “the English Hippocrates” **Thomas Sydenham** (1624-1689) emphasized the danger to the patient of not only the actions of medical worker that injure his mentality, but also other probable factors, including undesirable consequences of medical manipulations. Therefore, at present iatrogenic diseases are called those diseases the development of which is connected with those or other actions of medical workers. So, along with the above-described psychogenic iatrogeny (iatropsychogeny), we may name:

• *iatropharmacogeny*: consequence of medicaments’ influence on patient - for example, collateral actions of preparations;

• *manipulation-caused iatrogenies*: adverse influence on patient during his examination - for example, complications at carrying out of coronaroangiography;

• *combined iatrogenies*: consequence of the influence of several factors;

• *so-called mute iatrogenies* – consequence of medical worker’s negligence.

**Medical secret**

Among deontological questions related to the care of patients it is possible to name the necessity to preserve medical secret. Medical workers have no right to disclose any data concerning patient that have deeply personal character. However, this requirement does not concern to the situations representing danger to other people: venereal and infectious diseases, infecting with human immunodeficiency virus (HIV), poisonings, etc. In these cases medical workers are obliged to inform the respective organizations about the received data immediately. With the purpose of carrying out sanitary-and-epidemiologic actions in the centre of infectious diseases’ occurrence, food poisoning or pediculosis, nurse is obliged to inform, within 12 hours from the moment of determining the diagnosis, the respective sanitary-and-epidemiologic station by phone and simultaneously to direct there the filled form of the emergency notification (the form No. 058/y).



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solve a diagnosis problem.

10. Humanistic principles of treatment demand resolute rejection of a method euthanasia as a way of deprivation of the person from sufferings, it is necessary to show mercy, sympathy, decency, to give the appropriate help, actively to struggle for life of the patient to approach of its biological death. The staff nurse has broken legal, moral, ethical standards.

11. The staff nurse should return trust of the patient is an important and specific medical means and to convince of a favorable consequence of illness.

12. The staff nurse has broken ethical, rules of law. Its responsibility is too before the law.



**Mistakes and medical offences**

Observance by medical worker of morally-ethical standards means not only the execution of his duties, but also the responsibility for the evasion from, or nonprofessional execution of his duties. In medical worker's activity both mistakes and medical offences may occur.

Mistakes in medical practice may be caused by delusions. Medical offences are caused by undue approach towards professional duties. One such offence is, for example, wrong introduction of medical preparations, especially strong ones, which may lead to tragic consequences.

Depending on a degree of weight of offences committed, medical worker is exposed to official penalties (reprimand, strict reprimand, transfer to less paid work, etc.) or is made answerable according to the existing legislation. Thus, the care of patients assumes the legal responsibility of medical workers, along with strict execution of the professional duties by them and observance of principles of medical deontology.

Belief systems are organized patterns of thought regarding the origin, purpose, and place of humans in the universe. These systems seek to explain the mysteries of life and death, good and evil, health and illness. Typically, belief systems include an ethical code of conduct about how people should relate to the world and its inhabitants.

Religions are patterns of thought and action that typically include belief systems, devotional rituals, organizational structures, and faith in a mystical power. Often, however, people develop their own belief systems, independent of organized religions.

**Ethical Principles**

Ethical principles are fundamental concepts by which people judge behavior. These principles help individuals make decisions and serve as criteria against which people gauge the rightness or wrongness of behavior. Laws are rules made by an authority with the power to enforce them. Although laws flow from ethical principles, they are limited to specific situations and codified by

detailed language. Ethical principles, on the other hand, are guiding ideals of conduct that speak to the spirit of a law rather than its letter.

Throughout recorded history, leaders of world religions have taught an overarching ethical principle commonly called the Golden Rule: "Do unto others as you would they do unto you." Some philosophers emphasize certain principles over others. For example, Kant held that duty was the central issue; Mills, the interest of all; Fletcher, love; Thiroux, human dignity; Gilligan, care and justice; and Nodding, care (Thiroux, 2003). A single, global principle for exemplary behavior is an attractive approach, but when people face real-life situations, they seek more precise guidance.

Over the years, five ethical principles have emerged as especially applicable to healthcare providers. They are: respect for human life and dignity, beneficence, autonomy, honesty, and justice. The Code of Ethics of the American Physical Therapy Association, described below, applies all five principles to practice.

## RESPECT FOR HUMAN LIFE AND DIGNITY

Respect for human life and dignity is one of the most basic of ethical principles. It requires that "individuals be treated as unique and equal to every other individual and that special justification is required for interference with an individual's own purposes, privacy, and behavior" (Rawls, 1971). This ethical principle elevates respect for the life, freedom, and privacy of all humans. Thiroux says this principle is necessary for any moral system because "there can be no human being, moral or immoral, if there is no human life" (1990). When applied to practice, respect for human life and dignity means that physical therapists:

Recognize and respect individual and cultural differences. Honor the lifestyle, personhood, and beliefs of clients. Demonstrate concern for the physical, psychological, and socioeconomic well-being of clients. Refrain from abuse, harassment, or discrimination of others. Strive to sustain human life and dignity while relieving suffering and promoting maximum physical and emotional well-being.



13. To the believing sick grandmother who was in hospital, it has been refused request to invite the priest. The grandmother has died without carrying out of necessary religious practices.

Whether possible responsibility, whom and which?

*Standards of the right answers:*

1. The doctor, the staff nurse has arrived incorrectly. Several minutes for granting of medical aid in case of a serious trauma, incompatible with life could not suffice. Behind all to these there is a sincere callousness, indifference to a human grief.

2. The doctor has arrived professionally- Imperfectly, negligently. After all, on expression of the known clinical physician of B.Votchal, “weak soul the doctor - the most dangerous as it will always find thousand possibilities if only nothing to make curative for the patient”.

3. The staff nurse has broken deontological norms of the activity which has led forgotten by it of an aphorism “noli nocere”.

4. The doctor not only has opened mothers of the sick child the fears, but also has without the slightest grounds presented the colleague as the nonprofessional doctor.

5. The doctor has broken collective nature.

6. The staff nurse should show tactfulness to the sick person, calm and cause the doctor on duty.

7. The medical worker should adhere to ethical standards: to explain to the patient inexpediency of the fears, to calm and change a bed of stay of the patient.

8. The sick had a serious illness of a liver because of abusing spirits, beer. The medical worker should explain tactfully to the patient about the reason of occurrence of its disease, the forecast, harm of abusing spirits, to lead sanitary-educational discussion and other.

9. Tactics of the doctor not the true. For morphological verification of the diagnosis it is necessary to take a peripheral lymph node on inspection not to worsen a condition of the patient бронхоскопией with transbronchial biopsy. It is undesirable to the patient to carry heavy investigations if one inspection can

8. At performance of the procedures intended by the doctor in-home to the patient with a liver serious illness, the staff nurse has paid attention to abandonment of a premise, dirty ware on a table and a dejectedness of the patient. During washing of hands in a toilet has seen many bottles from under spirits and beer.

Of what it is necessary to think? What should be tactics of the medical worker?

9. In the patient "To" it is diagnosed megacarcyoblastoma. At inspection the increase in intrachest peripheral lymph nodes is marked. For morphological verification of the diagnosis took on biopsy all lymph nodes.

Whether correct tactics of the doctor?

10. The patient "In", 85 years, knowing that she cancer patient (a cancer to a stomach IV the item), some times asked the staff nurse to enter to it a double dose of narcotic substance to stop its suffering. The staff nurse, seeing suffering of the patient, the patient died has entered to it a double dose of morphine, from what.

Whether the patient "In" voluntary had the right to go from life?

State a legal estimation to actions of the staff nurse.

11. At inspection of the patient the staff nurse has carelessly expressed that illness of the patient incurable that has appeared incorrect. The patient has felt physical and mental anguish.

What it is necessary to make to the patient to obtain compensation for moral harm?

12. The staff nurse has informed the wife of the patient, under its request that her husband cancer patient. The husband when the woman has informed it to it has committed suicide. At opening the cancer is not diagnosed. What rights of the patient were broken by the staff nurse and in what there will be its responsibility?



BENEFICENCE

Beneficence means doing good to benefit others. Although some writers separate beneficence (doing good) from nonmalfeasance (not doing harm), Franken (1973) suggested the ethical principle of beneficence is a continuum, from a neutral not harming to a positive doing good—that is, from not inflicting harm to preventing harm and promoting good. At a minimum, beneficence means maintaining professional competence. However, it also means acting in ways that demonstrate care and nurturance. When applied to practice, beneficence means that physical therapists:

- Attend to the needs of clients, thoughtfully assessing mobility level.
- Provide timely, appropriate interventions to advance the treat plan.
- Accurately evaluate the effectiveness of an intervention.
- Communicate important observations to other members of healthcare team.
- Achieve and maintain professional competence.

AUTONOMY

Autonomy is the right of self-determination, independence, and freedom. It is the personal right of individuals to absorb information, comprehend it, make a choice, and carry out that choice. Physical therapists carry out the principle of autonomy by providing accurate, scientific information to clients, assisting them to understand the information and make decisions based on it. When applied to practice, autonomy means that physical therapists:

- Inform clients about available options regarding their treatment.
- Make sure clients fully understand the actions and risks of treatment options.
- Respect and accept decisions clients make about their own care or the care of another person for whom they are legally

responsible.

- Implement and evaluate interventions chosen by clients.
- Respect and hold in confidence personal information of clients, divulging it only when they or their legal guardian give permission.

HONESTY (TRUTHFULNESS, FIDELITY)

Honesty means truthfulness in word and deed. Even when conveying unwelcome information to clients about their illness or treatment options, a physical therapist does so truthfully and with compassion, only withholding information from clients when they are minor children or adults with legal guardians. Dishonesty and deceit are especially grievous when they involve theft of pain-relieving drugs or devices. Honesty means absolute truthfulness regarding professional credentials and financial matters, never charging for unearned services or accepting commissions, discounts, or gratuities for covert gain. It means obeying both the spirit and the letter of the law. When applied to practice, honesty means that physical therapists:

- Provide factual, scientifically based, and relevant information to clients about their care, including its benefits and risks.
- Accurately report and record critical data, regardless of personal consequences.
- Place the welfare of clients above personal or professional gain.
- Charge reasonable fees, and then only for services actually performed.
- Keep promises and abide by contracts.
- Represent professional credentials and achievements truthfully.

JUSTICE

Justice implies fairness and equality. It requires impartial treatment of clients. Like other ethical principles, justice is based on respect for human life and dignity. The historic image of justice



injection places has arisen a necrosis fabric which has led to necessity of amputation IV a finger of the left brush.

What norms were broken by the staff nurse?

4. The professor the pediatrist has appointed to the child with the heavy form of illness of Littlja of an injection of aminazine. Parents of the child lived in suburb, therefore appointment it was necessary to direct to local polyclinic. The doctor of polyclinic, having read the recipe, has advised not to apply intended by the professor a medicine as they destroy kidneys and, carrying out appointment of the professor, it will lose the child. Mother with fear has told about it to the professor and has addressed again to it for council.

What has the practicing doctor of mother opened?

5. In families of doctors known to all city the 30-year-old daughter, too the doctor tragically was lost. Parents have applied “to the main thing” to the doctor to help at least with transport, on what he has answered that is not the head of funeral bureau and times of enrolment of citizens have ended, they have broken its state affairs.

What principles were broken by the head physician?

6. At 21.30 the patient who has arrived in the afternoon, has addressed to the staff nurse with the request of date to it soothing mixture and soporific as he cannot fall asleep from a belly-ache. At mixture acceptance its hand strongly shivered, and when gave a glass, the sister has felt that its palm was damp. In the history of illness the doctor did not appoint soporific. The patient has been raised and demanded a medicine and "soothing" again.

What should be tactics of the medical worker in this case?

7. Emotionally unbalanced and impressionable patient the neighbor in chamber has declared that on its bed the young woman who has died of a cancer. The patient cried and demanded to change their mattress, a blanket and a pillow as was afraid to "catch" a cancer.

What tactics of the medical worker in this case?

disorganization of a mental and spiritual condition of the patient.

3. The rights of morals, moral behavior of the person in a society.

4. Aristotle.

5. A science and practice of morally-ethical duties of the physician.

6. Moral and psychological bases of mutual trust of the doctor to the patient and on the contrary.

7. Keenness, consistency, patience, politeness, affability, honesty, tenderness, caress, sympathy and self-respect.

8. Professional erudition, observation, ability to logic judgment of diagnostic and medical manipulations.

9. Modesty, simplicity, neatness, ability to create celebratory conditions in medical institution.

10. Principles of value and norms of behavior which people adhere.

***Tasks for self-checking:***

1. In the car near hospital there were two children and the woman after accident. The doctor has not approached to the car, has not examined, and has suggested to approach on acceptance branch, but the staff nurse on duty has refused flatly them to accept without a direction from polyclinic.

To what the case in point testifies? How you estimate actions of the doctor and the staff nurse? What behind it costs?

2. To sick "M" of 10 years, it is urgently necessary to transfuse blood. His parents on religious sights have refused flatly. The doctor has not explained to parents that threatens their child. Qualify actions of the doctor.

3. The staff nurse of polyclinic branch (the work experience on a speciality of 18 years), assisting the surgeon at out-patient operation concerning a good-quality tumor of a finger of the left brush, has shown rough negligence - it has not checked up structure of a contained bottle and has filled a syringe for anesthesia by ethyl spirit instead of новокаина. As a result in



is a blindfolded woman with a scale, weighing an issue on the basis of objective evidence and judicial precepts. Justice means that scarce resources will be distributed equally, using the same criteria for everyone. When applied to practice, justice means that physical therapists:

- Assess needs for physical therapy and interventions with equal diligence.
- Attend to the needs of clients, without prejudice according to their personality, disability, race, religion, gender, age, or lifestyle.
- Evaluate and communicate information about treatment plans without bias.
- Deal fairly and equally with professional supervisors, colleagues, and subordinates.

ETHICAL DILEMMAS

A dilemma is a perplexing problem that requires a choice between conflicting alternatives. An ethical dilemma is a moral problem that requires a choice between two or more opposite actions, each of which is based on an ethical principle. For example, a physical therapist may need to decide whether to honor the ethical principle of honesty and disclose the unlikely value of a treatment to cure an illness or to honor the principle of beneficence and withhold the information in order to give the client hope.

Resolution of ethical dilemmas requires careful evaluation of all the facts of a case, including applicable laws, consultation with all concerned parties, and appraisal of the decision-makers' ethical stance (honoring end results or obeying fixed laws).

Nowadays, ethical dilemmas in healthcare facilities arise more frequently because modern medicine can keep hearts and lungs functioning much longer than thinking brains. To help resolve these perplexing issues, many institutions appoint ethics committees made up of healthcare professionals, ethicists, lawyers, and clergy. The task of ethics committees is to help decision-makers resolve ethical dilemmas. Often these committees use an ethical decision-making process such as the following:

- Gather relevant facts about the client's age, diagnosis, advanced health care directive, and applicable laws.
- Identify and clearly state proposed actions together with the ethical principles represented by each proposed action.
- Determine who can make the decision and assist the person or persons to make it.
- Provide emotional support for everyone involved in resolving the dilemma.

To reduce the number and complexity of ethical dilemmas, and in support of the ethical principle of autonomy, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that all adults discuss their wishes regarding extraordinary treatment measures with their families, sign a legal document called an advance healthcare directive, and appoint someone to make healthcare decisions in their stead if they should become incapacitated (JCAHO, 2009).

**Codes and Standards of Ethical Conduct**

Codes of ethics are formal statements setting forth standards of ethical behavior for members of a group. In fact, one of the hallmarks of a profession is that its members subscribe to a code of ethics. Every member of a profession is expected to read, understand, and abide by the ethical standards of its occupation.

In order to make explicit the values and standards of professional physical therapists and their assistants, the American Physical Therapy Association publishes a Code of Ethics, Guide for Professional Conduct of Physical Therapists, Guide for Conduct of Physical Therapist Assistants, and Standards of Ethical Conduct for the Physical Therapist Assistant. These documents are regularly revised and updated, with the latest codes and standards effective July 2010.

**CODE OF ETHICS FOR PHYSICAL THERAPISTS**

The Code of Ethics for the Physical Therapist delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association. The purposes of this Code of Ethics are to:



9. This case is a vivid example jatrogenie and underlines, what important word of the medical worker with which it is necessary to be careful.

**To topic 8**

1. Consecutive dialogue with the patient consists in:
   1. Observance of principles of deontology;
   2. Observance of principles of ethics;
   3. Observance of a medical aesthetics.

2. Medical ethics are based first of all on:
   1. Intelligence;
   2. Spirituality;
   3. Justice;
   4. Humanism;
   5. Mercy;
   6. Self-sacrifice;
   7. Sympathy.

3.
   1. To medical ethics carry...
   2. Illness includes...
   3. Ethics are...
   4. Concept of ethics has introduced...
   5. To medical deontology carry...
   6. The trust to the patient is based on...
   7. To moral lines belong...
   8. Intellectual lines are...
   9. Aesthetic lines include...
   10. The morals consist in...

*Standards of the right answers:* 1(2; 1; 3); 2(2; 1; 4; 3; 5; 7; 6)

**3:**

1. A science and practice of application of principles of morals in professional work of medical workers.

2. A complex of functional, metabolic and morphological infringements in activity of different bodies and systems and

on the professor that owing to your treatment at me has developed vesicular breath".

What has developed in the patient?

What error was admitted by the doctor?

9. The sick staff nurse on a specialty against heavy neurotic infringements had severe pains in a stomach site. Behind a direction of the doctor has been directed to a hospital. The next doctor has spent laparatomy. At audit of belly emptiness except sterile it is revealed nothing. After operation the staff nurse has taken an interest at the doctor that at it have shown. In the answer has heard: "There was something". The sick had severe pains in a stomach, has arisen hysterical парез the right extremity. Owing to there was a necessity of treatment long time in clinic of functional infringements of nervous system.

To what this case testifies and what he underlines?

*Standards of the right answers:*

1. The Doctor-surgeon has broken ethical, behavior moral standards in dialogue with the patient. It has no imagination about hospital art, neither about деонтологии, nor about humanity.

2. The doctor had no right to hand out a direction of the patient with the diagnosis "sharp leucosis". It has led "jatrogenie" what has arisen because of the doctor and is traumatization mentalities of the sick person.

3. Brigade actions not lawful, the patient was not in due time given medical aid, is mentioned ethically-deontological principles.

4. Actions of medical workers lawful, they should not give out medical secret.

5. The doctor has ignored elementary principles of humanism, showing that callousness of the soul and callousness.

6. Actions managing branch the wrongful. The mentioned ethical standards.

7. The revealed professional illiteracy of the doctor, mentioned deontological principles.

8. At the patient has developed jatrogenie owing to the use not clear to it of the medicines, which steels the reason of experiences and even the conflict to the doctor.



Define the ethical principles that form the foundation of physical therapist practice in patient management, consultation, education, research, and administration.

Provide standards of behavior and performance that form the basis of professional accountability to the public.

Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.

Educate physical therapists, students, and other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.

Establish the standards by which the American Physical Therapy Association can determine if physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

**Principles**

- Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)
- Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
- Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.
- Physical therapists shall be trustworthy and compassionate in addressing the rights and need of patients. (Core Values: Altruism, Compassion, Professional Duty)
- Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients over the interests of the physical therapist.
- Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural difference of patients.
- Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.
- Physical therapists shall collaborate with patients to empower them in decisions about their health care.
- Physical therapists shall protect confidential patient information and may disclose confidential information to appropriate authorities only when allowed or as required by law.
- Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)
- Physical therapists shall demonstrate independent and objective professional judgment in the patient's best interest in all practice settings.
- Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner



4. The person "In" has declared to the acquaintance “E” a meeting in female consultation of its 15-elderly daughter. The acquaintance “E” suspects the daughter in circulation to the gynecologist concerning abrasion. In female consultation to it it has been refused the information, referring to hospital secret.

Qualify actions of medical workers.

5. The known Petersburg doctor Spasky has just come back from the wounded A.S.Pushkin, has been caused to seriously ill. The patient asked the doctor to tell, whether it can cure it. On what the doctor has answered: “That here such. All of us we will die, the father! Here and Pushkin dies. You hear?! And we can die!” The patient with groan has leant back on a pillow and Pushkin has died this very day, as.

Than has ignored best of doctors in due time?

6. In children's hospital “the link sided share pneumonia” has arrived the 6-year-old child of "M" with the diagnosis. In hospital with it the father has decided to be. Managing branch has forbidden the father to look after the child having told that can resolve only mothers of the child.

Lawful actions managing branch?

7. To the 13-year-old teenager who has arrived in hospital from pioneer camp with suspicion on an acute appendicitis, medical aid as he was not agree operative treatment has been postponed. The reference to parents on the consent to operative treatment has been directed. Only at revealing of signs of peritonitis operative intervention has been spent, without having waited the answer of parents. The child died.

What error was admitted by the doctor?

8. The intern on detour has reported that at receipt in hospital at the patient was listened crepitating, and at present inspections - vesicular breath. The patient have decided to write out from a hospital, on what he has specified: “As it is possible to write out today me if the day before yesterday you have reported

3. ☐ - false
4. ☑ - true
5. ☑ - true
6. ☐ - false

***III.*** **1 - A; 2 - C; 3 - B; 4 - C; 5 – A; 6 - A.**

***IV.***

| | |
|---|---|
| A | 2 |
| B | 1 |
| C | 3 |
| D | 5 |

**To topic 7**

***Tasks for self-checking:***

1. The surgeon has examined the patient who was in a grave condition in connection with gangrene of a lung with pus break in pleural emptiness and occurrence empiema of pleurae on what has loudly informed: “Here it is too bad”. All present have been excited. The surgeon has been surprised: “That I here such have told? Actually a condition of the patient is hopeless”.

What principles were broken by the doctor-surgeon?

2. The local doctor has received results of analyses, has written a direction to hospital where has specified: “sharp leucosis” also has given on hands of the patient. At the sick psychopathic reaction has developed, in a grave condition it delivered in clinic. What error was admitted by the doctor?

What are traumatization mentalities?

3. The citizen “E” suffered 27 years bilateral share pneumonia. That it did not have an insurance medical policy (was on a visit at parents), the doctor caused to it from station of first aid and the local doctor have refused hospitalization which became a cause of death “E”.

Whether lawful actions of a brigade?



experience, and patient values.

- Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
- Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
- Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.
- Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, and other health care providers, employers, payers, and the public. (Core Value: Integrity)
- Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
- Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (patients, students, supervisees, research participants, or employees).
- Physical therapists shall discourage misconduct by healthcare professionals and report illegal or unethical acts to the relevant authority when appropriate.
- Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.
- Physical therapists shall not engage in any sexual relationship with any of their patients, supervisees, or students.
- Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.
- Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)
- Physical therapists shall comply with applicable local, state, and federal laws and regulations.
- Physical therapists shall have primary responsibility for supervision of physical therapy assistants and support personnel.

- Physical therapists involved in research shall abide by accepted standards governing protection of research participants.
- Physical therapists shall encourage colleagues with physical, psychological, or substance related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
- Physical therapists who have knowledge that colleagues are unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.
- Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.
- Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)
- Physical therapists shall achieve and maintain professional competence.
- Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, healthcare delivery, and technology.
- Physical therapists shall evaluate the strength of evidence and applicability of content presented during the professional development activities before integrating the content or technique into practice.
- Physical therapists shall cultivate practice environments that support professional development, life-long learning, and excellence.
- Physical therapists shall promote organizational behavior and business practices that benefit patients and society. (Core Values: Integrity, Accountability)
- Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
- Physical therapists shall seek remuneration as is deserved



C. Fragmentation, Ligation, Screening, Selection
D. Ligation, Screening, Selection

*IV. Match the term with the right definition.*

| | |
|---|---|
| **A. Medical ethics** | 1. the normative ethical position that judges the morality of an action based on the action's adherence to a rule or rules. |
| **B. Deontological ethics** or **deontology** | 2. system of moral principles that apply values and judgments to the practice of medicine |
| **C. Bioethics** | 3. subsection of ethics, actually a part of applied ethics that uses ethical principles and decision making to solve actual or anticipated dilemmas in medicine and biology; |
| **D. Cloning** | 4. the direct human manipulation of an organism's genome using modern DNA technology |
| **E. Genetic engineering** | 5. process of producing similar populations of genetically identical individuals that occurs in nature when organisms such as bacteria, insects or plants reproduce asexually. |

*Standards of the right answers:*

***I.*** 1. Bioethics.
2. Cloning.
3. Experimental medicine (biomedical research).
4. Gene therapy.
5. The Nuremberg Code.
6. Organism cloning.

***II***. 1. ☑ - true
2. ☐ - false

from solely including humans to including the non-human world.
5. ☐ Cloning is the process of producing similar populations of genetically identical individuals that occurs in nature when organisms such as bacteria, insects or plants reproduce asexually.
6. ☐ The first organisms genetically engineered were bacteria in 1873 and then mice in 1984.

*III. Choose one right answer to the question.*

**1. The term Bioethics which from Greek means "bios" life and "ethos" behavior was coined:**
A. in 1927 by Fritz Jahr
B. in 1970 by the American biochemist Van Rensselaer Potter
C. in 1972 by Professor Rudolf Jaenisch
D. in 1869 by James Potter

**2. The fundamental principles of Biological medicine was announced:**
A. in the Jaenisch Review
B. in the Potter Report
C. in the Belmont Report
D. in the Jahr Summary

**3. The first organisms genetically engineered were:**
A. virus and cell
B. bacteria and mice
C. mice and cat
D. human cells

**4. The Nuremberg Code is a set of research ethics principles for human experimentation set as a result of:**
A. Dachau Trials
B. Auschwitz Trial
C. Nuremberg Trials
D. Belsen Trial

5. Cloning of any DNA fragment essentially involves four steps:
A. Fragmentation, Ligation, Transfection, Screening/Selection
B. Beginning, middle part, ending.



and reasonable for physical therapy services.

- Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.
- Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients.
- Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.
- Physical therapists shall refrain from employment arrangements, or other arrangements that prevent physical therapists from fulfilling professional obligations to patients.
- Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, and globally. (Core Values: Social Responsibility)
- Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
- Physical therapists shall advocate reducing health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.
- Physical therapists shall be responsible stewards of health care resources and shall avoid over-utilization or under-utilization of physical therapy services.
- Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

**Questions for self-control:**

1. What is the deontology?
2. What is the medical ethics?
3. The main tasks of medical deontology?
4. The main principles of medical deontology?

5. What is the historical background of medical deontology?
6. What are the jatrogenic diseases?
7. What world codes of ethics do you know?



**To topic 6**

*I. Find the right term for the given below definition.*

1) _____ is study of the ethical and moral implications of new biological discoveries and biomedical advances, as in the fields of genetic engineering and drug research.
2) _____ is process of producing similar populations of genetically identical individuals that occurs in nature when organisms such as bacteria, insects or plants reproduce asexually.
3) _____ is basic research, applied research, or translational research conducted to aid and supports the body of knowledge in the field of medicine.
4) _____ is the genetic engineering of humans by replacing defective human genes with functional copies.
5) _____ is a set of research ethics principles for human experimentation set as a result of the Subsequent Nuremberg Trials at the end of the Second World War.
6) _____ is the procedure of creating a new multicellular organism, genetically identical to another.

*II. Put ☑ where the statement is true.*

1. ☐ Nazi human experimentation was a series of medical experiments on large numbers of prisoners by the Nazi German regime in its concentration camps mainly in the early 1940s, during World War II and the Holocaust.
2. ☐ Molecular cloning refers genetic engineering of humans by replacing defective human genes with functional copies.
3. ☐ The term “Bioethics” (Greek bios, life; ethos, behavior) was coined in 1927 by Professor Rudolf Jaenisch, who "anticipated many of the arguments and discussions now current in biological research involving animals" in an article about the "bioethical imperative," as he called it, regarding the scientific use of animals and plants.
4. ☐ Ecological ethics is the part of environmental philosophy which considers extending the traditional boundaries of ethics

Should you tell the parents about your mistake?
a. No because the error is a trivial one.
b. No because no harm is done.
c. No because the mother will never find out.
d. Yes because an open and honest approach to errors is most appropriate.

6. A 32 year old woman was admitted to the Trauma Intensive Care Unit following a motor vehicle accident; she had multiple injuries and fractures, with several complications which continued to develop over the first couple of weeks. The patient rapidly developed Adult Respiratory Distress Syndrome, was on a ventilator, and was continuously sedated. Shortly after the patient's admission, her parents were contacted and remained vigilant at her bedside. The parents reported that the patient was one month away from having her divorce finalized. The patient's husband was reportedly physically and emotionally abusive to her throughout their five years of marriage. The parents had not notified this man of the patient's hospitalization, and reported that visit by him would be distressing to the patient if she were aware of it. The patient's soon to be ex-husband is her legal next of kin.
Should the husband be responsible for treatment decisions which the patient cannot make?
a. No, because there is an implied consent by law for provision of "emergency" medical treatment in such cases.
b.Yes because there is a divorce proceeding.
c.Yes because the law sets an explicit time limitation on implied consent based on an "emergency."
d.Yes because the father is the surrogate decision-makers for the patient.

*Standards of the right answers:*

1(a); 2(d); 3(d); 4(b); 5(d); 6(a).



## TOPIC 2.
## Stages of formation of the medical deontology during various times.

The term ‘DEONTOLOGY’ has been in wide use in the medical literature over past years) is *a set of ethical standards and principles of behaviour of medical workers while executing their professional duties.*

Ancient sources concerning medical ethics and deontology:

- “*The Laws of Hammurabi*” (laws of Ancient Babylon, 18th century B.C.),
- *“About the physician”, "The Oath"* and *"The Law"* by Hippocrates (5-4 centuries B.C.),
- Indian *“The Book of Life”* (“*Ayurveda”* – 5-4 centuries B. C.).

✓ The term "ethics", meaning “a concept of human morals” was introduced by Aristotle (384-322 B.C.).

Middle Ages:

- “*The Canon of Medical Science”* and *“Ethics”* by Ibn Sina (Avicenna, 10-11 centuries),
- The medical school of Salerno (1213)

✓Jeremy Bentham (English philosopher, lawyer, priest; 1748-1832) introduced the notion of deontology as meaning “… the teaching on the due behaviour of a person while achieving his end” (18 century).

Russian medicine:

- “The Word Concerning Piety and Moral Qualities of a Hippocratic Physician” and “The Word Concerning the Ways of Teaching and Learning the Practical Medicine” by Matvey Yakovlevich Mudrov (1776-1831),
- “Letters from Heidelberg” and “The Diary of an Old Doctor” by Nikolay Ivanovich Pirogov (1810-1881).

The Nuremberg process, 1947:

- the verdict to the Nazi physicians,
- “The Nuremberg Code”, postulates not legal, but also moral regulations of medical experiments.

**1947 - the World Medical Association was created**.

Its main action was the adoption of

- **"The Geneva Declaration"** – the oath of a physician – the doctor (**1948**),
- the **International Code of Medical Ethics** (**1949**),
- "**The Helsinki Declaration of Human Rights**" (**1964),**
- "**The Helsinki-Tokyo Declaration**" (**1975**),
- "**The International Declaration on Human Rights" (1983).**

Medical ethics has its roots in antiquity. In different historical periods, depending on changes in morality of society the ethical principles changed too.

There is no other profession that could be compared with the profession of medical officer as responsible for the health, life and the fate of the sick person. This explains the abundance of laws, manuals, codes and regulations of the thousands of years of medical standards of conduct of the employee. These criteria are in different historical epochs have changed, but the essence remains the same: requirements for physical, moral and intellectual qualities of health care worker, as well as its professional liability has always been particularly high. Whoever gets this title, voluntarily assumed the duty to carry out these rules immaculately throughout life.

Among extant priceless cultural monuments of the past, reflecting the development of ethics and deontology in medicine, special attention should be ancient Indian treatises, works of outstanding physicians and philosophers of the ancient East, ancient Greece and ancient Rome. Already in the initial stage of the development of medical ethics in the slave formed during the general requirements for the preparation and work of the doctor, his personality, the external and internal appearance.

In Mesopotamia medical ethics maintained not only monetary rewards for successful treatment, but also the responsibility of the doctor in case of failure of the disease. In ancient Babylon more than 2,000 years BC. there was a code of King Hammurabi, which along with the rules determined by the provision of medical care and evaluation of the work of physicians , payment for various types of medical care . For



3. A patient tells his family that he would never want to be "kept alive like a vegetable". The term "vegetable" should be understood by the doctor to mean:
a. The patient does not want any heroics or extraordinary treatments.
b. Pull the plug if the patient is ever in terminal state on a respirator.
c. If the patient is in a comatose state, let him die.
d. The doctor should interpret the term as vague and not helpful in advance care planning discussions unless it is clarified.

4. An elderly man with end-stage emphysema presents to the emergency room awake and alert and complaining of shortness of breath. An evaluation reveals that he has pneumonia. His condition deteriorates in the emergency room and he has impending respiratory failure, though he remains awake and alert. A copy of a signed and witnessed living will is in his chart stipulates that he wants no "invasive" medical procedures that would "serve only to prolong my death." No surrogate decision maker is available.
Should mechanical ventilation be instituted?
a. The presence of a living will or other advance directive obviates the responsibility to involve a competent patient in medical decision making.
b. If the patient has remained awake and alert, his living will is irrelevant to medical decision making.
c. The potential risks and benefits of mechanical ventilation need not be presented to the patient because of the presence of a valid living will.
d. Even if the patient refuses mechanical ventilation therapy, his wishes need not be honored because he is in the emergency room.

5. An 18-month-old child presents to the clinic with a runny nose. Since she is otherwise well, the immunizations due at 18 months are administered. After she and her mother leave the clinic, you realize that the patient was in the clinic the week before and had also received immunizations then.

c. Misrepresentation of the product through untrue statements made by the manufacturer or seller
d. All of the above

*Standards of the right answers:*
1(c); 2(d); 3(c); 4(a); 5(d); 6(d); 7(d).

1. An elderly woman told her daughters that if she ever ended up with dementia she wouldn't want to live like that. Years later she developed senile dementia and her daughters had her move into a nursing home. Although she did not recognize family or friends, she enjoyed the company of others and the nursing home's cat. When she stopped eating, her daughters were asked whether she should receive a feeding tube.
a. The daughters may approve the insertion of a feeding tube with the proviso that future triggers could lead to its removal or nonuse.
b. The daughters should consider their mother's previously stated wishes as an advance directive and must not place a feeding tube.
c. The daughters cannot decide for their mother because of lack of both a power of attorney for health care and an advance directive.
d. Before placing a feeding tube, the daughters should obtain a court order.

2. A patient who has coronary artery disease and congestive heart failure shows his physician his advance directive that states he wants to receive cardiopulmonary resuscitation and other forms of life-sustaining treatment has deeply held beliefs that suggest that not trying to live is tantamount to committing suicide.

What should the doctor do and say to the patient in response to this?

a. The doctor should educate the patient about the near futility of CPR under these circumstances.
b. The doctor might want to ask the patient to explore this further with the chaplain.
c. The patient's expression of a preference should be explored to understand its origins.
d. All the above.



example, section 215 of the Code reads: " If a doctor makes anyone a serious operation with the help of a bronze knife and heal the sick, or if he will take anyone a bronze knife cataracts, eye to heal so he can get for it ten Szekels of silver."

It was a very high fee, since 1/30 Szekels was the average daily wage of a skilled craftsman. However, if the work of the doctor and was ranked high, the error of the doctor and his failures were punished very severely. In paragraph 218 of King Hammurabi Code stated that" if the doctor will make anyone a serious operation bronze knife and cause the patient 's death or if he will take someone with cataract eyes and destroy the eye , he shall be punished by amputation of hands".

Much attention was paid to the physician ethics in ancient India. In the famous Indian treatise "Ayurveda" ("Science of Life"), composed in the VI century BC, the teachings of the ancient Indian physicians (primarily Sushruta) contains wonderful thoughts about the duty doctor, his behavior with respect to the patient. According to these ancient beliefs, the doctor had to be of high moral and physical qualities, to show compassion to their patients, to be patient and calm, never lose my temper. In ancient India, there were also rules of conduct for the physician with respect to the patients in the preoperative and postoperative periods of dying patients and their relatives.

According to ancient legends, one of the 14 precious creatures who were created by mixing the gods of the earth and the sea was a scientist and physician. His position in society was very high, but also the requirements for it demand more. He was equally posses all the parties of the Healing Art.

"Doctor, inexpert in operations comes at the bedside in confusion, like a cowardly soldier who first came to the battle - wrote in his treatise Sushruta - same doctor, who can only operate and neglecting theoretical knowledge does not deserve respect and can even endanger the life of kings. Each of them has only half of his art and looks like a bird with only one wing. "

In ancient India, there was a sermon of healing art teacher spoke to his disciples at the ceremony dedicated to the completion of training.

It shows in his treatise **"Charaka Samhita ".**

"You must strive with all my heart to heal the sick. You do not have to betray their patients, even at the cost of his own life ... You do not have to get drunk , do not have to do evil or have evil friends ... You have to be prudent and always strive to improve their knowledge. When you go into the house of the patient, you have to send their words, thoughts, mind and senses to nothing, except to his patient and his treatment ... Nothing of what is happening in the house of a sick person, you should not talk to anyone ... who, taking advantage of the knowledge acquired, could damage the patient ... "

In the Vedic era, the ancient physician ought to adhere to the following code:

"Always be patient, attentive and courteous,
Be humble, obeying case iron logic of the mind,
Try to give healing the sick,
Requiring no victims, no good for yourself."

In addition, a serious error the doctor had to pay a large fine.

Deeply humanistic understanding of the role of medicine in enhancing human health is reflected in the monument of ancient **Chinese medicine** - the book Huang Di Nei Jin, "About the nature and life." In this book, there have been attempts to define the basic rules that should be guided in their practice every doctor. One of them is the need to inspire patient confidence in the recovery. Great importance was attached as an individual approach to ill because of its character traits. Among these rules, and the advice of doctors and has this advice: "To be able to keep the heart in the chest" (i.e. preventing excessive reactions to react to different situations in life). On a deep understanding of the role of prevention in health in ancient China evidenced by the following instruction: "Medicine can not be saved from death, but is able to prolong life, to strengthen the state and the people with his advice."

A lot of attention, along with the moral education has also been given the improvement of clinical skills. To this end, greatly



2. Unlawful acts are always:
a. Unacceptable
b. Unethical
c. Punishable by legal means
d. All of the above

3. Violation of a professional organization’s formalized code of ethics:
a. Always leads to prosecution in a court of law
b. Is ignored if one’s membership dues in the organization are paid
c. Can lead to expulsion from the organization
d. None of the above

4. Law is:
a. The minimum standard necessary to keep society functioning smoothly
b. Ignored if transgressions are ethical, rather than legal
c. Seldom enforced by controlling authorities
d. None of the above

5. Conviction of a crime:
a. Cannot result in loss of license unless ethical violations also exist
b. Is always punishable by imprisonment
c. Always results in expulsion from a professional organization
d. Can result in loss of license

6. The basis for ethical conduct includes:
a. One’s morals
b. One’s culture
c. One’s family
d. All of the above

7. Sellers and manufacturers can be held legally responsible for defective medical devices and products through charges of:
a. Fraud
b. Breach of warranty

operation. Radical surgery is carried out. Metastases weren't revealed.

**According to what principle patient was informed about reason of increase of operation's extent?**

Task 10. Operation was operated for hemorrhoid. He consented to be operated after some years of disease, as he embarrassed his disease.

**According to what principle physician doesn't inform relatives and friends about diagnosis of the patient?**

Task 11. During taking of anamnesis in mother of ill child physician was finding out that this child was result of 2nd pregnancy and 1st term labor, and 1st pregnancy of mother was ended by aborts. During writing of conclusion physician didn't indicate this fact at mother's request.

**What ethical rule physician does follow to?**

*Standards of right answer for tasks:*

1. Principle of confidentiality.
2. Principle of truthfulness.
3. Principle of well-informed consent.
4. Principle of confidentiality.
5. Principle of charity.
6. Principle of confidentiality.
7. Confidentiality.
8. Justice.
9. Truthfully.
10. Confidentiality and justice.
11. Confidentiality.

**To topic 5**

1. Unethical behavior is always:
a. Illegal
b. Punishable by legal means
c. Unacceptable
d. None of the above



encouraged for the doctor to speak with colleagues, to discuss with senior and more experienced physicians about complex diseases. Novice doctors recommended developing their memory and thinking.

For example, in ancient China highly appreciated the feat in the name of the doctor of the patient. An eloquent testimony to this adage was common in those days: "Saving one human life is better than to build a seven-story pagoda."

In the ancient Persian medicine most important requirements doctor had his broad education, in-depth knowledge of medicine, erudition, ability to communicate with patients, listening to him quietly and conscientiously treat. In **Persia**, there were three categories of physicians: "healer's holiness", "healer's knowledge" and "healer's knife." The most common was the first category of doctors whose duty was not only healing in the truest sense , but the ability to mentally influence the patient 's own personality , their mental and moral qualities. Ancient physicians trained in the art of observation to identify the disease early in their development. Methods of diagnosis were incredibly effective. The doctor was infinitely patient and attentive to inexhaustibly patient observations, which allowed him to detect such subtleties, which were presented to the uninitiated just incredible. Not by chance the great healers of the past have left a memory of himself, which survived the centuries. Obviously, the secret of their success lies in a combination of drug therapy or the use of natural factors with a subtle understanding of the psychology of the patient and the ability to affect it.

In all countries in the era of the slave personality physician regarded as one of the most revered and respected as a doctor depended largely on human health and life. Often the doctor acquired an aura of the great and all-powerful, God endowed with unearthly abilities. No accident that the countries of the ancient East, some well-known doctors were raised to the rank of gods. One of the first was deified by the legendary Greek physician Asclepius - the father of Hygeia - the patroness of health and Panacea - patroness of curative medicine.

## THE HIPPOCRATIC WRITINGS (CORPUS HIPPOCRATICUM):

The next step in the development of medical ethics slave society is medicine **Hippocrates**. During this period in Greece philosophical questions of ethics and morality was widely studied.

According to legend, the oath dates back to the direct descendants of Asclepius, she passed orally, as a family tradition, from generation to generation. Written by Hippocrates oath was the first time in the Ionian dialect of the Greek language in Hellenistic Alexandria at Gerofile (Herophilos, approx. 300 BC) And Erasistratus and became a document from the III century BC.

The greatest physician of antiquity, Hippocrates first tried to systematize the rules of medical ethics based on the experience of medicine. In his famous “Oath " in the books "About the doctor" and " About the favorable behavior", "About the Art", in the "Aphorisms", written about two and a half thousand years ago, he created a code of moral standards, mandatory for those who elected for life doctoring their profession. Norms of behavior therapists were formulated in accordance with existing knowledge at the time of the person and his health. Hippocrates recommended directed to cure the patient efforts of not only the doctor, but all the others: "It is not only the doctor should consume it all that is necessary, but the patient, and the surrounding, and all external circumstances should help the doctor in his work". None of the Hippocratic treatise was said about the distinction between freemen and slaves, for all recognized the same rights to care, attention and respect from the doctor. To evaluate the Hippocratic humanism, it should be noted that these great thinkers of ancient Greece, such as Plato and Aristotle, who lived after Hippocrates, was still considered a slave "talking animated instrument" and denied him the right to be called a man.

Humanism Hippocratic medicine is that it selflessly served each patient, regardless of his social status. Hippocrates created a set of laws for many generations of doctors, and they are worthy of the torch through the ages true humanism kindled a great thinker. Usually by the end of the period of study, Hippocrates, turning to his disciples with a warning, says that this doctor should



office, is given out to the relatives exclusively in case of personal appeal and showing of documents, identifying personality; in those cases, when authorities of legal order need information about the patient, it is necessary to do special enquiry.

***Example:*** child of famous parents appealed for aid to traumotological office independently in connection with beating by coevals, was appointed for hospitalization in condition of moderate severity. During the same day information about appealing of child was enquired. Persons were presented like victim’s relatives. It was refused in informing. During the same day some private appealing from periodical press were done in connection with fact of patient’s appealing.

**What principle was observed by physicians of traumatological office? Does have physician right to spread information by telephone?**

Task 7. The woman with femoral fracture is in the ward. During clinico-instrumental examination it was revealed that she has 6 weeks of pregnancy. But she is wife of worker of Embassy of Ukraine in Turkey, which had long official trip (more than 6 weeks) during traumatizing of his wife. She demanded nothing to say about results of researches to the husband. Information about pregnancy, revealed in patient, wasn’t said to him.

**What principle of biomedical ethics was observed?**

Task 8. Patient with frank signs of violent trauma is in the ward. But patient asserts that she “fell down”. Physician, in spite of patient’s request, independently sent telephone message to the police office about presence of patient with unknown character of trauma in the hospital. During investigation it was found out that patient’s distant relation lives in the same flat together with victim. He terrorizes all living in this home. Patient feared to tell the truth because of fear to him. Eviction of this man from the flat and his future prosecution was result of inquest.

**What moral principle made physician do it?**

Task 9. Operation is carried out to the patient in connection with appendicitis. Signs of cancer of the caecum were revealed during

months). This pregnancy is first, welcome, until this time she during long period was treated in connection with sterility. Dysphagy is developing on background of pregnancy, taking its normal course. During examination cancer of cardial part of the stomach (4 degree with penetration into left lobe of the liver) was revealed. Approximate life span in this situation is 6 months.

**Who must resolve (decide) about abortion and according to which principle, if physician (oncologist-gynecologist) recommends abortion to the woman, taking into account stimulating influence of pregnancy to growth of tumor and harmful influence of cancerous intoxication to development of fetus?**

Task 4. Patient M., 27 years old, was treated in connection with systemic lupus erythematosus. According to standard examination, Wassermann test was carried out. Last one was positive. It was fault of laboratory doctor and nurse that neighbors in ward heard about results of analysis. They became to look down at the patient. The patient quarreled with husband; severe psychic reaction with exacerbation of systemic lupus erythematosus' symptoms was developed in her. It was very difficult to reassure patient and her husband, explaining possibility of specific positive reactions in case of systemic lupus erythematosus.

**What principle of biomedical ethics was disordered by laboratory doctor and nurse?**

Task 5. Patient S., 58 years old holds leading post in large company. He was admitted to the clinic in severe condition; diagnosis of systemic lupus erythematosus was made during examination. Boards of directors made an inquiry about condition of health of S., but physicians didn't give information about patient's disease, following to observance of rights of medical ethics. In some period remission of systemic lupus erythematosus occurred. Patient went to the work, holding the same post.

**About which rule foregoing case does say to us? When this rule can't be observed?**

Task 6. Information about patients, appealed to traumatologic



be kind, fair, humane and disinterested, that he must remember decorum, to be modest in dress and behavior. Students then uttered words of the oath, the greatest monument of medical ethics, which later became known as the "Hippocratic Oath":

**"I swear by Apollo, Asclepius doctor, Hygeia and Panacea and all the gods and goddesses, taking them as a witness, to perform honestly, according to my ability and my judgment, the following Oath and written commitment: to consider who taught me medical skill on par with my parents, to share with them their wealth and , if necessary, to assist him in his needs; his children as my own brothers, and this art, if they want to study, teach them free of charge and without any contract; instructions, oral lessons and everything else in the teachings tell their sons, the sons of his teacher and students related obligation and oath according to the law health, but no one else. I direct mode patients to their benefit in accordance with my ability and my judgment and causing any harm and injustice. I will not let anybody if asked me a deadly drug, nor will such a plan; Similarly, I will not give to a woman an abortive remedy. Pure and undefiled I will conduct my life and my art. I am not in any way will not make cut for stone disease sufferers, leaving it to the people involved in this case. In every house I have entered, I go there for the benefit of the patient, being far from all vile, unjust and harmful, especially love affairs with men and women, freemen and slaves. Whatever the treatment - as well as without treatment - I have not seen or heard about human life from the fact that the cord should not be anything to disclose, I keep silence about considering such things secret. I performing inviolable oath shall be given happiness in life and in art, and thank all the people for all time; transgress the same and giving a false oath but will reverse it".**

<u>"Oath" includes nine ethical principles or commitments:</u>

- Obligations to teachers, colleagues and students;
- The principle of non-malfeasance;
- Obligation to assist the patient (principle of charity);
- The principle of caring for the patient and the use of the

dominant interests of the patient;
• The principle of respect for life and a negative attitude towards euthanasia;
• The principle of respect for life and a negative attitude to abortion;
• The obligation to waive intimate relationships with patients;
• A commitment to personal development;
• Medical secrecy (confidentiality).

Hippocrates, creating an oath, however, pursued and their mercantile interests - his disciples shared with him earned. He was the first to take the money for tuition, was very surprised by what his contemporaries (before this medicine taught sons or «service" at the temple). He also belongs to the statement: «Getting to the treatment of the patient, the doctor must agree on the amount of remuneration - it gives the patient hope of recovery. For free only hopeless patients are treated. "Not to mention that some of the recommendations contradict the noble principles of Hippocrates' Oath». Speaking about the tactics of treatment of incurable diseases, it does not advise physicians to treat them not to lose practice. According to him, "medicine should not extend a hand to those who have defeated the disease".

However, with the name of Hippocrates associated idea of high moral character and ethical conduct sample doctor. Many provisions of the "Hippocratic Oath" are not lost their significance to the present day.

In the works of Hippocrates, a lot of attention paid to the norms of relationship between doctors. If the doctor is more difficult to diagnosis or treatment, he must consult with his colleagues. "There is nothing to be ashamed of, if a doctor, difficult in any case, the patient and not seeing clearly because of heir inexperience, requests to be invited other doctors with whom he could find together the patient's position and that would have promoted him to find help... Doctors, together examines the patient , should not quarrel with each other and make fun of each other, because I was with an oath declare that the judgment had one doctor should not excite the envy of the other, it would be to show weakness".



c) interrelation in medical collective;
d) interrelations of medical workers and society;
e) all foregoing.

7. What is subject of physical secret?
a) information about patient's condition during his/her disease;
b) information about fact appealing for medical aid, condition of patient's health, diagnosis of his/her disease and other information, obtained during his/her examination and treatment;
c) all foregoing.

*Standards of the right answers:*
1(a,b); 2(a,b,c,d,e); 3(a); 4(a); 5(a); 6(e); 7(c)

**Tasks**

Task 1. Men, 40 years old, was consulted a doctor. After examination and taking of necessary analyses syphilis was confirmed in him. Physician, coming back from the work, during natural talk with friends named surname and diagnosis of this patient. Patient's family heard about disease through third persons and it is disintegrated later on.

**According to which principle physician doesn't have right to name surname and diagnosis of his patient?**

Task 2. Patient admitted with clinical picture of partial adhesive intestinal obstruction. Resection of the stomach was carried out in past in connection with peptic ulcer of the stomach. The main method of diagnostics of this disease is X-ray. On plan X-ray film it was revealed, that surgical needle (which doesn't cause any semiology) is in abdominal cavity. Intestinal obstruction is liquidated.

**What principle of medical ethics was disordered? Is it necessary to say to the patient about finding?**

Task 3. Woman, 40 years old, is pregnant (term-16 weeks or 4

2. In which cases is it possible to give physical secret without consent of patient or his/her legal plenipotentiary?

a) with purpose to examine and treat citizen, which can't say one's own will;
b) in case of threat of spreading of infectious diseases, mass poisonings and lesions;
c) according to enquiry of preliminary and investigation organs, public prosecutor and court in connection with carrying out of investigation or hearing;
d) in case of helping to minor, age to 15 years old, for informing of his/her parents or legal plenipotentiary;
e) in presence of grounds to suppose, that damage of men's health is result of unlawful actions.

3. Is information about carried fertilization and personality of donor physician secret?

a) yes, it is;
b) no, it isn't;
c) sometimes.

4. Is well-informed voluntary consent of the patient (or confidential persons) necessary preliminary condition of medical intervention?

a) yes, it is;
b) no, it isn't;
c) to patient's discretion.
d) to physician's discretion

5. Is management of ethical situation in collective function of leader of medical institution?

a) yes, it is;
b) no, it isn't;
c) to leader's discretion.

6. What interrelations include norms and principles of medical ethics and deontology?

a) interrelations of physician and patient;
b) interrelations of physician and patient's relatives;



What is the time of Hippocrates gave the morality of the doctor, evidenced by the fact that the book "On the doctor", intended for novice doctors, opens a section that describes how to be a doctor, his office, that the cabinet, everything must be adapted for the use of the patient. In addition, the doctor should have good appearance, good clothes, to be reasonable, it must be "like the person on your lovely and kind and, as such, a significant and merciful..." "It must be just and equitable in all the circumstances, because in many need help matters can be justice, and a doctor with a lot of sick relations: they commit themselves at the disposal of doctors..."

Even for the modern physician Hippocrates interesting description of the doctor's office, it is interesting because from the point of view of Hippocrates all in the office should be subject to the use of the patient. He writes about the convenience of the place, the degree of brightness ("not to upset weak eyes"), about the height of the chairs for the sick, for drinking water, a clean and soft things to wipe wounds, eyes, and so on.

In his writings, Hippocrates forms the main deontological rule:

"There must pay attention to all that apply, benefited."

**Ibn Sina**, known in the West as Avicenna, was one of the most famous physicians of his time, not to mention a great philosopher, mathematician, and astronomer. He was born in 980 AD at Afshana near Bukhara, or what is now modern Iran. As a child, he showed exceptional intellectual prowess. By the age of ten, he was well versed in the Qur'an, the Islamic holy book, and proficient in other Persian and Arabic literature, as well as the basic sciences.

By the age of 18, Avicenna had a reputation as a physician and was summoned to attend to a Samani ruler. He was successful in treating his patient and in gratitude for Ibn Sina's services; the King allowed him the use of the royal library. Avicenna was thrilled and devoured the contents of the library. By 21 years of age, he was in a position to write his first medical book. He traveled extensively throughout modern day Iran and in Jurjan, met his famous contemporary Abu Raihan al-Biruni. In Hamadan,

he wrote his famous book: Al-Quanun fi-al-Tibb or the “Canon”. At the same time, he treated one of the kings of the Daylami dynasty for severe colic. Avicenna worked extremely hard and thus life was very strenuous for him. During the day, he attended to medical practices. At night, he lectured and dictated notes to students from his two great books: the Canon, a medical textbook, and Shafa, a book of philosophy. However, after these sessions, Avicenna attended parties in which he was well known as a drinker and a womanizer. Therefore, Avicenna, even though a great physician, was a human, like all the other people around him. Friends told Avicenna to slow down and take life in moderation. However, he responded by saying: “I prefer a short life with width to a narrow one with length”. In other words, he wanted to fully experience each day and the things life has to offer, than to live a long but misadventures life. This extensive mental exertion as well as political turmoil spoilt Avicenna’s health and he died of “Colic” at the age of 57 (1037 AD). He had tried to treat himself with celery seed enema and an opium mixture to prevent his colic seizures, but the treatments were unsuccessful. Some historians believe that Avicenna’s death was perhaps due to an overdose of these treatments, given to him by his servants. However, this conclusion remains controversial. Avicenna wrote about 100 famous books, all in Arabic except two in Persian. He wrote extensively about philosophy, mathematics, music, astronomy, medicine, theology, and poetry. However, his most famous book by far was the Canon. He wrote this book because he wanted a text that would teach medicine as an integrated and connected subject. Such a book had never existed before and thus the need for it was apparent. It took Avicenna about 8 years (1015-1023 AD) to write the Canon, but it was well worth the effort. The Canon enjoyed being the major reference in medical schools for over 600 years in the near East and Europe. In the words of Dr. William Osler, a famous Canadian physician, the Canon has remained “a medical bible for a longer time than any other work”. The Canon was translated to Latin by Gerard of Cremona, a monk, between 1150-1187AD, and went through 30 editions in Europe. The Canon consists of five volumes or one million words. Volume one describes the nature of the human



3. The sensitive and merciful relation to the sick person;
4. To humanism.

8. The term “deontology” it was offered by:
1. English philosopher Bentamom;
2. Nicolas Van Tulpoju;
3. Shveninger;
4. Ambruaz to Steam.

9. The medical aesthetics finds out:
1. Concrete aesthetic factors which predetermine positive influence on a mental and physical condition of the patient;
2. Principles and high samples of universal morals in professional work;
3. Ethical problems of concrete clinical medicine;
4. Multifactorial disorganization of a mental and spiritual condition of the patient.

10. Who possesses words: “If the patient solves, to what doctor to address, to what treats grasses, to another which treats a knife he first of all will address to what treats a word”:
1. A.Morua;
2. To Bekhterev;
3. To Botkin;
4. To Rudansky;
5. To Gippokrat;
6. To Votchal.

*Standards of the right answers:*
1(1); 2(3); 3(4); 4(1); 5(2); 6(1); 7(3); 8(1); 9(1); 10(5).

**To topic 4**

1. Observation (keeping) of physical secret is necessary for:
a) protection of man’s internal world, its autonomy;
b) protection of social and economic interests of personality;
c) making of basis of confidence and frankness of interrelations “physician-patient”;
d) supporting of prestige of medical profession.

2. Gnaws nails;
3. An easy inclination of head on one side;
4. A sight aside;
5. A sight in forgery.

2. A zone of intimate dialogue:
1. From half-meter before direct corporal contact;
2. From above 0, 5-1,5 m;
3.1, 5-3 m;
4. Over 3

3. Who enters into a zone of intimate dialogue?
1. Good friends;
2. Businessmen;
3. Relations of the chief and the subordinate;
4. Acquaintances, parents with children, the doctor, the hairdresser, nurses.

4. Medical ethics include:
1. The benevolent relation and responsibility to the patient;
2. An oratory question;
3. Rhetorical means;
4. Stylistic means.

5. On what the trust to the patient: is based
1. On influence of the doctor on sick by suggestion;
2. On the moral and psychological beginnings of mutual trust of the doctor to the patient and on the contrary;
3. On influence of the doctor on sick by belief in a favorable consequence of illness.

6. A clod words “aliis inserviendo ipse consumor” belong
1. To Nicolas Van Tulpe;
2. Andre Mauro;
3. Avicena;
4. To Aristotle;
5. Hippocrates.

7. To sympathy carry:
1. Deep penetration into essence of sufferings of the patient;
2. To a physical and spiritual condition of not strong person;



body, anatomy, physiology, the definition of health, illness, medical treatment, causes and symptoms of disease. Volume two consists of one of the first descriptions of the Scientific Method. Volume three describes the pathology of each organ, 21 in all, from head to toe. Volume four consists of fever, crisis, medical signs, symptoms, diagnostics, prognostics, and minor surgery. Finally, volume five is a manual for the preparation of compound medicine, i.e. pharmacy and pharmacology. The Canon was an important step towards greater understanding of medicine and the importance of observation and experimentation. It combined Avicenna’s findings with previous Greek and Arabic works and provided a logical and coherent way of organizing medical information. It also recognized the contagious nature of disease and the spread of disease by water, soil, and vectors, such as mosquitoes. In addition, the Canon pointed out the importance of dietetics, the climate and the environment on health. Furthermore, the surgical use of anesthetics was described and 760 drugs were considered, including their methods of application and effectiveness. In addition to his great medical text, Avicenna made a number of other significant contributions to the field of medicine. For example, his view of cancer was generally what we accept today. He described cancer as a swelling or tumor, accompanied by pain and rapid growth, and initially hidden. He described the process of tumor growth by stating that vessels form around it, a process today known as angiogenesis. He also mentioned that cancer most frequently occurs in hollow organs, such as the lungs, and has the ability to spread and affect other organs, what is today called metastasis. He stated that early cancer may be cured but not when it is advanced. In addition, small cancers may tolerate excision, but all blood vessels around them must also be removed to cut off the food and oxygen supply. Avicenna believed that there were two purposes for cancer medications: First, total arrest of cancer and prevention of progress, and second, prevention and treatment of the ulceration. He also mentioned that advanced cancer should be left untreated except for correction of the diet. Therefore, Avicenna was very knowledgeable and open-minded for his time, about 1000 years ago. Avicenna also made advances in the fields of Anesthesia and

Analgesia. For example, he proposed oropharyngeal intubation and tracheotomy as a means for overcoming respiratory distress. He also identified a great number of plants with pharmacological action, some of which are used today in herbal remedies. Some examples include Mandragora, Henbane, and opium. Another significant contribution made by Avicenna was the proposal of a number of guidelines for testing new medications. He set out seven rules for testing the effectiveness of new drugs. His first rule states that experimentation must be done on the human body and not on other animals, to allow an accurate assessment of the actions and efficacy of the drug. His second rule is that drugs must be free from extraneous accidental quality, i.e. be pure. His third rule states that drugs must be used on a simple, not, composite, and disease. In other words, do not test a drug on a patient with diabetes, heart disease and lung cancer for example, because it is then impossible to see what the exact mechanisms and effects of the drug really are. His fourth rule indicates that drugs must be tested on two contrary diseases to ensure its effectiveness. Rule five states that the strength of the drug must correspond to the strength of the disease, i.e. a very potent drug for a very severe disease and a less potent drug for a milder disease. Rule six mentions that the time of action must be observed. This is important for dosages and pharmacological action. Finally, his seventh rule states that the effect of the drug must be consistent. These rules form the fundamental basis of today's clinical drug trials. Again, Avicenna's innovation and open-mindedness are apparent. In summary, Avicenna was one of the most influential physicians of his time. His greatest contribution to medicine was the Canon, compiled from previous Greek works and Avicenna's own findings. The Canon was used as a primary tool in many medical schools for over 600 years. Even today, as we enter the dawn of a new millennium, Avicenna's work is quoted in many medical books and the fundamentals of what he created still remain with us.

In 1948, the World Health Organization adopted the "**Geneva Oath**" doctor, based also put "Hippocratic Oath."

The Declaration of Geneva of the World Medical



14. Substantive provisions of professional medicine:
1. Respect for life;
2. An interdiction of actions of a trespass to the patient;
3. Respect for the person of the patient;
4. Medical secret;
5. Respect for a trade;
6. Humanism;
7. Care.

15. Written codes of ethics for health care practitioners:
a. Evolved primarily to serve as moral guidelines for those who provided care to the sick
b. Are legally binding
c. Did not exist in ancient times
d. None of the above

16. A Greek physician who is known as the Father of Medicine:
a. Hippocrates
b. Percival
c. Hammurabi
d. Socrates

17. A pledge for physicians that remains influential today:
a. Code of Hammurabi
b. Babylonian Ethics Code
c. Hippocratic Oath
d. None of the above

*Standards of the right answers:*
1(a); 2(1; 2; 3; 4); 3(1; 3); 4(1; 2; 43); 5(1; 2); 6(2); 7(3); 8(1; 2; 3); 9(1; 2; 3); 10(1; 2; 3; 4); 11(1; 2; 3; 4); 12(5; 6; 7); 13(1; 2; 3); 14(1; 2; 3; 4; 5); 15(a); 16(a); 17(c).

**To topic 3**

1. Mistrust is when:
1. The interlocutor rubs eyes;

9. Infringement of medical professional duties can be subdivided on:
1. Infringements technical;
2. Infringement the tactical;
3. Infringements diagnostic;
4. Infringement in the course of conversation with the patient;
5. Infringement for "failure".

10. Specify ways become the best for associates:
1. Most to rise above in the knowledge and relations to business;
2. To belittle people round itself;
3. To give itself an advantage aura;
4. To keep people in awe;
5. To belittle authority of the colleague.

11. Infringement of principles of secret probably at such situations:
1. When illness can lead to serious consequences in a family, for associates;
2. At a syphilis, on AIDS;
3. When illness threatens a society as a whole;
4. The statement of a priority of value of human life, value of health.

12. The heaviest and major problem of the doctor:
1. Support;
2. Ability to listen;
3. Respect for the patient;
4. To sympathies with the patient;
5. The help to the patient;
6. To look fool in the face;
7. Not to lose hope.

13. Humanism of Hippocrates medicine:
1. The limited;
2. The poor;
3. The hopeless;
4. The assured;
5. The restrained.



Association

(Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, in September 1948, supplemented by the 22nd World Medical Assembly, Sydney, Australia, in August 1968, the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th World Medical Assembly, Stockholm, Sweden, September 1994)

" Became a member of the medical community :
• I pledge myself to dedicate his life to serving the ideals of humanity;
• I WILL GIVE to my teachers respect and gratitude they deserve;
• I will fulfill my professional duty in conscience and dignity;
• health of my patient will be my first consideration;
• I will respect the secrets entrusted to me, even after the death of my patient;
• I will support all my forces honor and the noble traditions of the medical community ;
• My colleagues will be my brothers and sisters;
• I will not permit considerations of gender or age, illness or disability, religion, ethnicity, nationality, race, political ideology, sexual orientation or social status to stand between the performance of my duty and my patient;
• I will show the highest respect for human life from the moment of her conception, and never, even under threat. I do not use my medical knowledge to violate the rules of humanity;
• I agree to accept these obligations solemnly, freely and fairly".

**Oath of the Islamic Medical Association of North America (adopted in 1977)**

"Praise be to Allah, the Master, the One, Majesty of heaven, the great and glorious; Glory to Thee, Eternal, created the universe and all its inhabitants, and phenomena of infinity and eternity. We do not serve any god except you, and abominable idolatry believes a crime.

Give us the strength to be truthful, honest, modest, merciful and objective. Give us the fortitude to admit our mistakes, correct our ways and to forgive others. Give us the

wisdom to comfort and guide all to peace and harmony. Let us understand that our profession is sacred, because the most valuable powered Thy gifts - life and mind.

Therefore, make us worthy of this title with honor, dignity and piety so that we can dedicate our lives to the service of man - whether he is poor or rich, literate or not, Muslim or non-Muslim, black or white - with patience and respect, valor and respect, knowledge and sleepless labors with love to you in our hearts and compassion for thy servants.

We take this oath in Thy name, the Creator of Heaven and Earth and following the precepts of thy open Thee Prophet Muhammad: "Whoever kills a living soul is not for the soul, and not for the wickedness on earth , he would like all people ruin . And the one who will save this soul, he seems to be all people will save from death".

**International Code of Medical Ethics**

(Adopted by the 3rd General Assembly of the World Medical Association, London, UK, in October 1949, supplemented by the 22nd World Medical Assembly, Sydney, Australia, in August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983)

GENERAL DUTIES OF PHYSICIANS:

• A PHYSICIAN SHALL always maintain the highest professional standards.

• A PHYSICIAN SHALL not afford their own benefit considerations influence the freedom and independence of professional judgment to be made solely in the interests of the patient.

• A PHYSICIAN SHALL put at the forefront of compassion and respect for human dignity and the patient is fully responsible for all aspects of medical care, regardless of their own professional specialization.

• Doctor should be honest in relationships with patients and colleagues, and to deal with those of his colleagues who show incompetence or seen in deception.



2. Observance of rules of external culture;
3. Observance of moral values;
4. Observance of medical etiquette.

5. Specify in the primary goals medical deontology:
1. Studying of principles of behaviors of the medical personnel, directed on the maximum increase of efficiency of treatment;
2. An exception of adverse factors in medical activity;
3. Observance of rules of internal culture;
4. Observance of rules of external culture;
5. Observance of medical etiquette.
6. Elimination of harmful consequences of defective medical work.

6. One of the basic problems medical deontology is:
1. Conscience;
2. A duty;
3. Honor;
4. Indifference;
5. Happiness.

7. Medical deontology it is defined in behaviors in the plan:
1. A moral duty;
2. A legal duty;
3. In aspect of duties of medical workers;
4. In respect of a moral, legal duty, in aspect of duties of medical workers.

8. It is necessary to understand as hospital secret:
1. The indication about the patient, what received by the medical worker from the patient or in the course of treatment also is not subject to disclosure in a society;
2. The indication about the patient, which the medical worker should not inform the patient (the diagnosis, the end of illness, which will harm the patient and other);
3. The indication to “a sacred lie”;
4. A contact establishment between the patient and the staff nurse;
5. A contact establishment between the doctor and the patient.

## TESTS FOR SELF-CHECKING.

**To topic 1-2**

1. Which of the following is the best definition of deontology?

1. The theory of deontology suggests that the act that produces the greatest good should be performed.

2. The theory of deontology suggests that law should have nothing to do with morality.

3. The theory of deontology suggests that the result that best accords with common sense should be performed.

4. The theory of deontology suggests that certain acts are right or wrong regardless of their consequences.

5. The theory of deontology suggests that we should make decisions based on what will make people happy.

6. The theory of deontology suggests that there is no right answer to ethical questions.

2. That concerns ethical categories:
1. A duty;
2. Conscience;
3. Honor;
4. Happiness;
5. Advantage;
6. Indifference.

3. Conscience unites with moral values:
1. Honesty;
2. Advantage;
3. Happiness;
4. Truthfulness;
5. Justice;
6. Moral cleanliness;
7. Respect of the rights of other people and the duties;
8. A duty.

4. Allocate key questions from ethics problems:
1. Observance of rules of internal culture;



With medical ethics are not compatible:

a) Self-promotion, unless specifically permitted by the laws of the country and the Code of Ethics of the National Medical Association.

b) Payment of fees for physician referral to the patient him or receiving salary or other remuneration from any source in the direction of the patient at a particular hospital , a specialist or to a specific assignment of a certain type of treatment without sufficient medical reason .

• The physician shall respect the rights of patients, colleagues, other health professionals, as well as to keep the medical secret.

• A PHYSICIAN SHALL only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition.

• Doctor should be extremely cautious, giving information about the discoveries, new technologies and methods of treatment through non-professional channels.

• A PHYSICIAN SHALL assert only that he has personally verified.

The doctor's duty to the patient :

• A PHYSICIAN SHALL always remember his duty of preserving human life.
• Doctors should appeal to more competent colleagues, if necessary, the patient examination or treatment is beyond the level of his own professional opportunities • A PHYSICIAN SHALL store the medical secret, even after the death of his patient.
• A PHYSICIAN SHALL always provide immediate assistance to anyone in need of it , except only in cases where it is satisfied in the desire and capabilities of other entities to do everything necessary .

DUTIES OF PHYSICIANS IN RELATION TO EACH OTHER:
• A PHYSICIAN SHALL behave towards his colleagues as I would like them to behave towards him.
• A PHYSICIAN SHALL not entice patients from his colleagues.

• A PHYSICIAN SHALL comply with the principles of the Geneva Declaration, approved by the World Medical Association.

**Questions for self-control:**

1. When the first mention of ethical principles in medicine?
2. are ancient treatises and authors are displayed ethical principles of treatment?
3. What is the role in the formation of the Hippocratic medical ethics?
4. List the main provisions of "Hippocratic Oath."
5. What are the main modifications of "Hippocratic Oath" exist today?
6. What are the ethical laws should be guided by a doctor?



different level, firstly, to prevent the disease by having a sexual lifestyle prescribed by God. In those cases where AIDS can be acquired without a sexual contact, for example, by transfusion in case of hemophiliacs, all measures should be taken to protect the individual. After AIDS has been acquired, it should be treated like any other chronic disease.

Muslim physicians never question the lifestyle of patients with other diseases like diabetes, hypertension, heart disease, nor do we discriminate against them or stop caring for them. Thus Muslim physicians have an obligation to continue caring for AIDS patients while taking the necessary precautions for themselves at the same time when participating in preventive measures and education.

within the life span of an intact marriage between husband and wife. The marriage is a legal contract not only between man and a woman, but also between God and the couple. Thus the question is whether the child was born of an intact legal marriage or outside the marriage. In case of a surrogate father, who is the real father and does the child have the right to know his identity? In case of a surrogate mother, who is the real mother, the one whose ovum is being used or the one who lets her uterus be used? Is renting the uterus with money for this purpose allowed or justified?

A woman who does not want to go through pregnancy, labor, or lactation can donate her ovum every month to different women, technically, to hire a uterus and have many children. In the case of mothers renting their own uterus in place of their daughters', with the sperm of their son-in law, totally disrupts the concept of marriage and social norms and of lineage. The Qur'an is specific in terms of lineage and definition of motherhood. It says, "No one can be their mother except those who gave them birth" (Qur'an 58:2). Qur'an also says, "He has established the relationship of lineage and marriage" (Qur'an 25:54).

Acquired Immunodeficiency Syndrome (AIDS) has become the plague of the century. In the United States alone, over 220,000 have been diagnosed and half of them have already died.

The ethical questions as to the care of AIDS are:

Who will pay for the cost of the billion of dollars spent on the care of AIDS patients since the insurance companies do not insure them?

Should the AIDS patient be quarantined and forced to change their lifestyle?

Should IV users be given free, clean needles, syringes and drugs since IV drug use and AIDS are very easily correlated?

Should HIV positive carriers carry an ID card?

Should everyone be tested for HIV without their knowledge, and if so, what should be done with the positive results in terms of employment and medical care?

Does paying for AIDS cases by the public or the government mean that they endorse the lifestyle of the patient?

Should Muslim physicians care for AIDS patients?

The Islamic response to AIDS is, in brief, directed at a



## TOPIC 3.
## The basic models of mutual relations in system "doctor-patient". Iatrogenic diseases, the reasons of their occurrence and an avoidance way.

***Basic models of mutual relations between a doctor and patient are a paternalistskaya and autonomous model of «weakened paternalism».***

All of people give birth free and equal in the dignity and rights». (Universal declaration of human rights, 1949)

Taking into account a human right on a health care, what models of relations between physicians-professionals and ordinary people allow to overcome these and other basic moral problems?

***1. Model of technical type***

One of consequences of biological revolution is an origin of doctor-scientist. Quite often a doctor behaves as a scientist-applied. Scientific tradition consists in that a scientist must be «impartial». He must lean against facts, avoiding all of the valued judgments. Only after creation of a-bomb and medical researches of nazis we realized all of foolishness and danger of such position. At first, a scientist, including applied, simply cannot be at leisure from values. Every day he is forced to carry out a choice - at determination of research purpose, at finding out of degree of meaningfulness of statistical information, at a selection from the endless area of experimental data of such information supervisions which are «important». And for each of these forms of choice as a ground the system of values is needed. Choice that matters, that presents a «value» must be made constantly. And it the more so right in relation to the applied sciences, including medicine. A doctor, which supposes that his task is in that, to give all of information a patient, and decision - after a patient, cheats itself, even if to acknowledge that in all of critical situations, wherein it is necessary to do a deciding choice, such appearance of actions would be in moral sense sensible and responsible. Moreover, even if in the process of decision-making a doctor would be able to avoid judgments of moral and other valued character, even if he

succeeded in business to carry out the impracticable ideal of freedom from the valued judgments, such appearance of actions would be. abusive for it from the moral point of view. He would grow into a technician, in a plumber which connects pipes and washes the littered systems, suffering no questions. And although I increased support reforms in a question about abortion, for me a doctor, which considers that abortion - it murder in complete sense of word, causes a deep anxiety, and here agrees to his realization or sends a patient to other doctor. I hope, not a single doctor will act thus, running into a request to kill a living man.

***2. Model of sacral type***

Moral disgust for a model, in which a doctor grows into a plumber, fully deprived own moral options, results in that go other limit, converting a doctor into a new priest. The known sociologist of medicine Robert N. Vil'son characterizes this model of interrelation a «doctor is a patient» as sacral. «Consulting room or hospital chamber, for example, - he talks, - has a certain aura of holiness»: «...patient is forced to look at the doctor as on a man, removed from all of prosaic and mundane». The model of sacral type results in that some authors name «Syndrome as». He shows up in words, but illness carries moral character. A phrase serves as a basic diagnostic sign: «speaking as...» So, advising a woman, accepting hormonal preparation during pregnancy, a doctor talk: «Chances not in behalf on birth of normal child, and, tell you as a doctor, - in this situation a risk is not justified». Is it necessary to ask, that allows a timber-toe by medical education to pronounce these words as doctor, but not as friend, how moral man or as a priest? Problematic already expansion of action of the special knowledge is their transfer from a technical area in the area of moral recommendations. Basic moral principle which expresses tradition of sacral type says of: «Giving a help a patient, not inflict him harm». Modern criticism of principle of uncasing of harm in something consonant a patient to criticism of patriarchy (a matriarchy in the west was not dominant). Patriarchy, dominating long time, is only other form of expression that model of sacral type. A word «Father» traditionally served as a metaphor for God and for a priest. And in classic literature on medical sociology, in



organs justified? Is the taking of animal organs justified? Is accepting organs from aborted fetuses justified? Is harvesting fetuses to get more fetal tissue justified? Is the cost of transplantation worth the benefit derived from it? The total cost of heart transplantation is in excess of several hundred thousand dollars, with an average post-transplantation life of two to three years, and the quality of post-transplantation life is not necessarily the same level as it was before the development of end-stage heart disease. I have not seen a single heart transplant patient going back to work.

Transplantation, in general, is permitted especially if it is a gift from a living donor to another living person. From the Islamic perspective, transplantation from the dead to the living may not be permitted unless a free will is available before the death of the person. The relatives and the physicians should respect the rights of the dead body even though their intention to save another life is noble.

The ethical questions in cases of abortion are when does life begin? If a fetus is a living individual than is terminating its life a murder? What are the rights of the fetus? Who guards those rights? Do both parents even if unwed have the same rights over the life of the fetus? What should be done with the pregnancy that is the outcome of a rape? Should all such pregnancies be terminated?

What if the woman wants to keep her baby even if she did not want it to begin with? Is promoting or not preventing abortion which will lead to more sales of aborted fetuses for transplantation of fetal tissue and organs or their delicate skin to make expensive cosmetics justified? Islam believes that life begins when the zygote is formed.

The women of pagan Arabia, before Islam, killed their infants for the fear of poverty or the shame of birth of a girl. Both of these acts have been condemned in Quran, but the women of today are killing their infants not for either cause but to sustain and enjoy the life of sexual freedom.

There are many questions in the area of biotechnical reproduction and surrogacy. Infertility is a disease and to desire to seek a cure for the disease is Islamic. However, this has to be done

medical or surgical care. Let us discuss the questions of rights and obligations.

These rights maybe considered in relation to the right to die, the right to abort a viable fetus, the right to have a child in case of infertility, or the right to donate or receive an organ, or the rights of the individual whose disease maybe due to an deviant lifestyle. Not only should we discuss the right of the individual, but also the rights of the spouse, relatives, physician and other care- givers, the unborn, and God. While discussing the rights, we must also discuss the obligations of the State, community, the individual, the spouse, and the relatives.

In the question of the right to live or die, the question is should one prolong the life or the misery. Who determines (the unconscious patient, the family, or the doctor), that the plug should be pulled and the life support system stopped? What is the definition of death, acceptable to both the medical technology and Islamic jurists? Is a living will justified? Is stopping the life support system an act of mercy, a medical decision, a murder, or a financial decision?

While Islam gives importance to saving life, it also makes it clear that dying is part of the contract with God and part of the journey on this planet. The final decision of the term is up to God. The quality of life is equally, if not more important than the life span on this planet.

Physicians and the family should realize the limitations of medical technology and should not attempt to do heroic measures for a terminally-ill patient who is in a vegetative state and cannot be resurrected to a quality of life acceptable to him. The heroic measures taken at the beginning of life like saving a premature baby are more justifiable than at the end of the life span. Islam consider euthanasia an act of murder. Islam do not see the difference between the gun used by a husband for his dying wife and the syringe used by the physician for his dying patient; both are weapons of death no matter what the intention of the killer was.

There are ethical questions in the area of organ transplantation. What are the rights of the living donor, the dead body, and the recipient. To prolong life, does the recipient have a right to take away the organ from the dead? Is the sale of the



the same literature which uses religious appearances as an analogy for expression intercommunication a «doctor is a patient», appearances of parent and child are always used. Just the same paternalism in the field of values and shown in moral principle: «Giving a help a patient, not inflict him harm». Depriving the patient of possibility to make a decision, he shifts it on a doctor. The same paternalism liquidates or, at least, takes to the minimum all of other moral grounds, necessary for the balanced ethics system. And although the group of physicians-professionals can confirm this principle as principle of professional moral, clear, that there is much more wide set of moral norms in society. And if the group of physicians-professionals accepts one norm, and society under those circumstances - other, a doctor gets in uncomfortable position, obligating him to decide: whether to identify with the norms of professional group or with the norms of more wide layers of society. That would plug in itself this more wide set of norms:

a) To be of the use and not inflict harm. Nobody, alien maximum tradition, can take off a moral duty to be of the use and here fully to avoid causing of harm. We will say about it from the beginning. Some the ethics, bringing of benefit and uncasing of harm two different principles consider, giving large moral weight the last principle. It is characteristic and for professional medical ethics. In actual fact distinction consists of that in that aggregate of moral norms, which are followed by the wide layers of society, principle: «Being of the use, not inflict harm», exists in a wide context and makes one element of all of great number of moral duties only.

b) Defense of the personal freedom. The fundamental value of our society is the personal freedom. It is needed for a man. The personal freedom of both doctor and patient must be on the defensive, even if it seems that it can inflict some harm. That is why society lets certain patients, to beforehand well-informed legally, to renounce procedure of blood transfusion or from other types of medical care, although it seems most people, that as a result of it enormous harm is inflicted a patient. Opinion no private group cannot serve as authority at the decision of question about that is of the use, and that harms (when oppose setting of

procedures, necessary for achievement of beforehand certain useful or harmful results). To assume the reverse means by mistake to extend the sphere of action of the special knowledge.

c) Guard of human dignity. Equality of all of people means on their moral qualities, that each of them possesses basic human dignities. Personal freedom of choice, control after the body and realization of human dignity assist after own life. Many steps in the process of hospitalization, providing of medical care and maintenance of patients, especially heavily patients, contain a threat human dignity. To the exhausted, decrepit person which with life link intravenous tubes, tracheotomy and colostomy, it is difficult to support self-respect. And nothing is present surprising in that many prefer to return home and there to die. In fact exactly there, under a native roof, they find forces and sense of dignity.

d) To tell the truth and carry out promises. Moral duties - to tell the truth and carry out promises - so sensible, and traditional, save the place in ethics, because they are needed for human relations. It is possible to be only sorry that these grounds of human co-operation are under threat of to the minimum and even removal for the sake of that, to conduct principle - not inflict harm a patient. This problem - much more wide and it is not taken to that, whether to tell the truth a patient with a terminal cancer tumor or expectant mother at which during conducting of amniocenteses on mongolism, in an uterus was discovered XYY chromosome. This problem arises up already then, when to the boy, who it is vaccinated from measles, talk: «It will not cause you not the least harm», or when a student-physician is presented in a hospital as «doctors». All of these cases can be justified, as methods to avoid causing of harm a patient. But undoubtedly, what in every special case (especially if to take into account duration of loss of trust), and during the protracted period of similar sort of violation of principle: To «tell the truth and carry out promises» can inflict harm, but not to bring some benefit. And a boy which it is vaccinated, and student-physician, guess, what to wait them in future from medicine. But even without it every parallel instance is encroaching upon dignity, freedom and humanity. Such actions can be justified sometimes, however much excusatory arguments must be very weighty.



University School of Medicine, and Chair, Medical Ethics Committee, Islamic Medical Association of North America says: “Sickness precipitates questions about himself and his future in the mind of a patient and drives him closer to God, whatever his distance might have been at the beginning of the illness. During illness, many patients go through spiritual growth and find their spirituality at the end. A physician's own belief may influence his treatment options for the patient's outcome. For example, a physician who is totally against abortion will never advise his patient to undergo an abortion, and a physician who does not value the sanctity of life may become a suicide-doctor. The Muslim physician, knowing that we have no right to take our own lives, should not assist his patient in that, either”.

Some of the rules of medical ethics include

**a) respect for the autonomy** and **b) beneficence.**

People are autonomous in the decision-making process if they are able to understand and make intelligent decisions for themselves which are intentional and voluntary. The right of patient self-determination accepted by the State is based on this principle.

The second principle is that of beneficence, which obliges persons to benefit and help others. This principle requires positive action to prevent what is bad or harmful, to remove what is bad or harmful, and to do, or promote, what is good and beneficial.

The Islamic principle of forbidding what is wrong and enjoining what is good illustrates this. The knowledge of medical technology obliges Muslim physicians to offer what medical justice requires. Medical justice by itself is a principle of fair distribution of benefits and burdens. Justice requires that persons receive that which they deserve and to which they are entitled. These principles involve decisions to allocate scarce health resources. The actual implementation of this principle remains somewhat controversial. Physicians' response to individual justice differs at times with "societal" justice.

Another rule is nonmaleficence. This principle obliges persons to refrain from harming others including refraining from killing them or treating them cruelly. It is one of the non-intervention. It also requires the person to exercise due care so that they do not unintentionally harm others such as malpractice in

## TOPIC 9. ISLAMIC ETHICS.

The introduction of newer technology in medicine in areas of life support in terminal patients, abortion, organ transplantation, biotechnical parenting, and care of AIDS patients has posed Muslim physicians and patients some new questions of ethics. The ethics is not being right or wrong, all black or all white, but as having shades of gray. It is the process of making better decisions or worse decisions compared to the worst decision. Islamic medical ethics are based on the priciples of the sanctity of human life and safeguarding its values, taking the lesser of the two evils. We look upon these issues from the perspective of Muslim physicians in that we have to face the dilemma in medical ethics on a daily basis.

Life, though short as it may look on this planet, is still a precious gift from God. Since we did not create our life, nor are the owners of it, we should not have the absolute power over it either. For our soul and spirit to live in our body for a certain period can be compared to living in a beautiful, leased apartment or house. The only thing which the landlord would like the tenant to do is to live with certain rules and regulations and do things to improve upon the apartment or house rather than destroy it. We have a duty to preserve our life and to use it for glory and pleasure in the service of God as the quality of life would permit.

The guiding principle in Islamic medical ethics which is mentioned in Quran and also in the Torah is, **"If anyone has saved a life, it would be as if he has saved the life of the whole of mankind."** However, the question that we are faced with, in terms of saving life, is at what cost and what quality. Does the quality of life modify our decision-making process and when resources are scarce, who takes precedence, the individual or the community?

In addition to the emphasis on preserving life and the quality of life, the principles of biomedical ethics include promoting and restoring health, alleviating suffering, respecting patients' autonomy, doing medical justice, telling the truth, and doing no further harm.

Shahid Athar M.D., Clinical Associate Professor, Indiana



e) Observe justice and restore it. The moral norms of wide layers of society go out outside the duty of providing the patient of help and uncausing to him harm as early as one requirement - requirement of the just distributing of services in a health protection. That we metaphorically named social revolution, strengthened our concern equality in distributing of basic medical services. If a health care is a right, it is a right - for all. It is not enough to demonstrate the individual cases of salubrity and happy statistical information about the health of population.

Presently histories a question about justice in distributing of medical services causes the special concern because of high level of discrimination. Justice is a demand refund. Health those, what was exposed to discrimination, must be supported and recovered above all things.

### *3. Model of collective type*

In the model of technical type a doctor grows into a plumber, deprived some moral qualities. In the model of sacral type moral authority of doctor is rendered by such influence on a patient, which represses his freedom and dignity. Trying it is more adequate to define a relation a «doctor is a patient», saving fundamental values and duties, some the ethics it is talked that a doctor and patient must see in each other of colleagues, aspiring to the general purpose - to liquidation of illness and defense of health of patient. A doctor is a «friend» of patient. Exactly in the model of collective type a trust plays a deciding role. When two men or two groups of people are indeed defended by general aims, their trust is justified, and the model of collective type is adequate. Such is a method of co-operation of comrade-in-armses. Here present equality and in dignity, and respect, and in the world of assistance, that was not inherently to the previous models.

However much social realism forces us to set a not simple question: is there some real soil in business for co-operation, for general aims and interests, what would allow to utilize the model of out of control association of colleagues in relations a «doctor is a patient»?

Some signs of association, movable the real general

interests, arose up in radical motion in defense of health and in free clinics, but however it is necessary to establish that ethnic, class, economic and valued distinctions between people convert principle of general interests, necessary for the model of collective type, in empty dream. It is necessary to create a model, in a greater measure proper terms and assuming equality between a patient and doctor in the field of moral, not accepting the utopian parcel of collective nature.

***4. Model of contract type***

The model of social relations, which corresponds the real terms, - it a model, based on a contract or agreement. In the concept of contract it is not necessary to inlay legal sense. It is necessary to interpret him rather symbolic as a traditional religious or marriage vow. In him two individuals or two groups of people operate on the basis of mutual obligations and expected mutual benefit. But duties and benefit, even if they are expressed a few mistily, have the scopes. Basic principles of freedom, personal dignity, honesty, executions of promises and justice are needed for the model of contract type. It is served as its pre-condition trust, even when evidently, that complete reciprocity of interests is not present. Social support is related to legitimization of this co-operation and provides his realization in the case of breach of contract. However considered it is that the obligations accepted in most cases will be absolutely observed.

There can be an authentic division of moral authority and responsibility only in the model of contract type. It allows avoiding the waiver of moral from the side of doctor, that characteristically for the model of technical type, and waiver of moral from the side of patient, that characteristically for the model of sacral type. It allows avoiding false and uncontrolled equality in the model of collective type. In relations, based on a contract, a doctor realizes that in the cases of meaningful choice after a patient freedom must be saved to manage the life and fate. If a doctor will not be able to live in tune with the conscience, entering into such relations, contract or annulled, or does not consist. It means that it is necessary to conduct more deep discussion of moral grounds on which decisions of medical problems to that or



internal diseases?

4. In what features of relations of the medical worker is in clinic of surgical diseases?

5. In what one of requirements of external culture of behavior consists?

6. What rules of external and internal culture?

**outpatient reception hours.**

Conditions of rest, attention, positive ethical, emotionally-ethical influence, observance deontologycal principles are an important condition for psychological mood of the patient at treatment. The medical worker should listen attentively to the patient and patiently give council.

**The features of the medical deontology in the conditions of scientific and technical progress.**

The image of the wise doctor is written by Antoine де to Sent-Ekzjuperi: "I believe that there will be a day when it is not known than the patient will be given at a hand of physicists... Without asking it about what, physicists take from it blood, will deduce any constants, will multiply their one on one, then, having verified with the table of logarithms, they will cure one uniform tablet. And nevertheless, if I will be ill, I will address to any to the old rural doctor. He will look at me an eye corner, will probe pulse, a stomach, and will listen. Then will cough, will light up a tube, will wipe a chin and will smile to me that it is better to appease a pain. It is known that I am grasped by a science, but also I am grasped by wisdom".

Certainly that today "techniques" separate doctors it is shown in a new fashion, they become dispatchers. But now humanism of medicine surplus harms not, and the lack of means is faster. Introduction of electronic-computer facilities, computer diagnostics, functional, biochemical, иммунологических systems will sharply raise productivity of hospital work, will improve health services of patients, will release the qualified doctors from routine, will allow to concentrate it attention to the patient, will improve carrying out of prophylactic medical examination of the population. But the scientific and technological revolution generates deontology problems, influences hospital secret, transplantation of bodies and other.

***Questions for self-checking.***

1. What communication of ethics with philosophical outlook?
2. In what one of requirements of external culture of behavior consists?
3. What specificity of relations of medical workers in clinic of



as these decisions will be accepted.

In the model of contract type a patient have legal grounds to trust that, as an initial system of values, used for acceptance of medical decisions, is founded in the system of values of patient, the great number of different decisions which a doctor must accept daily at helping to the patients will be carried out in accordance with the valued orientations of patient.

In addition, in the model of contract type of decision accepted so, that a confidence is saved that both a patient and doctor is morally cleanly. In the context of contract relations at individual level control of patient after making a decision is provided without the obligatory participating of patient in making of every banal decision. Similar appearance at social level is carrying out control of community in the field of health protection. The association of amateurs gets (and it is necessary to give) status of subject, incoming in contract relations. Thus, made a decision the association of amateurs, however accepted everyday medical decisions can be medical workers on the basis of trust. If a trust is lost, a contract is annulled.

Medical ethics in the epoch of biological and social revolutions examines the lots and lots of new and difficult moral problems: artificial impregnation, neurosurgery, «pills of happiness», death of brain and use of medical technology in soldiery aims. However much everyday crisis situations in a moral plan can be not so eccentric. Whether a medical problem is eccentric or it is no more difficult, than ordinary task on physics, and in that and in other case deciding role in it will play the spirit of moral responsibility, which depends on the choice of the proper model of moral relations between the associations of professionals and amateurs. This is authentic foundation for medical ethics in the epoch of revolutionary transformations.

**Principle of the informed consent: call paternalism**

«Guardian's» model of relations between people loses the positions in public life. Taking a start in a policy, the idea of partnership got to the most secret corners of life of man.

Paternalism, traditionally reigning in medical practices, though with large resistance, but however yields to a place

principle of collaboration. The moral value of autonomy of patient appeared so high, that benefaction of doctor despite will and desire of patient began to be considered impermissible.

Under the informed consent voluntarily acceptance of course of treatment or therapeutic procedure is understood a patient after the grant of adequate information a doctor. It is possible to select two basic elements of this process: 1) grant information and 2) receipt of consent. The first element plugs in itself the concepts of voluntarily and competence. Imputed a doctor in a duty to inform a patient about: and) character and aims of the treatment offered to him; б) substantial risk related to him; in) possible alternatives to this type of treatment.

From the ethics point of view a concept of alternative is the offered treatment central in the idea of the informed consent. A doctor gives advice about the most acceptable from the medical point of view variant, but a final decision is accepted by a patient, coming from the moral values. Thus, a doctor behaves to the patient as to the purpose, but not as to the mean for achievement of other purpose, let it be even health.

The special attention at informing is spared also to the risk, to relate to treatment. A doctor must affect four aspects of risk: his character, seriousness, probability of his materialization and suddenness of materialization. As speech goes about opening of substantial risk, there are questions, in what cases to consider a risk substantial; say, whether a serious risk will be «substantial», probability of materialization of which is minimum. Such approach facilitates a doctor his task, but a doctor conduces of relation is a patient, that to ethics sense of the informed consent.

Answer for a question «as (in what volume)?» to inform a patient related to the problem of the so-called standards of informing. Originally in medical and judicial practice at the estimation of volume and character revealed to the patient of information followed a «professional criterion», requiring from the doctor of grant such information, what other most doctors would be given in the same circumstances. Then this criterion was rejected in behalf on the standard of «reasonable personality», in obedience to which a patient must be supplied any information which reasonable personality would like to have, in order that to



possibility. The doctor should calm the patient, give it hope of treatment. Even pathologists, who see a considerable quantity of death, have until the last minute hope if illness mentions also their most - “Dum spiro spero”.

The doctor should explain to the patient that disease is heavy, long treatment is necessary, deterioration of the general condition changes in due course on the best.

**Tactics of the medical worker in clinic of internal illnesses.**

In therapeutic branches there are patients of a different profile: with diseases of cardiovascular system, a gastro enteric path, respiratory organs, kidneys, etc.

The long separation from a family, usual professional work, also fear for a condition of the health assists development of a complex of different psychogenic neurotic reactions. Develops somatic psychogenic decomposition, the course of the basic somatic disease becomes complicated, and it in turn lifts a mental condition of the patient. In clinic of internal illnesses constantly it is necessary to observe somatogenic and psychogenic infringements, especially at persons of advanced and senile age, at HD, IDC hearts, at stomach ulcer. Medical workers should be especially tactful, adhere to psychotherapy principles. It is not necessary to specify in treatment at the psychiatrist at all, it will lead to infringement of contact to the patient, insults and strengthening of neurotic reactions, already iatrogenic character. It is necessary to concern all complaints patiently, to show the psychotherapeutic approach which is for them one of important methods of treatment.

**Tactics of the medical worker in clinic of surgical illnesses.**

In preoperative and especially in postoperative the periods much depends on the sensitive, attentive relation to the patient. It is important to come into benevolent contact to the patient, during conversation it is important to find out character of its fears, to calm, change the relation to treatment. Many patients are frightened a narcosis, “to fall asleep forever”, to give out the secrets, etc.

**Tactics of the medical worker in the conditions of**

joyful mood.

Considerable role in formation of aesthetic qualities of the person of the doctor maintenance of external requirements of its reference by it in clinic - fashion, behavior manners, speech, feature of gait, a timbre of a voice will play, etc.

**Tactics of the medical worker in clinic of children's illnesses.**

The medical worker should show constantly care, warmth, attention and thus to compensate absence of parents. It is necessary to prepare the child for procedure, to calm her, to encourage, find contact, especially in branch where children of early age are treated. The careful, attentive relation to the child, desire to understand it is this big art where professional level closely unites with the person of the medical worker.

Considerable difficulties arise at medical workers at dialogue with parents. It is necessary to have endurance to explain and listen to their fear and despair. But when the lethal end of disease comes nearer, it is necessary to prepare parents carefully.

Medical workers should be counterbalanced, sustained as the worker who resolves to itself roughness, brings an emotional unbalance, tactlessness of harm more, than will help the sick child. Medical workers should adhere to soft tone of speech; have an affable, mild and kind smile. It is impossible to take away last hope from parents, and to focus them on long treatment and those doctors will use the best efforts for reduction of sufferings of their child. In no event it is impossible to tell “a deadly outcome”, “the child dies”.

**Tactics of the medical worker in oncology.**

Ontological patients worry for the further destiny; they constantly ask about a tumor and metastasize. In conversation with them it is necessary to be careful, to carry out psychotherapeutic actions. There mentality is considerably emotional, vulnerable and jet. Therefore ethics infringement: mutual relations between medical workers it is perceived sharply, especially in a heavy intoxication, feeling the illness end. In such cases the loud laughter, loud language of staff nurses, doctors are inexpedient, it quickly assists patients on balance infringement. Each person subconsciously hopes for recover, does not trust in death



make a decision about treatment. And finally, lately all of the greater influencing is got by a «subjective standard», requiring, that doctors, as far as possibly, adjusted information to concrete interests of separate patient.

From point of ethics, a «subjective standard» is most acceptable, because he leans against principle of respect of autonomy of patient, acknowledges independent informative necessities and desires of person in the process of acceptance of not simple decisions. «Information must be differentiated, as for a patient there can be individual or heterodox persuasions, unusual problems, related to the health, unique history of family, so on». Speech goes, certainly, only about grant medical information.

In an initial period of forming of doctrine of the informed consent basic attention was spared the questions of grant information to the patient. Last years scientists and practical workers are anymore interested by the problems of understanding of the got information a patient, and also achievement of consent concerning treatment.

Voluntarily consent - on principle important moment in the process of acceptance of medical decision. Voluntarily of the informed consent is implied by unapplication from the side of doctors of compulsion, deception, threats etc. at acceptance of decisions a patient. It is possible to talk in this connection about expansion of purview moral, moral estimations and requirements in relation to medical practice. The waiver of paternalists’ ethics with its univalent benefaction was accompanied the overvalue of values of traditional principles of medicine and, in particular, principle «sainted lie». True, let cruel, today gets priority in medicine. There was imputed a doctor in a duty to be more honest with the patients.

However, it admits, a doctor does not come running to deception, threats and other rough forms of manipulation a patient. And however, where guarantees, that is not pressure from the side of doctor? When is a patient indeed free, to give a voluntarily consent? Not simple question.

Formulary of consent filled a patient helps to provide voluntarily of consent in some measure. It is a document, confirmative, that «negotiations» between a doctor and patient

passed satisfactorily. Formulary signs not only the two interested parties but also witness.

At the same time filling of formulary, proper the produced requirements, is necessary, but by an insufficient condition in achievement of aims of the informed consent. A major moment understands of the got information a patient.

Under a competence ability to make a decision is understood in bioethics. *Three basic standards of determination of competence are selected: 1) ability to make a decision, based on rational reasons; 2) ability to come as a result of decision to the reasonable aims; 3) ability to make a decision in general.*

Thus, the general standard of competence is the following: a person is competent, even if only if this person can accept acceptable decisions, based on rational reasons.

The problem is especially important for competence for psychiatry. In modern legal psychiatry a person ignores incompetent only on the basis of fact of psychical illness. If ability to make a decision is not damaged pathology, a patient has a purchase option from the possible alternative types of treatment and right on the waiver of treatment. It is a concrete display of departure of psychiatry from paternalism and claim of such moral values, as respect of personality and autonomy of individual.

*There are two basic models of the informed consent - event and judicial.*

In an event model a decision-making is meant by an event in certain moment of time. In practice it looks like the following. After the estimation of the state of patient a doctor diagnoses and makes the recommended plan of treatment. A conclusion and recommendations of doctor get a patient together with information about a risk and advantages, and also about possible alternatives and their risk and advantages.

Weighing obtained information, a patient thinks over a relative risk and advantages of every type of treatment and then doctors does an acceptable choice which most corresponds his personal values. On a surface this model fully conforms to the basic requirements of the informed consent. An accent is done on grant complete and exact information a patient in the moment of



fading of storming emotional reaction.

**Psychological leadership.**

Only under conditions of psychological leadership probably present, instead of false trust to its professional actions. After all such, on expression of clinical physician B.S.Votchal, “timid weak the doctor - the most dangerous as it will always find thousand possibilities if only nothing to make, of course, kind, curative for the patient”.

**Deontologichesky role of verbal dialogue with the patient.**

It is necessary to remember expression of Russian clinical physician V.M.Bekhterev: “If to the patient after conversation with the doctor it be not become easier, it not the doctor”. To transform a word into the reliable accomplice and the friend in struggle against illness - one of professional duties of the doctor.

**The duty** is one of the basic problems medical деонтологии, as well as medical ethics.

Medical deontology defines due in behavior not in respect of a moral or legal general duty, and in aspect of duties of the medical worker.

“Ignoramus the actor - stinging, ignoramus the engineer - unprofitable, ignoramus the doctor - dangerous. About what the patient has entrusted the doctor is a secret. Protect it as a holiday if it does not threaten with danger to associates or a society”.

“Surround sick of love and a reasonable consolation, but the main thing leave it in ignorance of that to it threatens”.

**Medical aesthetics.**

The medical aesthetics is a complex of morally-aesthetic education of the physician, enrichment of its spiritual outlook, development in it sense of beauty. Medical ethics and deontology are indissolubly united with a medical aesthetics. Art is an important subject of a medical aesthetics. The knowledge aesthetic, fine is obligatory in vocational training and professional work of the physician. Art needs for the optimal display of the medical trade use of salutary force of works of art and creative images in struggle against human illnesses. The medical aesthetics predetermines positive influence on mental and physical pledge of the patient, improves its state of health, causes spiritual calm and

of the patient against action of pathogenic factors. It is formed on the basis of deep understanding of corporal, spiritual and mental pledge of the patient, its belief concerning correctness of the diagnosis and medical tactics, on belief in a favorable clinical course.

**Morally-mental support.**

Main objective of morally-mental support - activization of a role and participation of the patient in medical-improving process, mobilization of protective forces of its organism in struggle against an illness. The effect of action of psychological support is shown by a positive course of disease.

**Psychological comprehension of corporal and spiritual problems of the patient.**

It is defined by concept of "sympathy", except verbal methods. At dialogue it is necessary to apply the preverbal. It is designated on a course of pathological process and efficiency of treatment.

**The humane relation to the patient.**

Humanism in a medical trade - the highest morally-ethical and spiritual display of sympathy for the sick person, “noli nocere”. Humanistic principles are defined by positions and requirements:

- Granting of adequate medical aid to the person irrespective of a nationality, religion, trades, the period, etc.;

- The consent or disagreement of the patient concerning carrying out of planned operative interventions or medical researches;

- Method rejection euthanized.

It is necessary to remember Nicolas's aphorism Van Tulpy “alis inserviendo ipse consumor”, words of doctor Gaaz “hasten to be good”.

**Sympathy and compassion.**

This original reflexion of physical and spiritual pledge of not strong person in its mental perception the doctor.

**Steadiness and self-control.**

The self-control, the counterbalanced and quiet reaction of the doctor, united with mental indulgent and sympathetic relations to the patient calm the patient and its relatives, predetermine fast



decision-making. However in an event model it is enough understanding of the got information is taken into account a patient, and possibility for a reflection and integration of information in the system of values of patient is small.

In opposition an event model the judicial model of the informed consent is based on an idea that acceptance of medical decision is the protracted process, and exchange must go information during all of time of co-operation of doctor with a patient. Treatment is here subdivided into a few stages, which can be described by basic tasks which they put: 1) establishment of relations; 2) determination of problem; 3) raising of aims of treatment; 4) choice of therapeutic plan; 5) completion of treatment.

In a judicial model a patient plays more active role as compared to in relation to by a passive role in an event model; more favorable terms are created for realization of self-determination of patient. This model allows ridding of formal attitude of doctor to toward to the patient and from the relapses of paternalism, showing up in limitation of control from the side of patient above motion of treatment.

On the whole a turn to the doctrine of the informed consent became possible due to the revision of conception of aims of medicine. It was traditionally considered that the first purpose of medicine is defense of health and life of patient. However quite often achievement of this purpose was accompanied the waiver of freedom of patient, and, and from his personality. A patient grew into the passive recipient of blessing, in the object of manipulations.

A primary objective of modern medicine is a help prosperity of patient; renewal of health is inferior this purpose as one of making elements.

The model of joint acceptance a doctor and patient of decision acknowledges about treatment, that both sides nothing substantial in the correct choice of treatment. Doctors on the basis of the experience give examination in relation to the prognoses of treatment, but only a patient knows the values which acquire a deciding value at the estimation of the expected results from treatment.

Respect of autonomy of individual is one of fundamental values of the civilized way of life. Any man is interested in that, to make a decision, influencing on his life, independently. Today self-determination of individual is higher value, and medical service must not be an exception.

**Iatrogenic diseases.**

Term «iatrogeniy» (from gr. iatros is a doctor + genes - originative are «illnesses, generated a doctor») was offered in 1925 the German psychiatrist O. Bumke for denotation of diseases, arising up because of careless utterance of doctor. However in 1970th after appearance international classification of diseases (ICD) he purchased a few other sense.

Accordant ICD-10, iatrogeny is any undesirable or unfavorable consequences of prophylactic, diagnostic and medical interferences or procedures, which result in violations of functions of organism, limitation of usual activity, even death; complications of medical measures, developing as a result of both erroneous and correct actions of doctor.

In domestic literature such names have also pathologies and complications of diagnostics and treatment, by accidents in medicine, medicinal illnesses, side actions of medications, «second illnesses».

An author gives description of forms of iatrogenic diseases depending on reasons of their development:

- direct injuring of patient by clumsy approach of doctor, medical personnel;
- indirect injuring, related to reading of medical literature;
- iatrogenic disease, related mainly to personality properties of patient, feel like psychopath, to the obtrusive reactions;
- wrong conducting of instrumental research, erroneous introduction of medications a doctor;
- form of iatrogeny, when even successful treatment of some disease the specialist of one or another type entails the origin of other pathology, requiring jurisdictions of doctor of other specialty.



The term “deontology” (deon - a duty and logos - the doctrine) has been offered for the first time in the thirties XIX century by English philosopher I.Bentam in the book "Deontology" or a science in morals.

That the doctor could give positive emotional action on the patient, it should be to it prepared intellectually, emotionally and morally.

The doctor under no circumstances cannot dispose of another's life (euthanasia).

Still Seneka say: “Art to prolong life is an art not to reduce it. Out live all not to harm”.

Contrary to a certain generality deontology has essential differences from medical ethics: medical ethics are the generalized norm of the moral status of the medical worker. Деонтология defines more concrete, specific moral lines of the doctor, depending on its narrow specialty, clinical features of an illness, character logic and psycho ethical lines of the patient and its environment. In modern theoretical and clinical medicine separate the general деонтологию which considers problems in all ethics, social aspect of health, and concrete deontology which concerns ethical problems of concrete clinical discipline - to therapy, surgeries, neurology, pediatrics, etc. the Doctor of each specialist should know substantive provisions of the general and own means and methods deontology.

The basic deontology aspects of clinical activity of the doctor:

- Trust to the patient;
- Morally-mental support;
- Psychological comprehension of physical (physiological) and spiritual problems of the patient;
- The humane relation to the patient;
- Sympathy and compassion;
- Steadiness and self-control;
- Psychological leadership in formation of diagnostic and medical processes.

**Trust to the patient.**

The trust is important and specific medical means. It is original biological and psychoemotional protection of an organism

and in veterinary science), but also in dialogue with it, arises both desire to be clear each other".

Avicenna has figuratively and brightly described an image of the doctor: "the doctor should own eyes of a falcon, hands of the girl, wisdom of a snake and heart of a lion".

By consideration of a problem of ethics of behaviors by medical workers it is necessary to allocate key general questions which need to be considered irrespective of where the medical worker works: to specific conditions of polyclinic and a clinic or hospital.

It is conditionally possible to allocate two questions:

- Observance of rules of internal culture: the relation to work, discipline observance, the economical relation to the general achievements, sensation of collective nature, friendliness;

- Observance of rules of external culture of behaviors: a good form, corresponding appearance (external neatness, necessity of shadowing cleanliness of the body, clothes, footwear, a snow-white dressing gown, a kerchief, a hat, absence of superfluous cosmetics, decency, decency, ability to behave among colleagues and patients, ability to conduct conversation according to conditions and conditions. As these components understand medical etiquette.

One of requirements of external culture of behaviors - mutual respect. "It not only is useful for each collective, but also decorates it" - A.S.Makarenko.

At conversation with the patient it is impossible to forget M.Ja.Mudrov's words that during inspection of the patient the patient surveys the medical worker.

The relation of seniors on a post to the younger should be tactful, based on respect for work and the person.

Already in the Indian code of laws of Manu "Vedy" enumerated rules of behaviors of the doctor. During an antique epoch on development of behaviors of the medical worker "Oath", the founder of scientific medicine of Hippocrates mattered. For all history of development of medicine only in 1967 on II World deontology the congress in Paris it has been made the first and uniform additions to a Hippocratic Oath:" I Swear to train all life ".



Single standard classification of iatrogenic will provide an opportunity to conduct a full analysis, which is necessary to develop methods of preventing, diagnosing and treating these conditions.

**Questions for self-control:**

1. What means the ethics of mutual relations of doctor and patient?
2. What are the moral actions of doctor in the conditions of dependence on him life and health of patient?
3. What are the basic models of mutual relations in the system "doctor-patient": paternalists' and autonomous?
5. Explain the principle of the "informed consent" and "collaboration" of doctor and patient.
6. What a problem of "distance" and deference to the rank of doctor and patient is in medical practice?
7. Name the concept about iatrogenic diseases, their principal reasons and consequences.

## TOPIC 4.
## Moral and legal aspects of physician secret.

In the II part of Criminal Code of Ukraine amount of clauses, which can be applied to medical workers concerning their professional activity, is increased, and reaches, at least, 20. “Illegal divulgence (spreading) of medical secret” is one of the offences, which is punishable criminally according to Clause 145 of Criminal Code of Ukraine.

Law directs that divulgence of medical secret is **object of offence** according to Clause 145 of Criminal Code of Ukraine. Medical secret is **subject of offence** according to directed clause.

***Physician secret*** is documented in a way information about disease, medical examination, inspection and their results, intimate and family sides of citizen’s life. Physician secret (information about patient) must be differed from medical secret (information for patient).

***Medical secret*** includes information about patient’s health, his/her present history, and also information about aim of proposed researches and treatment, potential prognosis of disease’s development, which must be presented by physician at the demand of patient, members of his/her family or legal representative, excluding cases when complete information can harm to patient’s health.

It is result of history, that physician secret isn’t only legal, but ethical-moral and philosophic concept also. It is ancient, but ageless theme, reflecting moral and society’s ideology at relations of physician and patient. In reality, physician secret appeared simultaneously with profession of physician, and, though, relation of society to it was different during various epochs, almost all great doctors, humanists and philosophers find its observation as one of the indisputable principles of medical action.

In this instance why is it necessary to distinguish clause, providing responsibility for illegal divulgence of physician secret?

Theoretically, it should seem ethical norms of society, formed during many centuries, suppose initially that every honest man must observe secret confided to him/her by other one. But it isn’t so simply. Old Testament admonished - “*Person, divulged*



necessary; to be modest and to have sensations of shame, abstention in food, firmness of the person and spirit at dangers; cheerfulness without laughter at a beautiful course of illness; secret preservation at different illnesses which are condemned; acceptance of clever and benevolent wishes; a deviation of harmful wishes; not to be superstitious, to be wise, uniting medicine with wisdom as, according to Hippocrates, the doctor who loves wisdom, is similar to the father”.

M.Ja.Mudrov has drawn to us a portrait of the doctor-humanist, the doctor-tutor thinking which should influence the patients, learn and bring up their personal example.

If the doctor is at a bed, sick person is excited and frightened. “Smile, encourage its kind expression of the person, gesture, a mimicry, be to it attentive. Listen to him, without interrupting, allow to it to be uttered, pour out the pain and you will already win the patient, half having solved a treatment problem. Develop it, speak with the patient spiritually. Remember: a word of the doctor strong hospital means. Apply it you were able also will reach the big successes. Not without reason a symbol of a trade of the doctor the Dutch doctor Nicolas Van Tulpius has offered a burning candle with the motto:“ Aliis inseviendo consumor ”, i.e.“ shining another, I burn down itself ”. The patient very attentively observes of the doctor, catches its each word, gesture. The word treats, but also the word will wound. Can wound and gesture, and even your sight. Well think over each word, gesture, a mimicry at a bed of the patient. Speak shortly, simply and clearly”.

Goethe wrote: “the Most amazing from this that was created by the nature, is a person of the person”.

“To become the doctor, - one of founders domestic эпидемиологии wrote J.S.Samoylovich, - it is necessary to be the faultless person”. It is necessary not only adhere to such ethical categories as a duty, conscience, justice, love to the person, but also to understand people, to own knowledge in the field of psychology. Without it there is cannot be and speeches about efficiency deontology actions on patients.

According to A.F.Bilibina, “... The psychology of treatment that at it occurs not only a meeting with the patient (it takes place

Morals are principles of value and a norm of behaviors which people adhere. The morals consist in carrying out actions which are correct behind the essence, and to avoid wrong - a deceit, injustice, cruelty

**Features of medical ethics** which distinguish it from the general are defined by specificity of professional work of medical workers and their special socially-public pledge.

Medical ethics study features of occurrence and development of professional morals of the medical worker, open moral value of medical work, value of humanity in performance of a professional duty, in struggle for health of the person. This humane relation to people, truthfulness, honesty, moral cleanliness, simplicity and modesty in public and private life, deep comprehension of a public debt, conscientiousness and selflessness in work, a great patience and endurance, love to the trade, to the sick person. Patriotism, love to the Native land should be a wreath of these moral qualities.

Allocate three basic groups of personal lines of the medical worker which characterize the moral, aesthetic and intellectual parties of the person.

**To moral lines belong**: keenness, consistency, patience, politeness, affability, honesty, tenderness, caress, sympathy and self-respect.

**Aesthetic lines**: modesty, simplicity, neatness, ability to create celebratory conditions in medical institution.

**Intellectual lines**: professional erudition, observation, ability to logic judgement of diagnostic and medical manipulations.

The doctor who informs the patient to face the truth, but not to lose hope on better - one of the hardest and major problems.

M.Ja.Mudrov in the performance "the Word about means to learn and study in applied medicine in practice or active iatrotegenics at beds of patients", told the following about necessary qualities of the doctor: "Having begun to love for the neighbors, I should cast to you all another: complaisance, readiness to come to the rescue of the patient day and night to be affable, merciful to poor or another's, to have mild insistence to the disobedient; to be polite, to have conversation only that is



*secret, loses confidence and can't to find friend by his/her soul*" (Sirach), but in New Testament it was directed - "*All secret can be open; all secret can be come out*" (the Gospel from Mark).

It is known, practice is criterion of truth, and practice showed the following: postulates, which must be like ethical axiom aren't law for men quite. "Information, concealed from enemy, must not be informed to the friend also, because it isn't guaranteed that friendship will last always" (Abul-Farag). That is why it is necessary to conduct ***short historical excursion.***

Concept "physician secret" was generated in Ancient India. Confidential relations of physician and patient are reflected in Indian aphorism: *"It is possible to fear brother, mother, friend, but physician - never"*.

Moral code of physician ethics was reflected in Hippocratic Oath also.

Then period, when attitude of society to "physician secret" was changed, came. Any mentions about it are absent in Oath of European physicians, which is known from the VI century A.C. Like was till XVI century, when works of Hippocrates were published in different countries of Europe (Italia, Switzerland, Germany, France). His authority reaches culmination and this period comes into history as "second coming of Hippocrates". At that time physicians, obtaining degree of doctor of medicine at Paris medical faculty, must were give "Faculty oath", made on the basis of "Canon", in front of bust of Hippocrates. It is known, when F. Rable was obtaining diploma of medicine doctor in Montpelier, not only gold ring, pulled by gold sash, mantle from dark heavy woolen cloth and crimson little cap were handed to him, but also book of Hippocrates works, which was started by "Oath".

Analogically to "Hippocratic Oath", at the beginning of the XX century nursing "Florence Nightingale Pledge" (it obtained name of founder of nurse profession, organized in 1861 in England first in world nurse business school) was composed also. In "Florence Nightingale Pledge" also it was directed to necessity of observation of secrecy of information from patient's life.

In the XX century number of international agreements was passed for regulation of relations between patient and physician.

"International Code of Medical Ethics" was one of the first documents. It was passed by Third General Assembly of World Medical Association (London, Great Britain, october, 1949), was added by 22nd World Medical Assembly (Sydney, Australia, august, 1968) and 35th World Medical Assembly (Venice, Italy, october, 1983). In "Code" it was proclaimed that "Physician must keep physician secret even after death of his/her patient".

Observation of "physician secret" was guaranteed also by "Lisbon Declaration of Patient's Rights", passed by 34th World Medical Assembly (Lisbon, Portugal, september/october, 1981). Clause D of this Declaration reads that - "*Patient has right to rely on the following - physician's relation to all medical and private information, confided to him/her will by like to confidential*".

Russia was going, as ever, in its way. Specific features of relation to problem of "physician secret" were in the following: traditions of priority of state interest over personal interest were always in Russia and now they go on being. Even Russian Orthodox Church as result of Peter I reforms (he insisted on informing of powers by confession's secret by priests) was converted into the part of state apparatus and couldn't be contrasted to state's invasion into private life.

Only from the middle of the XIX century graduates of all medical faculties of Russia, like the European colleagues, became to give "Faculty oath" solemnly. In its text was the following: "*I ... promise to keep saintly family secret, trusted to me and don't use confidence of other persons for harm*". Great humanist, therapeutist M.Ya. Mudrov in "Speech about method to teach and study practical medicine" also puts the same idea.

Debates about interrelations of men with society, including expedience of "physician secret's" observation, were carrying out repeatedly on the verge of XIX and XX centuries due to efforts of imitating "intellectuals", which were making up with "de′classe´ lumpen". Militant populists find it survival like "confession's secret" and call to open and transparent interrelations of physician and patient.

The most radical position belongs to A.F. Koni. He think that in cases of serious threat to social interests prohibition of divulgence of "physician secret" stops to be in force, i.e.



**TOPIC 8. The problems of deontology and medical ethics in different areas of professional work of the doctor.**

> "The medicine cannot be chopped on two pieces - laboratory and clinic as it is impossible to separate medicine from soul medicine... Understanding unity of a human body, the true doctor treats both despair, and organic infringements ". (A.Morua)
>
> "Over medicine as can be over one science, the wonderful cover of heroism" is stretched. (Gugo Gljazer)

The prevailing part of professional work of the doctor-clinical physician is occupied with its mutual relations with patients. Illness is not only a complex functional, metabolisms' and morphological infringements in activity of different bodies and systems, and both difficult and multifactor disorganizations of a mental and spiritual condition of the patient which needs to be considered always to the doctor at an establishment of the diagnosis and in the course of treatment of the patient.

Actual there are M.Ja.Mudrov's words of that "... There is a sincere medicine which treated a body". This art hardness to spirit which wins corporal pains, grief, alarm will inhale also.

**Ethics** (from greek. ethos - the custom, system of norms of behavior) defines morals rules (from an armour. moris - custom) and moral behavior of the person in a society.

Introduction term in practical use by Aristotle and in this ethical lecture is the Gospel.

**Medical ethics** are a science and practice of application of principles and high samples of universal morals in professional work of medical workers - the doctor, the average and younger medical personnel, based on high spirituality, intelligence, internal culture, on moral virtues - despicableness, decency, humanism, justice, милосердые, sympathy, to self-sacrifice. Medical ethics establish and regulate norms of moral behaviors of the physician in dialogue with patients, its relatives, colleagues, employees

all current research about how the brain works supports this position.

On the other hand, when only the higher parts of the brain have stopped, the body and the brain can still do quite a lot - more than is even the case with whole brain death. This can be disconcerting, because it doesn't seem right to declare someone "dead" when their body is still functioning. Such a definition can also be open to potential abuse due to the need for organ donations. Organs harvested from someone suffering only higher-brain death are in better shape and end up surviving better than those harvested from people judged by the other two definitions, making this standard appealing for some of the wrong reasons: profit and gain.

Distinguishing between the death of the person we know and love and the death of the biological organism is a difficult matter. For some people, it may not even be possible. Death is less a bright, sharp line than it is a gradual process, because life itself is not a single event or a single thing, but rather a host of interconnected events and circumstances. Death happens as those interconnected process shut down over time, one by one.

A social consensus needs to be reached as to where we decide that medical care might be ethically withheld or withdrawn from a human being. Not everyone will necessarily agree, but some level of mutual satisfaction is required due to the very difficult and contentious issues involved.

**Questions for self-control:**

1.What is the deontology?
2.What is the medical ethics?
3.What is the death?
4.What is the brain death?
5.What is the euthanasia?
6.What countries the euthanasia was admitted?
7.What are the rules of patients of life and death?



"*physician can count himself/ herself free morally and legally from observation (keeping) of revealed or given to him/her patient's secret*". Speaking in 1893 among members of Society of syphilidologists and dermatologists, he said, if a patient with syphilis isn't accessible to persuasion not contract a marriage, "*from physician's cover must occur citizen*".

Follower of S.P. Botkin - V.A. Manassein, which during 20 years was the Heard of the Chair of Private Therapy in Petersburg Medic-Surgical Academy, vas his irreconcilable opponent. From 1880 to the end of his life he was publishing weekly paper "Physician', famous due to unordinary pointed publications. For it V.A. Manassein was named "knight of physician ethics", "conscience of physician estate", besides not only in medical environment, but in whole society also. Relation of V.A. Manassein to "physician secret" deserves special conversation, as his position was contradictory to social moral in many respects. By evidence of V.V. Veresayev - "*Manassein was standing for absolute physician secret's observation in any cases* ..." For confirming of this thesis Veresayev analyzed some examples. Railway machinist appealed to oculist for medical aid. Examining him, physician made conclusion that patient is color-blind... Physician said him about disease and recommended to renounce from work of machinist. Patient answered that any other work is unknown for him and he can't renounce from his work. What must do the physician? V.A. Manassein answered - "*He must keep silence ... physician doesn't have right to let out secrets, which he heard due to his profession, it is treachery in relation of the patient...*"

His relation to the patient with syphilis was other example, characterized position of V.A. Manassein. It was the following: "*Silence is terrible in the same cases, however we personally would stand for observance of patient's secret for society's interests; if secret will be divulged in the name of most lofty action even, dozens, hundreds of syphilitics were afraid to treat and, consequently, will be syphilis - breader greatly ...* " Conflict of society's interests is on hand, members of society can be suffered due to machinist's color-blindness or spreading of syphilis and patient's interests, which can lost work in connection with

divulgence of his disease's secret by physician or negative relation and social isolation.

V.V. Veresayev spoke also for protection of "physician secret". He emphasized that *"... question about men's right... becomes fundamental and central question of physician ethics*". He was not single. Many authoritative physicians support him. For some time attacks to institute of "physician secret" ended. In medical world calmness ascended the throne, but it was for a short.

Revolution of 1917 was finished. And moral abnormality of separate physicians after 1917 became immoral state politics. State tried to maximal control over all aspects of its citizen's life, including questions, connected with men's health. Lenin- the main ideologist of that time declared, that - *"... for us morality, taken out humane society, is absent, it is illusion. For us morality is subordinate to interests of class struggle of proletariat.* "

In 1925 national commissar of public health service N.A. Semashko declared that "physician secret" is survival of old "caste" medical practice owing to fear of patient's loss and old silly prejudice - "shame for one's own disease" . He proclaimed that - *"... soviet public health service heads for abolition (liquidation) of "physician secret" as survival of bourgeois medicine and this survival must be dieing off as socialism will be built".* It seems surprising, but, speaking with this slogan (which is destructive for medical ethics), N.A. Semashko didn't faced with objection of physicians. During debate in January, 1928 in Moscow even Professor A.I. Abrikosov supported him totally. Only V.V. Veresayev with his world authority objected to national commissar of public health service. In preface to 12th publication of "Notes (transactions) of physician" (1928) Semashko undergone criticism. *"Point of view of N.A. Semashko practically leads to terrific flippancy and disgraceful neglect to natural patient's right"* (V.V. Veresayev). But during that period rights of "state small screw" alarmed nobody.

Such situation was to the end of 60 years (XX century) when government of Soviet Union was forced to think of men's rights under pressure world sociality. But in this situation also "non-standard" approach (with taking into account ideology) was



Whole-Brain Death

The definition of brain death was first developed by the Ad Hoc Committee of the Harvard Medical School back in 1968, and in 1980, hospitals were permitted to start using it as a determination of death in patients. Generally speaking, people have been comfortable with this definition. Individuals who suffer from whole brain death don't appear different from those who are covered by the traditional definition of death - they do not move, they do not breathe on their own, and without technological intervention, neither their heart nor their lungs will do anything.

Nevertheless, this definition is not without its problems. Even though a person might suffer from whole brain death, he can still have a heartbeat which only ends due to the failure of the lungs. If the lungs are forced to keep breathing, such people can continue to digest food, excrete waste, and even bear children. Are these the actions of a dead person? Then perhaps that question is phrased badly - they are not the actions of a dead body, but is there a person there anymore?

Although it is nice to imagine that the brain is totally dead, this isn't actually true. In about 20% of cases, some brain activity can still be detected on occasion. Thus, even whole brain death does not mean that the brain has ceased functioning entirely. Because of this fact, some researchers have argued for a more limited idea of how much of the brain needs to stop working.

Higher-Brain Death

According to advocates of higher-brain death, only the cessation of functioning in those parts of the brain responsible for consciousness and higher reasoning powers is necessary for the death of the "person" aspect of the brain and body. When the "person" is dead, the body might still be functioning - but for all practical intents and purposes, there is no ethical reason to keep the body alive.

Quite often, people will ask that they not be kept alive through medical technology if the higher parts of their brain no longer functioning. They believe that everything which makes them a unique person is controlled by those parts of the brain, and

live and die with as much dignity, control, and comfort as possible in light of whatever decision society makes.

Ethical Dilemmas at the Beginning and End of Life

What is life and what does it mean to be alive? What is death and is there any "bright line" that allows us to definitively say that someone is no longer alive but is now dead? When does a person cross over from life to death? By what standards can we mark the "death" of a human being? Most of the time, these would seem like very simple issues. However, knowing when a person is no longer alive is a fundamental problem when it comes to medical situations like organ transplantation. After all, we don't want to remove the organs of someone who is still living! Deciding when a person is no longer alive also has significant consequences for just what we consider a "person" to be.

There are three different definitions of "death" which have been used by the modern medical community: traditional heart-lung failure, whole-brain death and higher-brain death. Which one we ultimately require will influence how we treat people in hospitals, how we get organs for transplant, and perhaps even questions surrounding abortion and stem-cell research.

Heart-Lung Failure

The most traditional way to tell if someone is dead has been to see if their heart is beating and if their lungs are breathing. These factors are relatively easy to determine, even under difficult circumstances, and it is generally clear that if neither the heart nor the lungs are operating, then the person must not be alive anymore. The development of advanced medical technology has, however, created problems for this definition of death. Today, we can use a variety of machines to force the heart and lungs to continue functioning long after they would have stopped on their own. Such people are not "dead" by this definition, but are they really alive? Many people leave instructions to have such machines turned off if tests indicate that their brain is no longer functioning, which shows that people no longer entirely believe that merely a working heart and lungs are enough to render one "alive."



found. Graduates of medical institutes became to take oath of Soviet Union's Physician, which differed from "Hippocratic Oath" markedly.

It is interesting, that in Soviet Union official oath of Soviet Union's Physician was taken only by two categories of citizens of USSR - serviceman and physicians. According to Decree of Presidium of Supreme Council of USSR of the 26th march, 1971, mark about taking oath of Soviet Union's Physician was done.

Apart from other obligations, physician took an oath - *"... to keep physician secret".* But due to total dependence of medical profession on party-state control concept "physical secret" was only declaratory. Obstacles to access to case histories and other information sources about any citizen of USSR were absent for representatives of authorities.

Such situation causes some incomprehension in medical community of West countries (V.V.Vlasov, 2002). "Physician Oath" was state act, confirmed by Presidium of Supreme Council of USSR and this fact contradicts to notion about self-regulation of physician community with its own professional ethics, which was passed on the West. Underlining of social obligations of physician to state and sacrifice (devotion) of doctor's person to communistic moral (it led to total dependence ideology) weren't understood on the West.

Clause 3 of Constitution of Ukraine, which was passed during 5th sitting of Supreme Council (28 June, 1996) declared starting principles of state politics in relations to personality, man, citizen. The men, his/her life, honour and dignity, inviolability and safety were declared the greatest valuable element in society. Clause 32 of Constitution of Ukraine guaranteed non-interference in private life, but simultaneously every citizen of Ukraine has right to acquaint with information about himself/herself and members of his/her family, which is in state and private institutions.

At the end of 90ths years interest to observation of man's right grew in the countries, formed on territory of Union of Independent states. It concerns "physical secret" also. "Ethical Code of Russian Physician" was passed by 4th Conference of Russian Physicians' Association in November, 1994. Clause 13

"Physician and patient's right to keep physician secret" directs, that - "*Patient may to rely on keeping of all medical and private information concerning him/her by physician. Physician doesn't have right to divulge information, obtained during patient's examination and treatment (including fact of appealing for medical aid) without permission of patient or his/her legal representative (agent). Physician must take measures, preventing to divulgence of medical secret. Patient's death isn't cause, which can release from obligation to keep medical secret."*

At the same time, demands to keep secret aren't absolute. Situations, when **giving or circulation of medical information**, aren't cases of divulgence of medical secret are directed in "Code". It **is possible:**

- with purpose of professional consultations;
- with purpose of carrying out of scientific researches, estimation of treatment-sanitary programmes, examination of qualify of medical aid and educational process;
- when physician doesn't have other possibility to prevent serious damage (injuring) of patient or persons, surrounding his/her;
- by pronouncement of court;
- if functioning laws provides necessity of divulgence of medical secret in other cases, physician can be released from ethical responsibility.

In all foregoing cases physician must inform patient about inimitable outing of information and, if it is possible, to get consent for it".

Foregoing quotation shows that clause 13 of "Ethical Code of Russian Physician", contrasting to laws of Ukraine, didn't differentiate term "physical secret" and "medical secret".

This defect (demerit) was liquidated after elaboration of project of "Code of physical ethics" by group of competent Russian scientists. Project was debated by delegate of XVIII All-Russian Congress of Physician (Moscow, 5-7June, 1997). Clause 3 of this project was dedicated to "physician secret". It directs, particularly, that:

1. Physician must keep "physician secret". Secret applied to



despite the best care available and who requests assistance in dying. Patients with severe physical disabilities, such as those with amyotrophic lateral sclerosis, advanced Parkinson's disease, or quadriplegia, also may request assistance in dying. Hospice care offers much less for these patients, and they may turn to their family physician for help. Many family physicians would like to assist such patients but fear legal repercussions. What should those physicians do?

It is disingenuous to deny assistance on the basis of pragmatic considerations, such as slippery slopes, outbreaks of mercy killings, and mistrust of white coats. Withholding and withdrawing treatment also can create slippery slopes, and these approaches have been opposed on the basis of inflated fears, but these concerns are now considered insufficient to justify a prohibition against these practices. Most Americans know the difference between the euthanasia-as-murder and the type of assisted dying being discussed, which is limited to patients suffering unbearably despite aggressive efforts to relieve physical and psychological pain, who request assistance voluntarily and who receive voluntary, compassionate, competent assistance by their physicians. A review process should be established to ensure that these criteria are met.

From an ethical perspective, the essential issue is whether the long-standing prohibition against killing, which many regard as absolute, should outweigh all other considerations, such as the patient's autonomy or the degree of pain and suffering. Does the situation of unbearable pain and suffering pose a special situation that our society ought to regard as an exception to the general prohibition of killing through granting certain types of patients the right to waive their right not to be killed? These two horns of the dilemma embody the crux of the issue, and all other concerns should be regarded as peripheral.

Assistance in dying is illegal in most of the United States and much of the world. Whether the legislatures and the courts should stand in the way of physicians who, with compassion and competence, are willing to assist this small category of patients is an issue that our society is in the process of resolving. The ethical obligation for primary care physicians remains to help patients

well as the patient's competence. If either physician suspects depression or another psychiatric disorder, the patient must be referred for counseling. The primary physician must inform the patient of all reasonable alternatives such as pain and symptom management and hospice care and must report all lethal prescriptions to the Oregon Health Division. The physician may not administer the medication.

No significant abuses of the Oregon law have been reported. During the first year, only 15 persons chose to end their lives under the terms of the law; all but two had metastatic cancer. Some ethicists have observed that the preference for assisted suicide over euthanasia reflects a cosmetic distinction analogous to the now-obsolete distinction between withholding and withdrawing of treatment. Regardless of the methods, the motives and outcome are the same. Preoccupation with taints and stigmas reflects more concern for image than integrity and may indicate a lack of courage rather than a commitment to principle.

Another concern is that, in the era of cost containment, dying patients will feel unduly pressured to choose suicide rather than spend societies and perhaps their family's limited resources. Although such external pressure would be inappropriate, it does raise the question of whether patients have an ethical obligation to limit the costs of their care as they approach the end of life.

Hospice physicians, who have pioneered in the development of pain and symptom management for terminally ill persons, offer help to get beyond the impasse of those physicians who feel torn between wanting to relieve the suffering of the dying but not wanting to serve directly or indirectly as the cause of their patient's death. Hospice medicine has shown that the pain of dying persons usually can be palliated by aggressive pharmacologic treatment and by attention to "total pain," which includes all the physical, emotional, social, spiritual, and financial sources of the patient's suffering. The existence of this expertise and the relative ease with which a family physician can master it imply an obligation to use these methods and, when necessary, to seek consultation from palliative care specialists.

An ethical dilemma persists, however, in the occasional case of a patient whose pain or suffering remains unbearable



all information about patient and his/her surrounding, obtained by physician during professional work. Patient's death isn't cause, which can release from obligation to keep medical secret."

2. Giving information about condition of patient's health to other physician, if it is necessary for following treatment or making diagnosis, isn't violation of "physician secret".
3. Release from "physician secret "can be occur:
    - if patient gives to it his/her consent;
    - if keeping of secret is danger to health or life of the patient or other persons essentially;
    - if laws are binding in it.
4. It isn't violation of "physical secret" when after carrying out of physician examination its result was given to juridical person according to enquiry of organ, representative by law. But physician necessary must to inform patient about it before beginning of examination. Any information, which is essential for grounding of results, following from examination, must be physical secret in the future also.
5. Physician must look after keeping of professional secret by persons, assisting or helping to him/her in the work. They must know only that part of secret, which is necessary for correct carrying out of their professional duties. Physician documentation must include only information, which is necessary for treatment.
6. Physician and persons, working with him/her must secure confidentiality of information, which is in tests of deoxyribonucleic acid, taken in patients and their relatives.
7. Physician must keep "physical secret" concerning to patient's anonymity during scientific researches or transferring of experience during training or advanced training of physicians.

As a result, physicians in Russia reached a deadlock. By law *"Every citizen has right... to take information about condition of his/her health, including results of examination, presence of disease, its diagnosis and forecast, methods of treatment and risk,*

*connected with it, potential variants of medical interventions, their consequences and results of carried out treatment. Citizen has right to acquaint with medical documentation, reflecting condition of his/her health directly.* " And at the same time: *"Information, which is in medical documents, is physician secret".*

Unfortunately, Code like foregoing is absent. Is it well or badly? It is well, as during its elaboration experience of neighbours can be taken into account; it is bad, as Criminal Code of Ukraine foresaw responsibility even, and what's more, not only for "Illegal divulgence of physical secret", but also for other types of divulgence of information about patient.

So, illegal divulgence of information about carrying out of medical examination with purpose of revealing of AIDS or other incurable infectious disease and its results brings responsibility according to Clause of 132 of Criminal Code "Divulgence of information about carrying out of medical examination for revealing of infection of man's immunodeficiency virus or any incurable infectious disease". Divulgence of physician secret, if at the same time it is secret of inquisition, can be qualified cumulatively by Clause 145 of Criminal Code and Clause of 387 of Criminal Code "Divulgence of data of before-inquisition or preliminary".

For qualification of crime according to Clause 145 of Criminal Code objective side of crime is necessary. Last one is characterized by deed as "divulgence" of physician secret, its "severe consequences", and causal (cause) connection between these deeds and consequences.

Term ***"divulgence"*** means oral or written informing of outsider persons about contents of documents, containing physician secret, publications or other giving publicity of specific information.

Suicide or self-crippling of victim, serious exacerbation of his/her disease, experiences etc. can be declared ***"severe consequences".***

Subject of crime according to Clause 145 of Criminal Code is special. This subject - medical workers and other persons, including official ones, which obtained information during performing professional or official duties. It is not to matter for



two physicians must accede to the request.

Some patient advocacy organizations, most notably the Hemlock Society and Choice in Dying (formerly Society for the Right to Die), urge the adoption of similar standards in the United States, with the government protecting physicians from criminal and civil litigation. These parties believe that aggressive attempts to prolong the lives of terminally ill persons are unnatural and torturous and that euthanasia and assisted suicide are more humane. Others, including many of the pro-life organizations, hold that the taking of a human life is what is unnatural and immoral and that patients and physicians should always, in the words of the Hebrew scriptures, "choose life." They also express a practical concern that acceptance of this practice will lead to a slippery slope involving involuntary and voluntary euthanasia and euthanasia for patients who are not terminally ill or not experiencing unbearable suffering. They point to an apparent erosion of standards in the Netherlands, where, for example, 1000 incompetent patients are euthanized per year. Supporters respond that the percentage of life-terminating acts performed without the explicit request of the patient is relatively small, that this percentage is stable or shrinking rather than growing, and that most of these cases represent patients who requested euthanasia before becoming incompetent.

Physician-assisted suicide has been proposed as a way to minimize the role of the physician in the action causing the death of the patient while enabling the physician to provide expertise necessary to make the death as painless as possible. The patient feels a greater sense of control, and the image of the medical profession is not tainted by a stigma of murder attached to the event.

On October 27, 1997, the State of Oregon legalized physician-assisted suicide. The Death with Dignity Act allows physicians to prescribe a lethal dose of barbiturates or other controlled substances to patients who are terminally ill. To qualify, the patient must be an adult resident of Oregon and must make one written and two oral requests; at least 15 days must separate the two oral requests. The primary physician and consultant must confirm the terminal diagnosis and prognosis, as

question, and in 1987, 62%.

Many fear that aggressive measures to keep them alive, administered against their will, may inflict more suffering and indignity than they wish to bear. Others worry that the pain and debilitation of the illness itself may become unbearable, and they want the assurance that escape through euthanasia or assisted suicide is available. These are legitimate concerns. One study suggested that terminally ill patients frequently are overtreated against their will and that physicians continue to undertreat pain despite advances in pain and symptom management. Another study has shown that most terminal geriatric patients prefer palliative care but that these "patients…exert strikingly little influence in the making of the treatment decision" and frequently are misinformed regarding the terminal nature of their condition. According to the study, a major factor is physicians' own discomfort with death. Physicians practicing in teaching hospitals were found to be particularly uncomfortable with death, less likely to disclose a terminal diagnosis, and more likely to provide curative treatment in the last months of life.

Some physicians have urged colleagues to take a more active role in helping patients who request assistance in dying. They regard such action as an acknowledgment of medical hubris and an expression of medical compassion and willingness to support the autonomous wishes of patients. The American Medical Association, however, and a number of prominent physicians and ethicists have opposed efforts to legalize euthanasia and physician-assisted suicide. Physician participation in euthanasia and assisted suicide would, in their view, violate the Hippocratic Oath and confuse patients, erode trust, and tarnish medicine's image as a healing profession.

The most widely publicized model of physician-endorsed euthanasia is found in the Netherlands, where the government does not prosecute physicians who abide by an agreed-on standard of care. The criteria for euthanasia are that the patient's suffering must be intolerable despite aggressive relief efforts; there must be a low probability of improvement; the patient must be rational and fully informed; the patient's requests for euthanasia must be voluntary and repeated consistently over a reasonable period; and



qualification of crime, this information was confided to person or was obtained him/her in other cases (casually even), but in connection with performing of professional or official duties - duties of physician, lawyer, notary, tutor, etc.

From subjective side this crime is characterized by mixed type of fault- by "purpose" in relation to deed and by "imprudence" in relation to its consequence.

According to Clause 145 of Crime Code, designed divulgence of physician secret by person which obtained it in connection with performing of professional or official duties (if this action results severe consequences), is punished by penalty, amount of which - to 50 minimums of citizens' incomes (without taxing), or by deprivation of right to hold specific post or carry out specific action within three years, or by corrective labour within two years.

**Questions for self-control:**

1. Give definition and essence of physician secret.
2. Tell the history of medical secret's formation - from Ancient India to modern Ukraine.
3. What are the patients's right?
4. What are the rights of confidentiality?
5. Guarantee of physician secret's observation.
6. The main principles of medical deontology.
7. Explain the contents of medical secret.
8. Enumerable the moral-deontological principles of physician.

## TOPIC 5.
## Medical errors: moral and legal responsibility of the doctor.

The medical activity is a very complex activity that involves not only a serious preparation, information and continuous improvement, and also a correct application of the acquired knowledge, but also liability for the activity that was done. In this debate, we try to mark the limits between the deontological liability, malpraxis and the legal medical liability, starting from the information presented above.

For a better understanding, we thing that it is helpful to answer to some questions such as: What is the medical ethic? What is the medical deontology? What is the medical liability? What is the malpraxis? When do we have medical error? When do we have culpability? What is the civil liability in the medical field? What about the penal one? What point can we extend the deontological liability to and where does the legal liability of a doctor start from?

We are beginning by defining the **ethic** as being the science that studies the theoretical and practical matters of moral. The term **deontology,** being the moral of a profession, was first introduced in this field by the British philosopher I. Bentham. The moral behavior rules have existed in the medical field from the ancient times and they have become **medical deontology** in time. This fair practice is used in the patient - doctor relation and also in the doctor-society relation.

The definition regarding the **liability** can be defined as being a reaction to a social deed that the society condemns. **The medical liability** results from the peculiarities of the medical profession and also from the unforeseeable and irreversible development of the medical act.

It is of great importance to mark the differences between the moral (deontological) liability and the penal one in the medical practice.

The public opinion and the professional conscience are going to sanction the moral deviation of the doctor. The Medical Board is the one that usually analyses such deviation, solving the problem according the rules of this institution. This institution



As patients approach the end of life and grapple with their mortality, their spiritual and religious concerns may be awakened and intensified. Although some physicians may feel uncomfortable discussing a patient's spiritual and religious concerns, he or she can listen respectfully without having to agree with the patient or having to misrepresent his or her own religious views. There is no value in physicians going beyond their expertise, nor imposing their religious beliefs on the patient. Patients who feel the physician really understands their wishes no longer feel isolated and alone in their final days.

One way to approach this issue is to ask the patient, “Is faith or religion important to you in this illness?”

### EUTHANASIA AND ASSISTED SUICIDE

Physicians have an ethical obligation to help patients live and die with as much dignity, control, and comfort as possible.

- The most widely recognized model of physician-endorsed euthanasia is in the Netherlands.
- In the state of Oregon, physician-assisted suicide is legal if the patient is an adult resident of Oregon; the patient makes one written and two oral requests; two physicians confirm the terminal diagnosis, the prognosis, and the patient's competence; and the patient is informed of all reasonable alternatives, such as pain management and hospice care.

The issues of euthanasia and assisted suicide have provoked considerable public debate and challenged long-standing notions of the physician-patient relationship and the nature of the medical profession. In the coming years, patients may turn increasingly to their family physicians for assistance in dying, and family physicians must be prepared to respond appropriately.

For some time, most Americans have favored legalization of some methods of ending the life of a seriously ill or impaired person. In November, 1993, 1254 adult Americans were asked, “Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended, or not?” Seventy-three percent responded yes. Public support of assisted death has increased steadily over the past decade. In 1982, 53% responded affirmatively to the same

abandoned in his final days. The readiness to listen and personal, caring contact are comforts that cannot be matched by modern wonder drugs and procedures.

When dying patients notice that people are avoiding them, they may interpret it as rejection because they have failed to get better or see it as the loss of love from family and friends. The latter situation is particularly traumatic, because it tends to negate relationships the patient has cherished throughout life. The pleasures and joys of a rewarding life can suddenly appear to lose their value as the dying patient reflects over past events if he or she is ignored or avoided during these final days. The dying patient's contentment depends on maintaining warm relationships with loved ones and continuing other satisfying interpersonal relationships, such as with the physician. If physicians and others withdraw from interaction with the terminally ill patient, much of the motivation for living disappears and is replaced by despair or terminal depression. The following plea to fellow health professionals is from a young student nurse who was terminally ill.

The physician should not raise false hopes or be overly aggressive in treating a terminal illness to help the patient maintain hope. Some patients find it best to plan for a little time and hope for more. A false sense of hope may deflect the patient and family from finding final meaning and value in their remaining lives together.

Even advanced cancer patients can maintain a positive outlook on life. The physician can help direct a patient toward an achievable goal such as pain relief, support for the family from a hospice service, or making a trip to visit relatives.

Hope increases when honest information is provided, and it is reduced when information is withheld. Even when death is near, the patient can hope for a measure of happiness during the amount of time he or she has remaining. The physician can support the patient's hope for a good quality of life in the remaining time, for spiritual healing, and for a final phase of life that has integrity and dignity.

Discussing Religious and Spiritual Issues



only sanctions the deviations that have broken the moral medical rules; the legal deviations are being sanctioned by the competent institutions. When according to the law there is the possibility of using the constraint of the state we deal with the legal medical liability.

According to the legal standard that has been broken, the legal liability can be:

1. **Administrative** liability (involves disciplinary and civil penalties)
2. **Civil** liability (is sanctioned by the Civil Code and in general it refers to the patrimony assets – goods, money). This term concurs with the medical malpraxis term.
3. **Criminal** liability (it is sanctioned by the Penal Code and it is formed out of serious antisocial deeds named perpetration).

The difference between error and medical culpability is of great importance for determining the medical liability as being a moral or a criminal liability. For a better understanding of the two terms it is necessary to understand the term of malpraxis. Malpraxis is the professional error committed during the medical act or medico-pharmaceutical act, error that causes damages to the patient, involving the civil liability of the medical staff, of the provider of medical, sanitary and pharmaceutical facilities and products. The definition tells us that in order to have a malpraxis situation there must be proved that an error happened during the medical act. What is and what can be considered to be a medical error? The answer is not an easy one. The error can be defined as being an unpredictable failure of a normal medical behavior. The error is related to the knowledge field, tiredness, the lack of the doctor’s psychological balance, the lack of the medical experience. It is an accepted possibility and it does not draw the doctor’s criminal liability.

The medical errors are divided in two categories: **objective** and **subjective.**

The objective error is the result of imperfection (exhaustive acknowledge) of a medical aria. The medical aria can

be an etiological agent, peculiarities of the illness, a certain reaction of the patient, applied treatment, complications that may occur during the evolution, etc. No matter how well prepared a physician is, in such a situation they would all commit an error reacting the same way. This situation is legally considered to be de facto error, and the situation caused by it does not draw the criminal liability, but the civil liability. Nevertheless, the patient can consider the restoration of damage if he had suffered damages and accuse the doctor or the system of an error. Certain technological imperfections or limits of the medical devices needed for clinical and preclinical tests are part of the objective error category. In this situation the physician cannot be held countable for the error, but the institution (hospital) that bought the device can be held countable. The subjective errors are committed because of the poor professional preparation which leads to a false representation of the medical situation. For the same reason (poor professional preparation) the technical methods and specialty manoeuvres can be wrongfully used. These refer to: surgeries, drug treatment, manoeuvres need for tests, the technique of taking care of the ill person, etc. In the same given conditions a different physician, a well prepared one could avoid causing damage to the patient, damages that could be caused by inability, superficial appreciation of the case, inaptness, etc. These are all part of the diagnosis errors field and they are based on improper examination, symptoms improperly interpreted, unawareness of the patient’s antecedents, not sending the patient for interdisciplinary checkups. The subjective errors draw the medical liability that can have civil or criminal consequences. Making the difference between the subjective and objective errors is not easy, but it can be done if the real work conditions that the medical staff had at hand are being analyzed.

Law: “the medical staff personnel are formed out of the doctor, dentist, pharmacist, nurse and midwife that offer medical services.” In order to mark the difference between the objective and subjective error committed by a doctor, it must be analyzed weather it was done everything possible in the given conditions to set a good diagnosis and choose the best treatment method or not, and if the doctor used all his knowledge and professional



being deserted. There is less fear of a painful death than of the loneliness and alienation that may accompany it. A patient particularly dreads being abandoned by the physician in the face of death and may need increasing levels of professional support as the illness progresses. This is particularly true if family and friends are not able to cope with the deteriorating condition and begin to avoid contact, contributing further to the patient's feelings of loneliness and abandonment. If the patient feels that he or she has no one with whom to discuss his or her condition or to relate in an open and honest fashion, despair is likely to ensue. The patient's fear of the unknown is easier to cope with if his or her apprehension can be shared with a caring physician who provides comfort, support, encouragement, and even a modicum of hope.

Each new problem of the dying patient should be viewed as a nuisance requiring relief or removal and approached with the vigor that a physician would devote to an acute, short-term illness. When a fresh complaint arises, the patient should be re-examined and attempts made to relieve the symptom so the patient will not feel unworthy of further attention. If everyday nuisances can be controlled or lessened, the patient will feel that there is sincere concern for making her or his remaining life pleasant. The physician should give attention to details such as improving the taste of food by fixing or replacing dentures or stimulating the patient's appetite, eliminating foul odors, or suggesting occupational therapy in an attempt to avoid boredom. The physician should take advantage of every opportunity to touch and examine the patient rather than standing apart. Gentle palpation of areas of pain or merely taking a pulse can convey a sense of concern and warmth and provide comfort for an apprehensive and lonely patient.

The physician and other health professionals can provide much support through conversation. The tendency to withdraw and reduce conversation contributes to the patient's sense of loneliness. Silence is an enemy of the dying and serves to widen their separation from society. Conversation is a social bond that affirms life and reduces anxiety by providing a means of catharsis. Saunders (1976) summed up the needs of a dying patient with the words of one patient: “Watch with me,” asking that he not be

- Have a family member or buddy (i.e., another "set of ears") present, because the patient may hear nothing after the word cancer.
- If family members are present, acknowledge everyone, and ask their relationship to the patient.
- Ask the patient and family what they already know, and determine how much they want to know.
- Be honest but not blunt, and ensure continued honesty.
- Watch your body language (e.g., convey concern; sit, touch, and look the patient in the eye).
- Let the news sink in (i.e., give the information, pause, and wait for a reaction), and encourage the patient to express feelings, fears, and desires.
- Assure the patient that treatment will allow as normal a lifestyle as possible.
- Assure the patient that you will do everything possible to make the remaining days pain free and comfortable.
- Schedule a follow-up visit with family members soon to answer questions and correct misconceptions.
- Communication is an ongoing process determined by the patient's coping mechanism and desire to know more.
- Do not underestimate the amount of information the patient wants. Talk less about diagnosis and treatment and more about the disease's impact on the patient and family.
- Do not avoid discussing prognosis, because lack of information increases anxiety.

<u>Positive Language to Use When Dealing with Dying Patients</u>

- I will keep you as comfortable as possible.
- I will focus on maintaining your quality of life.
- I want to help you live meaningfully in the time you have left.
- I will do everything I can to help you maintain your independence.
- Maintaining your independence and dignity will be my top priority.
- I will do my best to fulfill your wish to remain at home.

he greatest fear of the dying patient is that of suffering alone and



experience. If the doctor's professional attitude was irreproachable, but still there was an inconsistency between the diagnosis and the real situation, then the objective error might be caused by the improper work conditions that happen during running a high quality medical act. In the given conditions a different doctor would have ended in the same situation committing a not objective error. Also, we can consider objective error when there is an inconsistency between the clinical diagnosis and the objective reality in the cases, given by the unusual symptomatology generated by a certain reaction of the patient or by different agents that influences the evolution of the disease. The doctor is going to be charge of committing a subjective error if the diagnosis' inconsistency is given by the doctor's lack of professional information or by using the information without diligence.

The medical staff has civil liability for personal acts that produced damages caused by errors, which include negligence, imprudence or insufficient medical information that happened during practicing the prevention, diagnosis and treatment procedure. The medical staff has civil liabilities in case of damages that are caused by the disobedience of the stated regulation regarding the confidentiality, informed agreement and the obligation of giving medical assistance. The medical staff has civil liabilities in case of damages caused while practicing the profession, even when the limits of their competence are exceeded; exceptions are made when the appropriate medical staff is not available in a case of an emergency. If the act that caused the damage is according to the law a crime then the civil liability does not remove the criminal liability. The medical staff is not liable for the damages and torts caused during practicing the profession when: a. they are caused by the work conditions, insufficient diagnosis and treatment equipment, nosocomial infections, side effects, risks and complications generally accepted, investigation and treatment methods, hidden flaws of the sanitary materials, equipments and medical devices, used medical and sanitary substances; b. in case of emergency they act with good faith according their competence.

The malpraxis can be part of the following categories:

1. **Civil malpraxis** – is the consequence of breaking some basic rules that can be classified the following order:

- the responsibility of treating and answering to emergencies
- applying some standards of caring (maximum and minimum)
- to make the best judgment
- the duty of care practice
- the duty of constant improvement
- the duty of obtaining the patient's agreement
- the appliance of proper diagnosis procedures
- the abandon of the treatment
- confidentiality
- the superior's liability (every negligence committed by the employees
  equally involve them superiors – the chief doctor)
- the trust relation between the doctor and the patient

2. **Criminal malpraxis** – the acts in this category can be fraud, documents alteration, illegal use of medication, illegal or criminal treatments (to induce an abortion), breaking the oaths, causing body injuries, infirmities or invalidities. When the death of the patient is a consequence of one of the above, the guilty one can be charged with murder.

3. **Ethical malpraxis** – the medical staff is acting following the ethical and conduct standards and also a mandatory conduct code for all those participating at the medical act: doctors, dentists, pharmacists, nurses and midwives. The rules of this code are part of the Code of medical faire practice. Disobeying these rules can indirectly affect the doctor-patient relation by lowering the quality of the medical act; the problems are analyzed and solved by the board that has the medical authority (Medical Board). In real life the most frequent malpraxis situation is the one that has civil consequences. That is why there are the malpraxis insurances. According to law, each doctor must be insured at an



abandoned, weak and helpless) than they are of death itself.

**How To Tell the Patient**

There is no need to answer questions the patient has not yet asked. One way to approach the subject is to ask patients what they think the problem is or how sick they think they are. The response may be straightforward ("I think I have cancer."), or the patient may indicate a wish to avoid the issue by saying, "I hope it's nothing serious." The patient's condition can be revealed gradually or in stages, such as telling him or her after surgery that there is a suspicion of cancer but that further information will have to wait for the pathology report. The physician should observe the patient's response to this initial hint and, based on that reaction, choose a method for presenting subsequent information.

"The total truth is revealed in small doses as the illness unfolds, affording the family the opportunity to get its feet under itself before another blow falls.…The patient and the family need to be eased into the truth…not slugged with it". Such a gradual disclosure is likely to lead to acceptance, whereas a harsh, sudden, or abrupt disclosure is likely to result in denial or severe depression. If the patient appears reluctant to accept the information, do not push the issue; instead, ensure that openings for discussion are made available periodically and further information provided when the patient is ready.

One statement that is never appropriate is "There is nothing more that we can do." There is always something the family physician can do to provide compassionate, comforting care to the patient and family. Saying this tells patients they are being abandoned and increases their feelings of isolation and vulnerability.

Delivering Bad News

- Choose a private, quiet place.
- Avoid giving bad news over the telephone, because there is no way to know what the reaction is or whether a support system is available.
- Allow adequate uninterrupted time—turn off your beeper.

uncomfortable in this situation may be found insulating himself or herself from the issue during hospital rounds by checking every inch of the intravenous tubing for air bubbles or otherwise directing his or her attention away from the patient, effectively ignoring overt and subtle clues to the patient's needs.

When the patient is ready to discuss her or his impending death, the physician and patient are probably past the most difficult stage, and the physician needs merely to listen, accept the patient's feelings, and respond to questions honestly. Most patients raise questions that indicate how much they wish to know, provided the physician gives them the opportunity. The most supportive and facilitative act the physician can provide is to sit and ask the patient, "Do you have any questions?" When asked in a sincere manner, patients who are ready to talk about their death will take advantage of the opportunity, but they may be reluctant under other, more hurried circumstances.

Patients usually indicate when they would like to discuss their prognosis, and they let the physician know when they would like to avoid the subject altogether and focus on more pleasant topics. Even patients who have reached a full level of acceptance of their terminal process cannot remain constantly focused on that subject and must divert their attention to more satisfying issues from time to time. Physicians should honor and respond to this need, just as they would respond to a desire to discuss pain or other problems.

What physicians say to dying patients is not as important as their willingness to listen. One of the most comforting steps physicians can take in caring for the dying is to allow them to talk about their fears, frustrations, hopes, needs, and desires. Talking about problems can be very therapeutic. Patients who are permitted to examine and discuss their feelings about death and dying are grateful for the opportunity and usually become less anxious, experience less pain, and accept their situation more easily. If they are denied this opportunity, especially when the terminal process is obvious, they may be convinced that the time remaining is too terrible to be discussed, and their anxiety will be significantly increased. Often, the terminally ill are more fearful of the manner in which death will occur (e.g., painful, alone and



insurance company. The insurance company pays the patient's damages, if a trial or a decision of the newly formed judging commission proves that the objective reality complies with the malpraxis situation.

Medical **fault** represents the breaking of a minimum of attention and prudence professional liability. It is considered that it wasn't fulfilled a liability or an act that had to be fulfilled and that there was an abnormal conduct that in similar conditions a different doctor with the same preparation would have not used.

To consider as fault a medical mistake, it must reach some conditions:

1) it must be obvious, material, proven;
2) it must exist beyond any doubt;
3) it must be the consequence of the lack of professionalism;
4) it must be considered mistake by other competent doctors.

In order to judicially charge a medical fault there must be a physical or psychological harm guilefully done and there must be causality connection between the deed and the damage. In conclusion, the definition of medical fault contains:

1) the existence of a professional duty;
2) guilefully unfulfilling that duty;
3) a damage caused by an action or inaction;
4) the prove of the causality connection between the medical act and damage.

In order to delimit the medical deontological liability of the legal liability, the Court must resort to the medico-legal report Commissions. The medico-legal appreciation of a fact as being medical fault is done according to the real circumstances and conditions at the moment of the doctor's contact with the patient.

These conditions and circumstances are:

**1. The professional fault through ignorance** (incompetence, inability, lack of knowledge) is present in the diagnosis or in applying the treatment if the doctor performs the medical activity without having the needed information or having a false information. Generally it is accepted that ignorance is the doctor's important mistake. It can be criminal in emergency cases, being fatal for the patient.

**2. The fault through improvidence** (imprudence) –

means committing a positive medical activity without foreseeing that illicit consequences might appear, even though it could have and it must have been foreseeable. Every professional, when performing normal professional provisions, must make the proper decision for each situation according to the real possibilities of provision that he is specialized in and according to the professional experience.

**3. The fault through negligence** (inattention) – the legal conditions of charging the

negligence include :

- not acting as any reasonable person in same working conditions and in the same situations;

- not avoiding a professional act that any other good faith professional would have in the same conditions.

The forms of manifesting the negligence are: haste, superficiality, fulfilling the right duties unconscientiously.

The following acts can be considered negligence: taking incorrectly the case history (the lack of dialogue with the patient), an inaccurate clinical test (a patient that is checked with the clothes on), not performing some preclinical routine tests, not taking some asepsis measures before the surgery.

**4. The fault through indifference** has the following conditions:

- the author of a certain action or inaction, knows that all the measures of protection were not taken, but hopes to avoid the unfavorable result of his activity.

- the negative results cause the patient a damage that is related to the doctor’s indifference.

Methods of the indifference are: under appreciation of the risk of the medical action or over appreciation of the means of action. In order to exclude a medical fault and to take in consideration the unhappy case the forensic expert and the Court must prove that:

- the good faith of the doctor that tried to do everything that was possible for the good of the patient.

- all the medical means were correctly used;

- all the medical conduct rules were followed related to the real work situation;



them, because most patients know the nature of their disease process to some degree. Because family physicians know their patients well, they should be able to gauge patients' desire to be told and their capacity to withstand the shock of disclosure.

A frank discussion of death or of how long the patient is expected to live may not be necessary or even indicated. A good understanding between doctor and patient may make open disclosure unnecessary. The physician's role may be primarily one of supporting patients during the progressive terminal course of their illness. However, such a situation should not be used by the physician who is uncomfortable with the subject as an excuse to avoid discussing the issue. The family physician's primary responsibility is to take the time to evaluate the situation, make sure the patient's true desires have been assessed correctly, and provide whatever support is needed, based on the patient's concepts and needs rather than those of the physician.

There are Questions for Determining a Terminally Ill Patient's Needs and Wishes.

- What do you fear most?
- What would you like to accomplish in the time left?
- What is your highest priority?
- How can I help you achieve this?
- What has been most difficult about this illness for you?
- How is your family (e.g., wife, husband, daughter) dealing with your illness?
- Is religion important to you?

The physician who can deal with death honestly is able to focus more attention on the patient and can determine the patient's level of awareness by listening and observing nonverbal cues. Clues to the patient's wish to discuss his or her condition may be nothing more than a deep sigh, a tear, or a shaky voice. The physician must be alert during busy hospital rounds for these or similar signs. The physician can pause to sit and encourage conversation if time permits or return later when more time is available. Whenever possible, however, the response should be at that moment, because the patient is more likely to communicate freely in a spontaneous situation. A physician who is

when society maintains two tiers of death: a traditional definition for most people, and a more lenient definition in those from whom organ procurement is being considered. The end of life must be uniquely established so as to foster trust in the quality of care provided to those who are acutely ill.

The definition of death involves the irreversible cessation of a person's brain function assessed either by the absence of spontaneous circulatory and respiratory drive, or if this is confounded by the use of artificial life support, then by brain death criteria. It thus becomes apparent that death in both cases is being diagnosed as the irreversible process rather than the precise moment and that the conventional dichotomy separating the two means of diagnosing death is invalid. There is philosophical support to the higher-brain centre equation of death. Descartes, in expressing "*I think therefore I am*," would suggest a separation between mind and body.

An Aristotelian perspective would reinforce the same:

*Now I say that man, and in general every rational being, exists as an end in*
*himself and not merely as a means to be arbitrarily used by this or that will.*
*Beings whose existence depends not on our will but on nature have, if they are not*
*rational beings, only a relative value as means and are therefore called things.*

Implicit is the assertion defining humanity by the ability to think, choose, and interact with one another, and that the absence of such capacity carries the implication of the end of human life. There is a danger that this could lead to idolizing intellectual capacity and bring into doubt the human status of the seriously mentally retarded. On a practical level, any such system would
difficult to implement as it would require a widespread change in public attitudes to accept a breathing person as dead.

**When To Tell the Patient**

The issue today is not so much whether to tell patients they have a terminal illness but how to share this information with



- the patient agreed for all the performed maneuvers;
- an interdisciplinary consultation was done when needed.

What happens in an emergency when the life or the health of the patient is endangered? How would the doctor be held countable for such a situation?

It is good to know, that in such a situation, the success depends on the doctor's preparation, which means that the doctor must have information about cardio-respiratory resuscitation, must have information about the emergency treatment that needs to be personalized from case to case. The success also depends on the organization and transportation of the patient to the closest medical facility. The doctor can not deny an emergency no matter the hour that he was solicited or the patient's address. The doctor must answer the solicitation and offer the first aid even outside the working schedule, exception are made during a force majeure case. Not answering to a patient's emergency call is charged by the law, so it represents a mistake. For the cases presented above, the doctor is exempted by the liability (he would not be held accountable) only in circumstances outside one's control.

As a conclusion to all the above, it can be said that a good quality medical assistance clearly the level of preparation of a medical assistance system. It also shows the way the society puts price on a life and the difference between theory and practice in the medical profession.

**Questions for self-control:**

1. What is the medical ethic?
2. What is the medical deontology?
3. What is the medical liability?
4. What is the malpraxis?
5. When do we have medical error?
6. When do we have culpability?
7. What is the civil liability in the medical field?
8. What about the penal one?
9. What point can we extend the deontological liability to and where does the legal liability of a doctor start from?

## TOPIC 6.
## Biomedical ethics. Main theoretical and practical aspects in modern society.

**Ethics** is the application of values and moral rules to human activities. **Bioethics** is a subsection of ethics, actually a part of applied ethics that uses ethical principles and decision making to solve actual or anticipated dilemmas in medicine and biology. Ethics seeks to find reasoned, consistent, and defensible solutions to moral problems.

Bioethics can be defined as the study of ethical issues arising from the biological and medical sciences.

**The subject of the biomedical ethics** is broader than *medical ethics*, which is basically physician-centred. Bioethics includes *health-care ethics*, which concerns ethical issues that involve other healthcare professionals besides doctors, such as nurses (*nursing ethics*). Another variety of bioethics is *clinical ethics* that deals with clinical and hospital care decisions taken with the aid of committees that include laypersons and outside consultants. Finally, there are issues in bioethics that fall outside the above categories, such as issues in genetics, use of reproductive technologies, experimentation on humans and foetuses, definitions of death, and priorities in distributing life-saving resources.

**Bioethics** is the study of the ethical questions that arise in the relationships among life sciences, biotechnology, medicine, politics, law, and philosophy. It also includes the study of the more commonplace questions of values ("the ethics of the ordinary") which arise in primary care and other branches of medicine.

The term ***Bioethics*** *(Greek bios, life; ethos, behavior)* was coined in 1927 by Fritz Jahr, who "anticipated many of the arguments and discussions now current in biological research involving animals" in an article about the "bioethical imperative," as he called it, regarding the scientific use of animals and plants

In 1970, the American biochemist Van Rensselaer Potter also used the term with a broader meaning including solidarity towards the biosphere, thus generating a “global ethics”, a



growth rate from the previous to the new regulations. These data suggest that while the potential donor pool may be enlarged, there is minimal tangible benefit in organ supply. Much of this is due to public reluctance to accept such changes manifested in exercising the right to not become donors. The controversies surrounding such mistrust are now outlined: An important distinction is the non-equivalence of death and terminal illness, of prognosis and current status. While there are no adequately authenticated incidents in which subjects meeting all of the criteria for brain death have recovered, the controversy also exists that brain death is an implication that the patient’s condition is irreversible. Indeed cardiac arrest occurs usually between 48 to 72 hours of brain death and thus the diagnosis is akin to that of terminal cancer where death is certain but not yet present. Indeed, a brain-dead pregnant woman was maintained from 22 to 31 weeks gestation to give birth to a viable infant and the question arises as to whether she was alive or simply an incubator. Similarly, blood pressure responses to surgical incision and spontaneous esophageal constriction were noted in a series of patients, and it was suggested that current criteria are not intended to identify the functional incompetence of all brain stem neurons, but rather to confirm the irreversibility of brain stem damage.

Social utility to harvest organs and free resources must not be put ahead of medical ethical considerations, but one must also be aware not to equate biological life of human organs with human personal life experience. The residual body function is devoid of the brain’s integrative function. Means of artificial life support were introduced with the expressed purpose of sustaining life by supplying the body’s needs when function was lost but structure remained intact. Indeed, mild hypoxic crises leading to transient ischemic attacks by definition cause reversible changes in brain cells leading to loss of function but preserved structure such that normal function can be irreversible changes have occurred and that recovery is impossible. Proponents of brain death state that it is the integrative function and not structure alone that defines brain activity; and that while cells may be alive, the capacity of the brain to act as an integrator cannot be resumed after prolonged periods of functional inactivity. A danger arises

the brainstem, may persist after brain death is clinically determined and hence their persistence does not contravene the declaration of death. Apnea testing became far more defined to include withdrawing ventilator support with a pCO2 between 40 and 45 mmHg and waiting for at least a rise in pCO2 to 50 mmHg to induce respiration. Given that this may take time e, the patient is oxygenated through at endotracheal tube catheter for tissue protection. The last change involved mandating that the assessment by the second physician must be made at least 24 hours after the first.

The 1987 revision made the criteria more stringent but made the protocol more lax. Testing for vestibulo-ocular reflexes was now performed with 120 mL of ice water in order to exclude the possibility of a blunted response in lieu of a complete absence of brain stem function. The second physician's assessment was now only required to occur between 2 and 24 hours after the first.

The physician responsibility concerning brain death.

Many anesthesiologists noted time of death as when the patient was removed from the respirator, but new protocols established time of death as the moment neurological function had irreversibly ceased. The most recent revision, 1999, involved the inclusion of brain death criteria for neonates, infants, and young children. Adult criteria can be applied to those patients older than 1 year. Patients older than 2 months should be evaluated with a minimum of 12 hours between assessments, and those full-term infants less than 2 months should have 24 hours between examinations. All patients less than 1 year should also have radionuclide scans to evaluate cerebral perfusion. To date, no criteria have been elaborated for preterm babies.

**Objections and Controversies**

Expansion of a donor pool by a more liberal definition of death is expected to herald public controversy fearing uncertainty about end-of-life care. In the short term, the reluctance met by the criteria precision caused a paradoxical decline in the number of transplants performed. In the long term, while total transplant numbers rose, there was no significant increase in the annual



discipline representing a link between biology, ecology, medicine and human values in order to attain the survival of both human beings and other animal species.

One of the first areas addressed by modern bioethicists was that of human experimentation. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was initially established in 1974 to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects.

However, the fundamental principles announced in the Belmont Report (1979) namely, autonomy, beneficence and justice have influenced the thinking of bioethicists across a wide range of issues. Others have added non-maleficence, human dignity and the sanctity of life to this list of cardinal values.

There are 6 major principles (important ideas) of the ethics in general which should be used in bioethics as well:

- ✓ **Taking care** - a doctor must do things that are good for the *patient* (the doctor is giving medical care to).
- ✓ **Non-hurting** – a doctor must not try to hurt his patients.
- ✓ **Autonomy** - the patient can say he does not want to be treated.
- ✓ **Justice** – talks about what is fair in giving people medicines and care. It talks about who gets what treatments.
- ✓ **Dignity** - the patient (and the doctor) have the right to dignity (respect for someone as a person).
- ✓ **Truthfulness (being honest)** – the doctor must tell the patient the truth.

**Biomedical ethics and bioethics in the relationship with ecological ethics, medical ethics and deontology.**

Biomedical ethics is interconnected with ecological ethics, medical ethics and deontology.

**Medical ethics** is the set of ethical rules that doctors follow. These ideas tell doctors how they should treat patients.

**Deontological ethics** or **deontology** is sometimes described as "duty" or "obligation" or "rule" based ethics, because rules "bind you to your duty", it is a norm hat should be used.

**Ecological ethics** is the part of environmental philosophy which considers extending the traditional boundaries of ethics from solely including humans to including the non-human world. It exerts influence on a large range of disciplines including law, sociology, theology, economics, ecology and geography.

**Bioethics** is the study of the ethical and moral implications of new biological discoveries and biomedical advances, as in the fields of genetic engineering and drug research.

In contrast to medical ethics that has existed since medicine became a profession, bioethics is a fairly recent phenomenon. It emerged in the 1960s in the U.S., and arose out of various public concerns.

Historians may disagree about which was the issue that triggered the birth of bioethics: the selection of patients for chronic haemodialysis in Seattle in 1962, or the initiation of heart transplants in 1969, or even the revelation of the Tuskeegee and Willow brook experiments in 1972. The assumption behind bioethics as a discipline is the view that ethical problems in medicine and the biological sciences can be solved by applying principles that are derived from moral philosophy.

**Biomedical research of different kinds in medicine.**

**Biomedical research** (or **experimental medicine**), in general simply known as **medical research**, is the basic research, applied research, or translational research conducted to aid and support the body of knowledge in the field of medicine. Medical research can be divided into two general categories: the evaluation of new treatments for both safety and efficacy in what are termed clinical trials, and all other research that contributes to the development of new treatments.

The increased longevity of humans over the past century can be significantly attributed to advances resulting from medical research. Among the major benefits have been vaccines for measles and polio, insulin treatment for diabetes, classes of antibiotics for treating a host of maladies, medication for high blood pressure, improved treatments for AIDS, statins and other treatments for atherosclerosis, new surgical techniques such as microsurgery, and increasingly successful treatments for cancer.



• Minimize errors in misdiagnosing dead people as living.
• Minimize unreasonable delay in diagnosis. Adaptability over a wide range of scenarios, hence must be largely clinically defined.
• Signs must be explicit to allow for verification without controversy.

The criteria for brain death.

Death is newly defined as the irreversible cessation of circulatory and respiratory function that, in the presence of artificial means of life support, can now be assessed by the absence of brain stem and cerebral function. The stated reasons for such changes involved an endpoint at which resuscitative and supportive measures transplant organs. The diagnosis of death must be confirmed by two physicians unrelated to the transplant team for this would be akin to conflict of interests in law or collusion in business. The cause of coma must be established and the potential for recovery excluded. Criteria involve unreceptivity to external stimuli and unresponsiveness to noxious stimuli, no spontaneous movements over the course of one hour, no brainstem reflexes (pupils, VOR with 20 mL ice water, corneal, pharyngeal), no stretch tendon reflexes, apnea despite disconnection from the ventilator for 3 minutes, and isoelectric EEG. Hypothermia and CNS depressant medication must be excluded as etiologies.Since the publication of the first criteria for brain death (1968), there have been four notable occasions when the criteria were changed. Guidelines were made more lax (1975), revised (1987), use of the criteria was more enforced (1991), and paediatric criteria were introduced (1999).

Between 1975 and 1976, changes occurred regarding EEG, apnea, spinal cord reflexes, and protocol. EEG was no longer a necessary component of the diagnosis, but simply a confirmatory test. A case series with 1000 isoelectric EEG patients and 147 patients with persistent activity, all of whom met the clinical criteria for brain death, demonstrated that all experienced cardiac arrest within a few days. While the test may identify patients with persistent neuronal activity, it
is not a predictor of outcome once brainstem function is clinically absent. Spinal cord reflexes, based on a reflex arc not involving

**TOPIC 7.**
**Deontological and ethical aspects of the right of patient for a life and mors.**

**Medical Death and Brain Death**

Advent of intensive care units brought to light the distinction between biological death and the end of the person. Previous to this, circulatory, ventilatory, and brain function were irrevocably linked because failure of one system inevitably leads the others to fail. Now, the ability to maintain circulation and ventilation to perfuse the body with oxygen raises the question as to when someone can be defined as dead. The reasons for this are in the necessity to free up medical resources as well as to assess the moment at which it is ethically permissible to remove organs from a cadaver. While this new notion of death must be ascertained by those unrelated to the transplantation team, this motivation of earlier organ procurement has been recurrently stated in the literature outlining guidelines for the diagnosis of brain death, thereby inextricably linking the two in the public eye. Following irreversible loss of brain function, all other organs will inevitably cease to function. The integrative function that characterizes human thought, action, coordination, and reaction is not recoverable.

As such, the medical basis for the diagnosis of brain death lies in that the recognition of this loss of function is doing little more than stating overtly the reason underlying the traditional diagnosis of death in the setting of inadequate perfusion. A legal basis for this definition exists to protect physicians from litigation subsequent to terminating resuscitative measures with the diagnosis of brain-death. Society is not so quick to accept such changes. History is fraught with examples of periodic fear about false-positives in ascertainments of death. It was popular among the affluent in the eighteenth and nineteenth centuries for coffins to be equipped with special ventilation and complex bell-signaling mechanisms to allow the presumed dead to survive and to alert others if they revived. It is from this fear that sprouts the mandate of any attempt to define brain death.

- Eliminate errors in misdiagnosing living people as dead.



**Nazi human experimentation** was a series of medical experiments on large numbers of prisoners by the Nazi German regime in its concentration camps mainly in the early 1940s, during World War II and the Holocaust. Prisoners were coerced into participating; they did not willingly volunteer and there was never informed consent. Typically, the experiments resulted in death, disfigurement or permanent disability, and as such can be considered as examples of medical torture.

At Auschwitz and other camps, under the direction of Dr. Eduard Wirths, selected inmates were subjected to various hazardous experiments which were designed to help German military personnel in combat situations, develop new weapons, aid in the recovery of military personnel that had been injured, and to advance the racial ideology backed by the Third Reich.

Dr. Aribert Heim conducted similar medical experiments at Mauthausen. Carl Vaernet is known to have conducted experiments on homosexual prisoners in attempts to cure homosexuality.

After the war, these crimes were tried at what became known as the Doctors' Trial, and revulsion at the abuses perpetrated led to the development of the Nuremberg Code of medical ethics.

**The essence of genetic engineering.**

**Genetic engineering**, also called *genetic modification*, is the direct human manipulation of an organism's genome using modern DNA technology. It involves the introduction of foreign DNA or synthetic genes into the organism of interest. The introduction of new DNA does not require the use of classical genetic methods, however traditional breeding methods are typically used for the propagation of recombinant organisms.

An organism that is generated through the introduction of recombinant DNA is considered to be a genetically modified organism.

**The first organisms genetically engineered were** bacteria in 1973 and then mice in 1974. Insulin-producing bacteria were commercialized in 1982 and genetically modified food has been sold since 1994.

**The most common form of genetic engineering** involves the insertion of new genetic material at an unspecified location in the host genome. This is accomplished by isolating and copying the genetic material of interest using molecular cloning methods to generate a DNA sequence containing the required genetic elements for expression, and then inserting this construct into the host organism. Other forms of genetic engineering include gene targeting and knocking out specific genes via engineered nucleases such as zinc finger nucleases or engineered homing endonucleases.

Genetic engineering techniques have been applied in numerous fields including research, biotechnology, and medicine. Medicines such as insulin and human growth hormone are now produced in bacteria, experimental mice are being used for research purposes and insect resistant and/or herbicide tolerant crops have been commercialized.

**In medicine genetic engineering has been used** to mass-produce insulin, human growth hormones, follistim (for treating infertility), human albumin, monoclonal antibodies, ant hemophilic factors, vaccines and many other drugs. Vaccination generally involves injecting weak live, killed or inactivated forms of viruses or their toxins into the person being immunized. Genetically engineered viruses are being developed that can still confer immunity, but lack the infectious sequences. Mouse hybridism's, cells fused together to create monoclonal antibodies, have been humanized through genetic engineering to create human monoclonal antibodies.

Genetic engineering is used to create animal models of human diseases. Genetically modified mice are the most common genetically engineered animal model. They have been used to study and model cancer (the oncomouse), obesity, heart disease, diabetes, arthritis, substance abuse, anxiety, aging and Parkinson disease. Potential cures can be tested against these mouse models. Also genetically modified pigs have been bred with the aim of increasing the success of pig to human organ transplantation.

**Gene therapy** is the genetic engineering of humans by replacing defective human genes with functional copies. This can occur in somatic tissue or germ line tissue. If the gene is inserted



9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

**Questions for self-control:**

1. Explain the theoretical and practical aspects of biomedical ethics in modern society.
2. What is the biomedical ethics and bioethics in the relationship with ecological ethics, medical ethics and deontology?
3. What are the biomedical researches of different kinds in medicine?
4. Explain the essence of genetic engineering.
5. Tell the essence of cloning and its ethical consequences.
6. What are the moral aspects of experiments?

for human experimentation set as a result of the Subsequent Nuremberg Trials at the end of the Second World War.

**The 10 points of the Nuremberg Code are** (all from United States National Institutes of Health):

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him/her to make an understanding and enlightened decision.
2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
3. The experiment should be so designed and based on the results of animal experimentation and knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is a prior reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.



into the germ line tissue it can be passed down to that person's descendants. Gene therapy has been used to treat patients suffering from immune deficiencies. There are also ethical concerns should the technology be used not just for treatment, but for enhancement, modification or alteration of a human beings' appearance, adaptability, intelligence, character or behavior. The distinction between cure and enhancement can also be difficult to establish. Transhumanists consider the enhancement of humans desirable.

**The essence of cloning and its ethical consequences.**

**Cloning** is the process of producing similar populations of genetically identical individuals that occurs in nature when organisms such as bacteria, insects or plants reproduce asexually. Cloning in biotechnology refers to processes used to create copies of DNA fragments (molecular cloning), cells (cell cloning), or organisms. The term also refers to the production of multiple copies of a product such as digital media or software.

The term *clone* is derived from the Ancient Greek word *κλών* (klōn, “twig”), referring to the process whereby a new plant can be created from a twig.

In the United States, the human consumption of meat and other products from cloned animals was approved by the ***FDA (Food and Drug Administration)*** on December 28, 2006, with no special labeling required. Cloned beef and other products have since been regularly consumed in the US without distinction. Such practice has met strong resistance in other regions, such as Europe, particularly over the labeling issue.

**Molecular cloning** refers to the process of making multiple molecules. Cloning is commonly used to amplify DNA fragments containing whole genes, but it can also be used to amplify any DNA sequence such as promoters, non-coding sequences and randomly fragmented DNA. It is used in a wide array of biological experiments and practical applications ranging from genetic fingerprinting to large scale protein production.

Cloning of any DNA fragment essentially involves four steps:

1. **Fragmentation** - breaking apart a strand of DNA
2. **Ligation** - gluing together pieces of DNA in a desired

sequence

3. **Transfection** - inserting the newly formed pieces of DNA into cells
4. **Screening/selection** - selecting out the cells that were successfully transfected with the new DNA.

**Organism cloning** (also called reproductive cloning) refers to the procedure of creating a new multicellular organism, genetically identical to another. In essence this form of cloning is an asexual method of reproduction, where fertilization or inter-gamete contact does not take place. Asexual reproduction is a naturally occurring phenomenon in many species, including most plants (see vegetative reproduction) and some insects. Scientists have made some major achievements with cloning, including the asexual reproduction of sheep and cows. There is a lot of ethical debate over whether or not cloning should be used. However, cloning, or asexual propagation, has been common practice in the horticultural world for hundreds of years.

Because of recent technological advancements, the cloning of animals (and potentially humans) has been an issue. The Catholic Church and many religious organizations oppose all forms of cloning, on the grounds that life begins at conception. Judaism does not equate life with conception and, though some question the wisdom of cloning, Orthodox Judaism rabbis generally find no firm reason in Jewish law and ethics to object to cloning. From the standpoint of classical liberalism, concerns also exist regarding the protection of the identity of the individual and the right to protect one's genetic identity.

Gregory Stock is a scientist and outspoken critic against restrictions on cloning research. Bioethicist Gregory Pence also attacks the idea of criminalizing attempts to clone humans.

The social implications of an artificial human production scheme were famously explored in Aldous Huxley's novel *Brave New World.*

On December 28, 2006, the U.S. Food and Drug Administration (FDA) approved the consumption of meat and other products from cloned animals. Cloned-animal products were said to be virtually indistinguishable from the non-cloned animals. Furthermore, companies would not be required to provide



labels informing the consumer that the meat comes from a cloned animal.

Critics have raised objections to the FDA's approval of cloned-animal products for human consumption, arguing that the FDA's research was inadequate, inappropriately limited, and of questionable scientific validity. Several consumer-advocate groups are working to encourage a tracking program that would allow consumers to become more aware of cloned-animal products within their food.

Carol Tucker Foreman, director of food policy at the Consumer Federation of America, stated that FDA does not consider the fact that the results of some studies revealed that cloned animals have increased rates of mortality and deformity at birth.

Another concern is that the biotechnologies used on animals may someday be used on humans. Some people may be more open to the idea of cloning of animals because most western countries have passed legislation against cloning humans, yet only a few countries passed legislation against cloning animals.

**There are also possible abnormalities due to cloning.** Researchers have found several abnormalities in cloned organisms, particularly in mice. The cloned organism may be born normal and resemble its non-cloned counterpart, but majority of the time will express changes in its genome later on in life. The concern with cloning humans is that the changes in genomes may not only result in changes in appearance, but in psychological and personality changes as well. The theory behind this is that the biological blueprint of the genes is the same in cloned animals as it is in normal ones, but they are read and expressed incorrectly. DNA arrays were used to prove this claim in the research lab of Professor Rudolf Jaenisch. Jaenisch studied placentas from cloned mice and found that one in every 25 genes was expressed abnormally.

Results of these abnormally expressed genes in the cloned mice were premature death, pneumonia, liver failure and obesity.

**Moral aspects of experiments.**

**The Nuremberg Code** is a set of research ethics principles