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Editorial

The Pressure for Euthanasia In Medically Developed Countries

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I write this from the state of Victoria in Australia which has recently enacted a law permitting both physician assisted suicide and euthanasia for people over 18 who are competent to make decisions. They must be suffering from an incurable illness, which causes intolerable suffering, and be expected to live for less than six months.

In attempting to understand why this legislation succeeded I have considered the many factors I think play a part in why this decision was made now and present them to provide some background for the discussions which will arise in many other jurisdictions over time.

The most important reason why individuals actively request euthanasia which isn't covered in the current Victorian, or most other similar, legislation is existential distress, loss of dignity, loss of control, and concern about future loss of dignity and control. These are the four principal reasons why people request euthanasia. Those requesting euthanasia for themselves rarely cite unbearable physical suffering or pain as the reason, though these latter issues are the reasons that advocates provide in the need for euthanasia, and they appear in all the legislation. The people who request euthanasia are concerned that they are, or will soon be, no longer autonomous beings and must rely on others to provide care and support. As an Occupational Therapist colleague of mine suggested people request euthanasia when they can no longer manage their personal toileting. This may seem to trivialize the issue; however, it is very real and accounts for people travelling to Switzerland for physician assisted suicide because they fear the consequences of age or disease, which will leave them relying on other people for their personal care needs.

I think there are several specific reasons why the push for the legislation came in Victoria at this time. There are some more general concerns that also lead to a decision to support euthanasia. However, those who have been driving the need for such legislation will often not be aware that these issues underpin their thinking.

Main Drivers for the Legislation, knowledge of the dying process and decrease in religious belief
There are three main drivers In the Australian context; the unfamiliarity of many people with the dying process, the concern about unnecessary medical treatment at the end of life, and the marked decrease in religious belief.

In Australia currently, the average age of death is 82, which means that many people in their forties and fifties and even sixties may not have experienced the death of close relatives or friends and so their only frame of reference is the media. In news reports death is often sudden and violent and either one of a "tragic case of a young person taken too early" or reports of war or environmental disasters killing large numbers of people in other parts of the world. While films and television dramas also include sudden violent deaths, there are also deaths from disease. However, in these cases the death is usually portrayed as peaceful and relatively quick, in that the person dies within one episode of a TV drama or within less than a quarter of a film. Even in

opera the person who dies is usually singing a long aria as she does so. Australian doctors, especially those working in Palliative Care, General Medicine, General Practice or Geriatrics, know that death is a process and many people die slowly over a period of days, sometimes up to two weeks and we know this is normal.

The lack of understanding of this as normal leads the family members in these situations to consider that their relative had a "bad death" and was suffering for many days and should have been able to be "put out of their misery" by medical intervention. As a counterpoint to this, though also part of the same lack of experience of dying for old persons, there are the concerns of family members that old people will be needlessly resuscitated in hospitals. This becomes a problem when no one has had a conversation with the older person, or their next of kin, about what they really want when they are close to death. Many older people accept that they are dying. They do not want to be resuscitated again and again from pneumonia, which used to be the old person's friend. Doctors will insist on resuscitation only when there is no information about what the patient wants. Often this occurs because there has been no discussion with the person or family before a medical crisis, so the old person is taken to the emergency department.

As well as these concerns by family members there has been a marked decrease in religious belief in the traditional Christian churches so that in the last Australian census the majority of people claim to have no religious belief. While the number of migrants from the Indian subcontinent, China, Taiwan and countries where Islam is the majority religion are increasing these numbers are still too small to have a major effect on the reported religious beliefs of the nation. Although the religions of the Book; Judaism, Christianity and Islam, consider that euthanasia is unjustified killing, some Christians and Jews in educationally and medically developed regions now consider that it is permissible in certain circumstances, though their leaders preach against it. The decrease in religious belief and practice means that more people are likely to consider euthanasia on its merits as a philosophical issue rather than considering whether there are any religious concerns. This change suggests that possibly more people would support legislation change and possibly engage with it themselves more than would have been the case thirty years ago.

Social, Cultural and Environmental Issues

When considering the more general issues that might be relevant to a discussion about death and dying and euthanasia the following points are also probably partially relevant for the recent Victorian decision though perhaps less obviously. These factors are family disconnections, our connectivity to everything, and the change to a client relationship from a doctor patient one.

1. As we know across the world there is an enormous movement of people, so that what began with organized migration to Western countries continues along with the flow of refugees to these and other countries. These movements lead to increasing disconnection between the generations due to the fracture of families, added to by divorce. So, when an older person is dying not only are there are less people immediately available to be present but also there are no longer the same shared events and memories to use in conversation with them as they transition towards death. So, the lack of connection means awkward conversations and an unwillingness to spend time with a relatively unknown person. This is not an issue that will arise in philosophical discussions about euthanasia however it is part of the background.

2. This may be related to the fourth point, our expectation that things are happening all the time plus a terror of being bored. As we spend more and more of our time checking our digital devices for news and updates we expect new things all the time and we have lost the ability to relax and engage in a situation where there is minimal stimulation. We dread being bored or being in a situation where we don't know what to say, when in fact the situation may not require us to say anything very much, just to listen and be with people.

3. A further issue is the change in medically and educationally developed regions from a doctor patient relationship to a client relationship where the client requests treatment of a doctor and often appears with "evidence" from an internet search. This flattening of the doctor patient hierarchy is generally a very good thing, allowing persons with medical problems to learn about the causes and management of their diseases and improve their health by being actively involved in their management. The problems arise when the "patient" no longer accepts anything the doctor says as expert and prefers opinion from other sources to the evidence that the doctor is providing from years of study and experience. People from countries with flatter democratic structures are particularly likely to consider that they are as knowledgeable as the experts and to demand that they can have whatever they request.

The predominance of Baby Boomers, people born in the 1950s and early 1960s, in senior political and management positions may encourage this client mindset. This group of people in developed regions have always got whatever they want, currently have better health than their parents at this age and are able to use the available resources, including the internet, to decide how they want to manage their lives. They do not want pain or suffering, or indeed ageing. So, as all groups do, they assume that everyone is like them and will want what they want, and in this situation, they have the political and organizational power to make things happen.

Conclusion

I consider that some or all of these various issues have been relevant in the decision that the Victorian parliament took in 2017 to legalize euthanasia and physician assisted suicide. I am sure that those who lobbied do not think that any of these issues were important in their thinking because they considered that they were advocating for people to be freed from suffering. However, it may be that they were advocating for suffering that they did not want to watch, not suffering that people undergoing it were clamoring for relief. It also moves away from the philosophy of palliative care to kill the suffering not the sufferer. Once we reduce the decision to a rights issue it becomes a consumer issue, one where the person can demand of their doctor that their life be ended because they don't want the suffering which might occur in the future.

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Review Paper

Various Faculty Teaching Styles To Support Student Learning

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ABSTRACT

This paper will focus on the various teaching styles for effective implementation of any subject in the classroom. Indeed, teaching styles denote various strategies that teacher uses to deliver his/her subject matter to the students within the realm of the instructional objectives.
There are several teaching methods, but it is left for the teacher to use the appropriate style. The teaching style should match the learning style of the students. The teacher's task is to ensure that learning is effective by using the appropriate method. This paper examines the concept of teaching and learning styles and also discusses various other teaching methods that can be used in a flipped classroom.

Key words: teaching methods, learning methods, teacher.

Teaching is an activity being carried out in a professional manner to bring a positive change on the learner. The teacher apart from updating knowledge should keep abreast with the basic principles of teaching that will help the teacher to be efficient in the discharging his/her duties. Teachers do impart training by encompassing the three domains cognitive, affective and psychomotor domain of the learner. Apart from this teacher should also know the various learners' styles of listening. And then modify his/her teaching accordingly. It is very well hoped that this paper throws a light on the above aspects of teaching for the teacher [1-5]. Well in order to carry out an effective teaching a good teacher should identify the learning style of students.

Learning involves acquiring knowledge or skills, attitudes and thereby modifying the behavioural pattern of an individual.
The learning style of students are as follows [6]:

a) Avoidant style – They are not enthusiastic teaching the subject and disinterested in attending class. They do not participate in activities.
b) Collaborative style – These students feel that they can learn by sharing ideas and talents they cooperate with teachers. They like working as a team.
c) Competitive style – These students believe that they must compete and out do others. They do learn material with focus on competition. They like to be the center of attention and to receive recognition for their achievements.
d) Dependent style – They learn only what is required. They do expect to be taught by a teacher. They look upon teacher as an authority figure for specific guidelines on what to do. They prefer didactic lectures.

e) Independent style – They participate in independent projects and are quite confident in their learning abilities. They prefer to work alone rather than with other students. They tend to determine their goals and learning process.
f) Participant style – They enjoy going to class and actively participate in all course activities. They do prefer lectures with discussion.

Students do have a combination of the styles too. As a teacher one has certain style of teaching which include [6]:

a) Authority or lecture style – This model is teacher centered and frequently consists of lengthy lecture sessions. Students should take notes. There may not be much interaction.
b) Demonstrator or coach style – Here the teacher demonstrates tarter what the student should know. And their lessons include multimedia presentations, activities and clinical demonstrations of physical signs.
c) Facilitator or activity style - Facilitators helps students to perform self-directed learning and develop analytical and critical thinking style. Also helps students to find answers and solutions through exploration. This challenges teacher to interact with students and also student to interact amongst each other.
d) Delegator or group style – As a delegator, teacher acts more as consultant and places the teacher in an observer role. It is best suited for lab activities such as Chemistry, Biology subjects' debate
e)

Although teaching styles have been categorized into various groups, today's ideal teaching style is more of a hybrid approach that blends the best of everything a teacher has to offer.
Hybrid or blended style – This style follows an integrated approach to teaching that blends the teachers' style and interest with students' needs. It enables teacher to tailor their style to student needs. Of course, it should focus the teaching objectives.
To make the class rooms interactive the use of laptops, video conferencing and podcasts play a vital role in today's teaching styles to accommodate the diverse needs of 21st century classrooms.

Students style	**Teachers style**
Avoidance style	One to one coaching
Collaborative	Facilitator, Group work
Competitive	Delegator, Lecture, Interact
Dependent	Lecture method, Demonstrate method
Independent	Lecture, Delegator
Participant style	Lecture with interaction, Collaborative

There is little doubt that the most dominant form of instruction is pedagogy, or what some people refer to as didactic, traditional, or teacher-directed approaches. A competing idea in terms of instructing adult learners, and one that gathered momentum within the past three decades, has been dubbed andragogy.
Pedagogy is derived from the Greek work "Paid" meaning child plus "agogos" meaning leading. Thus, pedagogy has been defined as the art and science of teaching children. In the pedagogical model, the teacher has full responsibility for making decisions about what will be learned, how it will be learned, when it will be learned, and if the material has been learned.
Andragogy (andr-meaning 'man') could be contrasted with pedagogy (paid-meaning 'child' and agogos meaning leading' [8].

In the minds of many around the adult education field, andragogy and the name of Malcolm Knowles [8] have become inextricably linked. For Knowles, andragogy is premised on at least four crucial assumptions about the characteristics of adult learners that are different from the assumptions about child learners on which traditional pedagogy is premised.

1. Self-concept: As a person matures his self-concept moves from one of being a dependent personality toward one of being a self-directed human being

2. Experience: As a person matures he accumulates a growing reservoir of experience that becomes and increasing resource for learning.
3. Readiness to learn: As a person matures his readiness to learn becomes oriented increasingly to the developmental tasks of this social roles.
4. Orientation to learning: As a person matures his time perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly his orientation toward learning shifts from one of subject-centeredness to one of problem centeredness.
5. Motivation to learn: As a person matures the motivation to learn is internal.

Lifelong learning is quite essential for medical experts so as to keep pace with the advancing knowledge and adapt to the dynamics of change which is a constant phenomenon in the medical subjects.
As the student enters from school to medical college they are coming from a pure pedagogical pattern to undergraduate that consists of a blend of Pedagogy and Andragogy. It will be like 60:40. As they go for Postgraduation ratio of Pedagogy and Andragogy will be 20:80. But there is a strong view that even in undergraduate medical education Andragogy should dominate so that the stimulus for lifelong learning is inculcated at that stage itself.

A constant update of knowledge through lifelong learning is quite essential in the medical field. This will help to render the best decision making and treatment for the patient, which is not only based on the knowledge acquired but also on the experience of doctors which is equally essential especially in the field of medicine. The latter human experience as one tool of education has been coined as humanagogy by Knudson [9].

Knudson [9] promotes humanagogy as a theory of learning that takes into account the differences between people of various ages as well as their similarities. It is a human theory of learning as opposed to a theory of child, adult or elderly learning. The accumulation of experience for example is a lifelong process that needs to be considered in educational planning. Inclusion of experience too likens this to a holistic approach of adult education [7].

What I strongly feel is that, for a lifelong learner in medical education, the best form will be a blend of Pedagogy, Andragogy and Humanagogy.
The Andragogy method can be implemented in a flipped class room teaching. Indeed, the flipped classroom is a teaching method that delivers lecture content to students at home through electronic means and uses class time for practical application activities which can motivate self-directed learning. It was promulgated by Jonathan Bergmann and Aaron Sams, high school chemistry teachers from Colorado, who began using recorded lecture in 2006 [3].

The flipped classroom has two components: moving the lecture outside the class, usually delivered through electronic means and moving the practical application assignments, formerly homework, into the classroom. The lecture format has evolved from sliders, audio, podcasts, or narrated presentation to video casts that may incorporate animations, screen captures and other multimedia content.

The strengths of flipped classroom are as follows –
More active learning opportunities, increase one to one interaction between student and teacher, inculcate the habit of self-directed learning, students are active and get involved rather than being inactive, more time to clarify material, more time to explore concepts deeply, more time for additional learning as various inputs from peers are there, more time for active learning, structured exercises help students to manage in small groups, more time for extended class room discussions, increase student responsibility for their own learning, work with peers to solve problems, fill each-others knowledge gaps, gradually build their own knowledge coordinating with what they already know.

Students may initially have confusion or discomfort but if instructor guides them properly and tell them what they are expended to do, then student understands and will enjoy traversing this rosy path of learning.
Indeed, in this model, student will be expected to know enough when they come to class to engage with each other.

During the flipped classroom as the students prepare and present they will be using the following various methods of learning:

1. Case study
2. Debates
3. Discussion
4. Panel discussion
5. Role playing
6. Simulation
7. Brain storming
8. Demonstration
9. Flip chart writing
10. Student centered cooperate learning
11. Web browsing

All the above will encompass cognitive affective and Psychomotor development methods.

Conclusions

Teaching is an attempt to bring about desirable changes in human behavior and learning abilities. Teaching methods should facilitate student learning and inculcate the habit of self-directed learning, so that it can be converted to lifelong learning. The flipped classroom model focuses on efficient use of class time and can accommodate different learners with varied styles. It allows students to take an active involvement in learning and use the array of teaching methods to present the contend efficiently. The teacher as facilitator can guide and use a combination of teaching methods for effective learning.

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Review Paper

Dealing with Academic Dishonesty

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ABSTRACT

The University has the responsibility to ensure academic integrity among its faculty and student community. Academic dishonesty is a misconduct that includes cheating, plagiarism, falsification and fabrication of any information, multiple submissions, violation of ethical and professional standards in academic programs and courses. The consequences of academic dishonesty can influence personal, professional, ethical and legal spheres. The students and faculty are responsible for complying with all University regulations and requirements of the respective Councils. Disciplinary action may be imposed on any student or faculty for violation of University rules and regulations. Some of the main causes for academic dishonesty are peer pressure, performance anxiety, excuse making, inability to manage the demands of student life, situations that encourage academic dishonesty, self-justification habits, unfamiliarity with what constitutes academic dishonesty and lack of understanding about consequences. The consequences of academic dishonesty are the penalties that the university can impose on the offending student or the faculty. Other consequences include social consequences, loss of intellectual property, inaccurate assessment, practical concerns, legal consequences, other social/academic consequences and diminishing self-esteem of students. Ethical principles and practices in the profession and the punishments and action imposed in academic dishonesty should be imparted to faculty and students. Group Assignments, research papers and writing assignments can be prepared regarding clearly defined citation expectations, describing plagiarism and paraphrasing, creating benchmarks and critical thinking. Therefore, preserving the academic integrity and preventing the growth of academic dishonesty is a pivotal part of Quality Assurance in the education system of the University.

Key words: academic dishonesty, medical colleges, academic integrity, students, university

INTRODUCTION

Every University has the responsibility to ensure academic integrity among its faculty and student community. Academic dishonesty is a misconduct that includes cheating, plagiarism, falsification and fabrication of any information, multiple submissions, violation of ethical and professional standards in academic programs and courses [1]. It also includes bribery, sabotage, deception, and impersonation. Scholars note that cheating was prevalent on the Chinese civil service exams thousands of years ago, even when cheating carried the penalty of death for both examinee and examiner [2]. Bribing the examiners was also common at that time and these have been recorded in the Ming-dynasty and Qing-dynasty story collections.

In this manuscript, selected studies are compared on the basis of my experience.

Good medical professional in addition to knowledge and skills must be equipped with high ethical and moral standards [3]; thus, increasing the quality of healthcare. The medical students are the cream of the society and are not expected to cheat in class tests or examinations. But the intense pressure to pass the examinations makes some of the students to be dishonest. Previous studies have reported academic dishonesty in the medical field. Cheating is prevalent in Croatian medical schools and academic dishonesty is seen as acceptable behaviour among numerous future Croatian doctors [4]. In Iran, the most frequently reported type of academic dis-integrity was found to be 'impersonating an absent student in a class' (93%) and the least frequent to be 'legitimising absences by using bribes' (5%). Only a small number of interns considered 'buying hospital shifts', 'selling hospital shifts', 'impersonating an absent student' and 'helping others to cheat in examinations' as representing academic disintegrity [5]. In another study from South India, 75% have given proxy for attendance and 49% have copied from others record book. During a theory exam, 74% of medical students have copied from their friends, 2% have tried to get the question paper before exam and 5% have influenced their teachers by unfair means to get more marks. During clinical/practical exam, 81% have got technical help, 45% had prior knowledge about the exam case, and 54% of them have falsely documented clinical findings [6]. Technological tools are also available for the students and faculty to facilitate plagiarism, falsification, fabrication of data, which gives rise to more challenges to the University. Thus, moral standards that are placed on each professional has two main obligations: the responsibility of developing his or her personal standards and the required self-discipline to practice in accordance with these standards [7].

Types of Academic Dishonesty

Medical field is ever growing, expanding and progressing day by day. Medical knowledge is available in literature in vast numbers of journals, books and World Wide Web. Plagiarism is nothing but adoption or reproduction of ideas or data of another person in your work and statements of another person without due acknowledgment. A review article published in 2017 described medical students plagiarising work of seniors and peers, self-plagiarism and plagiarizing from other sources without acknowledging the reference [8]. Academic plagiarism is on the rise in India also. Increasing pressure to publish, deficient training in ethical scientific writing, ignorance, oversight and lack of statutory controls and clear policies to deal with scientific misconduct in academics has led to the rise of research misconduct which can severely impact growth of India's higher education system [9]. Therefore, The Tamil Nadu Dr. MGR Medical University has introduced the plagiarism detection software which provides the percentage of copied contents that are taken from other research papers. All the postgraduate dissertations, Ph.D Thesis are analysed using the software. As the students and faculty are aware of this implementation, there is a decrease in plagiarism in the University.

Fabrication of data is inventing imaginary data to satisfy the required results and outcome. In Netherlands, a study conducted among 315 scientists concluded that 15% of the scientists admitted they had fabricated, falsified, plagiarized, or manipulated data in the past 3 years. And the scientific misconduct was more common among younger scientists working in a university hospital [10]. The Tamil Nadu Dr. MGR Medical University tackles fabricating data by reviewing the research work of students stringently. Review committees are set up to frequently evaluate the progress of the research projects. Deception is providing false information to the teacher/instructor concerning a formal academic exercise. One of the common examples is giving false excuse for missing a deadline. The student laments that somebody at home has fallen very sick. Some of them provide false claims of submitting the work and that it is lost. Teachers need to have contact with students and learn to deal with them.

Cheating is an attempt to give or obtain assistance in a formal academic exercise (like in examination) without due acknowledgment. Most of us would have seen it in examination process. In my experience as a medical teacher for more than three decades and as an administrator, I have seen students falsely asking for scribe in the pretext of having fracture of the

fingers or wrist. I refer to the medical board and surprisingly the medical board given their statement with no fracture at all and seem fit to write the examination. I have also noticed the students used rubbers to share answers for MCQs, used ear phones. For this purpose, my University had strictly instructed affiliated institutions to ban mobile phones in the examination halls and install CCTV Cameras and mobile jammers.

Students often resort to provide money for assignments and test answers. This very often happens in the engineering field. Some commercial centres advertise to complete the projects for students for money. This is rare in the medical field but it does happen. However, some students may attempt to sabotage other students work. They try and cut pages from the library books or attempt to wilfully disrupt other student's experiments. On rare occasions, students may take effort to impersonate another student; assuming a student's identity to provide an advantage for the student. To prevent this, the University releases hall tickets for examinations with photos and encourages CCTV cameras in the examination halls.

Causes of Academic Dishonesty

Most of the students attempt dishonest behaviour due to peer pressure. They try to achieve high marks or perform the assignments at a faster pace. Some students are anxious to perform well and therefore resort to dishonest ways. Sometimes they observe other students cheating and join them. However, the most common reason is that the students are unable to cope with the pressures of their social and academic lives. A study of pharmacy and medical students in New Zealand found that students' actions (honest or dishonest) were guided by family and friends, the need to do well, issues of morality and institutional guidelines [11]. A study among nursing students in South Africa reported the pressure to succeed academically was a major factor influencing the decision to engage in cheating behavior [12]. And medical students in Ethiopia reported that lack of preparation for exams, academic workload or other assignments, need to obtain good marks and desire not to fail exams were the major cause of academic dishonesty [13]. Occasionally students may complain that their professors expect too much or are too difficult to understand. Rarely if any questions are asked in the examinations out of syllabus, students tend to cheat.

There are some situations that encourage academic dishonesty. When the course regulations do not spell out clearly the consequences and penalties of violating the academic integrity standards and when the medical teachers and instructors are not careful in enforcing academic integrity standards. In some centres the teachers encourage dishonesty to get good name. Therefore, teachers have to be careful as the students look up to them and copy them. Like anti-ragging, students must be made aware that they will be suspended or removed from the institution if they practice academic dishonesty. Also, when they copy and cheat in examinations, they should be aware that they will be debarred for three months or years or consecutive sessions as per the norms of the University.

Consequences

There are many consequences of academic dishonesty. The most obvious consequences of academic dishonesty are the penalties that the university can impose on the offending student or the faculty. Once dishonest behaviour becomes a habit, it will be harmful to the society as well as to the person itself. For e.g. students who cheat, may continue to do so at work, in family life and other aspects of life. The patient does not need such doctors who are dishonest and unethical. A legal case can be filed against them. Other consequences are loss of intellectual property, [14] inaccurate assessment, practical concerns, other social/academic consequences and diminishing self-esteem of students [15]. Students with low self esteem may have difficulty in their careers and families. Therefore, all students must be taught bioethics.

Dealing with Academic Dishonesty

Establishing a culture of integrity starts at the University level and can filter down to the individual medical teachers of the medical colleges. The medical faculty must become familiar with institution's policies, regulations and practices. They also need to notify students of the policies and regulations wherever a marks or grades are involved, syllabi, assignments and project sheets, statement of expected behaviour, etc. They should develop in-class exercises to help students with proper methods of citation, encourage them to attend research methodology workshops and provide classes on how to write a paper. They should design tests and assignments to minimize opportunities to engage in dishonest behaviour. For example, negative markings, Multiple Choice Questions (MCQs) and online tests. Establish clear rules on the use of electronic devices in class. If permissible, deal with isolated instances on an informal in-class basis but be sure to observe all class and institutional procedures are maintained. Once a culture of integrity has been embraced at the institutional level, it can be instilled in individual students, faculty, and administrators [16].

The University approach for the administrators involves review institution's policies regulations and practices: look for comprehensive statements on dealing with instances of academic misconduct. Make sure the policies and regulations are in line with Central Councils and the institution's mission, policies, customs, and/or existing honor code and that they are being followed meticulously. Make sure that faculty and students can find the policies and academic decisions (website, handbooks, orientation). Publications of an online Frequently Asked Questions guide to issues of Academic Dishonesty so that students and faculty can access reliable information anytime [17]. Review syllabi/curricula, if necessary, compose a short statement or web page URL that can be inserted into a syllabus. Create opportunities for faculty, administrators, and student leaders to talk about academic dishonesty frequency of instances, effective responses, due process, etc. Periodically review the process for compliance and practicality. We have to teach other teachers and other students about what is dishonesty, regulations, rules, policies and what are the punishments involved. Further, penalties should be given consistently through a fair evaluation process since mixed messages regarding penalties for academic misconduct may in fact encourage students to engage in academic misconduct [18].

CONCLUSIONS

The University needs to take initiative for its faculty to become familiar with curriculum, policies, regulations and practices. The students should be notified of the policies and regulations wherever marks/grade is involved: syllabi, assignment and project sheets, statement of expected behaviour. The colleges need to remind students of expectations just before starting a test or assignment. The faculty can further design tests and assignments to minimize opportunities to engage in dishonest behaviour. Group Assignments, research papers and writing assignments can be prepared regarding clearly defined citation expectations, describing plagiarism and paraphrasing, creating benchmarks and critical thinking. Clear rules need to be established on the use of electronic devices in class. If permissible, deal with isolated instances on an informal in-class basis but be sure to observe all class and institutional procedures. It is therefore critical that the University make concerted effort to include bioethics into the curricula and establish sound academic integrity policies. Thus, preserving the academic integrity and preventing the growth of academic dishonesty is a pivotal part of Quality Assurance in the education system of the University.

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Review Paper

Thoughts On A New Draft Bill On Living Will

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ABSTRACT

Introduction: As advancement of life expectancy in years is occurring, people are living long life. Most of them need life support for terminal illness at the end of life. Many of them do not wish to continue sufferings of vegetative life & would like to terminate or discontinue the life support machines or medicines.
Factual Situation: A living will – also known as an advance directive – is a legal document that specifies whether or not you want to be kept on life support if you become terminally ill. 2It permits individual to authenticate their wishes in a written form so that these can be carried out if the relevant situation arises. In addition to the living will, one can select a health-care proxy or health-care power of attorney who is allowed to make decisions for him or her if he or she is incapable of making those choices.
FAQs on Living Will: Who can make a Living Will? An adult with a sound and healthy mind. What it should contain? The circumstances in which medical treatment should be withheld or withdrawn. It should specify that the Will can be revoked any time. How to Create a Living Will? Many people hire a lawyer to prepare their living will. Most people can create this simple document - along with the other typical estate planning documents - without the high legal fees by using a quality software application that accounts for their state's laws.
Make Your Own Will: You can create a legally binding health care directive (living will) without paying an attorney by using reputable estate planning software, like Nolo's award winning Will Maker Plus. It should give the name of the "guardian or close relative" who will give the go-ahead for starting the procedure of passive euthanasia. The Will shall be attested by two independent witnesses and preferably counter-signed by the Judicial Magistrate First Class (JMFC) assigned the jurisdiction by the District Court. The JMFC shall preserve one hard copy, along with one in the digital format, in his office. JMFC shall forward a copy of the Will to the Registry of the District Court JMFC shall inform the immediate family of the executor, if not informed. A copy will be handed over to an official in the local government or municipal corporation or panchayat concerned. This authority shall nominate a custodian for the Living Will.7
Scenario in India: The Supreme Court has given a landmark decision on 7th March, 2018 on Living Will as per Section 11 C. It has confirmed the right to a dignified death as a part of the right to life under article 21 section 11 of the Indian Constitution. The Supreme Court passed a judgment upholding the legality of withholding or withdrawing life-saving medical treatment from terminally ill patients. Families are pushed into poverty tending to the out of pocket expenses of life support.

Key words: living will, euthanasia, assisted suicide

INTRODUCTION

As advancement of life expectancy in years, people are living longer life. Most of them need life support for terminal illness. Many of them do not wish to continue sufferings of vegetative life & would like to terminate or discontinue the life support machines or medicines. In accordance, the Supreme Court has allowed individuals to create a 'living will', which will permit medical professionals to withdraw life-support systems under certain circumstances.

A living will – also known as an advance directive – is a legal document that specifies the type of medical care that an individual does or does not want in the event he or she is unable to communicate his or her wishes. [1]

It is a legal document that specifies whether or not you want to be kept on life support if you become terminally ill and will die shortly without life support, or fall into a persistent vegetative state. [2] It permits individual to authenticate their wishes in a written form so that these can be carried out if the relevant situation arises. In many countries, Advance Directives are legally valid and enforceable; they reduce the use of life-sustaining treatments, which often merely prolong life without improving or even maintaining the same level of health. [3]

In addition to the living will, one can select a health-care proxy or health-care power of attorney who is allowed to make decisions for him or her if he or she is incapable of making those choices. [4]

Types of Euthanasia

Active versus Passive euthanasia

"Active euthanasia" is taking specific steps to cause the patient's death, such as injecting the patient with poison. In practice, this is usually an overdose of pain-killers or sleeping pills.

"Passive euthanasia" is usually defined as withdrawing medical treatment with the deliberate intention of causing the patient's death. For example, if a patient requires kidney dialysis to survive, and the doctors disconnect the dialysis machine, the patient will presumably die fairly soon. Perhaps, the classic example of passive euthanasia is a "do not resuscitate order". Normally if a patient has a heart attack or similar sudden interruption in life functions, staff will attempt to revive them. If they make no such efforts but simply stand and watch as the patient dies, this is passive euthanasia. [5] In other words, the difference between "active" "passive" is that in active euthanasia, something is *done* to end the patient's life; in passive euthanasia, something is *not done* that would have preserved the patient's life. The moral difference between killing and letting die. Many people make a moral distinction between active and passive euthanasia. They think that it is acceptable to withhold treatment and allow a patient to die, but that it is never acceptable to kill a patient by a deliberate act. [6] An important idea behind this distinction is that in "passive euthanasia" the doctors are not actively killing anyone, they are simply not saving him.

Voluntary vs Involuntary

"Voluntary euthanasia" is when the patient requests that action be taken to end his life, or that life-saving treatment be stopped, with full knowledge that this will lead to his death.79 "Involuntary euthanasia" is when a patient's life is ended without the patient's knowledge and consent. It usually means that the patient is unconscious, unable to communicate, or is too sick and weak to be aware of what is happening or to take any action on his own behalf. [7]

The Aruna Shanbaug case which changed euthanasia laws in India

A landmark verdict

The Supreme Court on March 9 ruled that individuals had a right to die with dignity, allowing passive euthanasia with guidelines. The need to change euthanasia laws was triggered by the famous Aruna Shanbaug case. The top court in 2011 had recognised passive euthanasia in Aruna

Shanbaug case by which it had permitted withdrawal of life-sustaining treatment from patients not in a position to make an informed decision.

The attack

Aruna Ramchandra Shanbaug was a nurse in the King Edwards Memorial Hospital in Mumbai. In November 1973, she was assaulted by ward boy, Sohanlal Bhartha Valmiki, of the same hospital while changing her clothes in the hospital basement. Valmiki strangulated Shanbaug with a dog chain around her neck.

Living in a coma

The attack cut off oxygen supply from her brain leaving her blind, deaf, paralysed and in a vegetative state for the next 42 years. From the day of the assault till the day she died on May 18, 2015, Aruna could only survive on mashed food. She could not move her hands or legs, could not talk or perform the basic functions of a human being.

What happened to Valmiki

In 1974, Valmiki was charged with attempted murder and for robbing Aruna's earrings, but not for rape. The police did not take in account that she was sodomized. A trial court sentenced Valmiki seven years imprisonment. This was reduced to six years because he had already served a year in lock up. Valmiki walked out of jail in 1980 and still claims he did not rape Shanbaug.

Facing opposition

The Supreme Court accepted the petition and constituted a medical board to report back on Aruna's health and medical condition. The medical board, comprising three eminent doctors, reported that the patient was not brain dead and responded to some situations in her own way. They felt that there was no need for euthanasia in the case. The staff at KEM Hospital and the Bombay Municipal Corporation filed their counter-petitions in the case, opposing euthanasia for Aruna. The nurses at KEM Hospital were quite happy to look after the patient and they had been doing that for years before petitioner Pinky Virani emerged on the scene.

Finally, at peace

On May 18, 2015, Shanbaug then 66, died of severe pneumonia. She was on ventilator support in KEM's acute care unit. [8]

Countries where active euthanasia is legal

As of March 2018, human euthanasia is legal in the Netherlands, Belgium, Colombia, Luxembourg,Canada and India. Assisted suicide is legal in Switzerland, Germany, South Korea, Japan, and in the US states of Washington, Oregon, Colorado, Hawaii, Vermont, Montana, Washington DC, and California. [9]

Netherlands

In April 2002, the Netherlands became the first country to legalize euthanasia and assisted suicide. It imposed a strict set of conditions: the patient must be suffering unbearable pain, their illness must be incurable, and the demand must be made in "full consciousness" by the patient. In 2010, 3,136 people were given a lethal cocktail under medical supervision. So-called palliative sedation has also become a widespread practice in hospitals, with 15,000 cases a year since 2005, according to the Royal Dutch Medical Association. Patients with a life expectancy of two weeks or less are put in a medically induced coma, and all nutrition and hydration is withdrawn.

France
Euthanasia and assisted suicide are against the law. The president, François Hollande, promised to look at the "right to die with dignity" but has always denied any intention of legalising euthanasia or assisted suicide. In 2005 the Léonetti law introduced the concept of the right to be "left to die". Under strict conditions it allowed doctors to decide to "limit or stop any treatment that is not useful, is disproportionate or has no other object than to artificially prolong life" and to use pain-killing drugs that might "as a side effect, shorten life".

United States
Doctors are allowed to prescribe lethal doses of medicine to terminally ill patients in five US states. Euthanasia, however, is illegal. Oregon was the first US state to legalise assisted suicide. The law took effect in 1997, and allows for terminally ill, mentally competent patients with less than six months to live to request a prescription for life-ending medication. More than a decade later, Washington state approved a measure .And last year, the Vermont legislature passed a similar law. Court decisions rendered the practice legal in Montana and, most recently, in New Mexico. In 2013, roughly 300 terminally ill Americans were prescribed lethal medications, and around 230 people died as a result of taking them. Some patients choose not to take the medication.

Germany and Switzerland
In German-speaking countries, the term "euthanasia" is generally avoided because of its association with the eugenicist policies of the Nazi era. The law therefore tends to distinguish between assisted suicide (*beihilfezumsuizid*) and "active assisted suicide" (*aktivesterbehilfe*). In Germany and Switzerland, active assisted suicide – i.e., a doctor prescribing and handing over a lethal drug – is illegal. But German and Swiss law does allow assisted suicide within certain circumstances. In Germany, assisted suicide is legal as long as the lethal drug is taken without any help, such as someone guiding or supporting the patient's hand. In Switzerland, the law is more relaxed: it allows assisted suicide as long as there are no "self-seeking motives" involved. Switzerland has tolerated the creation of organisations such as Dignitas and Exit, which provide assisted dying services for a fee.

Belgium
Belgium passed a law in 2002 legalising euthanasia, becoming the second country in the world to do so. The law says doctors can help patients to end their lives when they freely express a wish to die because they are suffering intractable and unbearable pain. Patients can also receive euthanasia if they have clearly stated it before entering a coma or similar vegetative state. [10] Advanced Directive (AD) is legally valid and enforceable in the USA [11] Canada, Australia and many countries across Europe. [12] ADs have been endorsed by the United Nations Convention on the Rights of Persons with Disabilities. [13] Whereas half of the Americans have ADs, the concept is unknown by many in India. [14] Australian Scientist Dr. David Gudall,104 years old, was born British but lived in Australia. At the end of his life, he flew to Switzerland for assisted suicide. He fought to die on his terms because of his deteriorating health. Since active euthanasia or assisted suicide is not legalised in Australia, he had to leave his country to die with dignity. [15]

Passive euthanasia, Active euthanasia & the Law in India
Passive Euthanasia Now a Legal Reality in India. Recognising “living wills” made by terminally-ill patients, the Supreme Court has held that the right to die with dignity is a fundamental right. Declaring the right to die with dignity as a fundamental right, the Supreme Court in a landmark judgment on 7 March 2018 passed an order allowing passive euthanasia in the country. [16] The apex court has said that an individual could make an advance “living will” that would authorize passive euthanasia under certain circumstances. Delivering the judgment, Justice Chandrachud

said, "Life and death are inseparable. Every moment our bodies undergo change… life is not disconnected from death. Dying is a part of the process of living." [17]
A Constitution Bench, led by Chief Justice of India Dipak Misra, in three concurring opinions, upheld that the fundamental right to life and dignity includes right to refuse treatment and die with dignity. [18] It can be done by means of the withdrawal of life support to patients in a permanent vegetative state. The decision was made as part of the verdict in a case involving Aruna Shanbaug, who had been in a Persistent Vegetative State (PVS) until her death in 2015.

This judgment was passed in wake of Pinki Virani's plea to the highest court in December 2009 under the Constitutional provision of "Next Friend". It's a landmark law which places the power of choice in the hands of the individual, over government, medical or religious control which sees all suffering as "destiny". The Supreme Court specified two irreversible conditions to permit Passive Euthanasia Law in its 2011 Law: (I) The brain-dead for whom the ventilator can be switched off (II) Those in a Persistent Vegetative State (PVS) for whom the feed can be tapered out and pain-managing palliatives be added, according to laid-down international specifications. The same judgement-law also asked for the scrapping of 309, the code which penalises those who survive suicide-attempts. In December 2014, government of India declared its intention to do so. [19]

Response from different religious leaders were in accordance with their religious scriptures. Christians and the Jains thought passive euthanasia was acceptable under some circumstances [20]. Jains and Hindus have the traditional rituals *Santhara* and *Prayopavesa* respectively, wherein one fasts unto death. The Jain vow of *santhara*, is observed by the Jains only in special circumstances. These are mentioned in the Jain texts. [21] Some members of India's medical establishment were skeptical about euthanasia due to the country's weak rule of law and the large gap between the rich and the poor, which might lead to the exploitation of the elderly by their families. [22] It was observed that the issue was not considered politically contentious in India." [23]

Frequently Asked Questions on Living Will

Who can make a Living Will ?
An adult with a sound and healthy mind can make a living will. It should be voluntarily executed and based on informed consent. It should be expressed in specific terms in a language "absolutely clear and unambiguous".

What it should contain?
It should contain the circumstances in which medical treatment should be withheld or withdrawn. It should specify that, the living will can be revoked any time.

How to Create a Living Will
People can hire a lawyer to prepare their living will. If you need to write or update a will or trust, you can take care of your living will at the same time. You can create a legally binding health care directive (living will) without paying an attorney by using reputable estate planning software, like Nolo's award winning Will Maker Plus. It should give the name of the "guardian or close r elative" who will give the go-ahead for starting the procedure of passive euthanasia. If there are more than one Living Will, the latest one will be valid.

How to preserve it ?
The Will shall be attested by two independent witnesses and preferably counter-signed by the Judicial Magistrate First Class (JMFC) assigned the jurisdiction by the District Court.The JMFC shall preserve one hard copy, along with one in the digital format, in his office. JMFC shall forward a copy of the Will to the Registry of the District Court JMFC shall inform the immediate family of the executor, if not informed. A copy will be handed over to an official in the local government

or municipal corporation or municipality or panchayat concerned. This authority shall nominate a custodian for the Living Will. [24]

Conclusions

It is a great victory for the patients who are terminally ill or on palliative care or vegetative to end their sufferings. It is inhuman to allow someone to die. At the same time, it is inhuman to see someone suffering terribly. We have to take the call as per the basic human rights of living with dignity and patients' autonomy that is living will.

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Ethical Viewpoint

Family Therapy – Ethical Issues from an Indian Standpoint

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ABSTRACT

Family therapy has not yet gained acceptance or popularity in the Indian context. The unique nature of the Indian family presents a number of challenges for the conduction and process of family therapy with Indian families. There are a number of ethical issues that arise out of these challenges and the present articles aims to highlight the common ethical dilemmas posed before therapists that conduct family therapy in India. Issues related to informed consent, confidentiality, online psychotherapy with family members that are abroad, unconditional positive regard and therapeutic neutrality are discussed. Issues faced when certain family members may need individual psychotherapy in addition to family therapy are also addressed.

Key words: ethics, family therapy, Indian setting

Family therapy, also referred to as couple and family therapy or family systems therapy, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members [1]. It emphasizes family relationships as an important factor in psychological health of an individual and eventually of a family as well. What the different schools of family therapy have in common is a belief that, regardless of the origin of the problem, and regardless of whether the clients consider it an "individual" or "family" issue, involving families in solutions is often beneficial. The involvement of families is commonly accomplished by their direct participation in the therapy session. The concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood [2].

Family therapy in India has not yet caught the fancy of patients coming in for psychiatric treatments. One the most commonly cited reasons for the same is the fact that family members may rarely have the time to be all together for a therapy session. Many a times, patients that come in for therapy have interpersonal problems and this may very often lead to the family therapy sessions being turned into sparring sessions which makes it difficult for the single therapist to handle. There are many ethical dilemmas when it comes to family therapy in general and therefore equally so in India as well [3].

There is a need for set of guidelines in order to follow and to maintain the effectiveness of this psychotherapeutic practice. Some therapists move from individual to family therapy and vice versa, whereas others conduct all therapy sessions with the entire family or a consistent family subunit. The ethical issues vary in importance depending on which therapeutic format is used. The following section discusses some of the challenges like responsibility, confidentiality, patient privilege, informed consent and the right to refuse treatment and therapist values [4].

Responsibility

One of the defining roles of any therapist is to advocate for the patient's welfare and protect their rights and so does a family therapist. It becomes a challenge when the protection of rights and welfare becomes a conflicting issue with more than one patient being handled at the same and that too within a similar family system. An Indian family regards the priority of welfare on the basis of several criteria- either the one who is senior most in the family or is the breadwinner in the family- it is rare to find and equitable status quo for the same. The challenge doubles in such a situation [5].

Additionally, individuals seek therapy when there are conflicting interests and goals within themselves or in the family. More often, the therapist is expected to be a relationship advocate and maintain a neutral stance in a family therapy session. Though this stance of the therapist is accepted by the family, there are instances where the therapist is expected to serve as a personal ally to an individual. It is also a challenge to determine as to which family member gets better served since the equal benefit of service to all family members is difficult to achieve. An added challenge to maintain responsibility as a family therapist is that when there are more than two people involved in a family system, it is difficult to say if the interests of one individual will not interfere with those of the others and the vice versa. Functioning as a relationship advocate sometimes has the paradoxical effect of actually creating variance between the aims of family members and those of the therapist as well. The challenge only adds on when there are clearly outlined conflicts on interest in the beginning but they divulge into various 'secret' conflicts (pertinent to certain individual members of the family). This happens when the seniors f the house feel that the younger members need not know 'everything' about the particular concern. Indian families often face this conflict in a parent-child conflict as well where the parent feels they can determine certain aspects of their child's life without their consultation whereas the child disagrees. The similar challenge is also seen between a senior and younger member of the house where the senior member assumes unsaid authority over the major decision making for the house.

Confidentiality and Informed Consent

The second challenging ethical dilemma is that of confidentiality. In the general practice of family therapy, the ethical challenge of maintaining confidentiality surfaces with questions in consideration- 'Who is the patient / client?', 'how is confidential information of more than one patient / client in the same family handled?' 'What should be the degree of disclosure and to whom?' and several such questions cross paths with the practice of family therapy. Confidentiality is a greater challenge in a country like India, where peoples' lives are inevitably blend with familial, societal and cultural influence closely [6]. In India, families often believe that there should be no secrets between family members and often want to know what the other family members are saying. The hurdle of what to disclose to whom, how much to disclose, when and how to disclose is also a part of the challenge of confidentiality in the family therapy setting. This leads to a dilemma for the therapist who tries to maintain utmost confidentiality but there are times when elder family members or the breadwinning member of the family demand to know details of sessions held with other family members especially the younger family members and children (for reasons they justify, as a matter of fact) and may thus impinge on boundaries that the therapist wishes to maintain [7]. When the therapist may try to maintain confidentiality, these family members may not like the same and express the same in non-attendance and non-cooperativeness during sessions.

Informed consent and right to refuse treatment are ethical nuances of any therapeutic practice. Thus, similarly so, they are also an essential element for family therapy. The procedure of informed consent and right to refuse treatment communicates an important therapeutic messages: No one family member is the "sick" or "crazy" person. No one person will be "treated" while others simply observe. No one will be excluded from knowledge about what is to transpire. Such an assurance is a promise to the individuals that family therapy addresses them as a system, there is shared responsibility for the problem and the solution- this in itself is a therapeutic step [8].

Psychotherapy for Individual Family Members

The third ethical dilemma is when some members of the family may need individual therapy sessions along with the regular family therapy sessions. The individual sessions need to be held separately and in within psychotherapeutic boundaries. This is even more important as patients in a family therapy setting when visiting the therapist for individual therapy may try to earn more favour from the therapist and may try and direct how the family therapy sessions move or even infuse the therapist with facts in individual sessions that may malign him or her thoughts or align them towards specific family members [9]. Therapeutic neutrality must be maintained by the therapist in such a condition, under all circumstances; and this is important as it may otherwise cause a therapeutic bias towards one family member and the skew the direction of family therapy as a whole.

The fourth ethical dilemma, attached to the third one, is whether the family therapist must take up patients for individual therapy or must assign another therapist for the same. The therapist must be mindful not take the court of an individual member (whom they may also be seeing for individual therapy) whilst during the family therapy setting. On the other hand, this is possible the therapist conducting family sessions shall lose the advantage of using the information garnered in individual therapy sessions for the advantage of the family in therapy. Thus, it is better that the same therapist conducts the sessions while maintain all professional boundaries and confidentiality and neutrality with an unconditional positive regard for all family members [10].

Duration of Therapy

The fifth ethical dilemma pertains to the duration of therapy and fee payment. Since there are multiple family members in family therapy and Indian families are big, how long should the duration of sessions be as 45 minutes to an hour may not be enough and whether should one charge more based on duration and number of people coming in for therapy sessions. While this may be done in consideration, it is also prudent to understand that charging more may lead to withdrawal from family therapy sessions due to cost and affordability issues. A therapist may gauge the priority of therapeutic work and take a decisional stance about the financial aspect of the same. As far as the duration of therapy is required, the therapist must adhere to certain time limits and keep an allowance for flexibilities in order to ensure the effectiveness of family therapy. Sometimes, it's okay to have the extension in session (depending on the gravity and urgency of situation) however, at times, it may just be futile and fatiguing for the family as well as the therapist [11].

Issues in Online Psychotherapy with Family Members

Unique ethical dilemmas also come in when one family member is abroad and may seek online therapy individually while being involved in family therapy sessions via online means. The internet-based medium may not be the best of the media for family therapy sessions considering the number of people involved, triangulated conflicts and the multi-fold addressing required to be done for the same. Apart from that, all the ethical issues that concern online psychotherapy are enveloped to play out in the situation where family therapy is involved. The ethical dilemmas of online psychotherapy as beyond the scope of this chapter, however, one can read more about the same, referring to the recommended reading section of this article [12].

Lack of Proper Training

It is also important to understand that there are ethical issues in training in family therapy in India. There are barely any training programs in family therapy in India and therapists who are trained abroad work with families abroad where the dynamics are different and it is very difficult to apply the same to Indian settings. In India, family therapy training is redundant in psychotherapy syllabi and training is restricted to teaching the theory alone. There is a scarcity of sound supervision in individual therapy and family therapy supervision is conspicuous by its absence. There is also a lack of trained teachers and supervisors to impart knowledge in the subject. Therefore, lack of training and supervision are added shortcomings with a lack of infrastructure and resources for the same in a developing country like ours [12].

Legal Aspects of Family Therapy in India

The legality and documentation of family therapy in India is another burning issue. The reason for the same is lack of legal regulations governing therapists and family therapy in India. Lack of documentation and case record guidelines in the Indian context can sometimes lead to poor, incomplete and shabby documentation that affects proper case records when there is a legal matter involved. There is a lack of computerized therapy session documentation in India and this leads to poor handwritten notes as very few therapists in India maintain painstaking handwritten records for session by session documentation of both individual and family therapy [13].

Another aspect related to legality is when the therapist may have to enter in as the relationship advocate when there is a legal matter involved during the period of family therapy- where two people may be waiving property matters or a divorce is due in course.

Challenges of the Indian Family

Last but not the least, is the ethical issues when incorporating schools of therapy built in the western context to suit the Indian context. Mother-in-law and daughter-in-law issues, fights between elder and younger daughters-in-law, fights within joint families and issues between newly married couples and their in-laws are all unique to the Indian context and the psychodynamics and family dynamics of the same needs to be understood in the Indian context through experience and are not documented in a book anywhere. Cultural and religious values need to be respected and treated with care in therapy settings and family therapists need to be cognizant of the issues at hand when handling families from orthodox religions or families with mixed marriages and religious or cultural diversity. Training for the same is never given and comes over time with the experience of being a therapist [14].

Conclusion

Thus, multiple ethical dilemmas plague the family therapist in India and it is important that therapists propagating family therapy are ready to meet these ethical challenges head on and take on the problems that may be faced in family therapy sessions. If thought upon, the scope of effectiveness of family therapy in a partly collectivist and partly individualistic country like India is immense. We, as a country, have the potential to benefit each other as a family system along with the values that we proud upon.

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Ethical Viewpoint

Ethical Issues in Pharmacogenomics

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ABSTRACT

Progress in medicine has led to the appearance of a new branch - pharmacogenomics. The use of genetic material in the patients' genotype has allowed for the development of new pharmaceutical products. Although pharmacogenomics leads to the production of effective and safe drugs, its applications raise important ethical, legal, social and regulatory issues. This technology will thus have an impact on the research and development of medicines and clinical practices in future. It will have an implication on the use and storage of genetic information as well. The ethical implications refer to the informed consent for genetic testing, personal autonomy regarding decision for DNA testing, confidentiality, the principle of equity. Discriminatory attitudes can be avoided, primarily through the management of the patients' genetic data under conditions of confidentiality.

Key words: ethics, pharmacogenomics, pharmacology

What is pharmacogenomics ?

For many years studies of pharmacogenetics have provided ample examples of causal relations between genotypes and drug response to account for phenotypic variations of clinical importance in drug therapy. The convergence of pharmacogenetics and human genomics in recent years has dramatically accelerated the discovery of new genetic variations that potentially underlie variability in drug response, giving birth to pharmacogenomics [1].

Pharmacogenomics - (pharmaco + genomics) is combination of pharmacology and genomics. It is the study of how genes affect a person's response to drugs. Pharmacogenomics analyzes how the genetic makeup of an individual affects his/her response to drugs. It deals with the influence of genetic variation on drug response in patients by correlating gene expression or single-nucleotide polymorphisms [SNP] with pharmacokinetics and pharmacodynamics. Pharmacogenetics focuses on single drug-gene interactions, while Pharmacogenomics encompasses a more genome-wide association approach, incorporating genomics and epigenetics while dealing with the effects of multiple genes on drug response [2].

Pharmacogenomics aims to develop rational means to optimize drug therapy, with respect to the patients' genotype, to ensure maximum efficiency with minimal adverse effects. Through the utilization of pharmacogenomics, it is hoped that pharmaceutical drug treatment can get a novel approach. Pharmacogenomics also attempts to eliminate the trial-and-error method of prescribing, allowing physicians to take into consideration their patient's genes, the functionality of these genes, and how this may affect the efficacy of the patient's current or future treatments (and where applicable, provide an explanation for the failure of past treatments). Such approaches promise the advent of precision medicine and even personalized medicine, in which drugs and drug

combinations are optimized for narrow subsets of patients or even for each individual's unique genetic makeup. Whether used to explain a patient's response or lack thereof to a treatment, or act as a predictive tool, it hopes to achieve better treatment outcomes, greater efficacy, minimization of the occurrence of drug toxicities and adverse drug reactions (ADRs). For patients who have lack of therapeutic response to a treatment, alternative therapies can be prescribed that would best suit their requirements. In order to provide pharmacogenomic recommendations for a given drug, two possible types of input can be used: genotyping or whole genome sequencing [3].

Ethical principles related to pharmacogenomics

Over the years, a number of guidelines have been set to ensure that biomedical research is performed in an ethical manner. The most important of them is the Declaration of Helsinki, which was issued by the World Medical Association in 1964.In recent years, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has also issued declarations regarding the human genome, human genetic data, bioethics and human rights, the latest being the Universal Declaration on Bioethics and Human Rights. This declaration discusses in detail the ethical issues relating to pharmacogenomics and its implications for health in developing countries. With regards to bioethics, the fundamental principles are:

- Respect for other human beings as moral equals (autonomy)
- The absolute need to avoid harming other human beings by our actions (non-maleficence)
- The relative need to do good to other human beings and to ensure that our actions are calculated always to achieve more beneficial than harmful effects (beneficence)
- The need to treat other human beings fairly, without unduly exploiting or otherwise deceiving them (justice).

These principles provide a framework for thinking through ethical questions in pharmacogenomics. Thus, each ethical issue will need to be considered in light of balancing these principles so that the most appropriate course of action can be decided upon [4].

Research and Development

The information to be used in clinical trials needs to be protected. This includes issues relating to consent, privacy and confidentiality [5].

The pharmacogenomics drug trials and genetic databanks require that people submit a DNA sample for analysis. In both contexts, it is important to ensure that consent is obtained before samples or genetic data are gathered and that the privacy of the participants is protected, as is the confidentiality of the genetic material. In pharmacogenomics research, as in other kinds of medical research, consent requires that participants "should be informed about the risks of the study, have the right to withdraw from studies at any point, and must give their explicit consent to participation." The Council for International Organizations of Medical Sciences (CIOMS) emphasizes that consent to pharmacogenomics trials should be voluntary as a matter of respect for autonomy. This means that participation in the clinical trial should not be dependent on the subject's involvement in a pharmacogenomics substudy. In their view, for studies that are specifically designed so that inclusion is based on the subject undergoing a pharmacogenomics test, participation is thus dependent on agreement to undergo such a test and thus participation in the study cannot be separated from their involvement in the clinical trial. UNESCO Declaration on Bioethics and Human Rights emphasizes that any scientific research should "only be carried out with the prior, free, express and informed consent of the person concerned."

CIOMS states following items to be included in informed consent forms [6]

- A statement of clear rationale
- Fields of study for sample use
- Length of time the samples will be stored
- Sample coding
- Options to withdraw the sample
- Expected benefits to the patient or others (if any)
- Potential risks

- Treatment of and participant's access to the study results
- Handling of intellectual property generated from the use of samples
- Ownership or custodianship of sample
- Ownership or custodianship of data
- Access to samples and data
- Liability of the investigator

The implications for patients will depend on how easily samples can be traced back to them. Hence it is essential to maintain anonymity. Genetic and clinical data would be collected during a trial, but a code linking patients with their samples would be destroyed after the trial so they could not be matched subsequently. However, this approach would not be suitable for a long term follow-up and in event of an adverse effect of drug. Hence it is imperative that the greatest degree of anonymity compatible with the research should be used to protect the privacy of participants. Researchers should explain to prospective participants how the samples will be stored and the implications for them [7].

Participants need to know whether the research is likely to give rise to information that is directly relevant to their health. In such cases, researchers may provide individual feedback to patients or offer individual test results only if patients ask for the information.

Before starting the research, it is important to conduct an ethical review of proposed research and that this review process should be undertaken by at least one independent research ethics committee. Independent ethical review is necessary for pharmacogenomics research to ensure that research proposals are ethically appropriate and that proper measures involving consent, privacy, the future use of genetic samples and other research issues are appropriately addressed.

Public policy

The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for the licensing of new medicines and genetic tests, based on an assessment of quality, efficacy and safety. The approval of Pharmacogenetic tests and medicines will also be under its remit. It is important that these tests should be reliable and of high quality. In some cases, a medicine will only be licensed if it is used in conjunction with a test [8].

Since Healthcare providers operate on limited budgets, Pharmacogenetics will provide information that is relevant to these assessments by allowing more accurate prediction of the cost of a treatment. Decisions about cost-effectiveness of treating different groups of people with the same medicine may be affected by pharmacogenetic information. However, an exclusive focus on cost- effectiveness, could lead to the possibility that small groups of people with rare diseases or genetic variations might not be given treatment. Justice and equity also need to be considered. Sometimes it will be right to allocate resources to treatments or conditions that might otherwise not be considered cost-effective, in order to ensure a fairer distribution of health care.

Ethnic variation

Although pharmacogenomics offers many potential benefits, one aspect that may hinder further progress in the field is the controversy over the use of race and ethnicity in pharmacogenomics research. There may also be stratification of patient populations based on racial or ethnic groupings with respect to treatment response. Some genetic variants are more common in certain racial or ethnic groups than in others. The fact that some genetic variants are more or less likely to be found within particular groups has implications for the design of clinical trials, and for public health decisions. At the same time, since there is considerable genetic variation within ethnic groups as well as between them, pharmacogenetics should provide a much more reliable way of predicting response to a medicine than relying on ethnic classification. Studies in population genetics, however, have demonstrated that substantial genetic variation occurs within populations [9]. The use of ethnicity in genetics research is controversial in many ways. Despite this controversy, evidence suggests that there may be an association between ethnicity and variable drug response.

Clinical issues

With the introduction of pharmacogenetics many more patients are said to undergo genetic testing than before. Accessible information and reliability of the sources remains important for both doctors and patients. Health professionals need to be given training to communicate information about pharmacogenetics. Additional resources will be needed to implement pharmacogenetic testing. Doctors will need more time with patients and required. These tests could be carried out either in GPs' surgeries, at a hospital, or at specialized testing facilities. However, the nature of the information revealed by the test also needs to be considered. There has been debate whether written consent forms and genetic counselling will be necessary when patients have pharmacogenetic tests. The possible factors to be considered include which information should be revealed and whether the test also reveals any additional information such as likely response to other medicines or susceptibility to an unrelated disease.

However, should testing become available and affordable, in the clinical context it raises ethical issues around the level of informed consent required to carry out pharmacogenomics testing for the purposes of drug prescription, and the risks posed by secondary information gathered through pharmacogenomics testing [10].With the advances in pharmacogenetic the medicines may be licensed after pharmacogenetic test, to ensure a patient is not at risk of a serious adverse reaction. Pharmacogenetic information could be relevant to life insurers as well, either in assessing claims or setting premiums. Pharmacogenetic information could be useful to inform decisions about which treatments should be funded for particular groups of patients. This would be similar to the use of information by public health providers to make decisions about the allocation of resources.

Conclusions

Many drugs that are currently available are "one size fits all," but they don't work the same way for everyone. It can be difficult to predict who will benefit from a medication, who will not respond at all, and who will experience negative side effects. These genetic differences will be used to predict whether a medication will be effective for a particular person and to help prevent adverse drug reactions. The introduction of pharmacogenetics will have an impact on the way in which clinical trials are designed and managed. It is speculated that pharmacogenetics can be used to improve the existing medicines as well.

The field of pharmacogenomics is still in its infancy. Its use is currently quite limited, but new approaches are under study in clinical trials. Claims of designer drugs, or 'the right medicine, for the right patient, at the right dose' are misleading, but it is important to discuss ethical, legal, regulatory and social issues that may be raised by improvements in predicting response to medicines. To obtain maximum benefits from pharmacogenetics we need to address legitimate concerns and safeguard against inappropriate use. There must be the right combination of constraints and incentives to protect and promote the interests of patients. In the future, pharmacogenomics will allow the development of tailored drugs to treat a wide range of health problems.

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Ethical Viewpoint Paper

Active Learning Techniques to Promote Student Learning

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Introduction

Survival in the 21st century warrants certain radical changes in the existing education system. It is not about just "knowing" a fact, but it is the "application" of the knowledge into practice, which is the key to an optimal outcome. When one enters the medical college, the first thing that one is made to learn is to forget one's common sense 1]. At present, our curriculum itself is afflicted with several ailments. The Currriculopathies include: Curriculosclerosis, Curricular Hypertrophy, Curricular disthesia, Curricular ossification [2]. Medical Education in India remains a process of training "the doctors of tomorrow with today's curriculum and yesterday's teaching-learning methods" [3]. We need to meet the needs of students with a wide range of abilities, aptitudes, differing value systems and culture and make the students learn to apply their knowledge in "total" care of patients. Active learning techniques will lend fluidity in the teaching-learning process, making it an enjoyable experience for the faculty and students.

Miller's Pyramid of Assessment

Miller's Pyramid of Assessment (Fig, 1) provides a framework for assessing clinical competence in medical education and can assist clinical teachers in matching learning outcomes (clinical competencies) with expectations of what the learner should be able to do at any stage [4].
Knows forms the base of the pyramid and the foundation for building clinical competence.
Knows How uses knowledge in the acquisition, analysis, and interpretation of data and the development of a plan.
Shows How requires the learner to demonstrate the integration of knowledge and skills into successful clinical performance.
Does focuses on methods that provide an assessment of routine clinical performance.

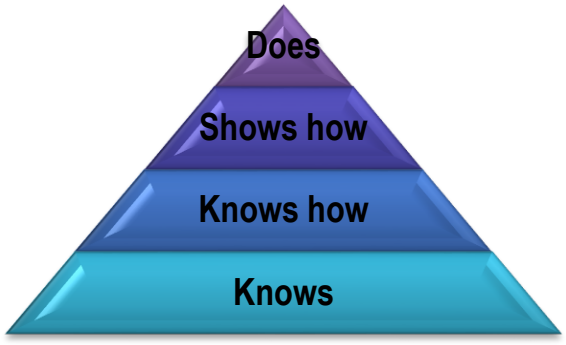

Fig. 1: Miller's Pyramid

Active Learning Techniques

Active learning techniques involve students in doing things and make them think about the things they are doing. The students become proficient in skills by practicing them, rather than being a mute spectator to the skill – by listening to the teacher or by reading about the skill [5]. Active hands-on teaching strategies and learning activities are the need of the hour. Teaching strategies refer to the structure, system, methods, processes that a teacher uses during instruction. Learning activities are the teacher-guided instructional tasks and assignments for students.

Learning approaches can be surface or deep. A surface approach to learning is an intention to do the task with minimal effort, usually by rote memorization, without any attempt to relate the concepts to existing experiences. A deep approach evolves from the need to comprehend and seek meaning, with a critical evaluation of knowledge [6]. Active learning can engage students in and out of class, as an individual or in groups, with or without technical tools. This can help students to think creatively, express ideas through writing, interact in small groups, understand personal values and reflect upon the learning process.

A Content-driven Development Model divides the content into various sections to be covered over the course span and then plans for techniques of content delivery. A Systematic Learning-Centered Design Model focuses on systematic learning tools to develop solutions to learning objectives. The 5 Es (Engagae, Explore, Explain, Elaborate, Evaluate) Inquiry Framework is based on the concept that the students learn and retain knowledge when they have had an exposure of variety of experiences that are framed by the facilitator [7].

Engage	Capture the interest of the students and give them an opportunity to demonstrate their prior knowledge
Explore	Facilitate activities that provide the students with an opportunity to explore the skill / concept
Explain	Facilitator provides concepts to formulate explanations for the phenomenon that the students have already experienced
Elaborate	Students are encouraged to apply knowledge for better understanding or better demonstration of skill
Evaluate	Review and Reflect on learning experiences

Brainstorming

It provides a large number of diverse ideas related to a chosen topic. Students can express their views without the fear of being criticized.

Role Plays

These engage students in real life case scenarios. They are short spontaneous or pre-decided assignments. They provide opportunities for critical observation of peers. They should be content-focussed, match learning objectives and be relevant. They can convey the message very effectively.

Problem-Based Learning

It is self-directed learning. A case scenario, a teaching model, a histology slide can serve as triggers. The learning objectives are defined by a small group of students with the help of a facilitator. They are given sufficient time to interact and explore all learning resources. The second session provides them an opportunity to present their findings. The facilitator then fleshes out the key messages and helps to formulate the concept map.

Fish Bowl

The participant speakers are seated in the centre of the room with other participants sitting around them in a circle (active listeners), seeing their interaction in the fishbowl. The interactions are moderated by a facilitator. The participants will swap their roles in due course of discussion.

Mind Mapping
It's a visual exercise to help students organize and structure complex content. It carves out a hierarchy of information to work out key components and their inter-relationship. There is a focus on a central idea, with branches to depict the importance of issues related to it.

Peer-Assisted Learning
Faculty evaluate and identify the students who need help with specific skills and determine the most appropriate students in the class to assist them with those skills. It expands the instructional resources, with positive and productive peer interaction. This approach helps the faculty to accommodate academic diversity.

Interactive lectures
These provide students with multiple brief opportunities for structured engagement. A short in-class activity is planned. Student-to-student talk is encouraged. Opportunities for conceptual clarifications are provided periodically within the lecture.

Ward Rounds
This time-tested approach is a powerful active teaching-learning tool. Faculty acts as a facilitator for structured case-based discussion for all domains of learning: cognitive, affective and psychomotor. This strategy is the best method to practice evidence-based medicine.

Debates and Quizzes make the learning environment vibrant and conducive to active learning.

Infusing Humor
This strategy should be used judiciously by the faculty and should convey the appropriate intended message.

Conclusions
The outcome of teaching-learning strategy revolves around three parameters: Comprehension, Analysis and Demonstration. Active learning techniques can provide students with greater responsibility for their own learning. The teacher assumes the role of a facilitator, who creates an environment conducive for active learning. This approach will foster several attributes: flexibility, creativity, pro-activeness, appropriate decision-making, effective communication and a spirit of team work.

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Ethical Viewpoint Paper

Incorporating 360^0 assessment in the classroom

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Introduction

It is an accepted fact that assessment drives learning. So, no curriculum, worth its salt, is incomplete without assessment and evaluation. These two words although unwittingly used synonymously, is in fact very different: assessment is the quantified data gathered of a learning experience [1].

Evaluation is the judgment of the gathered data. (at the simplest definition).

The arena of medical education is most challenging as the multifaceted incorporation of all the three domains i.e., cognitive, psychomotor and affective [2].

The assessment and learning experience have to be synchronised [3].

Although, every aspect taught to the medical student should be evident in his professional behaviour. This sets out a problem in assessment that belongs to the affective domain. The paradigm shift of the ideology of medical education from 'knowledge acquisition' to the present been a welcome change. 'competency', based has to' problem solving' [4].

Reset physician training on the right track.

The inclusion of bioethics in medical curriculum is a rhetoric.

Assessment technologies are ever increasing and gaining infective at the stage of curriculum designing right from identifying the desired, accordingly choose in the assessment strategy and design the teaching learning experience. The wide array of assessment tools are listed vide table 1 [5].

Table 1

Bioethics assessment strategies

Knowledge	**skill**	**Attitude**
Paper based standardised	OSE	portfolio
Lists	Case based theories	Milestones
MCQs	Simulator	360 degree review
AG	Observed clinical	Patient opinion
Assignment	encounters	Critical incident reports
Case scenario analysis		Review professional laps
		Review patient
complaints		
		Patient opinion
		Self administered rating
scale		

It is beyond the scope of this article to review each assessment strategy but will focus on the 360 0 multisource feedback assessment strategy. This technique has been quickly adopted right from bringing influence approaches to the health care industry

What is 360^0 assessment ?

It is based on actual behavior in a clinical setting which includes multiple sources of information Assessments completed by many people using checklists or rating scales to assess various competencies; evaluations are summarized to provide anonymous feedback.

- It provides information on overall practice patterns
- Communication, interpersonal skills and professionalism are assessed
- Reliability is better

Table 2

Goal of 360 feedback:
• To provide physician with broad based feedback [6]
• Facilitate development of insight, focusing development and future initiative

Table 3

Impact of 360 degrees feedback
- Improved quality of care provided
- Quality improvement initiatives [7]

Table 4

Advantages	
- Multiple stakeholder assessing	
- Comprehensive review	
- Aspects hither to unassessed	• Attitude • Communication • Inter personal skills • Team work • Clinical acumen • Synthesis and application • Need based • Cost effective

Table 5

Challenges
- Inescapable paradoxes
- Roles
- Group performance
- Measurement
- Rewards

The multidimension of expected behaviour of the 'physician', leaves a lot to be described on the highly subjective assessment strategy of affective domain [9].

In psychometrics, predictive validity is the extent to which a score on a scale or test predicts scores on some criterion measure. For example, the validity of a cognitive test for job performance is the correlation between test scores and, for example, supervisor performance ratings [10]

Content validity is an important research methodology term that refers to how well a test measures the behaviour for which it is intended. For example, let's say your teacher gives you a psychology test on the psychological principles of sleep [11].

Construct validity is "the degree to which a test measures what it claims, or purports, to be measuring." ... Modern validity theory defines construct validity as the overarching concern of validity research, subsuming all other types of validity evidence [12-13].
Even, if the high scores are achieved it cannot predict the continued use of ethical principle, in professional life. Knowledge and awareness does not predict the use of ethical principle in all professional interactions [14]. The Millers pyramid of learning shows the levels of psychomotor and affective domains. Vide table 2 and 3. These levels are easier to assess at its lower levels but of herculean proportions towards the top [15].

Table 6

CREATING	Proficiency leads to innovation
EVALUATING	Making judgements
ANALYSING	Breaking the concept into parts and understand how each part is related to one another. Understand and clarifies
APPLYING	Use the knowledge gained in need
UNDERSTANDING	Making sense of what you have learnt
REMEMBERING	Recalling relevant knowledge from long term memory

The novel and varied assessment strategy serve to achieve a valid and reliable assessment in medical education. This is more easily achieved. But in the area of ethics and professionalism there is still no wholesome assessment tool [16].
Incorporating the 360^0 in assessment in to the classroom, is indeed relevant. Intentionality or understanding by design is a catchword among educationists. If the physicians are being assessed continually by the 360 system, it is only appropriate to incorporate, in the curriculum for medical education, itself at the beginning [17].
The resource framework of implementing this is an ordinary task and involves dialogues and networking. This simplified flow chart is listed in table 7 [18].

Table 7

- Steps 360 degrees assessment
- Role identification
- Competency identity
- Assessment 360 administer to various roles
- Self analysis
- Gap analysis
- Home lacking skills
- Quality health care delivery

This is calculation can include a 12 item or even 8 dimensions assessment chart. A maximum of 6-8 rates can be randomly selected by the audience heads and coordinators [19].
At the first year of MBBS students would require rating such as Anatomy/Biochemistry/Physiology, Pharmacology, Pathology, Microbiology and Forensic Medicine

Table 8

Faculty (1 senior, junior)
Peers (4 classmates)
1 attender, 1 clerk/secretary)
Ancillary staff (2)

The third and fourth year, will have a rater list similar to the residents. A clarification about students having accountability and responsibility in observing this function, is questionable. It suffices to say, that even their perspective is important.
At the end of this evaluation by various rates, the examiner, himself should give a self-appraisal, using the same form [20].
This leads to quantifying the 'gap analysis' and initiative for homing special skills and attitudes can be undertaken.
The impact use of this early incorporation makes the learning mandatory due to its importance being given in the assessment. In some this would become second nature, indicating internalisation. Moreover, this teaching increases the likelihood of a decent behaviour.

Status of tool
Among the presently available tools this tool is widely acceptable despite feasibility issues. Studies have shown the positive correlation of such assessment technique adopted early. Another inescapable factor is that the transition of the medical student into the physician would be smoother in the real time context. The students adopt the right behaviour early end, be aware of expectations, this delivering the necessary outcome.
The choice of assessment technology keeps widening and forays into new areas find the panacea, ailing assessment. A continued 360^0 assessment and predetermined intervals would maintain conformity and uniformity. A record of all the feedbacks in anonymity helps to force a review oneself and rest the standards to be achieved.

Portfolio
Learners record their experiences, their self-assessment of the experiences and define and update learning goals.

Portfolio Advantages include:
- Includes a variety of supporting documentation reviewed periodically by supervisor/program director
- Can sample a large breadth of content areas
- Promotes self-assessment and goal-setting
- Can identify areas of deficiency in individual experience and program design
- Can assess progress over time
- Based on experiential learning principles [21].

Milestones
The Accreditation Council for Graduate Medical Education (ACGME) introduced the milestones as a means to track progress and skill acquisition in residency training.
The milestones describe a developmental progression of observable behaviors within a set of previously described core competencies. Residency programs can use the milestones to provide more specific feedback and evaluation to residents, ensuring that they acquire the necessary knowledge, skills, and attitudes for advancement within their programs entrance into independent practice. The ACGME would use program performance on the milestones for accreditation decisions.
This relative new concept assesses also the aspirational level.

It conglomerates the development of learning at every level and each domain leading to enhance likelihood of the certainty of learning [22].

Conclusions

The incorporation of 360 assessment is a early adoption, that sets out clearly the expected outcomes. The feasibility issue is a major challenge but it can be surmounted with appropriate management. The intentionality allows for reiterating the expected skills and attitudes.

The importance given to assessment of a certain skill/behaviour also responsible for heightening its relevance.

The 360^0 assessment can reasonably asses the affective domain learning i.e., bioethics, communication too, is the focuses, specific personally interactive feedback. This 360 degrees multi source feedback is being piloted by the authors and results shall be presented and published in due course.

The concept of portfolio and milestones can be added to 360 degrees assessment with the room for undergraduate students' wholesome assessment [23].

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Ethical Viewpoint Paper

Solidarity and Cooperation – some perspectives

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Introduction

Solidarity has recently been gaining more prominence in bioethical, public health and global health debates. The history of solidarity is patterned. Throughout its history, the concept has been imbued with different meanings, with the common denominator being that solidarity is a prosocial notion. We define solidarity is as a (shared) commitment to accept responsibility (in the wide sense of the word) to support others with whom people recognise relevant similarities. Defined in this manner, solidarity can be clearly distinguished from related concepts such as altruism or charity [1].

In the context of bioethical policy and practice, solidarity has the potential to ground just, effective public policy and can motivate individuals and governments to participate in programmes intended to alleviate common threats. It primarily means that all individuals must come together and work towards a common cause. There are many instances in health care where solidarity has helped for the greater good of mankind [2]. The following paper shall look at various instances in healthcare where solidarity has resulted in better results for mankind.

Strikes and Violence Against Doctors

Nowadays with the rising cases of violence amongst doctors there is a growing scenario where doctors rise up together when there is violence against them for no fault of theirs. This has led to a law that has been evoked to protect against violence towards doctors.

It is believed that when the cause is just and backed by the right intentions, any form of agitation is reasonable. The same way a doctor's strike when just and with the right intention of greater good of most doctors is considered fine. The strike must not be political or aimed at political ambitions, it should not be because of one man's ire against the government or an act meant for the aggrandizement of one's ego or a means to show one's power [3].

The criterion of just cause often demands a utilitarian philosophy determinant which demonstrates that ultimately, the beneficial repercussions of the strike on the health system that must outweigh the temporary disruption and suffering caused by it. During the strike it is pivotal that doctors must demonstrate the right intention and they should remain benevolent to their cause while avoiding gall spewing acts that may compromise their just cause [4].

It is very essential that doctor's that strike be assured of success in some way as very often many strikes in the long run prove futile and catastrophic. For example the strike by junior doctors citing an increase in stipends led to the government increasing the stipend by 20% while medical course fees were hiked within a month of this ruling by 60%. Thus the loss financially was for the doctors who ended up paying more than they did prior to the strike [5].

In strikes, multiple medical bodies must come together and work in harmony towards the common aim without affecting the common man and seeing that no casualties of life result due to the strike. This is one area where solidarity has been used with success for just demands to enhance the quality of life of doctors. There has been a spate of violent incidents all over India against doctors and only when the doctors come together will they be able to put together their human resource to protect the lives of their own comrades while they work towards protecting the lives of other fellow human beings. A doctor is a selfless person but a human being nevertheless and this is something that never must be forgotten when providing service to mankind.

Global Polio Eradication Programme and Solidarity

Polio eradication has happened on a war footing across all nations worldwide. The reasons the polio eradication programme was successful was cooperation and coordination between various agencies, public private partnerships, grass root workers being involved and a united effort at an individual, state and national level. Many non governmental organizations joined hands with government bodies and this resulted in united efforts in both rural and urban areas to eradicate polio. There has been also enough of advertising and roping in of national and international celebrities that made the campaign successful and made people move towards the eradication and enhanced attendance at the pulse polio programmes. There has also been a rise in solidarity here which placed solidarity over national pride and resulted in nations getting together towards this common cause [6].

Solidarity and Hospice Care

Solidarity is also seen in hospice care worldwide. Hospice care involves end of life care where multiple issues may plague the patient in question. The hospice care team is made up of multiple partners starting with the doctors, nurses, ancillary staff, therapists and relatives of the patient that put all personal goals aside and work unitedly towards the development of a holistic care to the patient and catering to his wellbeing at the end of life. The various facets of care that range from medical to social and spiritual are incorporated in one roof and the best support is provided to patients and caregivers for their wellbeing [7].

Solidarity and Disaster Management

Global humanitarian aid doctors should adopt policies of solidarity with strife-torn and disaster-stricken communities rather than charity, and ensure aid workers have the requisite skills to deliver their specific mandates. A catastrophe is always tragic, but we can rescue this thought from it all: we need to find ways to consolidate and reinforce the social capital of our nation. We need to stick together and feel proud of our identity so we may strengthen the bonds that unite us. We all know what happens in times of disaster. The mask of civility and morality constraining our selfish, animal instincts fall away. People panic, mobs form and there's looting, arson and mayhem [8].
When natural disasters hit, the people affected are in need of immediate and swift help. States have developed protocols and services to respond first; however sometimes not even good planning can anticipate the scales of some natural disasters, nor the area or number of people affected. The situation is even worse in countries with outdated protocols and small disaster/emergency budgets. Protecting lives and reducing suffering becomes a case for practicing community solidarity and support in order to reach all those who need help, as international humanitarian aid takes more time to deliver. Multiple agencies need to work together to achieve this aim keeping personal goals aside and only then will results ensue [9].

Solidarity and Dementia Awareness

Care, building on the foundation of solicitude, includes joy, compassion, commitment, and respect: care rejoices in the existence of the person with dementia, care responds supportively to the needs of the person with dementia … care is loyal even as the loved one fades from the sphere of familiar self-identity and becomes almost unknowing and therefore unknown, but still remembered [10]. There are six principles that he describes as the core of an ethics of dementia –

- Something can be done for (and with) individuals with dementia.
- Many factors can cause excess disability in individuals with dementia. Identifying and changing these factors reduce excess disability and improve functioning and quality of life.
- Individuals with dementia have residual strengths. Working with them to build on these strengths improves their functioning and quality of life.
- The behavior of individuals with dementia represents understandable feelings and needs, even if the person is unable to express them. Identifying and responding to these needs reduce the incidence of behavioral problems.
- The physical and social environment affects the functioning of people with dementia. Providing the appropriate environment improves their functioning and quality of life.

- Individuals with dementia and their families constitute an integral unit. Addressing the needs of families and involving them will benefit both the person with dementia and the family.

As the virtue of solidarity moves the caregiver from "doing for" to "being with," it indeed becomes the virtuous mean between the twin vices of neglect of and oppressive care for the person with Alzheimer's disease. It is this Aristotelian mean to which we need to strive [11].

Solidarity and Autism Spectrum Disorders

It is vital that everyone should be committed to promoting acceptance, encounter and solidarity through concrete support and by encouraging renewed hope, thereby contributing to overcome the isolation and, in many cases, the stigma to which people with autism spectrum disorders are also subjected, and often their families too [12].

This must not be an anonymous or impersonal accompaniment, but one of listening to the profound needs that arise from the depths of a pathology which, all too often, is difficult to diagnose, but — especially for the family — must be accepted without shame or withdrawal into solitude.

In the realm of assistance to people affected by autism spectrum disorders, it would be beneficial to create a regional network of support and services which are comprehensive and accessible. In addition to parents, these should also involve grandparents, friends, therapists, educators and pastoral workers. These figures can help families overcome the feelings, which can sometimes arise, of inadequacy, helplessness and frustration [13].

Solidarity and Ethics

Solidarity from an ethical standpoint is at various tiers – [14]

Tier 1: Interpersonal level – The first, 'lowest' tier applies to the level of individuals. At that level, solidarity comprises manifestations of the willingness to carry costs to assist others with whom a person recognizes sameness or similarity in at least one relevant respect. The recognition of similarity with one (or more) other people in one relevant respect can take many forms: it entails the awareness of being associated, by choice, by 'fate', or other circumstances, with others.

Tier 2: Group practices – In cases in which a particular solidaristic practice at the inter-personal level becomes so normal that it becomes more widely seen as 'good conduct' in a given situation, it can solidify into forms of institutionalization. This is the case, for example, with self-help groups. On this tier, solidarity can be described as manifestations of a collective commitment to carry costs to assist others (who are all linked by means of a shared situation or cause).

Tier 3: Contractual and legal manifestations – If these values or principles solidify not only into social norms but manifest themselves in contractual or other legal norms, then we have an instance of Tier 3 solidarity, the 'hardest', most fixed, form of solidarity. Examples are welfare state and social welfare arrangements, but also contracts between different private actors and international declarations or treaties.

Conclusion

Recent work has stressed the importance of the concept of solidarity to bioethics and social philosophy generally. But should it feature in documents such as the Universal Declaration on Bioethics and Human Rights as anything more than a vague notion with multiple possible interpretations. The suggestion that solidarity should feature more centrally in international regulations is a valid one and the concepts of solidarity and the differences between solidarity, justice, equity and cooperation must be a part of routine bioethics curriculums.

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Original Research Paper

Ethical Dilemmas Faced by Oncologists: A Qualitative Study from A Cancer Specialty Hospital in Mangalore, India

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ABSTRACT

Ethical problems routinely arise in the hospital and more so in the field of Oncology which is today the world's second leading cause of death. From the perspective of documenting the ethical issues in cancer, innumerable studies from the developed countries have shown that oncocare contains numerous issues. However there have been no studies in these lines from India. The present study was undertaken to ascertain the most common ethical dilemmas plaguing the cancer specialists at a super-speciality cancer care hospital at Mangalore. The investigators used an in-depth semi-structured face-to-face interview with the willing participants that included cancer specialties in the areas of surgical, radiation, medical oncology specialities. The focus was principally in the area of ethical dilemmas faced in diagnosis and care of cancer patients as per standard qualitative study protocol. The results indicated that breaking the bad news, discussing end of life issues, judicious treatment planning considering cost factors and conveying side effects of cancer treatment were the major issues that posed significant dilemmas.

Key words: Ethical dilemma, cancer specialists, oncologists, end of life issues, breaking the bad news.

Introduction

Globally cancer is today an important ailment plaguing humans and reports suggest it is the second leading cause of death [1]. Further disturbing reports suggest that in the coming decades the incidence of cancer will rise primarily because the altered life style and increase in the proportion of aging population [2]. The concerns are profound especially for low- and middle-income countries as there is a disproportionate increase and the rural-urban, economic and gender disparity is strikingly predominant and is exerting huge stress on the healthcare system that has limited resources to cater to the requirement [3].

With regard to India, data indicate that cancer will be a major health issue in the future decades and most of the afflicted people will be from the rural areas and in the productive age group [4-5]. Further, from a doctor patient ratio there is a huge disparity and recent reports indicate that there is only one oncologist to treat every 2,000 cancer patients [6]. The major concern is that cancer, being a life-threatening disease requires the constant supervision and care through out the

treatment period and later [7]. The concern for the physician primarily is to consider the patients' best interests [7-9]; and plan a treatment that is beneficial, does no harm than documented in the proposed treatment plans/regimen and to also consider the patients and their family caregivers concerns [7-9].

At times the healthcare system catering to the afflicted person also has to consider the well being of the family caregivers [7]. Cumulatively all these issues subject the treating doctor/s to dilemmas that are profound and at difficult to handle. Studies in the existing literature indicate that there have been no documents on the ethical dilemmas Indian oncologists face when caring for people afflicted with cancer. The present qualitative study conducted is an attempt towards understanding the dilemma.

Methodology

This was a qualitative study and was conducted under the aegis of UNESCO Bioethics Education and Research Unit of the UNESCO Chair in Bioethics, Haifa at Mangalore Institute of Oncology Mangalore, India. The study was conducted with oncologists after obtaining the permission from the institutional ethics committee in April 2018. Purposeful sampling was used and the inclusion criteria included cancer specialties in the areas of surgical, radiation, medical oncology specialities. The principal researcher approached the volunteers and after explaining the research objective were invited to participate in the study. Informed consent was obtained from all the participants before the start of the interview and assured that the information would remain confidential with the investigator.

The researchers used an in-depth semi-structured face-to-face interview with the participants and with direct questions. The focus was principally in the area of most commonly encountered ethical dilemmas faced in cancer diagnosis and care. The study started with the question which is the most dilemmatic situations you face in treatment of cancer. In addition to this in-depth question like can you explain more. Can you give an example for my better understanding was also followed to get more and clear data. The interviews were immediately transcribed verbatim and typed. Each interviews lasted between 20 to 30 minutes each. Subsequently the transcripts were revived line by line multiple times and after several reviews of texts. The related codes were pooled and merged according to similarities and differences.

Results

Two medical oncologists, three cancer surgeons and two radiation oncologists were included in the study. One of the interviewed specialists was a female. The age of interviewees was between 29–68 years and the mean number of years in profession was 19.5 years (6–30 years). The results are discussed in the five themes on which the principal questions were based and are here with.

1. **Breaking the bad news:** In India, many oncologists and doctors avoid informing the patients of their cancer and its prognosis. This is principally because most of them believe that informing the patient that he has cancer can decrease his hope and can have an adverse effect on the treatment adherence, cure and survival [10-11].

One of the participant said *"It is very difficult to tell a person that he has a cancer. The worse is when the patient is young and has dependents to care for"*. Another senior consultant said *"Informing a person that he has cancer is difficult but worse is to tell that recurrence or spread has occurred especially in the ones who under gone the treatment"*. Another consultant said *"I have a real problem when the family member says to hid the prognosis while the patient wants to know what the ailment is"*.

2. **Providing information on prognosis of the disease:** If breaking the bad news that an individual has cancer is an issue, the problem is compounded when the prognosis is bad [7-12]. When the prognosis is bad the dilemma is on whether, when, how and how much to inform the patient about the diagnosis and prognosis.

One of our participants expressed *"It is a very difficult job and have to be caution while telling a person that he has a cancer. I tell the results but also see that they do not lose hope when the disease can be cured or controlled."*
Another said that: *"Saying a bad prognosis is horrible and I try to avoiding telling that he or she may die in may be 6 months time"*

3. **Discussing end of life issues:** Numerous studies in the past have shown that discussing end–of-life issues and care is a major issue [12-14] and that the treating physicians face ethical dilemmas like on uncertainty about the disease progress, the most suitable treatment that does not affect quality of life [7-8].

One of the participants said *"It is hard to tell patients or their family members that cancer is progressing and that the patient will die".*
Another participant said *"I had a difficult time in telling an elderly lady that her husband had advanced disease because she herself was a severe diabetic and needed care. I did not know how she would take care of him and self".*

4. **Considering cost factors:** Treatment of cancer is expensive and financial discussions on the treatment costs are of importance [15]. The oncologists opined that financial difficulties are very important and have a forbearing on their treatment plan.

One of the participants said *"Oncology drugs are highly expensive and the financial condition of the patient affects my treatment decision. I had a woman who required herceptin but she could not afford it. I had to decide against it".*

5. **Conveying side effects of cancer treatment:** The treatment of cancer is associated with side effects. At times the side effects are so severe that it debilitates the patients and affects the quality of life and previous reports have suggest how importance it is to address these issues [11, 16]. In our study, one of the participants said *"telling an unmarried individual that he or she may become infertile after chemotherapy is emotionally hard".*

Discussion

Ethical issues exist in all fraternities of healthcare and also in cancer care where some issues are different than that in other disciplines. In developed countries, the ethical issues in various disciplines of healthcare and cancer in specific have been studied in detail and documented. Further a conscious attempt is made to train healthcare professionals in handling the ethical issues [17-18]. This pilot study was conducted to ascertain the dilemmas faced by cancer specialist in the diagnosis and care of afflicted people.
The most important ethical predicament expressed by most participants was that breaking the bad news especially recurrence and spread of cancer and discussing end-of-life issues presented highly dilemmatic situations. This is principally because most patients want to know about their prognosis from the cancer specialists and to break the bad news for a disease associated with severe morbidity and death is difficult [18-23]. In this regard the request of family members not to reveal the cancer diagnosis to the patient aggravates the physician's dilemma [19-22]. In some countries the onus is placed on the treating doctor to initiate a conversation with the cancer patient and their family with an aspiration that it can reduce the anxiety in the patient and their family members and also provide with a realistic appraisal of the ailment [20-23].
The other important dilemmatic issues facing the specialists are amount of details to be provided, discussing end of life issues, judicious treatment planning considering cost factors and conveying side effects of cancer treatment [7-9, 21, 23]. The observations from the study indicated that oncology has in it a set of dilemmatic issues and breaking the bad news was the most common. The study also indicated that almost all volunteers were unaware of the protocol for disclosing unfavourable information or breaking the bad news. Further studies are warranted in these lines

for planning on India specific structured teaching program for the healthcare professionals involved in catering to the medical needs of people with cancer and their family.

Conclusions

The present study for the first time address the most important ethical dilemmas cancer specialists face on a day to day basis. The results suggest that breaking bad news, end of life issues, judicious treatment planning, considering cost factors and conveying side effects of cancer treatment were the major issues that posed significant dilemmas. The biggest drawback of this study was that this was a single centre study, was conducted with a small sample size and focused only on the ethical dilemmas faced in clinical setup on a day to day basis. Attempts were not made to address issues like on ethical issues in clinical trial, cancer genomics and investigational drugs as was not a common issue in the study centre. Further studies are warranted with a bigger sample size sub specialities in oncology, years of experience and parts of India. The information obtained will be very useful as it will help us formulate a structured teaching program for the healthcare professionals involved in care of cancer patients.

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Poem

I am Human Too…..

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Here I lie in bed again ……awaiting my next meal,
Students pointing at me "That's the TB case", … as if it's no big a deal.
What happened to the thoughtfulness, just a little bit of feel?
I am a patient lying here……. not a soulless rock….,
Fighting against a disease that takes months to heal.

One comes and starts with "I'll be taking your history",
Other one comes and suddenly palpates my radial artery
"Lymph nodes palpable …suggestive of lymphadenopathy?"
What are they trying to do with me? It still remains a mystery.

My chest seems achy, I am tired of coughing.
I hear you say..."Hey, listen to that wheezing"
My belly hurts ....I have been constipating,
But that doesn't matter to them, 22 students near me
One by one auscultating……

I put back my shirt once it is all done,
They write few things and towards their classes they run.
Am I doing good or bad…..?, Am I improving or not ….?...said no one.
Advices were written but informed to me by none.

I hear you talk with other friends so please don't walk away.
If everyone showed a little compassion I wouldn't feel this way.
Next time … before you take my history …. ask me if I am doing okay?
I am not merely a patient, I am a human …. fighting with my disease everyday.

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Scope of the Journal & Instructions to the Authors

Global Bioethics Enquiry is a journal of the UNESCO Chair in Bioethics and publishes reviews, original research papers, commentaries and case studies related to all issues in the field of Bioethics. Original viewpoints and narratives as well as poems in the field of bioethics are welcome. The journal also has a student section where articles in the field of bioethics written by undergraduate and post graduate students are considered.

THE EDITORIAL PROCESS

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