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Editorial

The concept of 'professional boundary' in psychotherapy

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Psychotherapy has been defined as a form of psychological treatment where a trained therapist enters into a professional relationship with the patient, with the aim of reducing certain symptoms, removing certain symptoms and bringing about overall growth and development of the personality of the patient[1]. Psychotherapy treatments occur within a construct that has been termed as the therapeutic frame. A simple definition of 'professional boundaries' is that they are the parameters defining the limits of a relationship in which one person (a patient or client) entrusts his or her welfare to another (a psychotherapist), and where fees or payments are made for the provision of a therapeutic service [2].
Professional boundaries is a concept in psychotherapy which is essential, largely out of concern for the growing number of cases of sexual misconduct by therapists, which led to malpractice litigation and severe damage to the reputation of mental health professionals [3]. There is a growing amount of cases of sexual misconduct being reported year after year where unqualified and untrained psychotherapists engage in both sexual and non-sexual boundary violations with their clients or patients [4]. This is relevant more so in India, where patients may submit whole heartedly to the therapist thinking him or her to be knowledgeable and responsible for providing a cure for their problems. Therapists in some quarters are known to take advantage of such vulnerable patients.

There are namely two types of boundary violations noted in psychotherapy viz. the non-sexual boundary violations which milder and the graver sexual boundary violations. Boundary crossingsare benign phenomena that do not occur repetitively and are discussable between the therapist and the patient, while being non-exploitative. In Indian culture, the psychotherapist or doctor is often viewed as a demi-god who will cure the patient. In such cases it is not unusual for patients to talk and enquire about the therapist's likes and dislikes or ask certain questions that may be personal during the course of therapy. Falling at the feet or touching the feet or sometimes kissing the hand of a doctor (who is perceived to be a healer) or therapist is common in our culture and cannot be viewed as a personal boundary crossing [5]. Many patients in therapy often enquire about the therapist, his native place, his family, what they do and whether he has children and how old they are. This is normal social enquiry that is rampant in our culture and must not be viewed as with a boundary crossing mindset.

It is normally seen that rigidity with respect to boundary crossings does no good for therapy. A good psychotherapist adjusts the treatment to the patient rather than expecting the patient to adjust to the treatment. Novice psychotherapists are trained and taught so much about boundaries in courses, that they show great concern about maintaining proper boundaries thereby becoming cold, rigid, formal and inapproachable in their way of dealing with the patient or client. Some patients reject such therapists who behave more professional than human and do not generally follow up for therapy. Rigidity about boundaries serves as hindrance in developing a good rapport with the patient in therapy [6].

This is a common reason why novice therapists complain of a lack of follow up amongst their patients. Patients in India want a therapist who is friendly, homely and yet a guide and an advisor. In such cases the therapist has greater responsibility bestowed on him where he serves as

an elder, friend, philosopher and guide for his patient. He may be looked upon in this role not only by the patient but also by the entire family of the patient. Rigidity and unfriendliness by the therapist in such cases will result in the patient seeking therapy elsewhere where he finds a therapist with the qualities he desires.

Boundary violations on the other hand, represent events or phenomena that are usually repetitive, harmful to the patient, and exploitative of the patient's dependent position in therapy. Sexual activity with the patient or engaging in a sexual relationship with a patient would be the gravest example. Other examples would be exploiting the patient financially or emotionally. The psychotherapeutic relationship is by definition a relationship where there must be equal power with both the therapist and patient. The psychotherapist is trained and paid to deliver a service based on skills acquired by specialized training. The patient may assume that whatever the therapist says or does is designed to help the patient. As a result, many patients innocently succumb to boundary violations under the feeling that it is for their own good [7].

A boundary transgression is used as an umbrella term that encompasses both boundary crossings and boundary violations. Another term of note is boundary blurring which is used to describe instances in which the boundaries are confused but not enacted in the form of a boundary violation.

In India, the doctor or therapist visiting the home of the patient is a common occurrence. The therapist as far as possible must conduct psychotherapy sessions in a clinic setting and must avoid visiting the house of the patient too often as chances of boundary violations occur. It happens many a time that a visit to the patient's house results in the therapist being offered lunch or dinner and a session that should last 30-45 mins may extend to a few hours building the chances for boundary violations and relationships other than that in a therapeutic frame. The therapist should refrain from becoming associated with various family members and relatives of the patient and must focus on the patient concerned. Even getting a 'rakhi' tied by the patient though sacred as a relationship must be avoided as the therapist must maintain his frame of reference. Even travelling on a vacation with the patient and his or her family for counseling sessions there must be avoided.

There are many examples of boundary violations that can occur and some of them are mentionedbelow –

1. Accepting gifts from the patients in therapy.
2. Physical touch with the patient in therapy.
3. Sexual contact with a patient undergoing therapy.
4. Excessive therapist disclosure in psychotherapy.
5. Meeting outside the therapy setting when not needed.
6. Having lunch or dinner with the patient at his / her home or outside.
7. Confidentiality violations.

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Review Paper

Why is Principlism limited in its' Utility in Psychiatric Settings?

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ABSTRACT

Principlism is one of the most influential approaches to bioethics in the modern times. The application of the four principles to ethical dilemmas in psychiatric settings permits some analysis but not necessarily, a complete resolution of the problems. The authors acknowledge that there is discussion by the principlists of what should be considered when the principles conflict, however, there is no clear cut approach in addressing various dilemmas in a systematic way in the event of the clash of the principles. So, while the principlism approach might enable us to describe a moral dilemma as a conflict between competing principles, it will not necessarily dictate any particular outcome. The authors highlight this point by discussing a specific ethical dilemma encountered in their clinical practice. Beauchamp and Childress's approach of resolving the conflict between two principles by using the model of specification is far from satisfactory. It does not specify which conditions in the specification model to be considered as very important in arriving at a solution. Also, if all conditions are given equal importance, what happens if only two or three conditions are met adequately to justify infringement of the principles. Authors conclude that principlists take a narrow approach and fail to consider a host of other arguments and issues when arriving at a solution to various ethical and moral dilemmas in clinical settings.

Key Words: principlism, ethical dilemma, moral theory, autonomy, non-maleficence, beneficence, capacity, consent

INTRODUCTION

Beauchamp and Childress advocated a four principle approach known as 'Principlism', which offered to guide in medical decision making [1]. In this article, the authors would like to argue their case that principlism does not offer much help in the event of conflict of the principles. They would like to illustrate this by highlighting a clinical scenario that they encountered in their clinical practice in a medium secure ward at Cheswold Park Hospital (a secure psychiatric hospital based in Doncaster, United Kingdom).

The four principles include:

1. Respect for Autonomy: According to this principle, patients should be treated as rational, autonomous agents, making their own decisions about their lives.

2. Non-maleficence: The principle that health care professionals should do no harm to their patients.
3. Beneficence: The principle that the health care professionals should only do "benefit" for their patients and to balance benefits against risks.
4. Justice: This principle is not retributive but distributive, and concerned with how scarce healthcare resources should be shared fairly between individuals.

ANALYSIS AND CRITIQUE OF PRINCIPLISM

The four principles' approach had its origins from some important judgments and approaches in the common morality and medical traditions. Beauchamp and Childress argued that all the prima facie principles are equal and universal and do not consider that any principle has any priority over all other principles. Gillon argued that the approach is *"compatible with a wide variety of moral theories"* and because it uses shared primae facie common moral norms, it helps us to avoid two polar dangers, moral relativism and moral imperialism [2].

Principlism uses features of various ethical theories that have a good support in the field of bio ethics. For example, in relation to the principle of beneficence, it acknowledges that Mill was right in being concerned with the consequences. Similarly, whilst addressing the principle of autonomy, it argues that that Kant was right in attaching importance of the individual person. However, it does not make any attempt to combine various concerns arising from these into a single adequate theory, rather than disparate concerns derived from several competing theories [3]. Also, principlism is criticized because the four principles can be accepted and used by other moral theorists (like deontologists and consequentialists), they do not provide an explanation of what morality is and a guide for answering moral questions and resolving moral dilemmas. Therefore, it can be argued that the four principles might act as intermediary levels of ethical reasoning between individual doctor- patient encounter and abstract moral theory.
It is argued that despite tendencies to compete for a prime place in moral theory, the four principles approach should not claim to be superior to other moral theories [4].
The advantages of principlism are that it is simple and universal in application and the disadvantages include neglect of emotional and personal factors, oversimplification of the issues, and excessive claims to universality.

Professor Gillon has advocated the use of the Beauchamp and Childress for many years and emphasised that the four principles approach is a widely and interculturally acceptable method for medical ethics analysis [5]. Danner Clouse and Gert argued that rather than clarifying difficult questions, principlism may be unsystematic and misleading. They further stated that *"principles of biomedical ethics" approach is mistaken and misleading. Principlism is mistaken about the nature of morality and is misleading as to the foundation of ethics…."*[6]

In general, it can be argued that when confronted with a moral dilemma, there would be a conflict between two or more of these basic principles from different angles. This causes considerable problems to health care professionals and leads to considerable debate and anxiety that the principles (which they fully acknowledge and accept) are in conflict with each other**.**

APPLICATION OF PRINCIPLISM TO AN ETHICAL DILEMMA IN A CLINICAL SETTING

We shall highlight an ethical dilemma that we encountered in our clinical practice that resulted in the conflict of various principles. The authors work in a secure psychiatric inpatient unit and we have a patient Mr B, suffering from a mental disorder, namely, Emotionally Unstable Personality disorder, Borderline type). Mr B is detained under the provisions of the Mental Health Act 1983. Mr B displayed long-standing pattern of maladaptive behaviours pervasive across a wide range of personal and social situations and associated with personal distress. Mr

B's symptoms and behavioural patterns of his personality disorder were characterised by a marked tendency to act impulsively, mood fluctuations, emotional instability, difficulty in maintaining any course of action that offers no immediate reward, an uncertainty about personal and sexual identity, liability to become involved in intense and unstable relationships. Also, significantly his presentation is characterised by recurrent threats and attempts of self-harm and suicidal behaviours by tying ligatures on numerous occasions. He also displayed aggressive and violent behaviours towards others and also damaged property on numerous occasions.

Mr B was prescribed various psychotropic medications for his symptoms, offered psychological interventions and encouraged to attend various groups and activities to improve his self esteem, confidence and also to aid in his independent living skills. Following a serious suicidal attempt, the clinical team discussed his presentation in great detail and concluded that Mr B needed to be maintained on a robust management plan. Mr B's management plan included continuous 24 hour one to one nurse monitoring and observation both in his bedroom and ward areas. In addition, he would be supervised by nursing staff in his bathroom and toilet, his room removed of most of the belongings as a precautionary measure, so that he would not use any items (for example, he can use clothing as a ligature and any sharp item to cut himself) for harming himself. As a part of the treatment plan, it was agreed by the clinical team that in the event of any violent and aggressive behaviours, Mr B could be administered intramuscular antipsychotic and anti anxiolytic medication without his consent. However, Mr B protested in relation to this management plans and argued that it would make him feel distressed and also, violate his privacy and dignity. He also continued to express active suicidal thoughts and maintained that that he was ambivalent about the consequences of his behaviours, even if this led to death. He strongly objected to this management and treatment plan.

In the above example, there is clearly a conflict between the beneficence and non-maleficence. The requirement of beneficence is to "do good" or to promote wellbeing of the patient and the clinical team to a large extent would achieve this by implementation of the strict treatment plans. The robust management plans would help in constantly monitoring Mr B's mental state and ensuring his safety. The risk of not having these plans may result in serious incident including suicide or harm to others. On the other hand, there is maleficence as a result of the imposition of various restrictions of the management plans. For example, there is invasion of the patient's privacy and dignity and this would affect the patient's self esteem considerably and would arouse feelings of shame and guilt. Also, the management plans may cause further psychological harm by evoking memories of some of the trauma issues (including abuse in his childhood) and thus, perpetuating his negative cognitions and behaviours.

Beauchamp and Childress acknowledged that when principles conflict, there are no readymade solution except to decide which principle is more important in that particular situation. Although Beauchamp and Childress discussed the concepts and obligations in relation to beneficence and non-maleficence, they do not exactly offer any solution in the event of clash between the 2 principles.

In the above moral dilemma, adopting a balanced approach, it was concluded by the clinical team the principle of beneficence would carry more weight and was a higher priority than non-maleficence. Thus, it can be argued that in the moral dilemma involving conflict between two or more competing principles, principlism approach would adopt a balancing approach, but it failed to give a definite solution or outcome. It was suggested that a possible solution might be to rank the principles in a hierarchy, but however, this would require justification, which is not provided by the principlism approach itself [6].

In relation to the principle of beneficence, the clinical team may have acted in a paternalistic way in deciding what is best for the patient. It can be argued that the clinical team is not taking into account the patient's views, who may be possibly competent (although, the capacity may be

fluctuating) as to what is best for himself. Although the patient may be competent, the principle of beneficence would trump all the principles because the clinicians dealing with detained patients will be acting within the constraints of the legal statutory framework emphasising significantly on issues like dangerousness and protection of others.
Although principlists offer a balancing model and further, a specification approach in relation to addressing the conflicts between various principles, it is far from satisfactory in dealing with moral dilemmas that I encountered in my psychiatric practice.

Beauchamp and Childress also acknowledged that the framework of the 4 principles approach helps to identify and reflect on moral problems. However, the framework does not contain sufficient content to address the nuances of many moral circumstances. It was argued by opponents of principlism that the balancing approach of the principles exposed the weakness of the principlism of being open-ended and lacking adherence and commitment to firm principles [1]. Beauchamp and Childress responded to their critics and introduced the concept of "specification". They advocated that "*Specification is a process of reducing the indeterminateness of abstract norms and providing them with action guiding content."* They further added "*Specification entails a substantive refinement of the range of scope of norms, whereas balancing consists of deliberation and judgment about the relative weights or strength or norms. Balancing is especially important for reaching judgments in individual cases, and specification is especially useful for policy development …"*[1]

Beauchamp and Childress listed 6 conditions that must be met to justify infringing one prima facie principle in order to adhere to another [1]. We would like to discuss 2 of the 6 conditions set out by Beauchamp and Childress which must be met to justify infringing one principle in order to adhere to another. For example, one of the conditions, (condition 2) specified by Beauchamp and Childress is "*The moral objective justifying the infringement must have a realistic prospect of achievement*." It could be argued that in the moral dilemma highlighted above, it is highly debatable to achieve any prospect of progress because any solution is temporary and it depends on the characteristics of the patient, severity of his mental disorder and his willingness to engage and cooperate in various treatments. Another condition (condition 5) stated, "The agent must seek to minimise any negative effects of the infringement". Considering the above dilemma, it is difficult to predict the negative psychological impact of the infringement (i.e., beneficence over non maleficance) and it sequale in the future, as it might evoke a whole range of psychological emotions including feelings of shame, disrespect, anger and hostility towards him and society. Similarly, the other four conditions specified would lead to some difficulty in explaining the infringement of the principles.
There is no doubt that principlism provides a useful "checklist" approach to bioethics. We concur with the view of John Harris, a critic of principlism that in addressing moral and ethical dilemmas, it is just not sufficient to identify the principle relevant to the particular dilemma, but, to consider analysing the arguments that are being debated in providing the solution [7].

In the above example, the clinical team had no problem identifying the underlying principles that were in conflict, but engaged in a serious debate in arriving at a solution, which was not morally, or ethically questionable. Although a balancing approach is considered which, is the usual way of arriving at a solution in the event of conflict of the principles it means that many strands of the analysis of the argument (in relation to the moral dilemmas) would be missed or ignored in order that one principle trumps over other principle. Thus, it cannot be said that any solution arrived as a result is absolutely morally right.

Discussion will now by focused on the principle of autonomy before considering its' importance in the moral dilemma of the above case. In relation to the principle of autonomy, Beauchamp and Childress noted, *"To respect an autonomous agent, is at a minimum to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs…"*[8]

Gillon, a noted principlist argued that autonomy is the "first among equals" [5]. He argued that autonomy is the key factor in ensuring that morality is possible and also, principles of "beneficence and non-maleficence to other autonomous agents both require respect for the autonomy of those agents." He further argued that justice is also a necessary component of the principle of autonomy because it takes into account the autonomous views of the people in trying to meet their needs and demands for resources. However, it was argued that Gillon's special emphasis for the principle of respect for autonomy contradicts his own view that the principles are prima facie universal moral principles [9].

Gillon also expressed as a result of the importance of autonomy, cultural variations can play an independent normative role in the development of the moral judgments. Dawson and Garrard did not accept that respect for autonomy is first among equals as a moral principle. They also argued that this special significance (as attributed by Gillon) to the principle of autonomy does not offer any independent moral role for cultural variation [10]. They rejected the plea from Gillon that there needs to be middle ground: between moral relativism and moral imperialism. Furthermore, Dawson and Gerrard emphasised that they disagreed with Gillon's claim that the respect for autonomy would outrank other principles, particularly the principle of non-maleficence. They emphasized tolerance as an important universal moral notion and leaned towards moral objectivism.

In our view, although Gillon emphasised the importance of autonomy and argued it is "*first among equals*", there is no significant analysis in the approach, and thus, not applicable to moral dilemmas in all situations. Furthermore, Gillon failed to address the interplay of conflict between other principles other than autonomy. Although the principlists (like Gillon) or its critics offer various perspectives to the approach of principlism, they do not offer any further guidance or useful analysis in addressing the conflict of the principles in solving the moral dilemmas.

Again, referring to the case of Mr B highlighted above, there is also clash between principles of autonomy and beneficence. Here, the autonomy, i.e., the views and wishes of the patient were not in line with the clinical team's opinion of what was in the best interests of the patient. However, the conflict between these 2 principles is less important in Mr B's case as he is detained in the hospital for treatment under a section of the Mental Health Act 1983. Under the Mental Health Act 1983, a person can be treated for their mental disorder without any need for a regard of whether an individual is competent to refuse treatment. However, the situation might be slightly different if Mr B was an informal patient in a psychiatric unit. In this scenario, given his presentation, is the same as described above, the principles of respect for autonomy, beneficence and non- maleficence would have competed with each other. Again, a similar balancing approach would have been adopted to ascertain which principle takes precedence over others.

In the event of clash between principles of autonomy and beneficence, it is argued that if the beneficence is understood in terms of how the patient regards what is the best treatment for him, (for example, if the patient has insight and when mentally well at some point, believes that the management approaches by the clinical team are effective) the potential conflict is lessened [11]. However, a counter argument is that if the harm or benefit is determined by the patient, then these concepts would be considered to essentially equate to the principle of autonomy.

Many ethical problems in psychiatry revolve around the issue of capacity. A patient's autonomy may assume that the patient's capacity to make rational choices is not impaired, either temporarily or permanently by mental or physical disorders. If capacity is limited or impaired, what principles then take over to guide action? Is the principle of beneficence in the form of paternalism implied in best interest standard the right approach to be adopted? These questions are not properly addressed by the principlists when they adopt a narrow approach of applying balancing approach model.

CONCLUSION

In conclusion, principlism is a useful approach, which provides a checklist of factors and a framework in approaching various moral and ethical dilemmas. There are some advantages to the principlism approach. For example, it is easy way to address problems that arise in healthcare settings. Also, these principles are universally accepted and thus ensure consistency in approaching various moral dilemmas (by balancing all the different principles.) However, despite claims of the universality nature of the principlism approach, it does not take into account the role of other factors, for example, principle of respect for autonomy being affected by compulsory detention of patients in psychiatric settings.

Although Gillon has adopted a view and attached a special significance to the principle of autonomy over other principles, his justification cannot be applied to number of moral dilemmas in clinical decision making. Also, he does not address the issue of what happens if there is a clash between two other principles other than autonomy (for example beneficence and non-maleficence). Although principlists have worked on the framework of addressing moral dilemmas in few situations, they have so far been unable to address the conflict of the principles in various ethical and moral dilemmas in various situations. For example, they failed to highlight a solution to a moral dilemma in a secure in-patient psychiatric setting where risk assessment and risk management form a cornerstone of clinical practice. In addition, they do not consider issue of the personal autonomy being attached less importance as a result of the deprivation of liberty due to a mental disorder and do not offer any approach to clinicians encountering such problems.

The authors conclude that the Beauchamp and Childress's approach of resolving the conflict between two principles by using the model of specification is far from satisfactory. It does not specify which conditions in the specification model to be considered as very important in arriving at a solution. Also, if all conditions are given equal importance, what happens if only two or three conditions are met adequately to justify infringement of the principles. We conclude that principlists take a narrow approach and fail to consider a host of other arguments and issues when arriving at a solution to various ethical and moral dilemmas in clinical settings.

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Review Paper

Environmental Ethics – The Fullest Extension of Human Ethics

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ABSTRACT

Ethics is defined as a set of moral principles that guide the conduct of both individuals and various social groups and "moral" refers to the ability of humans to judge between right or wrong and good or bad. Environment means 'something that surrounds'. 'Environmental ethics' can be defined as the human attitudes and values that influence individual behavior and government policy toward nature. The study of environmental ethics is to ensure that human actions do not do further damage to the natural world. This is vital if we desire that future generations can live peaceful and prosperous lives in harmony with nature and continue to enjoy all the amenities offered to man by Mother Nature. The obligation rests with each and every one of us today to take the responsibility to save our planet for future generations. We must save and preserve our natural resources in such a way that future generations will be able to live in harmony with nature and enjoy its benefits.

Key Words: environment, ethics, environment ethics, morals.

INTRODUCTION

"Ethics" may be defined as a set of moral principles that guide the conduct of both individuals and various social groups. The word "moral" refers to the ability of humans to judge between right or wrong and good or bad. Moral principles of an individual are shaped by exposure to a multitude of human behavior and value systems during their formative years. These are internalized by an individual through his/her personal growth and self-realization and the continued socialization process. The set of values in a society specify certain duties and obligations, norms and permissions; of what is considered acceptable and what is regarded as no-acceptable behavior.

Environment means 'something that surrounds'. This includes all our surroundings both natural and man-made elements. However, when we consider the term 'environmental ethics', we usually refer to the non-human natural environment. 'Environmental ethics' can be defined as the human attitudes and values that influence individual behavior and government policy toward nature[1]

In other words, environmental ethics may be understood as the logical interpretation of the relationship between human beings and their natural environment. The study of environmental ethics is to ensure that human actions do not do further damage to the natural world. This is vital

if we desire that future generations can live peaceful and prosperous lives in harmony with nature and continue to enjoy all the amenities offered to man by Mother Nature.

Environmental ethics is normally divided into can be divided into two categories: (1) anthropocentric and (2) non-anthropocentric.
Anthropocentric environmental ethics considers the non-human natural world as a whole to a means that serves human ends [1]. It assumes that only human beings have moral value. Thus, although humans have responsibilities regarding the natural environment, they do not have direct responsibilities to the natural world [2]. Therefore, it can also be regarded as ethics "of human beings for the use of the environment".
Non-anthropocentric environmental ethics, in contrast, assumes that both humans and non-humans have mutual and intrinsic value to each other. We understand the dependence of all livings things on plants, which are the true autotrophs as they make their own food. All other animals are dependent on plants or other smaller animals which are considered as part of the food chain. Humans therefore, have responsibilities towards their own species, as well as to all other non-human entities of the natural world [3].

Characteristics of Environmental Ethics [4]

Firstly, environmental ethics is extended
Environmental ethics extends beyond the immediate community, state or even the nation to include not only all people everywhere, as well as animals and the whole of nature – the biosphere – both now and beyond the imminent future to include future generations.
Secondly, environmental ethics is interdisciplinary
The field of environmental ethics involves various inter-related subjects and areas of consensus such as ethics, political sciences, environmental economics, environment sciences and eco-sciences, for example. Each of these fields offers distinctive perspectives and approaches to the field of environmental ethics, and in turn environmental ethics offers important fundamental knowledge for these disciplines. Hence it is important that in order to solve many of the problems we face today, all issues are considered with an interdisciplinary approach.
Third, environmental ethics is plural
As discussed, environmental ethics is a discipline where myriad ideas and contrasting perceptions vie for importance and implementation. Each specific subject provides unique and, in some sense, reasonable ethical justifications for environmental protection. The approaches may be different, but the ultimate goals are similar, and the consensus is that it is everyone's duty to protect the environment. As envisaged from an Indian standpoint we find that the basic concepts of environmental ethics and protection are embodied in many of our rich and varied cultural traditions. This pluralism of philosophies and multiethnic perceptions is critical for environmental ethics to retain its vitality.
Fourth, environmental ethics is global
It is well established fact that environmental pollution does not respect state or national boundaries and so no country should be burdened to contend with this problem alone. The global ecological crisis is a reality that we all have to address with solidarity to have any hope of success. People everywhere must reach a consensus and cooperate at the personal, national, regional, multinational and global levels in order to win the battle against the global environmental crisis.
Fifth, environmental ethics is revolutionary
A revolution is required in order to battle this crisis and find a way to rectify the mess that the world finds itself in. Environmental ethics requires us to challenge the dominant and deep-rooted anthropocentrism of generations and understand that our duty extends to future generations and all living beings that co-exist on the planet. We must understand that we are responsible for what condition we leave this planet for future generations.

Sustainable Development

Policy makers and planners are united on the subject that rather than talk of development alone what we need to plan for is 'sustainable development'. Sustainable development necessitates that equilibrium is maintained by finding common ground between socioeconomic and environmental needs. It can be defined as: "A continuing process of mediation among social, economic and environmental needs, which results in positive socioeconomic change that does not undermine the ecological and social systems upon which communities and society are dependent. Its successful implementation requires integrated policy, planning, and social learning processes; its political viability depends on the full support of the people it affects through their governments, their social institutions, and their private activities" [5].

It is evident that each and every member of the society (which aspires to implement the ideals of sustainable development), and individual members to uphold environment-friendly practices if the goals of sustainable development are to be attained. Sustainable development encourages productive activities which would maximize social welfare but would not contribute to the depletion of the resource base for future generations; it requires that development planning follow the principle of minimizing wastage, minimizing generation of pollution, and maximizing recycling. It is mandatory that, development policy strategists, planning commissions, and even the recipients of the planning outcomes all follow strict ethical norms and commit towards protecting the environment. It is vital to inculcate good environment friendly practices into the daily habits and practices of the society, in order that the goal of sustainable development is achieved.

Ethics and sustainable development

Ethics identified by Murcott [6] as compatible with sustainable living are:

(1) To refrain from killing;
(2) To treat and value all natural and cultural systems that support us as possessors of their own intrinsic value;
(3) To consume only to such extent that is necessary to meet one's basic needs. Any surplus should be used for the purpose of ensuring justice and equity for the current generation as well as for generations to come;
(4) Keeping in mind that humans and nature cannot be separated, "nature", should be studied with "a deep sense of humility and wonder and the tools of science and technology must be used for the well-being of humans and nature"

Finding solutions to environmental issues

One of the major means by which solutions can be found is through the inculcation of environmental ethics from the earliest stages and ensuring that it becomes part and parcel of all daily activities and social behaviour. Just as a child grows up in society learning what is good and bad, right and wrong – similarly good environmental ethical practices need to be introduced and reinforced at all levels [7,8,9].

Charity begins at home

When a child is exposed to the concepts of "right" and "wrong", it is vital that a child is made aware of the right ways he/she should interact with the environment. In this way it is possible to instil a sense of environmental ethics that will make an individual behave and act in environment friendly ways, from the very early stages of his/her life. If a child is brought up in a house where the parents and elder siblings care about trees and plants, avoid the wastage of water, follow the habit of recycling, etc, the child will follow these same practices for a lifetime. Parents should teach their children how critical the environment is for all of us, and the importance of protecting the environment always.

Power of peers

After the family the next crucial social stage is the peer group of the child, young adult and adult as well. Finding the approval of peer group is a major motivating factor in defining an

individual's social behaviour. If any one member of a peer group acts in an environmental friendly manner, others are also inspired. Thus even if one member of the peer group is environmentally conscious and is able to motivate the others in the group, soon all the other members are likely to exhibit environmentally favourable behaviour.

Cleanliness is next to Godliness

Religion is an important part of any social foundation and forms the core of the value structure of an individual. Almost all religions emphasize that the environment is an invaluable part of God's creation, and all humans have a obligation to preserve it. The relationship between all the creations of God must be based on justice and equity. Ideal living is to live in harmony with nature and preserve the environment so that it remains the same for future generations to enjoy and appreciate the marvellous creations of nature. All religions can utilise their inherent ability to motivate and mobilize large numbers of society to carry out drives to clean up the environment and also to sustain living habits that are ecologically and environmentally friendly. Religious customs such as bursting of firecrackers, immersion of idols into water bodies that harm the environment also need to be curbed through education and finding environmentally friendly alternatives.

Providing holistic education

Schools and colleges are other social institutions which play an important role in character development and habit formation into an individual. Many additional moral values, beyond what is taught in a family, can be learned in an educational institution. The most important aspect is that a student looks up to his/her teacher as a role model, and therefore abides with the teachers' instructions more zealously than directions given by parents. The school curriculum can be revised to include topics related to environmental issues and concerns. This will bring about awareness in them to incorporate environmental friendly behaviour and planning. In turn they should also educate others on which practices should be followed and what are the practices that cause harm to society.

It is pertinent to ensure that not only should information be shared but along with that practical examples and alternatives should be made available – for example just telling slum dwellers not to use firewood for cooking is not going to benefit anyone unless alternatives such as '*smokeless chulas'* or '*green stoves*' are provided to them. The cost involved in buying these 'green' alternatives will be paid back to the society by virtue of the cleaner air for all.

Getting the message across

In the modern world, mass media, various social networking sites and instant messaging applications on smartphones are ensuring that information can easily and efficiently be disseminated literally all across the globe almost instantaneously. As most of these have the capability of sending text, photos and video – the reach of such technology is actually limitless. Environmental issues can be disseminated to the people in a manner, which appeals to them. Celebrities too can also be used to spread the messages regarding good ecological practices and following an environmentally friendly life-style [10].

Towards a 'greener cleaner' environment

It is important to understand that each and every one of us should be 'careful' of all our deeds and actions. Many of the small innocent things we do- actually cause greater harm when done in large numbers. Not switching off the engine at long signals and traffic snarls seems innocent but adds greatly to the levels of atmospheric pollution. Similarly setting off firecrackers or unnecessary waste of water, electricity and all natural resources by a large number of '*careless individuals'* all adds up to an ever-worsening situation. What is worse is that very often these are the actions of the educated and economically privileged classes. Simply banning things or increasing taxes to discourage emissions has not and will not help. As Einstein once said "We solve our problems using the same thinking as when we created them".

The obligation rests with each and every one of us today to take the responsibility to save our planet for future generations. We must save and preserve our natural resources in such a way that future generations will be able to live in harmony with nature and enjoy its benefits.

Rigorous and focussed initiatives with practical training in order to preserve our planet should start as early as possible and carry on throughout the educational curriculum. Governments across the globe should empower pollution control authorities with wider and stringent legal powers for punitive action [11]. Technical experts and Captains of industry should be appointed as consultants to clean up and regulate errant industries and sectors. No more can we ignore the situation and believe that it will sort itself out as it is already too late. A mass movement of ethically-driven and committed persons, all across the economic spectrum, is essential for the envisaged changes to be effective. Working together in solidarity towards the common goal of cleaning up the environment is the only way that this monumental problem can be controlled effectively in the years ahead.

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Review Paper

Maintaining Ethical Approach in Rare Diseases in Bulgaria

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ABSTRACT

Ethical approach towards rare diseases should be introduced at highest possible level in every national framework, as it is directly related to the right to the highest attainable standard of health. Although most rare diseases are genetic diseases, they can also result from environmental exposures during pregnancy or later in life, often in combination with genetic susceptibility. Some are rare forms or rare complications of other common diseases.The main problems posed by rare diseases defined at European Union level have focused the attention to some ethical consequences raised by the lack of recognition and visibility of rare diseases; plus the lack of detailed strategies for rare diseases; and the lack of European cooperation, coordination, and regulation for rare diseases. In Bulgaria, the national authorities are still taking actions to ensure the proper recognition and visibility of rare diseases. In Bulgaria, the National registry of patients with rare diseases is established and maintained by the National Center of Public Health and Analyses.Bioethics Mediation in daily clinical practice. Bioethics Mediation will be patient-oriented and respect the principles and values of both of the two sides of healthcare.

Key Words:rare diseases; diagnosis, quality, healthcare services, commission on rare diseases

INTRODUCTION

Rare diseases are a threat to the health of patients as they are life threatening or chronically debilitating diseases with a low prevalence and a high level of complexity. Despite their rarity, there are so many different types of rare diseases that millions of people are affected. Because of their low prevalence, their specificity and the high total number of people affected, rare diseases call for a global approach based on special and combined efforts to prevent significant morbidity or avoidable premature mortality, and to improve the quality of life and socioeconomic potential of affected persons.

Although most rare diseases are genetic diseases, they can also result from environmental exposures during pregnancy or later in life, often in combination with genetic susceptibility. Some are rare forms or rare complications of other common diseases.

Some rare diseases have prevalence near the threshold of 5 per 10,000, such as Gelineau disease, triple X syndrome, scleroderma or neural tube defects. Most rare diseases are very rare, affecting one in 100,000 people or less, such as Gaucher disease, Ewing sarcoma, Duchenne muscular dystrophy, or Von Hippel-Lindau disease.

There is also a great diversity in the age at which the first symptoms occur; half of the rare diseases can appear at birth or during childhood (such as Williams' syndrome, Prader-Willi

syndrome, and retinoblastoma). The other half of rare diseases can appear in adulthood (such as Huntington's disease, Creutzfeld-Jacob disease, amyotrophic lateral sclerosis).
Several years ago, the main problems posed by rare diseases defined at European Union level focused the attention to some ethical consequences raised by the lack of recognition and visibility of rare diseases; a lack of detailed strategies for rare diseases; and a lack of European cooperation, coordination, and regulation for rare diseases.
The lack of formal identification in health systems imposes medical and financial barriers in receiving treatment for an unrecognized disease. This does not allow achieving a significant improvement of life-quality for thousands of rare disease patients.
The difference in availability and quality of care provided to patients with rare diseases by the national healthcare services for diagnosis, treatment, and rehabilitation decreases the chances of achieving significant prolongation of life of patients with rare diseases. Patients often face lack of quality information and appropriate support at the time of diagnosis, as well as lack of appropriate multidisciplinary healthcare, which results in a devaluation of the main principles in health systems such as universality, access to good quality care, equity and solidarity.
Without correct diagnoses, people with rare diseases are not considered rare disease patients and are thus restricted in their ability to seek appropriate medical attention and social assistance in their respective healthcare systems.

According to the reference portal for information on rare diseases and orphan drugs Orphanet, of the thousands of known rare diseases for which a clinical identification is possible, only 250 of them have a code in the existing International Classification of Diseases (ICD) (10th version). An appropriate classification and codification of all rare diseases is necessary in order to give them the necessary visibility and recognition in national health systems. The ICD is being revised to better reflect progress in health sciences and medical practice. In line with advances in information technology, ICD-11 will be used with electronic health applications and information systems. The upcoming World Health Organization's (WHO) 11th International Statistical Classification of Diseases and Related Health Problems (ICD-11) is expected to be finalized in 2018.

The ICD is important because it provides a common language for reporting and monitoring diseases. This allows the world to compare and share data in a consistent and standard way – between hospitals, regions and countries and over periods of time. It facilitates the collection and storage of data for analysis and evidence-based decision-making. WHO has established various Topic Advisory Groups to serve as planning and advisory bodies in the update and revision process for specific areas.
The production of basic information on which to build the classification of rare diseases in ICD-11 was assigned to Orphanet. It contributed to the whole ICD revision process, considering that rare diseases involve all areas of medicine. Orphanet collects series of rare diseases classifications mainly based on scientific grounds (etiology and mechanism). To complement these classifications, a clinical in-house classification is developed to meet the needs of the clinicians. All the classifications, regularly updated as scientific knowledge evolves, can be viewed on the Orphanet website and have served as a basis to build ICD-11.

Even though many affected individuals live full and happy lives and may not experience pain or suffering, many families remain profoundly affected by genetic conditions, in spite of improved treatment, education, and support services. There is a substantial cost to society for non-institutional, outpatient, educational, medical and social services, as well as lost economic output from family members who care for persons with genetic disorders.

Genetic conditions occur with similar frequencies in different nations and irrespective of the socio-economic status of individuals. A meaningful right to health care must include access to services for the diagnosis, treatment, and prevention of genetic disorders. The priority assigned to

genetic services with respect to other health services is a matter of public health policy in each country.
Within genetic services, efforts should be directed towards extending the reach of genetic services at the primary care level, with the utilization of technologies and personnel that are appropriate to the needs, expectations, and beliefs of the community.
The difficulty in obtaining the correct diagnosis is one of the most important issues for rare disease patients, because it may take years or even decades before a final diagnosis is obtained. Late diagnoses delay the beginning of adapted treatments and can have severe irreversible, debilitating and life-threatening consequences. When seeking diagnosis, patients frequently consult numerous doctors, undergo multiple examinations and often receive various incorrect diagnoses resulting in inefficient and even harmful treatments.
The individual consequences of improper diagnosis include the worsening in clinical status, plus psychological damage often related to medical denial of the undiagnosed disease and, in some cases, death.

Another important issue, which has an ethical approach, is the lack of good clinical practice guidelines for some of the existing rare disease conditions. This is mainly caused by the segmentation of medical specialities and lack of application of a multidisciplinary approach to care for patients suffering from a rare disease.
In an attempt to solve the difficulties faced by patients with rare diseases, at the European Union level there has been introduced the development of European reference networks (ERNs) for rare diseases. These networks should serve as research and knowledge centres, updating and contributing to the latest scientific findings, treating patients from Member States and ensuring the availability of subsequent treatment facilities where necessary.

In Bulgaria, the national authorities are still taking actions to ensure the proper recognition and visibility of rare diseases.
In 2014 Bulgarian authorities adopted the Ordinance on the conditions and procedures for registration of rare diseases and designation of the Centres of Expertise and Reference Networks for rare diseases. This act contains the main provisions for the establishment of a Commission on rare diseases; on the consistency of a List of rare diseases and the establishment of National registry for rare diseases. The Ordinance also sets out specific rules and procedures for designating Centres of Expertise for rare diseases [1].

The Bulgarian Commission on rare diseases consists of a total of 16 members, of whom 7 are medical specialists and 4 representatives of the Ministry of Health. It supports the activities of the Minister of Health and the Director of the National Center of Public Health and Analyses (NCPHA) on matters concerning rare diseases. The National Center of Public Health and Analyses is a structure within the national healthcare system, which is responsible for carrying out activities for protecting public health, promoting health and preventing diseases, and providing information for healthcare management.

Additional competences assigned to the Bulgarian Commission on rare diseases include advice to the Minister of Health in relation to his competences and issuing opinions on proposals for inclusion of diseases on the list of rare diseases, as well as assessment of the activities of the National Registry of patients with rare diseases and assessment of Centres of Expertise and Reference Networks functioning in Bulgaria.

The List of rare diseases is mainly used:

1. in the procedures for designation of Centers of expertise and Reference networks for rare diseases;
2. in relation to the National Register of patients with rare diseases;
3. for the development of medical science and practice;

4. when planning diagnostic activities, treatment, monitoring and rehabilitation of rare diseases;
5. for the establishment of European and international cooperation in exchange of information and scientific experience when providing medical care of patients with rare diseases.

The List of rare diseases is introduces based on a rare disease dossier, which contains specific data such as: name, definition and code (ICD and ORPHAcode) of the disease; epidemiological data for Bulgaria and the European Union, compliance with the official definition for rare disease; diagnostic criteria and guidelines; treatment, follow up and rehabilitation guidelines; prevention guidelines (if applicable); proposals and recommendations for organization, funding and management of the medical services for the diseases in question; description of experience with specific patients with the disease in question (if available).
The specifics of rare diseases create challenges for the registration of patients. The genetic nature of most rare diseases suggests the need to investigate and track family related cases, which is not always possible. The combination of a small number of cases and a large geographic scope of data collection requires multiple collaborations and exchange of information, usually at international level, often constrained by legal frameworks. The need for resources to create and maintain registries for rare diseases often puts into delay the introduction of such database.

In Bulgaria, the National registry of patients with rare diseases is established and maintained by the National Center of Public Health and Analyses. All medical treatment facilities in Bulgaria, including the Centres of Expertise, are mandated to submit epidemiological data to the Registry, as the data should cover all rare conditions that are present in the List of Rare Diseases. The NCPHA is required to prepare and publish annual reports on the epidemiology of rare diseases in Bulgaria. These reports include information contained at the National registry of patients with rare diseases, as well as on diseases dossiers.
In Bulgaria, the NCPHA is the competent authority leading, controlling, monitoring and coordinating information activities in the healthcare, as it unifies medical and statistical documentation for the health status of the population. It is also responsible for development, implementing and maintaining national standards of coding in hospitals. Its activity also directly reflects to the conditions at the healthcare system in relation to rare conditions.

An ethical approach towards rare diseases should be introduced at highest possible level in every national framework, as it is directly related to the right to the highest attainable standard of health. Health care and treatment for rare diseases should meet the requirements of criteria providing better access to consultations and medical exams, multidisciplinary approach in preventing misdiagnosis of rare diseases, as well as psychological treatment and support in cases of misdiagnosis. In stages of prevention, research and treatment, patients should be provided with good information quality and proper conditions for autonomous decision-making, as this will guarantee the exercise of the main human right to health.

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Ethical Viewpoint Article

Bioethics Mediation in Health Care Settings: An Innovative Approach to Shaping Shared Solutions in Ethics Disputes

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ABSTRACT

Bioethics mediation combines the clinical substance and perspective of clinical ethics consultation with the tools of the mediation process, using the techniques of mediation and dispute resolution to help patients, families and healthcare providers enmeshed in conflicts as they wrestle with decisions about life and death. Mediation has long been used to resolve disputes. In the hospital setting, where health care providers faced with intense demands on their time, are called on to explain complex information and deliver bad news to physically and emotionally vulnerable patients and their families and where large number of physicians, nurses and other providers interact with one another and with the patient, it is not surprising that communication breaks down and disputes arise. Bioethics mediation training and services are now available for medical staff conflicts, difficult patient care decisions, employee disputes, medical malpractice claims and bioethics disputes. Bioethics mediation in daily clinical practice. Bioethics Mediation will be patient-oriented and respect the principles and values of both of the two sides of healthcare.

Key Words: bioethics, mediation, clinical practice, empathy.

INTRODUCTION

Scientific and technological medical achievements and the prolongation of human life cause many inconvenient situations which break down the relationship between physicians and patients. These two groups have different perspectives and this difference usually creates physical and emotional stress and makes both sides vulnerable to anxiety, anger, pain, fear, frustration, grief, uncertainty, confusion [1]. Due to the complexity of clinical practice, conflict is everywhere and every time in clinical medicine and not only between physicians and patients but also with providers, administration, payers, and beyond. it has been suggested that moral puzzlements and bioethics conflicts which arise in life and death decisions are really more of a disagreement

than an ethical dilemma. These bioethics conflicts are almost always about the "proper" and "appropriate" plans for future care; so they are called bioethics or clinical ethics conflicts. It is a common conclusion that most times, bioethics conflicts are caused not from the deficient quality of medical care or the negligent treatment but from absent or ineffective communication. Communication is very important issue. It is an ethical duty in health care setting for every physician and health care provider [2]. In most cases the patients deserve the genuine communication based on trust, honesty and empathy. Ineffective communication plays an important role but it is not the only cause of bioethics conflicts [3]. There is another significant parameter which called moral ambiguity. The philosophical term for the state of moral ambiguity is "aporia" which includes the state of perplexity. In the situation of moral aporia, there is the morally appropriate course of action and a possible consensus among the parties. This happens because all the people who are involved in clinical practice (doctors, nurses, patients, families, government) have their own principles, their unique deeply held values and religious beliefs which affect their lives, their priorities and finally affect their decisions. Despite their difference, all these people want the same thing; for others to respect their values. In clinical ethics, a range of ethical options is acceptable. This creates a pluralism of choices which could satisfy the partners and facilitate agreements on outcomes.

Until now, the Clinical Ethics Consultation (CEC) approach has been defined as a service and is provided by an individual or a consultant team or committee when ethical issues in a clinical case are raised. Its main aim is to enhance the process and outcomes of patient care by helping to identify, analyze and resolve ethical issues [4]. The resolution of ethical problems in the CEC approach is usually a recommendation in a situation of moral aporia. This recommendation is subjective because one set of principles and values is favored over all others and thus it is a single correct resolution. Ethics committees usually reach decisions on a majority vote. They exercise hierarchical authority and unfortunately exclude patients from the decision making process. Experience shows that this way of consulting does not provide desirable results both for physicians and patients. It is necessary to adopt a more effective approach to ethical problems which will be open, collaborative, and transparent and patient-oriented. This is Clinical Ethics Mediation or Bioethics Mediation approach; two terms which are used synonymously. Mediation has long been used to resolve disputes. It is a private, voluntary, informal process in which an impartial third person, the Mediator, facilitates a negotiation between people in conflict and helps them to find proper solutions that meet their interests and needs. In simple words, mediation is a form of assisted negotiation [5]. This process is now used in a variety of medical settings to deal with disputes over Medicare and Medicaid and to resolve medical malpractice claims. Furthermore, mediation tools are being used to aid in disclosure of adverse medical events.

Bioethics mediation is a novel approach for resolving ethical dilemmas which could arise in the daily clinical setting or health care institutions. It uses skills of dispute resolution, emotional intelligence, interpersonal communication and active listening in order to resolve agreements among caregivers, patients and families. The objective is to reach a solution of the dispute which is patient centered and accepted by all the people which are involved. Last but not least, this resolution should comply with the law and the principles of medical ethics. Bioethics mediation is aimed to facilitate a consensual resolution of a dilemma or a shared decision about the best care plan for the patient, while simultaneously respecting patients' needs, rights and cultural values. Bioethics mediation promotes the autonomy of the patients and gives them the opportunity to be heard. Unfortunately, in the context of modern medical facilities, it is common practice for the patients' or their families' voices to be muted, if not lost. Bioethics mediation enhances patients' satisfaction, strengthens their trust and confidence in caregivers, improves the quality of clinical work environment, promotes the positive image of health care institution, prevents legal complications and contributes to risk management. Bioethics mediation is most effective as an intervention method when it is applied as soon as the first sighs of discord appear. Its purpose is to prevent the climaxing of disagreement into conflict and possible litigation.

In this way it meets the needs of caregivers and patients in helping them deal with ethically charged and emotionally loaded clinical situations [6]. The role of the bioethics mediator is crucial. First, he/she should create a "moral space" in which parties can express thoughts and feelings without fear or judgment regarding issues on which they may have important differences. The bioethics mediator should encourage and permit parties to tell their aspects of the story while minimizing disparities of power, knowledge, skills and experience which separate medical professionals, patients and families. He/she should help patients and families understand the uncertainty that surround diagnosis and treatment. This understanding of uncertainty is a precondition when considering options about care and a critical basis for accepting the outcome, especially if this outcome is death of the patient. Finally the bioethics mediator should ensure that the consensus can be justified as a principled resolution, compatible with the principles of bioethics and the legal rights of patients and families.

A mediative bioethics intervention is a fluid process which is divided artificially into eight stages. It is clear that in real life events never proceed in a predictable and orderly manner. The first stage is about assessing the situation and preparing the mediation with meet with the involved parties together or separately. In the second stage, the mediation is begun. The mediator introduces the patient (stage three), he represents and refines the medical facts (stage four), he gathers information (stage five), he solves the problem (stage six), he reaches a resolution (stage seven) and finally makes a follow-up (stage eight) [7]. Concerning the qualifications which a bioethics mediator should have, these are many and various. First of all, the bioethics mediators should be familiar with the code of medical ethics, with the principles of bioethics as beneficence, non-maleficence, patients' autonomy and social justice, with clinical realities and the knowledge of the attitude and situation of both parties (patients and clinicians). This leads to the fact that bioethics mediator usually could be professionals, members of ethics committees in medical institutional, bioethicists, social workers and medical consultants. Apart from the necessary knowledge, a bioethics mediator should have good communication and interpersonal skills. The necessary communication skills are active listening, non verbal communication, questioning, paraphrasing, reflecting, reframing, summarizing and reality testing. The interpersonal skills are rapport building, demonstrating respect, empathy, authenticity, eliciting the moral view of the involved parties, distinguishing positions from interests and managing the process. The above qualifications are acquired after an intense bioethics mediation training program in order that the bioethics mediators be effective to manage conflicts which are caused from communication breakdowns, cultural differences, disparate value systems and ethical dilemmas.

CONCLUSION

Scientific and technological medicine achievements and the prolongation of human life cause many inconvenient situations which can break down the relationship between physicians and patients. The amount of disappointed patients and frustrated physicians in combination with increased lawsuits against healthcare providers require the incorporation of Bioethics Mediation in daily clinical practice. Bioethics Mediation will be patient-oriented and respect the principles and values of both of the two sides of healthcare. Thus, this new manner of consultation could reduce physical and emotional stress between patients and physicians, helping both sides handle difficult situations more efficiently and improving the quality of healthcare.

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Student Bioethics Wing Paper

Human Experiments: Past, Present and Future

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ABSTRACT

Human experimentation is systematic, scientific investigation that can be either interventional or observational and involves human beings as research subjects. The most pivotal question in research ethics is not whether we should be doing research and experimentations on humans but can we justify exposing individuals to risks associated with it, just for the sake of progression of medicine- is addressed in this article. It is of paramount importance that pros and cons be balanced before the start of any study and correct procedures followed for every step of the research and human experimentation, keeping mind the ethics involved.

Key Words: human experimentation, research, ethics.

"Better not perceive yourselves too high, O humans. We only value mankind as our experimentation object"
Toba Beta

Human experimentation is systematic, scientific investigation that can be either interventional or observational and involves human beings as research subjects [1]. Human experimentations are controversial because it interferes with the inherent dignity and fundamental rights of humans [2]. The most pivotal question in research ethics is not whether we should be doing research and experimentations on humans but can we justify exposing individuals to risks associated with it, just for the sake of progression of medicine.

History is riddled with stomach-turning, mind-unsettling stories of human experimentation. In 1796, Edward Jenner inoculated smallpox virus into an unknowing 8 year old boy, himself aware of its lethality yet unfazed. The oldest and most commonly used human cell line, HeLa cells, instrumental for research into Polio, Cancer, AIDS and gene mapping was isolated from Henrietta Lacks, an unsuspecting uneducated, poor African-American women from Baltimore, who died penniless and without even a tombstone. In 1940s, to test the effectiveness of Penicillin as a cure for Syphilis, US conducted unethical human experimentations in Guatemala. In this NIH funded experiment, doctors paid prostitutes infected with syphilis to have sex with prisoners, asylum patients and soldiers and when this didn't work, they inoculated syphilis bacteria onto men's penises and on their forearms and faces. The Genetic Studies of Genius, started by Lewis Terman at Stanford University to disprove the then-current belief that gifted

children were sickly, socially inept, and not well-rounded, is now the oldest and longest running longitudinal study in the world [3]. This study has often been criticized for not having a generalized sample, as selection was based on recommendations and largely constituted of children from white and upper or middle class families [4]. Furthermore, Terman meddled in his subjects' lives by giving them letter of recommendations and pulling strings to get them admitted to Ivy League schools [5-7].

At the end of the Second World-War and after the conclusion of the Doctor's trial in Nuremberg, as a response to horrors of human experimentation done in Nazi Germany, a set of rules governing what was legal and what was not during any human experimentation was devised. The Nuremberg Code contained a list of 10 research ethics principles such as informed consent and absence of coercion; properly formulated scientific experimentation; and beneficence towards experiment participants [8-9]. Declaration of Geneva and Universal Declaration of Human Rights built up on these founding principles to bring under its ambit several other medical crimes and human rights violation.

"We slow the progress of science today for all sorts of ethical reasons. Biomedicine could advance much faster if we abolished our rules on human experimentation in clinical trials, as Nazi researchers did."

Paul Nitze

While the above quote is a reminiscent of Cold War ideology, the world is still not too far from rampant practice of unethical and questionable human experimentations. In 2002, the United States Office for Human Research Protections (OHRP) suspended nearly all federally funded medical research involving human subjects at Johns Hopkins University, after investigation of death of a previously healthy volunteer [10]. In 2014, during a trial for an experimental vaccine against Rotavirus in India, 2000 children received placebo in spite of presence of two highly efficacious vaccines already in the market [11].

The setting up of Institutional Review Board (IRB) with the purpose to protect the rights and welfare of humans participating as subjects in a research study is a step in the right direction. Also known as Independent Ethics Committee (IEC), its functions are to approve, monitor and review biomedical and behavioral research involving humans as subjects and to conduct risk-benefit analysis wherever required. Another decisive step in human experimentation was taken recently with the development of Organs-on-Chips by Wyss Institute at Harvard [12]. Organs-on-Chips are engineered microchips that recapitulate the microarchitecture of living organs such as heart and lungs and can be used to rapidly assess response of new drug or therapy without using humans or animals as research subjects.

While it may still be a long time before a considerable progress is made in ethical practice of human experimentation, it is of paramount importance that pros and cons should be balanced before the start of any study and correct procedures followed for every step of the research.

"The first step in the evolution of ethics is a sense of solidarity with other human beings."

Albert Schweitzer

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Student Bioethics Wing Article

Professional v/s Personal: How to Make it Work

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ABSTRACT

This writing deliberates upon how to achieve an optimal work-life balance, considering the professional and personal spheres of an individual's life. With a detailed step to step explanation of how one can achieve work-life balance, the article concludes by emphasizing upon the individual differences that one must always consider. Work life balance is an important establishment in every individual's life as it allows one to live optimally at a personal and professional level. Nevertheless, the bigger picture in everyone's life is different and has its one own relevance to the individual.

Key Words: professional life, personal life, work-life balance

We as physicians - present and future - all begin our education and careers striving to save the world by healing one ill patient at a time. Our drive, dedication and devotion towards restoring the sick to health push us into long days and nights studying and practicing to attain our goal. In this process of medical school we tend to get caught up in all of our textbooks, practical and cases; however, we look past these difficult times towards the light at the end of the tunnel, which is seeing our patients hale and healthy. Naively we believe that life becomes easier once our education has been completed only to realize that clinical practice involves a whole new set of hurdles that we must overcome. Not only do these hurdles include our professional workload, but also our personal lives which continue to grow and move forward as we do.

Our attempt to balance professional and personal lives may not go as we intend: this puts us at a great risk of developing the dreaded burnout. This burnout causes us to become disgruntled, which can then affect our patients negatively (physically and emotionally, among other aspects of their health), causing them to exhibit noncompliance or even worsen their condition. If the patient continues to deteriorate, our work load and stress level rises in a futile attempt to re-establish the patient to their previous healthy state thus creating a vicious cycle. In order to prevent this vicious cycle in taking over our commitment to the field of medicine and the patients we serve, we must learn to balance our professional and personal life so that we may be able to treat our patients with the utmost care while also taking into account our personal lifestyle (health, family, pleasure and leisure).

Before we delve into how to achieve proper work life balance, we must first understand what it entails. Work consists of our ambitions, goals and careers. Life contains not only our friends and

family, but also the way we see and believe in ourselves. Work life balance is "satisfaction with one's entire life—professional and personal." This does not necessarily mean that both should have a fifty-fifty allocation of our time, energy and resources. However, we must keep in mind that each person has their own definition of balance—some may perform better with longer working days while others may prefer more time with their loved ones in order to recharge and be better suited to take on the day's work [1].

Now that we have an understanding of work life balance, we must also know the consequences of its absence. These consequences include, but are not limited to, poor health, exhaustion and strain on our relationships. Long days with little sleep cause us to suffer from exhaustion, which may obscure our ability to treat our patients effectively. This will not only cause damage to the patient's wellbeing but also our professional reputation. Furthermore, with increased pressure at work, we are more prone to develop stress. Stress is a known causative factor for several medical conditions including weakened immune system, heart related disorders, mental disorders and the list goes on. Additionally, stress puts us at a higher risk for substance abuse and suicide. Moreover, if we work excessively, we will miss important moments with our friends and family. This can lead to an inability to build and nurture relationships with others which can lead to isolation and the negative psychosocial effects that it may bring [2].

One of the primary steps in achieving a work life balance is learning how to prioritize our careers with our lifestyles. We must spend time truly trying to figure out what we hold most dear and remove the unnecessary things that eat away at our precious time. Everyone will have different priorities, so it is essential to prioritize based on our own needs rather than those of others. We must also remain firm in the decisions we have made regarding these priorities in order to reap the benefits. To prioritize our needs and desires, we must realize that compromise is a necessity. By learning how to compromise, we begin to understand what we truly hold dear, even though it may mean not spending as much time as we previously thought we would in the hospital with our patients [1].

The next step becomes increasingly challenging in this day and age: we must learn how to put down our phones and unplug once in a while. In this day and age, technology has become one of the greatest assets in our professional as well as personal lives. We are able to communicate with patients and diagnose conditions like never before. However, technology comes with a cost. This constant connection to work inhibits us from truly leaving and dedicating our energy elsewhere. Patients may call after hours, colleagues may want a second opinion, insurance companies may seek to clarify claims, etc. In doing so, we end up stepping away from our other endeavors just to be drawn back into work. Hence, we must exercise control over separating work from play. It is required that we make quality time truly count by disconnecting from work when we are with our loved ones [3].

Moreover, we must practice what we preach when it comes to exercise and relaxation. It is necessary to take a few minutes for ourselves to unwind and rejuvenate [3]. This in turn has been shown to increase productivity and decreases inefficiency.

Finally, none of this will happen overnight. It is crucial to begin small and gradually progress to achieve success [3]. We need to take baby steps, one at a time, before we can appreciate the results. It is also important not to get discouraged when we fumble.

Therefore, to put everything we have discussed so far into perspective we need to step back and look at the big picture. Every person will have a different picture staring back at them, but in an effort to achieve a healthy balance we need to follow these four simple but essential steps: prioritize, compromise, exercise, and start small. With these in mind, our initial spark and drive to heal our patients can stay aflame despite our realization that we are also merely humans who have their own necessities that need to be addressed from time to time.

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Student Bioethics Wing Paper

Cadavers are Indispensable Teachers: The Cadaveric Oath and Human Dignity

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ABSTRACT

Cadavers are very difficult to procure especially in a society like India where many religious groups with different ideologies and belief systems believe that the soul of the dead does not achieve salvation if the body is not cremated in its intact form at death. This belief system plays an important role for people to decide whether or not to do body or even organ donation, for that matter, for the purpose of anatomical dissection. However, growing awareness in the lay population is now changing this situation slowly and gradually the number of voluntary donors may rise. Body donation must be encouraged as it is the only ethical means of procuring cadavers. Body donation units must be established in all medical schools and hospitals which work with cadavers routinely, to overlook whether the procedures of cadaver procurement, study and final rites are being carried out in an ethical manner.

Key Words: cadavers, body donation, cadaveric oath

CADAVERS AND THEIR EDUCATIONAL SIGNIFICANCE

The word "Cadaver" is derived from the old Latin phrase "cadere" which means 'to fall'. In legal context, it means a corpse. In medical context, cadavers are referred to as the bodies of deceased human beings used for purposes of learning anatomy and surgery, or for research.

Cadaveric dissection plays a vital role in the Anatomy curricula in various parts of the world. Dissection helps in understanding the spatial relationships, textures, consistencies and anomalies in various body organs and structures, and helps in providing a clear picture of human anatomy. It is of particular significance for surgical trainees who may practice complex procedures on the cadaver before operating on a patient. Cadavers have thus remained important for learning anatomy and surgery.

A Brief Timeline of Unethical Sources of Cadavers

From c.300 BC to early 17th Century, executed persons' and grave-robbed bodies were the only source for dissection [1]. Academic dissections were frequently fully public and thus became a great dishonor for the dissected and their families as the dissection was felt to ''violate [d] both its [the corpses] personhood and its social identity by rendering it unrecognizable and unsuitable it for a conventional funeral'' [2]. Due to this stigma associated with cadaveric dissection, instead of addressing this issue of much sensitivity, various governments of the early 17th Century Europe used dissection in a death sentence in addition to capital punishment[1], making dissection of the convict's body after execution a much more ignoble punishment than capital punishment itself as considered by many at that point in time [3]. In the early 18th century, unclaimed bodies of "paupers", inmates of prisons, psychiatric and charitable hospitals became a source for cadavers [4]. By the end of 18th Century, any unclaimed bodies were used for purposes of dissection [5]. The most glaring example of unethical practice in anatomical dissection in the 20th Century perhaps was the directive of the Ministry of Education of the Third Reich of Germany (1939) to deliver bodies of all the executed to nearby anatomy departments.

Cadaver: A Grey Entity in Bioethics

Various ethical dilemmas shroud cadavers, especially with respect to their procurement and dissection. A number of questions come to surface when ethical treatment of cadavers is considered.

(1) Autonomy versus Anatomical knowledge?

Until late 1960s, no consideration to autonomy of cadavers was given by many societies [6]. Later on, autonomy of the deceased and whether he/she was willing to donate his/her remains for dissection during life was considered. However, whether our knowledge of anatomy is a "trade-off" for the autonomy of the deceased is still questionable.

(2) Depriving proper final rites?

A cadaver, once dissected, ceases to remain in the intact form. Its identity is distorted and as such, the cadaver cannot be given a final resting place in intact form, which is considered by many societies to be a deprivation of final rites in a proper manner. This is true of certain Hindu communities in India and some other communities in the world, such as the Native Americans [7].

(3) Rich versus Poor?

The cadavers procured mostly belong to the socioeconomically deprived members of the region, as unclaimed bodies are still used in India and other parts of the world for purposes of dissection. It is questionable whether only the poor are required to provide us with fruits of anatomical knowledge and that the wealthy, who can afford to perform the final rites of their dead, are excluded from the purpose. Thus, it seems that the poor alone donate their mortal remains for the purpose of furthering our knowledge of anatomy and surgery.

(4) Breach of Privacy?

The Article 9 of the Universal Declaration on Bioethics and Human Rights upholds that the privacy and personal information of human subjects be respected [8]. However, we are unsure

whether this is also applicable to cadavers, as they are no more living persons. This dilemma is felt by those of us who routinely handle cadavers and as such dissection of cadaveric remains are performed in groups of students which may or may not be considered to be a breach of privacy.

(5) Respect for Human Life?

All of the concerns raised finally converge to one important question: Do we respect human life that is the very essence of the principles of Autonomy, Beneficence, Non Maleficence, Equity and Justice? This is a sensitive question, because we, the healthcare providers, who work for furthering health and improving patients' lives, must possess an inherent compassion and respect for human life as we strive throughout our careers for improving patients' health. Thus, it seems that cadavers have extrinsic value in that learning anatomy is facilitated by them, but the intrinsic value that they were once living human beings just like us is not to be forgotten.

These dilemmas have brought a change in modalities of teaching anatomy in some parts of the world. Various methods (quote them) have been used as to decrease or completely do away with cadaveric dissection from the curricula of anatomy in medical schools.

However, it is still believed that cadaveric dissection is the best means of learning anatomy and its pedagogical value trumps over the prejudice associated with it [9]. However, others have argued that these are only emotive arguments, which are yet unsubstantiated as far as evidence-based medicine is concerned [10]. In most of the world, however, it is still a practice of cadaveric dissection that holds a place of prominence in anatomy curricula, which also is true in India. Hence, we all need to treat the cadavers with dignity, a sense of gratitude, empathy and compassion.

The Cadaveric Oath

In order to imbibe the values of respect, empathy and compassion towards the cadaver, the Cadaveric Oath has been prescribed to be taken by first year medical students on the first day of their Anatomy class. While the exact wordings differ based on different settings, the following principles are the keystone of the Cadaveric oath [11]:

- Moral obligation to treat the human remains with respect and dignity
- Compassion and Gratitude towards the cadaver
- Gratitude to the next of the kin of the cadaver for their endeavor to serve selflessly
- To Emulate the act of the donor

The cadaveric oath serves as the first tool to teach Bioethics, as encounter with a cadaver in the anatomy dissection hall is one of the first incidents where the new healthcare student has the opportunity to learn ethical treatment of these human remains. It also facilitates to imbibe empathy, compassion, and respectfull treatment to the deceased in the minds of medical students which shows the path to "treating cadavers as people" and thus is the first step to good practice.

"Treating" the First Patient

Certain set of dissection room etiquettes are of much significance when handling and dissecting human remains because a thin line separates ethical from unethical conduct. Students sometimes mock the expression of the cadavers and try to improperly treat them. These innocent errors must be avoided, as they may develop into a trait to mistreat the cadaveric remains. Also,

photography is not to be done unless required for scientific and/or learning purposes, and when done, must not reveal the identity of the deceased. No misdemeanor is vital for respecting the remains. Dissection is to be performed only for learning; no mutilation to be resorted to. Defaulters must be duly penalized. Covering the parts not being dissected with gauze is important to preserve the remains and to protect the dignity of the dead. Dissecting only under the supervision of the tutors is also necessary so that the anatomical aspect is equally appreciated by the students as the teachers, which is the ultimate aim of cadaveric dissection.

The "Great Teacher"

One solution to the current ethical dilemmas that have limited cadaveric dissection can be learnt from the example of Thailand. In Thailand, the sole source for cadavers is body donation.[12] Cadavers are regarded as "Ajarn Yai" [12] (the Great Teacher in Thai language) and immensely respected for their unselfish donation of their bodies after death. Students know the name, medical history and cause of death of the 'Ajarn Yai' which helps build empathy, compassion and understanding of students and develop a bond with his/her Ajarn Yai. Elaborate Dedication & Cremation ceremonies according to Buddhist rituals take place and the remains are cremated after the course of dissection is over. This presents a moral aspect in that cadavers are treated as teachers rather than as patients.

Life after Death: A Conclusion

Body donation must be encouraged as it is the only ethical means of procuring cadavers. Body donation units must be established in all medical schools and hospitals which work with cadavers routinely, to overlook whether the procedures of cadaver procurement, study and final rites are being carried out in an ethical manner. Whether cadavers are the best modality for learning anatomy as held by many is yet debatable, in the centers where cadaveric dissection is a part of the curriculum, cadavers must be treated with due care, dignity and compassion. The Cadaveric Oath is the first tool for teaching Bioethics and also imbibing altruism and respect for the deceased in the minds of the students. Etiquettes in dissection room are of great significance in shaping the mindset of medical students to become doctors of good moral fiber and the ones who respect human life.

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Original Research Paper

Physician challenges in medical error disclosure – a case study in undergraduate medical student education

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ABSTRACT

Background: Medical error is a mistake committed by health professionals which results in harm to the patient. Medical errors can occur due to wrong diagnosis, error in administration of drugs, error in performance of surgical procedures, error in the use of equipment or misinterpretation of laboratory findings. When medical errors occur, the most common dilemma faced by doctors is whether to disclose the error to the patient. Physicians often conceal the error due to fear of negative consequences. If medical error disclosures are handled well - patient trust in physician could increase, can be used to improve processes (enhance patient safety) and prevent lawsuit on the hospital.

Methodology: Undergarduate medical students were taught a step-wise communication process to handle disclosure of medical errors after watching role play videos depicting disclosure conversations. The role play videos depicted the wrong way and the right way of disclosure conversation. A survey was taken to assess the attitude and perception of the students after teaching about communication process. Students answered questions related to three case scenarios. For each question, three response scripts represented increasing amounts of information (no disclosure, partial disclosure, full disclosure) was taken. Principles of bioethics that are violated due to non-disclosure of medical errors were discussed.

Results: About 98% of students disclosed medical errors to the patients (partial or full disclosure).It was challenging to make a disclosure conversation after an error occurred. Students voiced the need for teaching communication skills for disclosure of medical errors in the medical curriculum.

Conclusions: While disclosure of medical error was felt important, in view of the principles of beneficence, non-maleficence and patient's autonomy, it was difficult to do so. Complete medical error disclosure should be managed as a group (health care team) process.

Key words: Medical errors, disclosure, doctor-patient relationship, bioethics principles, patient safety

Introduction

Medical care can be double-edged sword. While doctors can save lives, they can also end up harming patients. In 1999,the Institute of Medicine published a report " To Err is Human:

Building a Safer Health system that estimated that as many as 98,000 patients in the United States die each year from preventable medical errors [1-2].

Making a mistake or causing an adverse outcome is perhaps the most devastating experience a clinician can have. Medical error is a mistake committed by health professionals which results in harm to the patient [3]. Medical errors can occur due to wrong diagnosis, error in administration of drugs, error in performance of surgical procedures, error in the use of equipment or misinterpretation of laboratory findings. When medical error occurs the most common dilemma faced by doctors is whether or not to disclose the error to the patient. Physicians often conceal the error due to fear of negative consequences.[4]If medical error disclosures are handled well - patient trust in physician could increase, can be used to improve processes (enhance patient safety) and prevent lawsuit on the hospital.

The doctor-patient relationship is fiduciary and is built on trust and truth telling. However as healthcare professionals one need to acknowledge that humans can commit errors and anticipate that errors can happen. A physician who has committed a medical error often faces an ethical dilemma as to how to disclose his/her mistake or whether to disclose or not his mistake [5]. The challenge of medical error disclosure is how to communicate the mistake to the patients family in a transparent way [6].
Healthcare professionals are ethically obligated to disclose information, to ensure understanding, and to allow for adequate decision making [7-8]. Disclosure of error to the patient will enhance the trust in physician and prevent law suit on to the hospital. Along with this, disclosure to the hospital management will help to improve processes and reduce errors in the future.

The undergraduate medical curriculum in India seldom teaches the process of medical error disclosure during their training. To ensure patient safety and patient care, medical students should be taught the communication process of medical error disclosure to patients and their families. Frequent trainings will ensure less medication errors in clinical practice and will help the medical student to be prepared when handling medical errors in real life situation. It is important to inculcate positive disclosure attitudes early in the medical education process [9].

This study was undertaken in second year undergraduate medical students with the following objectives.

1. Create awareness about reporting medical errors
2. Understand the principles of bioethics violated in Non disclosure of Medical Errors
3. Teach undergraduate medical students communication process of handling medical error disclosure to patients and relatives.

METHODOLOGY

Seventy nine II MBBS students participated in the study. Participation in the study was voluntary. The concept and ethical dilemmas faced during medical error disclosure was briefed to the students. Trainees learn disclosure skills through direct observation of supervising physicians [10].

Students watched role play videos of two scenarios each of which centred around a medical error and each of which showed a disclosure conversation with the patient's family [11].First the wrong way of disclosure was shown followed by a second video showing the correct way of disclosure. A senior physician of the team led the disclosure conversation.
Students were told to think what has gone wrong in the conversation and what could have been done better. The video showed an elderly patient admitted to an hospital who required a central line to be put in the neck. However, the intern who did the procedure, nicked the apex of the lung, giving a pneumothorax to the patient and further complications.

The role play video was followed by a discussion to highlight the key points in medical error disclosure. A step wise disclosure process was discussed.

Step wise Disclosure Conversation Process [11-12]

The most important principle in medical error disclosure is to remember that it is a disclosure process and not an event.

The first step after a medical error has occurred is to prepare ourselves to disclose the error.

Common emotional responses

There will be common emotional responses of fear, guilt, shame, sense of failure and isolation. Physicians need support in working through their own emotions and responses. It is important to get a personal handle over our emotions so that we don't walk in the room with the emotions and distract from our most important mission i.e. to be there for the patient. We are taught to be healers and there is not enough training on human factors. We are human and that we can make errors. It is important to anticipate the errors and devise a system to minimise the errors. We should acknowledge our feelings and if we don't it may negatively impact our relation with the patient. Feeling of fear, of loss of reputation, feeling alone which may be exacerbated by our colleagues' reaction, judging each other when things have gone wrong can come in the way of our explicit expression of the medical error to the patient. Medical error disclosure is a team effort. The conversation should be led by the senior most physician. Expression of empathy should come very naturally to the physician.

Preparing for the conversation

Second important step is to set up the meeting with the patients family so that it is private, not distracted and totally focussed. Choose a private room for the disclosure conversation. Take along people with whom the patient has developed a relationship during his treatment. It could be the nurse, pharmacist or intern. It is important to address the family as a team.

Communicate the facts clearly. Sit down in front of the family and make eye contact. Be clear as to what happened. Most important challenge is to translate the facts into non-jargon and not rushing through an explanation. Physician should speak in a clear language which is understandable for the patient and his family.

Do not speculate

One may have only part of the information about what happened. It is important to avoid speculation. It is like saying I think you have A but you may also have B or C. This should be avoided as it creates more confusion and is destructive for the doctor-patient relationship. One has to be mindful about creating the sense of trust. If you don't know the answer to the questions, say you don't know and say you will get back.

Allow patient to express feelings.

There is a natural tendency to get out of the situation as soon as possible. It may happen one may rush the conversation. It is important to allow the patient to express his/her feelings. We always hope that the patient would say its ok and that they forgive the doctor. It is not the patient's job to forgive the doctor. But if they forgive, it should be considered a gift. It is important for patient to ask questions. If we wait for questions, patient may not ask them as patient may be feeling intimidated. Therefore it is important to ask if they have any questions. We cannot control patient's reaction. As doctors we have to control our emotions.

Express Empathy and Apology

It is important to express empathy and say "I am sorry that this happened". Apologies may help deter legal action and promote more effective settlements. Physicians need to respond to medical errors with an apology. However, apologies should be used with caution. Apologies that accept responsibility are more effective than similar expressions that simply express sympathy [13].

Learning from the Medical Error

As an institution it is important to learn from medical errors that have happened. It is important to have team reflections about what was learnt from the disclosure. Did we do the disclosure conversation the right way and how it can be improved.

Physician support

Disclosure coaching and peer support are useful to help prepare for disclosure conversation so that we learn to present in a compassionate way to patient about our accountability, improving patient safety and quality in future.

Avoid Common Pitfalls

There are some pitfalls that we fall into as clinicians. It is important that we do not over blame ourselves or blame others for the medical error that happened. It is very natural for us to do this when facing our own fallibility. It's a difficult moment when instead of making patient feel better we make them feel worse. When we blame ourselves excessively it is like asking for forgiveness from the patient's family unconsiocusly. It is important not to blame ourselves unless we know for sure we are to be blamed. Another problem is to avoid using jargons and lacking expression of empathy.

The goal of medical error disclosure conversation is to have the discussion in a compassionate and transparent way regarding what happened to the patient. It is important recognizing we have emotions that will make us vulnerable to be not expressing that compassion in a way that the patients can feel. Identifying our own emotions and not walking into the room with those emotions requires preparation. Being very explicit about being empathic in our language, posture and behaviour, stating facts in a clear way that does not allow jargon is important. Allowing patient to express his emotions, welcoming questions from patients, not overblaming, expressing empathy, apologising clearly and making sure that this is a process and that you are available for further questions and as an institution you have learnt from the error is very important. You should get back to patient when you have more information and make sure you follow that promise.

To test the attitude towards medical error disclosure students answered a survey questionnaire on three case scenarios (Table 1) after watching the video and following the discussion.

The Survey Questionnaire focussed on four questions mainly

1. How likely would you be to disclose this error to the patient?
2. What would you most likely say about what happened?
3. What most closely resembles what you would say about the cause of the error?
4. What would you most likely say regarding an apology?

For each question, three response scripts represented increasing amounts of information (no disclosure, partial disclosure, full disclosure). The text of these responses has been published previously [14].

RESULTS

The results of the survey are in the table below (Table 2)

Disclosure content

Respondents varied widely in the information they would disclose to patients. Overall, 79% of students chose statements explicitly stating that an error had occurred, whereas 19% mentioned the adverse event but not the error (Table 2). When asked how they would describe the cause of the error, 36% chose a specific description of exactly what the error was, 56% offered non- specific information, and 8% said they would not volunteer any explanation unless asked.

Table 1 – The Case Scenarios

Case Scenario	Description
Insulin overdose	You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a 0. The following morning, the patient is given 100 U of insulin, 10 times the patient's normal dose, and is later found unresponsive, with a serum glucose level of 35 mg/dL (1.94 mmol/L). The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.
Hyperkalemia	You administer a new medicine with a common adverse effect of increasing the potassium level to an outpatient with hypertension. The patient's baseline potassium level is normal (4.0 mEq/L). You order a repeat blood test to measure potassium level, to be drawn the next week, but forget to check the laboratory results. Two weeks after the patient begins taking this new medicine, the patient starts feeling palpitations and goes to the emergency department. In the emergency department, the patient experiences an episode of ventricular tachycardia, requiring cardioversion. The patient's potassium level at this event is 7.5 mEq/L. The patient is hospitalized for 4 days, and makes a full recovery. The patient returns to your office for a follow-up visit. On reviewing the patient's chart, you see the overlooked laboratory results, which showed the patient's potassium level had increased substantially from 4.0 to 5.6 mEq/L. Had you seen this elevated potassium level earlier, you would have discontinued the new medicine and treated the hyperkalemia, likely avoiding the life-threatening arrhythmia.
Retained Sponge	You are seeing a patient 3 weeks after elective splenectomy for ITP. The splenectomy was technically challenging because of the patient's obesity, but seemed uncomplicated. At this follow-up visit, the patient complains of vague persistent LUQ pain. You send the patient for an abdominal x-ray film, which shows a foreign body consistent with a retained surgical sponge in the patient's LUQ. You remember that the sponge count was correct at the end of the procedure. However, you also remember that you packed off a small bleeding vessel near the stomach with a sponge, and do not recall removing this sponge. When you review the postoperative records, you observe that a math error was responsible for a falsely correct sponge count. You believe a subsequent operation to remove the retained sponge is indicated, and expect the patient will make a full recovery.

RESULTS

Type of disclosure	**Insulin Overdose**	**Hyperkalemia**	**Retained Sponge**
No of participants	N=79(%)	N=79(%)	N=79(%)
	How likely would you be to disclose this error to the patient?		
No disclosure (no reference to adverse event or error)	I would definitely not disclose this error 0 (0%)	I would definitely not disclose this error 2 (3%)	I would definitely not disclose this error 3 (4%)
Partial Disclosure (mentioned adverse event but no error)	I would disclose this error only if asked by the patient 17 (22%)	I would disclose this error only if asked by the patient 17 (22%)	I would disclose this error only if asked by the patient 11 (14%)
Full Disclosure (explicit statement that error occurred)	I would definitely disclose this error 62 (78%)	I would definitely disclose this error 60 (77%)	I would definitely disclose this error 65 (82%)
	What would you most likely say about what happened		
No disclosure (no reference to adverse event or error)	Your blood sugar went too low and you passed out. 3 (4%)	Your potassium level got too high, which led to a dangerous heart rhythm. 5 (6%)	The x-ray showed an abnormality that could be serious. Another operation will be required to investigate and correct this problem. 4 (5%)
Partial Disclosure (mention adverse event but not error)	Your blood sugar went too low because you received more insulin than you needed. 9 (11%)	The new medicine we started caused your potassium level to become too high, which led to a dangerous heart rhythm. 23 (29%)	During the surgery, a sponge was inadvertently left in your abdomen. Another operation will be required to remove the sponge. 11 (14%)
Full Disclosure (explicit statement that error occurred)	Your blood sugar went too low because an error happened and you received too much insulin. 67 (85%)	You had a dangerous heart rhythm because an error happened and we did not notice that the new medicine had caused your potassium to become too high. 51 (65%)	We will have to do another operation because an error happened and a sponge was left in your abdomen. 64 (81%)

	What most closely resembles what you would say about the cause of the error?		
No Disclosure (no information volunteered about cause of error)	I would not volunteer a cause of the error unless the patient asked me. 4 (5%)	I would not volunteer a cause of the error unless the patient asked me. 10 (13%)	I would not volunteer a cause of the error unless the patient asked me. 5 (6 %)
Partial Disclosure (non-specific information hinting at cause)	This occurred because of a miscommunication about your insulin order. 43 (54%)	This occurred because of a mix-up regarding your laboratory results. 55 (70%)	This occurred because of a problem with the sponge count. 35 (44%)
Full Disclosure (detailed description of why error happened)	My handwriting is sometimes difficult to read. I wrote your order for "10 U" of insulin and the "U" looked like a "0." Therefore, you received 100 units of insulin instead of 10. This also slipped by our nurse and pharmacist. 32 (41%)	I did not remember to check the results of the laboratory tests you had drawn the week after you started the new medicine. The laboratory and the nurse also did not notify me about the high potassium. 14 (18%)	This occurred because I forgot that I had put a sponge deep in your abdomen to control some bleeding. Also, the sponge count was done incorrectly, so I was unaware that not all the sponges had been removed. 39 (49%)
	What would you most likely say regarding an apology?		
No Disclosure (No apology)	I would not volunteer that I was sorry or apologize. 1 (1%)	I would not volunteer that I was sorry or apologize. 5 (6%)	I would not volunteer that I was sorry or apologize. 3 (4%)
Partial Disclosure (expression of regret)	I am sorry about what happened. 35 (44%)	I am sorry about what happened. 27 (34%)	I am sorry about what happened. 28 (35%)
Full Disclosure (explicit apology)	I am so sorry that you were harmed by this error. 43 (54%)	I am so sorry that you were harmed by this error. 47 (60%)	I am so sorry that you were harmed by this error. 48 (61%)

Among the 79 students who indicated they would definitely disclose the error, many limited disclosure content (79% described the error as an adverse event and 21% made partial or no disclosure of the cause of the error). Nearly all students (96%) would offer some form of apology, but students were split between conveying a general expression of regret (38%) and making an explicit apology (58%).

Limitations of the survey

The study revealed that in hypothetical situations, 98% of students were willing to disclose medical errors, however in real life situations it may not be so. Although physicians believe that medical errors should be disclosed to patients and their families, they often hesitate to do so. The survey was restricted only to medical students.

Principles of Bioethics and Non disclosure of medical errors [15-16]

The principles of bioethics that are violated in non-disclosure of medical errors was discussed with students. By not disclosing a medical error, the doctor conspicuously places his own interests above that of the patient to the detriment of the patient, thereby violating a patient-centered ethical principle.

DISCUSSION

Disclosing medical errors to patients have ethical rationales such as informed consent, truth-telling, justice and fairness [15]. If a doctor conceals a medical error, he's violating the principles of bioethics. According to the principle of autonomy it is patient's right to have full information about the treatment and any error if occurred. Physicians tend to hide the error when patient do not ask about it, and this is referred as deceptive approach .Principle of autonomy supports truth telling therefore, disclosure of fact with the patient is highly justified. Deceiving patients interferes with the doctrine of informed consent since patients may not understand the reason or need for additional interventions or a longer hospital stay that becomes necessary as a means of rectifying an undisclosed error. It is therefore important to disclose errors in order to respect autonomy and facilitate the giving of informed consent.

The principle of beneficence in medical practice refers to avoid and prevent error by doing well. Failing to disclose a medical error that has occurred to a patient and letting the patient assume that what he or she is going through is due to the disease is unkind and violates the principle of beneficence. On the other hand, the patient's knowledge and understanding that a mistake or error has occurred may relieve anxiety about slow recovery or complications and will certainly bring benefits.

The principle of non-maleficence emphasizes that one should not cause harm to oneself and others. When patients come to a health care system to seek care, they trust the system and health care providers. They expect competency and believe that physician will provide the best treatment in accordance with the principle of beneficence. As a moral obligation, the principle of beneficence guides us to remove condition that will harm others, and prevent harm from occurring to others .Although an error may harm a patient, failure to disclose the error to the patient makes the situation worse. A patient may worry needlessly about his or her prolonged stay or worsening condition thinking it is a result of the underlying disease. Knowing that what is happening is a result of an error that occurred may prevent this psychological distress from impacting negatively on the patient's condition. Informing the patient about the mistake and letting him or her know about the necessary steps taken to reduce the harm and prevent further occurrence of such errors [17].

The justice ethical principle ensures that patients are treated equitably, and the benefits and burdens of treatments are fairly distributed and communicated. Patients should get what they are owed or what they deserve. The principle of justice therefore dictates disclosure of an error in order to ensure compensation to patients. Patients may be owed compensation for increased health care costs or lost wages in addition to an apology, which nearly all patients demand as the minimum. More specifically, healthcare professionals have an ethical obligation to ensure that the distribution of medical resources to patients would not lead to unanticipated medical errors [18].

There are numerous challenges while disclosing medical errors. Medical errors are not usually the fault of a single person delivering health care but due to a flawed system [19]. Changing systems is more complex than punishing a person who makes an error. Fixing flaws in the system is the only way to prevent the same errors from happening over and over again.

Medical institutions have been slow to change their systems because doing so requires at least three things:

1. Admitting that errors are made
2. Communicating the errors to patients and families, throughout the institution and, often, to the media
3. Suffering the uncertain consequences of an error's disclosure, which are commonly thought to include malpractice lawsuits.

There needs to be a culture where individuals do not feel penalized for reporting errors [20]. Moral courage is needed if doctors are to do the right thing when medical errors occur. This moral courage can be facilitated by institutions having policies and guidelines on disclosure of errors in place, training doctors and other hospital staff on how to disclose medical errors and providing emotional support for doctors who make mistakes in their efforts to treat patients and save lives [20].

CONCLUSION

From the case study it can be concluded that medical students will face the ethical dilemma of medical error disclosure during their training and in clinical practice. Because of no training during the undergraduate curriculum, students face distressing challenges when faced with medical error disclosure which compels them to conceal errors. This further affects the doctor-patient relationship and the healthcare system.
Therefore formal teaching of medical error disclosure in a transparent way during the undergraduate medical training is greatly needed. Ongoing teaching of medical students on importance of disclosure and developing communication skills will help prepare the students in handling medical error disclosure.

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Letter to the Editor

Auto Euthanasia Request: An Ethical and Moral Dilemma

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National Faculty, 3T Training Programme of the UNESCO Chair in Bioethics

Respected Sir,

This letter provides the ethical and clinical elaboration of auto-euthanasia in elderly couples, a previously unexplored phenomenon in the Indian perspective. A couple undergoing treatment for geriatric depression with a psychiatrist strongly wish to die together at a self-directed moment, despite not suffering from a life-threatening disease but having moderate depression. The couple was living by themselves and all the children are abroad.
Auto-euthanasia with self-determination and a wish to die is presented here in light of geriatric mental health issues. The decision to end life is largely based on the anticipatory fear of further deterioration and no help available as well as how one would live without the other depending on whose death occurs first. The couple's need for auto-euthanasia was an obstacle that had to be overcome and their concerns differed from the concerns voiced by the treating psychiatrist. The role of depression in leading to their need for auto-euthanasia is also questioned. Various clinical and ethical issues are elucidated that a treating doctor may encounter when working with such cases [1].

Double self-euthanasia is a term (or double auto-euthanasia) is a term used to refers to a couple's intentional act to end his or her life independently; based on a persistent wish to die; decided after careful consideration; implemented in a careful manner and associated with self-deliverance, self-determination, reasonability, rationality, and dispassion [1].

This case explores the complex clinical and ethical issues that surround a case of an elderly couple wishing to engage in spousal self-euthanasia on grounds that they had lived their life and that life was not worth living any more. The strongly desired to die at a predetermined time and moment though they did not suffer from any life threatening disorder except moderate depression [1].

Key Issues that Came Up in the Clinical Interview

- Both had reached a state of embodiment where they felt threatened by their own bodies [2].
- Both had reached a temporal impasse where they did not wish to deteriorate further.
- They were both socially and emotionally empty and full at the same time – a rare feat.

- Two individuals with highly intertwined lives were the subjects involved here.
- Concept of emotional emptiness and concept of self-identity in both the members needed further exploration.
- There was also a strong sense of feeling complete in their lives.
- No pressure or coercion present in their request.
- Both were mentally competent and denied that their actions were as a result of depression - but how could one assess and explain this clinically.
- Both were fully aware of the emotional implications of such a decision and wanted to discuss the same with their children.
- A self-appointed time of death seen as a way of regaining full control on their life.
- The need for the doctor to distinguish between suicidal thoughts in depression and pure death wishes is paramount in this case.
- Does one have the right to end one's life the way he or she wants to – is the eternal ethical and moral question ?
- Should this phenomenon looked at clinically or should we also assess the existential and phenomenological aspects in addition to the ethical aspects ?
- What role does the treating doctor and psychiatrist play in this case and the ethico-legal implications in such cases.
- These and many such issues shall come up in the future when more such cases may come to a treating doctor for advice or opinion [3].

Yours sincerely,
Dr. Avinash De Sousa

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