Print ISSN 2207-7715
Online ISSN 2207-7723

UNESCO Chair in Bioethics (Haifa)

United Nations Educational, Scientific and Cultural Organization

Global Bioethics Enquiry

The Scholarly Publication of the UNESCO Chair in Bioethics

Volume 7, Issue 2
SEPTEMBER 2019

The scholarly publication of the UNESCO chair of Bioethics

GLOBAL BIOETHICS ENQUIRY

Issue 7 (2)

September 2019

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics (Haifa)

Editorial Board

TABLE OF CONTENTS

Editorial

Ethics of Rational Polypharmacy in Psychiatry

Reetika Dikshit[1] Avinash De Sousa[2], Russell D'Souza[3]

[1]Assistant Professor,
[2]Research Associate
[1,2]Department of Psychiatry, Lokmanya Tilak Municipal Medical College, Mumbai.
[3]Director and Head, Asia-Pacific UNESCO Chair in Bioethics, Haifa.
Corresponding Author: Avinash De Sousa
E-mail: avinashdes888@gmail.com

INTRODUCTION

Psychiatric polypharmacy refers to the prescription of two or more psychiatric medications concurrently to a patient. The basis for this definition is solely quantitative and does not take into account the clinical pertinence of the use of these medications (for example, the presence of multiple diseases) or the adequacy of the proposed therapeutic regimen [1]. The term polypharmacy suggests that more medication is being used than is 'clinically indicated.' The number of medications that constitute polypharmacy however, has not been defined in the available literature [2].
The commonly used definition of psychiatric polypharmacy is the use of two or more psychiatric medications in the same patient, [3] or using two or more medications (of the same chemical class or same pharmacologic actions) to treat the same condition [4].

TYPES OF POLYPHARMACY

Due to the increasing prevalence and complexity in psychiatric polypharmacy, it is categorized as follows:

1. **Same-Class Polypharmacy:** refers to the use of more than one medication from the same class (e.g. use of two selective serotonin reuptake inhibitors in a case of depression).
2. **Multi-Class Polypharmacy:** is the use of full therapeutic doses of more than one medication from different classes for the same symptom cluster (e.g. use of valproate along with an atypical antipsychotic, such as olanzapine, for treatment of mania).
3. **Adjunctive Polypharmacy:** Use of one medication to treat the side effects of another medication from a different class, is described as Adjunctive Polypharmacy (e.g. using trazodone for insomnia caused by bupropion).
4. **Augmentation Polypharmacy:** refers to the use of one medication at a lower than normal dose along with another medication from a different class in full therapeutic dose for the same symptom cluster (e.g. addition of low dose haloperidol in a patient responding partially to risperidone); or the addition of a medication that would not be used alone for the same symptom cluster (e.g. augmentation of antidepressants with lithium or thyroid hormone).
5. **Total Polypharmacy:** is the total count of medications used in a patient, or total drug load. [3]

IS POLYPHARMACY REQUIRED IN PSYCHIATRY

The practicing guidelines promotes synergistic drug combinations. Majority of psychiatric patients benefit from synergistic use of drugs; they are also essential in achieving and maintaining recovery. In clinical practice it is very difficult to achieve remission or recovery with monotherapy. So, the use of polypharmacy in psychiatry is rational [5]. Irrational polypharmacy includes clinicians fear

about poor and unstable state of patient, sloppy diagnosis, stuck in cross titration of drugs, blind adherence to specifications of guidelines, inadequate knowledge of receptor pharmacology or a lack of attention to it [6].
Rational polypharmacy combines drugs with synergistic therapeutic effects between the drugs. Multiple drugs with each for a specific target symptom. Each evaluated individually for efficacy and side effects and adjusted optimally. Elimination of each one that is no longer necessary [5].

Polypharmacy contributory factors:

1. **Patient related:** Age, Multiple comorbidity, Intellectual disability, Acute hospitalisation.
2. **Healthcare related:** Multiple providers, Medication errors
3. **Doctor related:** Untreated medical problem, Improper medication selection, Medication use with no selection

ETHICAL ISSUES IN PSYCHIATRIC POLYPHARMACY

The objectives of ethics of polypharmacy in Psychiatry are –

Informed consent
Medical paternalism implies seeking consultation = consent for treatment. Considering patients right a greater emphasis should lay upon conveying nature of illness, treatment options available and freedom to choose. Consumer protection compels the medical professional to provide a detailed information for their own protection. The Constituents of an Informed consent are –

- Information to be provided by psychiatrist
- Competence of patient to comprehend information provided
- Freedom to choose
- Liberty to ask and further clarification/information and to withdraw the consent whenever patient wants to.

In such situations, prescribing rational polypharmacy can be challenging.

Voluntary and involuntary treatment
As psychiatric patients do not consider themselves to be ill, they have to be treated against their will. They should be evaluated on principle of beneficence As soon as conditions requiring compulsory treatment are no longer required the consent for continuation of medicines from patient should be taken. Psychiatric treatments shall be initiated only on clinical considerations and shall be in accordance with scientific knowledge and professional ethics. The patient's welfare should be the primary factor determining the choice of treatment modality.

Respect for patients and his human rights
Each patient has to be respected as an individual and the aim of treatment should be towards an early restoration of the functioning of the individual. Nothing should be done which could be perceived as violation of human rights of the individual. Every treatment method should be in conformity with the basic human rights, polypharmacy may produce adverse reactions and hence the use can be challenging.

Third party responsibility
In modern era, medical treatment has no longer remained within the confines of doctor-patient relationship. Many external agencies influence both content and form of treatment eg. Insurance companies, caregivers, NGO. In India, where most treatment facilities are government funded the ability of drugs and number of trained personnel could be main factors affecting the decision making of treatment. However, pharmaceutical companies are also nowadays indirectly influencing the treatment decisions. This can hamper the decisions made for the use of polypharmacy.

Psychiatric research

When research involves human-beings certain safeguards are a must. The Helsinki declaration provides the guidelines for use of human subjects in research. Any research that does not benefit the patient should not be undertaken. The role of polypharmacy in research is till date debatable.

REFERENCES

1. Rollason V, Vogt N. Reduction of polypharmacy in the elderly: A systematic review of the role of the pharmacist. Drugs Aging 2003;20:817–32.
2. Linjakumpu T, Hartikainen S, Klaukka T, Veijola J, Kivelä SL, Isoaho R. Use of medications and polypharmacy are increasing among the elderly. J Clin Epidemiol 2002;55:809–17.
3. Medical Directors Council and State Medicaid Directors. Alexandria, Virginia: 2001. National Association of State Mental Health Program Directors: Technical Report on Psychiatric Polypharmacy.
4. Kingsbury SJ, Yi D, Simpson GM. Psychopharmacology: rational and irrational polypharmacy. Psychiatr Serv 2001;52:1033–6.
5. Jakovljević M .How to increase treatment effectiveness and efficiency in psychiatry: Creative Psychopharmacotherapy. Psychiatr Danub 2013;25(3):269-73.
6. Kingsbury SJ, Yi D, Simpson GM. Psychopharmacology: rational and irrational polypharmacy. Psychiatr Serv 2001;52(8):1033-6.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Review Paper

Importance of Ethics in Drug Advertising

Chitra Khanwelkar[1], Vivek Phirke[2], Poovishnu Devi T.[3], Sujata Jadhav[1], Vandana Thorat[1].

[1]Department of Pharmacology, Krishna Institute of Medical Sciences, KIMSDU, Karad
[2]Cognizant Technology Solutions
[3]Krishna College of Physiotherapy, KIMSDU, Karad.
Corresponding Author: Chitra Khanwelkar
E-mail: hodpharmacology@kimsuniversity.in

ABSTRACT

The drug promotional literatures are used as one of the source of drug information by a busy practitioner due to time constraint. The information in these literatures should be unbiased, factual, evidence based and non-misleading; otherwise the prescriber's choice of drug may get influenced. The doctors should develop an art of critically evaluating the promotional literatures. Direct to consumer advertising of drugs should be stringently controlled by the regulatory authorities so as to increase safe use of drugs.

Keywords: Drug promotional literature, WHO guidelines, Ethics, DTCA.

INTRODUCTION

Unbiased sources of drug information play a vital role in any physician's clinical practice. After graduation from medical school, the practicing doctor can get information from text books, scientific journals, conferences, continued medical education programs, Drug Indices, Pharmacopoeias, Drug Compendia, Internet. Though all these sources are authentic, they have their inbuilt shortcomings. Text books are revised only once in few years and may not contain information of new approved drugs. Pharmacopoeia contains lot of other information like purity, ingredients etc. Internet is having lot of information and due to pro and anti information about a single molecule; the prescriber might get confused or might get unnecessarily influenced. Considering the busy schedules of practicing doctors in country like India, the prescriber use the information given by pharmaceutical companies through medical representative's visits, drug promotional literature in form of leaflets, booklets, videos, models etc; for deciding choice of drug to be prescribed. The prescribers are tempted to believe the information blindly and this is boosted by gifts and perks offered to them by companies. Though information obtained from these literatures cannot be said to be completely unscientific and false, to some extent it can be misleading, biased and may be hiding few facts, because ultimately, they are prepared to enhance sell of that medicine.

The World Health Organization has set guidelines for ethical promotion of drugs [1]. In India standards are set by Organization of Pharmaceutical Producers of India (OPPI) [2] adhering to guidelines given by The International Federation of Pharmaceutical Manufacturers and

Association (IFPMA). But unfortunately, all these guidelines are not followed or implemented effectively in India and many other developing countries.

ETHICAL ISSUES IN DRUG ADVERTISEMENTS

There are many objections raised about ethical behavior and factual information provided pertaining to the drug advertisements and promotional drug literatures –

1. The promotional drug literatures are printed on very glossy papers and have very attractive photographs, pictures. Actually, this should not be an ethical issue, as the very purpose of these advertisements is commercial and to attract the prescriber. But printing unrelated pictures like beautiful smiling face of a girl or a film artist on a vitamin supplement preparation/ hematinic product advertisement, printing famous athlete's photo on calcium supplement, a giraffe picture on baby food can be called misleading. Few advertisements give wrong ideas about efficacy of drug. e.g. In the advertisement of an analgesic, an old patient of knee joint arthritis is shown running in marathon after taking drug. All these attracting techniques should not influence prescriber's choice of drug, as the prescriber needs to be learned and expected to think scientifically. Such advertising gimmicks will definitely influence the lay person and therefore they are objectionable in direct to consumer advertising (DTCA) of drugs.
2. **Printing exaggerated claims about effect and potency of that product:** It is objectionable and misleading if there are claims like 'The best among all', 'First line', 'Safest', 'First choice of physicians' etc. Sometimes the claims are not only exaggerated but are false also. In a study about evaluation of drug promotional literature (DPL) provided by medical representatives at a tertiary care hospital in India; 61.3% DPLs had at least one claim. The authors reported many false claims, like multivitamin preparation has memory enhancer, Montelukast and fexofenadine as cardio safe, ofloxacin and cefixime as gold standard for acute uncomplicated urinary tract infection [3].
3. **No educational value:** The advertisement should contain information about indications, adverse effects, drug interactions, contraindications, dosage regimens of that medicinal substance as guided by WHO [1], but many advertisements give incomplete information. The indications and advantages are printed in bold and larger font and are eye catching. The adverse effects and interactions are most of the times very incompletely mentioned and in a very small font which is impossible to read for prescriber. This practice is very harmful for patients if doctors depend on DPLs as source of drug information. Few studies about validation of DPLs based on IFPMA guidelines and WHO guidelines report the deviation from these guidelines. Clinical indications were correctly mentioned in 51.85% DPLs in one study [4] and 94.7% in another [5]. The adverse reactions were completely mentioned only in 23.7% [3] and 14.7% [5] DPLs. Interactions mentioned in only 17.5% [3] and 6.7% [5] DPLs. Dosage regimens were given in 38.1% [3], 59.25% [4] and 42% [5] DPLs. It was surprising that in one study 42% DPLs were not having mention of pharmacological actions of drug [5].
4. **Playing with emotions:** Some advertisements particularly of nonprescription, OTC drugs give some emotional touch to the pictures or information. These drugs can be purchased by lay public from chemist shops. The consumer's choice of brand can get influenced by such advertisements. A prospective mother can purchase calcium, iron and vitamin preparations by getting influenced by picture showing breast feeding mother and a chubby baby. She can purchase a product which shows very emaciated baby and a tag line "You definitely don't want your baby to look like this". Here fear is created in her mind that if she does not take this drug her baby will become unhealthy. Another example is the advertisement of a lipid lowering drug showing a man getting severe chest pain suggestive of heart attack.
5. **Hiding of important information:** A rare but life-threatening adverse effect or interaction might not be printed in the literature. In a study done by Kothari Parli and others, 194 DPLs were evaluated. Significantly high % of DPLs had incomplete information about

adverse effects, safety precautions, contraindications and drug interactions [3]. This is highly unethical as this can lead to irrational prescribing.

6. **Lame scientific proofs and references:** Many a times to support the claims about efficacy, safety of the new molecule in comparison with existing old molecule, references of clinical trials are given. But if we see in detail, these are publications by same manufacturing pharmaceutical company. Sometimes out of context sentences picked from authentic textbooks are also printed on advertisements. This definitely creates false assurance about safety and efficacy of that product in the prescriber's mind. Many a times the quoted comparative studies are not valid studies. But mere mention of some study apparently increases credibility of study. In a study out of total 299 claims about superiority of drugs in DPLs only 75 claims were supported by references. Out of these 75 references 10 were not retrievable, 4 were from journal articles, 4 were from data file and 2 were from websites [6].
7. **Modified Graphs and charts:** In this era of evidence-based medicine, doctors get impressed if graphs are given in drug information, its authenticity increases. The unethical issue in this aspect is giving graphs having numerical distortion, improper X or Y axis, chart junks like presence of extra grid lines, color schemes to make readings of advertised drug more prominent. Thus, deceptive presentation of results may have prominent influence on prescriber's mind.
8. **Legibility of generic name:** Usually the brand name is highlighted by using dazzling colors and very big font size. The generic name of drug is many times in very small font. This definitely encourages brand prescribing. Now fortunately writing generic name in prescriptions is made mandatory by the regulatory authorities.
9. **Direct to consumer advertising (DTCA):** In India marketing of drugs is directed to doctors and DTCA is not allowed. Because of this advertising in public press, magazines, radio public gets information about diseases and they start approaching their doctors for that treatment. This increases the sale of the drug. Drug companies can powerfully touch important feelings of public like fear of death, value of own and loved one's life, fear of disability, vulnerability of age, gender. Though DTCA are not allowed in many countries, they definitely create public awareness about disease and availability of treatment and motivates patient to become active decision maker about own health. But in country like India and many other developing countries having uneducated population; either DTCA is dangerous or it may be wasteful also.

In India for nonprescription allopathic drugs and drugs of alternative medicinal systems (Unani, Ayurveda, Homeopathy) DTCA is not prevented. Advertisements of these drugs are released in newspapers, magazines, radio, television and internet. Most of these advertisements are violating the guidelines of WHO, IFPMA and OPPI. They are unscientifically presented like advertisements of the cosmetic products. Many film stars are involved as models in these. Mostly drugs recommended for obesity, hematinics, antitussives, drugs in erectile dysfunction, nutraceuticals, pain balms and purgatives are advertised like this. These advertisements are not mentioning generic names of drug, adverse effects, contraindications, interactions. False tall claims are freely made in these advertisements. People purchase and consume these drugs without consulting doctors. Ayurvedic preparations are found to contain non permissible levels of heavy metals. Few cases of chronic lead poisoning are reported where patients were taking some such products as medicine for diabetes. Another risk associated with use of such drugs is, patients get false assurance about taking treatment for the diabetes, hypertension etc. and they stop their allopathic prescribed medicine without consulting doctor. Due to this they might be losing control on blood sugar and blood pressure. Many interactions of these drugs with allopathic drugs are also documented. Thus, advertising of these drugs done without considering WHO guidelines may result into fatal consequences or morbidities in patients, unknowingly.

In a comparative study of drug advertisements in scientific journals it is reported that the fulfillment of the IFPMA criteria was significantly higher in non-Indian journals (mainly journals from the

United States and United Kingdom) than in Indian journals [7]. This clearly suggests that stringent control of regulatory authorities on DPLs in developing countries in required.

RESPONSIBILITY OF PRESCRIBERS

In this scenario the onus of rational prescribing lies on prescribers. They should take precaution while deciding about drugs to be prescribed. They can use information obtained from advertisements for getting knowledge about drugs, but should verify its authenticity. They should depend more on peer discussion, text books and authentic scientific journals. They should be able to read promotional literature critically and should develop scientific approach. They should realize the importance of time-tested new drugs and should remember that every new drug may not be better than the established one. As per Indian Medical Council (Professional Conduct, Etiquette and Ethics) Amendment Regulation 2009 part I, a medical practitioner shall not receive any gift, travel facility, hospitality from drug manufacturing company. Ethically this practice of drug companies is to be condemned by doctors as they feel compelled to prescribe a certain drug due to these obligations. The prescriber should be courageous about raising questions about false claims, wrong information in drug promotional literatures. Currently the students of medical schools are not given education about guidelines of drug advertising. Very few medical schools have a practical exercise dealing with critical appraisal of promotional drug literature.

Patients should take medicines only after consulting the doctors. They should not get tempted by the attractive claims in advertisements. Creating awareness about risks in self medication practices among society is very important step to be taken. The health professionals can contribute to this noble work. If pharmaceutical companies, prescribing doctors and patients play their roles ethically and responsibly, the rational use of drug will be enhanced and safety in use of drugs will be increased. This will consequently reduce economic burden on health care system of nation.

REFERENCES

1. Ethical Criteria for Medicinal Drug Promotion. Geneva: World Health Organization; 1988. Available from: http://www.who.int/medicinedocs/documents/whozip08e/whozip08e.pdf.
2. OPPI Code of Pharmaceutical Marketing Practices. Organization of Pharmaceutical Producers of India (OPPI); 2012. Available from http://www.indiaoppi.com/OPPI%20Code%20of%20Pharmaceutical%20Practices%20%20- %202012.pdf.
3. Parli K, Reema R, Devang R, Supriya M. Evaluation of promotional drug literature provided by medical representative at a tertiary care hospital. Int J Pharm Sci Res 2017;8(4):1744-50.
4. Shagupta A Naikwadi. Critical Analysis of Indian Drug Promotional Literature (DPL) Using World Health organization Criteria For Ethical Medicinal Drug Promotion. IOSR J Dental Med Sci 2017:1:49-54.
5. Hoovinahole S, Kamath A. A study of adherence of drug promotional literatures from various clinical specialties to the World Health Organization ethical criteria for drug promotion. J Pharm Negative Results 2016;7:37-41.
6. Jadhav SS, Dumatar CB, Dikshit RK. Drug promotional literatures (DPLs) evaluation as per World Health Organization (WHO) criteria. J Appl Pharmaceut Sci 2014;4(6):84-8.
7. Vachhani PM, Solanki MN, Desai MK. An evaluation of drug promotional literatures published in scientific medical journals. J Pharm Biol Sci 2016;8:248-52.

****

Acknowledgements: Nil
Funding: Nil
Conflict of interest: None

Original Research Paper

How To, or Not To Intervene – Some Ethical Dilemmas Encountered by Mental Health Professionals

Supreet Kaur Bhasin[1], Aditi Sharma[2], Triptish Bhatia[3], Smita N. Deshpande[4]

[1]University of Delhi
[2]Developmental Psychologist, Children First, Safdarjung Development Area, New Delhi
[3]Research Unit, Centre of Excellence in Mental Health, PGIMER-Dr. RML Hospital, New Delhi
[4]Professor & Senior Consultant, Centre of Excellence in Mental Health, PGIMER-Dr. RML Hospital, New Delhi
Corresponding Author: Smita Deshpande
E-mail: smitadeshp@gmail.com

ABSTRACT

Background: Indian mental health care professionals share some ethical concerns similar to those of their Western counterparts e.g. boundary violations, confidentiality issues, caregiving by multiple healthcare workers of varying competence, as well as additional issues around decisional autonomy, cultural issues around psychometric assessments and chiefly, hierarchical relationships with healthcare workers.
Methods: Authors (SKB, AS) shadowed young healthcare professionals across duties such as ward rounds, detailed history taking, while conducting psychometric assessments and during psychotherapy sessions but did not directly interact with the patients. The epistemological position of authors was social constructionism, with the method of enquiry being participant as observer, employing unstructured, direct observation.
Results: A total of 11 post graduate trainees (7 in clinical psychology, 4 in psychiatry) and 2 certified junior clinical psychologists were observed for a period of 60 days. Key themes emphasizing the ethical dilemmas encountered by mental health care professionals were extracted from case notes.
Discussion: Major themes found were: confidentiality vs clinical demands and constraints, autonomy vs. consent and assent, informed consent vs. deception, clinical judgement vs. results on standardized assessment instruments and power hierarchy vs equivalence via disclosure.
Conclusion: The current exploratory study provides a small but significant insight into the challenges and ethical dilemmas encountered by young mental health professionals. It highlights the complex problem of abiding by the ethical principles, growing need to make culture specific ethical decisions for an acceptable model of mental health treatment and developing a healthy trusting relationship between healthcare providers and patients, and their families. Students and faculty need to be alert to ethical issues, teaching of ethical principles following the case-based approach advocated by the UNESCO Bioethics Chair may be the best option. Role plays and other active modes of learning need to be started as soon as students begin interacting with patients.

Keywords: boundary violations, confidentiality, constraints, ethics, dilemmas, mental health.

INTRODUCTION

Ethical dilemmas and concerns are an important part of any healthcare system, but ethical treatment needs to be tailored to local realities and constraints [1-2]. Indian mental health care professionals share some ethical concerns similar to those of their Western counterparts [3] such as boundary violations, confidentiality issues, caregiving by multiple healthcare workers of varying competence, however, they also face additional challenges like- issues around decisional autonomy, cultural issues around psychometric assessments and chiefly, hierarchical relationships with healthcare workers [4-8].

Ethical dilemmas and concerns are thus a part and parcel of the Indian medical system. For instance, confidentiality has to be often compromised, primarily due to the lack of proper infrastructure [9]. Similarly, both psychiatrists and clinical psychologists are aware of but do not report non-sexual boundary violations. These include receiving gifts, making friends, accepting free waivers and services from patients [10]. The plausible reasons for toleration of these boundary violations are that such behaviors are believed to be culturally sanctioned [10], out of fear of making the patient feel rejected [7] as well as lack of appropriate guidelines defining the professional boundaries of a doctor patient relationship in keeping with our social milieu [11].

Therapists in addition face peculiar dilemmas when faced with patients whose belief systems, values and moral principles are incongruent with their own: around marriage, gender identity, abusive violent interpersonal relationships or extramarital relationships [7,12]. Likewise, certain psychotherapeutic principles may not resonate with therapist or patient, and their regular clinical use risks wounding the mind, spirit and body of the patients [13-14]. In such cases, the quality of the relationship and treatment by the therapist is likely to be affected, yet in India, a referral might not always be possible due to paucity of available resources [9].

An Indian mental health care worker hence, is swamped with ethical dilemmas, but literature specifically focusing on the forms and nature of these challenges as well as on the means of resolving them is less common [15]. Furthermore, there are no culture sensitive ethical guidelines for psychiatric and psychological health treatment in India [2,8].

Emerging out of these concerns, the objective of the current study was to develop an understanding of some ethical challenges and dilemmas observed by the authors in a free, tertiary care, post graduate teaching government hospital in New Delhi. This cross-sectional qualitative study used field notes of unstructured observation as the research tool. Unstructured observation was used because it accounts for the context, is sensitive to the impact of physical environment, provides comprehensive understanding of the varied interactions and can be holistic in nature [16]. Field notes were descriptive (sensitive to the factuality, physical settings, context etc.) as well as reflective (indicative of unanswered questions, thoughts and critical thinking of the researcher). Field notes were then re-examined and analyzed to form themes.

METHODOLOGY

Detailed observations were carried out by the first two authors at the Department of Psychiatry and Clinical Psychology at the Dr. Ram Manohar Lohia Hospital in New Delhi as a part of their post graduate internship training. Authors were expected to shadow clinicians as they went about their regular work. Field notes were maintained regularly and discussed. The authors (SKB and AS) shadowed the mental healthcare trainees and professionals but did not directly interact with the patients. Patient encounters were observed both when the patient (and caregiver) presented to the OPD for the first time, as well as during follow ups. All behavior occurring during the patient-doctor interaction were noted, without any pre-decided categories. The epistemological position of the authors was social constructionism, with the method of enquiry being participant as observer, employing unstructured, direct observation.

RESULTS

A total of 11 trainees (7 post graduate non-medical trainees in clinical psychology, 4 post graduate medical trainees in psychiatry) and 2 certified junior clinical psychologists were observed for a period of 60 days (510 hours) from 26th May 2016 - 22nd July 2016. These 13 mental health professionals were observed during ward rounds, detailed history taking, while conducting psychometric assessments and during psychotherapy sessions. However, no senior clinicians or psychology faculty were observed. Key themes with regard to the ethical dilemmas encountered by mental health care professionals were extracted from the field notes, using the word 'patient' when medical interventions are described, and 'clients' when psychological tests or interventions are described.

Clinical constraints and demands vs Maintaining Confidentiality: Being a government hospital, the OPD was usually crowded with huge number of patients, with scarce resources. Consequently, young junior doctors and psychologists found themselves sitting in cramped spaces, several of them huddled together, each attending to a patient and their primary caregivers in one room. Working under such circumstances, made it impossible to observe confidentiality, and overhearing of personal narratives and challenges of the patients was common. Contrarily, some people found solace in being stuck in similar compromised situation of healthcare as well as of mental illnesses.

Autonomy vs Absence of Assent/consent: Children may be reluctant to participate in psychological assessments, mandated for assessing their IQ, learning disabilities or behavioral problems, but they had to obey their parents. Assent from children was not mandated for psychometry or psychotherapy.

Informed consent vs Use of Deception: Persons presenting to the department were often cognitively impaired. Occasionally, 'deception' was employed albeit with the intention of helping the patient/caregivers: using placebos for drug dependent patients to ensure abstinence, or agreeing with the patient's cognitive bias to obtain full details of his or her thought disorder (could the validation further decrease insight or prolong the course of treatment?), using a substitute term (perhaps less serious or less stigmatizing) instead of naming the actual diagnosis. During management, practices observed were: offering or using only one form of psychotherapy without considering client conviction, convenience and other factors such as the client-therapist interaction and the context. In the main, these practices were observed without malicious intent and although not deception in the true sense, did limit choices.

Clinical Judgment vs Standardized assessment instruments: Sometimes, there was discrepancy in clinical judgment about the client's functionality and the score obtained on psychometric assessment tool. For instance, individuals with substance abuse feigning a lower score on dependency index, while their personal narratives and family's description conveyed otherwise. Similarly, young children performed poorly on the psychological tests of learning disability and IQ, but their functionality appeared otherwise.

Power Hierarchy vs Equivalence via Disclosure: It was not uncommon to find the clients perceiving the therapists as their guide and an all-encompassing source of knowledge. Clients did not wish to enter the therapeutic alliance as equals, and instead desired to be led by the insights of the therapist and to surrender to him/her. Despite being cognizant about the advantages of self-disclosure, during the observation not a single episode of self-disclosure was observed.

DISCUSSION

While many themes highlighted in the results above are commonly practiced by healthcare workers not only in Psychiatry, Psychology but also in many other fields of medicine (for instance, life threatening situations, incurable diseases), these issues need to be described and debated.

The inability to provide full privacy because of infrastructural limitations or intrusion by family caregivers was common. Confidentiality, by ensuring a trusting relationship between the doctor and the patient/client, encourages treatment adherence and fosters a trusting relationship. Public healthcare systems are unable to provide for the needs of the burgeoning urban population, due to overcrowding and old buildings, not equipped for the huge inflow [9]. However, in the socio-

cultural environment of a country like India, privacy means being barred from an inter-dependent and close-knit society [17]. Therefore, the ability of the patients/clients and their caregivers to be unguarded about their vulnerable mental health status, generated a feeling of togetherness.

Most family members assumed that, since they were bringing the patient to the hospital, and would manage the patients at home, they deserved to be fully informed. Additionally, in case of patient with psychotic symptoms, and resulting conflicts, the family pressurized the therapist to divulge confidential information, which is in congruence with previous reports [4,5,18].

Family members felt even more offended in cases where their child perceived the client-therapist relationship to be more trustworthy. The prevailing social belief is that children should not hide anything from the family. Hence, parents felt justified in demanding all information about the child [18-19]. In India, due to the vertical collectivistic culture between the elderly and children in family, the power of parents in decision making is near absolute [22, 6]. The authoritarianism of Indian parents reduced the autonomy of young children and adolescents, so the therapists had to overlook the child's assent and prioritized parents' consent. In case of children and adolescents, assent should be sought before performing any psychological assessments [20]. Children, by the age of 9 years possess the cognitive capacity to decide about participating in an activity [21]. Assent was seldom sought in the hospital setup, and where the child and parents disagreed about participating in the psychiatric or psychological treatment, the decision of the parents was abided by, perhaps because parents sought help for disability certification which would materially benefit both the child and the family [23].

In the majority of instances, parents accompanied their adolescents to therapy sessions. Parents felt that their child lacked capacity to express his/her own wishes due to inhibitions, or because they believed that owing to the psychiatric illness, their child did not know his/her best interest. Therefore, the parents insisted that they be included in all the clinical processes, as also described by others [15,18]. Yet, adhering to parental expectations was problematic for the therapist in case of adolescents, who usually insisted on being treated as an autonomous individuals and perceived therapy as safe space for expressing individuality.

Informed consent was compromised upon not only for children and adolescents, but sometimes also for adults who were believed to be incompetent. Sometimes, the family believed that in case the patient got the liberty to choose the treatment, s/he would deny the problem, which would worsen her/his physical and psychiatric health.

Deception has been defined as an act, wherein the investigator either provides false information so as to misinform the patient or withhold true information from the patient [24]. Interviewers used deception to gather detailed symptomatology from challenging patients by validating their point of view-e.g. by agreeing to their versions of delusions or hallucinations. The motive of doing so was to benefit the patient, yet it was also a form of misinformation. Using a substitute term for the actual diagnosis was another form of deception. The efficacy of a therapy may depend on patient conviction, convenience and other factors such as the patient-therapist interaction and the context instead of the disease; asserting supremacy of one form of therapy over other could be questionable [25, 5], yet clients were not offered a choice. Firm belief in and insistence upon medications even in case of mild anxiety and depression, despite evidence to the contrary [26] was widespread.

If clinical judgement was inconsistent with psychometric results, psychology trainees questioned their own competency, or feared introducing subjective bias in empirical testing despite evidence to the contrary [27, 28]. Consequently, despite feeling unconvinced with the results of psychometric testing, the psychology trainees wondered whether to abide by the unconvincing psychometric score or their own clinical judgment.

Historically, only the sacred healers were thought to possess ultimate knowledge of medicine and life [29]. Consequently, the clients extended similar beliefs and emotions towards the contemporary healers- the health professionals, exhibited similar relationship dynamics in professional relationships [5, 15]. Perhaps, the clients trusted their therapists and held strong blind faith unto them [4,7]. However, living up to the ideal image of a healthcare professional impinged upon other inter-related ethical principles such as self-disclosure. Self-disclosure by the therapist positively affect the therapeutic alliance, since it reduces the taboo felt by the patient. Self-

disclosure is a key element in creating an empathetic bridge between the professional and the patient, and more importantly, it being insightful for the therapist, leading to fresher perspectives to therapy [30]. But in the present situation, personal revealing statements were viewed as boundary violation and thought to diminish the trustworthiness towards treatment. This often created an ethical conflict within the therapists, since on one hand, they were withholding from self-disclosure despite knowing its benefits, but on the other were equally preventing harm to the patient by not risking their loss of faith in the treatment. Therapists assumed that self-disclosure would invariably translate into developing multiple relationships with the patient, especially in the case of children and adolescents, and choosing not to self-disclose protected them from entering into multiple relationships like friendship or career mentorship with the children. Although multiplicity of relationships could mean boundary violation on part of the therapist and breach of ethical principles yet refraining from self-disclosure also impacted the inspiration and direction the children expected to find as part of the psychological contract in the embodied 'guru-chela' [31] relationship.

It was not uncommon for patients to visit their consultants and therapists with gifts or sweets, as a token of gratitude. Did the cultural sanctioning of souvenirs or gifts as gratitude overlook the boundary violation taking place? Despite awareness about the non-sexual and sexual boundary violations, medical healthcare professionals in India are said to be underskilled - even incompetent- in establishing healthy boundary norms between themselves and the patient [4, 32]. This may be due to ambiguous limitations of self-disclosure. Consequently, their attitude towards self-disclosure oscillated between polite discouragement, varying from self-protecting self-disclosure, to undue disclosure ensuing a role reversal between the doctor and patient [33].

In addition, the healthcare professionals, sometimes also chose to use less-than-clear explanations to disclose the diagnosis so as to soften its impact. This helped in maintaining a trusting and safe relationship between the therapist and client, presumably ensuring compliance to treatment and family acceptance. This is in congruence with several reports that health care professionals exercise deception to manage the behavior of the patient [34] and to manage the patient's environment [35].

Our study thus sheds light on the multi-layered, culture specific ethical dilemmas faced by mental health professionals, but is limited by small sample size, restriction to single medical institution and lack of triangulation with observation. Moreover, no senior clinicians or clinical psychologists were observed. Observations were part of an internship by the first two authors; hence we may not have captured the nature of all forms of ethical quandaries or the mechanisms of resolving them.

CONCLUSION

The current study provides a small but significant insight into the challenges and ethical dilemmas encountered by young mental health professionals on an everyday basis. This exploratory study points at the complex problem of abiding by the ethical principles, growing need to make culture specific ethical decisions and guidelines for an acceptable model of mental health treatment, and developing a healthy trusting relationship between healthcare providers, patients, and their families. Students and faculty need to be alert to ethical issues, teaching of ethical principles following the case-based approach advocated by the UNESCO Bioethics Chair may be the best option. Role plays and other active modes of learning need to be started as soon as students begin interacting with patients.

REFERENCES

1. Hays PA. Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. Profess Psychol Res Pract 2009;40(4):354-60.
2. Asnaani A, Hoffmann S. Collaboration in Culturally Responsive Therapy: Establishing a Strong Therapeutic Alliance across cultural lines. J Clin Psychol 2012;6:187-97.
3. Pope KS, Vetter VA. Ethical dilemmas encountered by members of the American Psychological Association: A national survey. Amer Psychol 1992;47(3):397-411.
4. Isaac R. Ethics in the practice of Clinical Psychology. Indian J Med Ethics 2009;6(2): 69-74.

5. Manickam, LSS. Psychotherapy in India. Indian J Psychiatry 2010;52(Suppl 1):S366-70.
6. Chadda RK, Deb KS. Indian family systems, collectivistic society and psychotherapy. Indian J Psychiatry 2013;55:299–309.
7. Bhola P, Sinha A, Sonkar S, Raguram A. Ethical dilemmas experienced by clinical psychology trainee therapists. Indian J Med Ethics 2015;12(4):206-12.
8. Konar D. Why Psychotherapy never picked up in India: Could there be a solution? Eastern J Psychiatry 2015;18(1): 39-41.
9. Bajpai V. The Challenges Confronting Public Hospitals in India, their origins and possible solutions. Adv Health, 2014;1-27.
10. Kurpad S, Machado T, Galgali R. Is there an elephant in the room? Boundary violations in the doctor–patient relationship in India. Indian J Med Ethics 2010;7(2):76–81.
11. Lehavot K, Barnett JE, Powers D. Psychotherapy, professional relationships, and ethical considerations in the MySpace generation. Profess Psychol Res Pract 2010;41:160-6.
12. Elliot GR. When values and ethics conflict: The counsellor's role and responsibility. Alabama Counseling Association Journal 2011;37(1):39-45.
13. Sindhu G. The Application of western Models of Psychotherapy by Indian Psychotherapists in India: A Grounded Theory. Antioch: Antioch University Repository and Archive, 2017.
14. Christopher JC, Wendt DC, Marecek J, Goodman DM. Critical Cultural Awareness: Contribituions to a globalizing psychology. Amer Psychol 2014;69(7):645-55.
15. Agarwal AK. A review of Indian psychiatry research and ethics. Indian J Psychiatry 2010;52(Suppl 1):S297–305.
16. Silverman D. Interpreting Qualitative Data: Methods for Analysing talk, text and Interaction. 1st ed. London: Sage Publications; 1993.
17. Neki JS. Psychotherapy in India. Indian J Psychiatry 1977;19:1–10.
18. DeSousa A. Ethical issues in child and adolescent psychotherapy: a clinical review. Indian J Med Ethics 2010;7(3):157-61.
19. Ascherman LI, Rubin S. Current ethical issues in child and adolescent psychotherapy. Child Adolesc Psychiatr Clin North Amer 2008;7(1):21–35.
20. Indian Association of Clinical Psychologists. Code of Conduct. (Adopted by IACP, circulated to its members). Lucknow: IACP Secretariat; 1993; 2014.
21. Leiken S. Minors assent, consent, or dissent to medical research. IRB Review on Human Subject Research 1993;15:1-7.
22. Malhotra S, Subodh BN. Informed Consent and ethical issues in Pediatric psychopharmacology. Indian J Med Research 2009;29(1):19-32.
23. Paraspoor A., Paraspoor MD, Rezai N, Asgari F. Autonomy of children and adolescents in consent to treatment: Ethical, Jurisprudential and Legal Considerations. Iran J Pediatr 2014;2:241-8.
24. Wendler D, Miller F. Deception in the Pursuit of Science. Arch Intern Med 2004;164:597-600.
25. Shamasundar C. Some personal reflections relating to psychotherapy. Indian J Psychiatry 2008;50(3):301–4.
26. Bernstein M, Brown W. The placebo effect in Psychiatric practice. Curr Psychiatry 2017;16(11):29-34.
27. Grove WM, Zald DH, Lebow BS, Snits BE, Nelson CE. Clinical vs. mechanical prediction: A meta-analysis. Psychol Assess 2000;12:19-30.
28. Sanders S, Doust J, Glasziou P. A systematic review of studies comparing diagnostic clinical prediction rules with clinical judgment. PloS One 2015;10(6).
29. Saini A. Physicians of ancient India. J Family Med Prim Care 2016;5(2):254-8.
30. Audet C. Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? Counsel Psychol Quart 2011;24(2):85-100.
31. Neki JS. Guru-Chela relationship: The possibility of therapeutic paradigm. Am J Orthopsychiatry 1973;43:755–66.
32. Khan M. Boundary Violations and The Curtain of Culture. Indian J Med Ethics 2010;6:76-81.
33. Beach MC, Roter D, Larson S, Levinson W, Ford DE, Frankel R. What do physicians tell patients about themselves? A qualitative analysis of physician self-disclosure J Gen Intern Med 2004;19:911–6.
34. Tuckett AG. The experience of lying in dementia care: a qualitative study. Nurs Ethics 2012;19(1):7–20.
35. Seaman AT, Stone AM. Little White Lies: Interrogating the (Un)acceptability of Deception in the context of dementia. Qual Health Res 2017;2:60-73.

****

Acknowledgements: *The salary of Dr. Triptish Bhatia is supported by the Stanley Medical Research Institute (07R-1712 to VLN) and National Coordinating Unit ICMR for NHMP Projects funded by Indian Council of Medical Research. The content of this paper is solely the responsibility of the authors and does not necessarily represent the official views of the funding agencies. We gratefully acknowledge the leadership of the movement for global bioethics- UNESCO Bioethics Haifa, and their leadership to organize the World Bioethics Day on October 19. This paper is an extension of the prize -winning poster on WBD 2019.*

Financial grants for this paper: Nil
Conflict of interest: None

Original Research Paper

Medical Ethics – Are We Talking Enough

Shimpa Sharma[1], Rakesh K. Sharma[2], Rajesh K. Khyallapa[3], Shweta Sharma[4]

[1]Pro-Vice Chancellor and Professor, Department of General Medicine,
[2]Dean and Professor, Department of Obstetrics and Gynaecology,
[3]Professor and Head, Department of General Medicine,
[4]Intern, M.G.M. Hopsital and M.G.M. Medical College, Kamothe, Navi Mumbai.
[1,2,3]D.Y. Patil Medical College and D.Y. Patil Education Society Deemed University, Kolhapur
Corresponding Author: Shimpa Sharma
E-mail: shimpasharma@gmail.com

ABSTRACT

The last three decades have seen major strides being made in the introduction and promotion of medical ethics in the medical school curriculum. Efforts to hone faculty skills and knowledge have come to the forefront. More emphasis has been placed on discussions on ethical issues in addition to subject-related deliberations. In India, medical ethics teaching remains largely a part of the 'hidden curriculum' in most colleges. This study aims to know the circumstances and opportunities currently available for the ethics education of students, a reflection of how far we have travelled on this path of delivering to society empathic and ethical physicians. It is of great pertinence in view of the fact that the Medical Council of India has from this year, included the teaching of ethics into the formal curriculum. It contributes to identifying wherefrom we start and focus our renewed efforts. Inclusion of what was earlier 'hidden' in the formal curriculum and its' implementation aim to ensure that the physicians of tomorrow acquire the knowledge and skills to recognize and handle ethical dilemmas in their practice.

Keywords: Ethics, medical students, medical, learning ethics, student uncertainty.

INTRODUCTION

In 1970, in one of her essays in the compilation "Sovereignty of God' philosopher Iris Murdoch stated that the ability of an individual to act in an appropriate manner 'when the time comes' "depends partly, perhaps largely, upon the quality of our habitual objects of attention" [1-2] Murdoch also recognized that choices can be made only within the world 'I can see', referring to the moral vision of an individual. Over two decades later PA Scott put forth an observation that "the quality of the practitioner's role enactment and moral sensitivity has a direct bearing upon patient care" [3]. These thoughts and observations when referenced to the field of medical ethics were before their times.

The World Medical Association at its' 51st annual General Assembly, held in Tel Aviv, Israel from October 13th -17th 1999, recommended "to all medical schools that the teaching of medical ethics and human rights be included as obligatory courses" [4]. The importance of ethics in medical education is irrefutable as is the emphasis on imparting this knowledge to all succeeding generations of doctors. Moral vision, so eloquently phrased by Murdoch, is increasingly a palpable

felt need in the present context. So that some aspects of ethics do not become representative of the complex whole, a deliberate knowledge and understanding of the subject is essential.

The last three decades have seen major strides being made in the introduction and promotion of medical ethics in the medical school curriculum. Efforts to hone faculty skills and knowledge have come to the forefront. More emphasis has been placed on discussions on ethical issues in addition to subject-related deliberations. In India, medical ethics teaching remains largely a part of the 'hidden curriculum' in most colleges.

Despite efforts to bring ethics education to the mainstream of medical curriculum, there is always more that remains to be done. The question we have to ask ourselves is 'Are we doing enough?' To this end, it was decided to go to the students themselves who are our target learners.

This study aims to know the circumstances and opportunities currently available for the ethics education of students, a reflection of how far we have travelled on this path of delivering to society empathic and ethical physicians. It is of great pertinence in view of the fact that the Medical Council of India has from this year, included the teaching of ethics into the formal curriculum [1]. It contributes to identifying wherefrom we start and focus our renewed efforts.

METHODOLOGY

Following approval from the Institutional Ethics Committee, questionnaire was applied on 150 undergraduate (UG) and postgraduate medical students present on a routine working day, with a response rate of 72.6% (n=109). UG students were from the 8th and 9th Semesters (final years of MBBS). Responses were collected on the same day within 2 hours. Data regarding demography, prior ethics training was gathered. The questions are shown in the figure below. Data analysis was done using SPSS version 20.0

Figure 1: Questions applied related to theme 'Are we talking enough?'

Select options that are applicable in your personal experience.

Q1. You have come across discussions on ethics in:

a. During medical lectures
b. During rounds or bedside teaching
c. On television during debates or in print media
d. Amongst fellow students
e. At medical conferences
f. During Medical Ethics Lectures

Q2. **You have felt the need to know more about ethics**

a. Never
b. During clinical rotations / in wards
c. Social gatherings (friends/family)
d. Discussions with medical colleagues or in college
e. Following discussions/debates on TV/print media, etc.

RESULTS

The sample consisted of 109 medical students and consisted of 47 undergraduate (UG) students and 62 post graduate (PG) students with a male:female ratio of 2.23:1. Of the respondents, 53.2% (n=58) accepted that ethics had been covered in their curriculum while others either denied (n=43) or were uncertain (n=8). In response to where they had come across discussions on ethics the responses were varied. Significantly higher number of students agreed that discussions on ethics were seen in medical lectures ($\gamma(1)=11.239$; $p=0.001$), in the wards during bedside teaching or clinical rounds ($\gamma(1)=22.028$; $p=0.0001$) and at conferences ($\gamma(1)=5.734$; $p=0.017$). Interactions

with other student-colleagues was not accepted as a likely source for ethics discussion (γ(1)=4.046; p=0.044).

Table 1 - Cross tabulation was done with the academic program of the respondent

Responses to 'You have come across discussions on ethics in'								
Discussions on ethics in		No	Yes	Fishers Exact Test		OR	95% CI	RR of 'No'
				2-sided	1-sided			
Medical Lectures	UG	22	25	0.016	0.012	0.363	0.160-0.820	1.935
	PG	15	47					
	Total	37	72					
In Ward	UG	18	29	0.033	0.024	0.387	0.163-0.915	1.979
	PG	12	50					
	Total	30	79					
On Media	UG	28	19	1.00	0.516	0.940	0.435-2.030	1.026
	PG	36	26					
	Total	64	45					
With other Students	UG	32	15	0.167	0.085	0.533	0.242-1.176	1. 279
	PG	33	29					
	Total	65	44					
In Conference	UG	17	30	0.695	0.405	1.192	0.546-2.606	0.897
	PG	25	37					
	Total	42	67					
Medical Ethics Lectures	UG	26	21	0.032	0.020	0.414	0.190-0.902	1.633
	PG	21	41					
	Total	47	62					

Students who admittedly received ethics training in UG were 2.5 times more likely to accept that lectures on medical ethics enabled discussions on the subject ($p< 0.05$) (Table 2)

Table 2 – Medical Ethics Lectures as discussion sources based on admitted UG ethics training

		Discussed in ME lectures		Fisher's Exact test		Odds Ratio	95% CI	RR of 'Yes'
		Yes	No	2-sided	1-sided			
ME taught in UG	Agreed	39	19	0.022	0.016	2.499	1.148-5.439	1.491
	Not agreed	23	28					
		62	47					

Students were asked about the situations where they felt the need for further knowledge on ethics. Students revealed significantly higher need in the wards (p=0.003) and lower need was reported in social gatherings and while following media discussions or debates (both p=0.0001). Chi Square test revealed no significant difference in the need for ethics knowledge expressed by UG or PG students in different scenarios that were presented to them. (Table 3).
Analysis of responses with their self-admitted training in ethics revealed significant association with the need expressed is seen in Table 4.

DISCUSSION

Student uncertainty on whether or not ethics had been taught to them in their UG curriculum is worrisome, unless one considers that ethics so far in Indian medical colleges has been predominantly part of the 'informal' curriculum. The term in itself implies a certain laissez-faire

approach to the transfer of knowledge, leaving the content, depth and extent of teaching to the judgement of the faculty.

Table 3: Felt need for knowledge of ethics in scenarios presented

Need	Group	Need for knowledge		Fisher Exact Test		Odds Ratio	95% CI	RR for 'No'
		No	Yes	2-sided	1-sided			
Never	UG	40	7	0.464	0.289	1.516	0.553-4.160	1.077
	PG	49	13					
	Total	89	20					
Wards	UG	16	31	0.841	0.45	0.875	0.396-1.935	0.918
	PG	23	39					
	T	39	70					
Social Places	UG	35	12	1.00	0.501	1.102	0.466-2.600	1.026
	PG	45	17					
	Total	80	29					
Colleagues	UG	20	27	0.701	0.404	0.843	0.393-1.809	0.901
	PG	29	33					
	Total	49	60					
Media	UG	36	11	0.577	0.268	1.446	0.609-3.433	1.104
	PG	43	19					
	Total	79	30					

Table 4 – Discussions on Media as a source of felt need for ethics knowledge

		Discussions on Media		Fisher's Exact test		Odds Ratio	95% CI	RR of 'No'
		No	Yes	2-sided	1-sided			
ME taught in UG	Agreed	48	10	0.17	0.009	3.097	1.280- 7.490	1.362
	Not agreed	31	20					
	Total	79	30					

The ability to perceive and imbibe the teachings in the informal curriculum are dependent on multiple variables such as students' maturity, training in identifying the 'hidden curriculum', skill of the faculty, the context, timing of interaction, time for discussion, etc. Deliberate training has been shown to improve the ability of students to understand the hidden curriculum, appreciation of its' importance and ability to perceive good behavior in the wards [5].

The need to define the interventions in the 'hidden' curriculum has been recognized by several medical schools in different countries. India too joins this group with introduction of the Attitudes, Ethics and Communication (AETCOM) module in undergraduate medical curricula from the current academic year [6]. To the sensitized and experienced, all clinical situations and interactions have elements of ethical interest and seeds of discussion. It is heartening to note that students acknowledged the medical lectures, conferences and clinical postings/wards as places of ethical discussion in addition to Medical Ethics lectures (Table 1). It should be pointed out that while this number is statistically significant, ethics is not about statistics but about individuals. The focus and efforts of fine-tuning our system should continue till not the majority but all students are sensitized to recognizing ethical situations and being able and willing to discuss these with the same attention as they do a clinical diagnosis. The higher proportion of aware PG students in comparison to UG students is easily explained by the fact that they work longer with patients, are more likely to be presented with ethical issues, their one-on-one interaction with faculty is higher and these create a background for higher number, variety and depth of ethical discussions. Promoting discussions amongst students on ethical aspects of education and patient care is important. This has to be

initiated and nurtured by the teachers and educators, creating an enabling and conducive environment for such discussions. However, it can only bear fruit if students are adequately sensitized, have the cognitive knowledge and are provided with a facilitative environment. Table 2 clearly depicts the difference made by students who self-admittedly were recipients of Medical ethics training, generating a hypothesis that they had attended the scheduled lectures on medical ethics. Since all students were from the same college and hence received similar overall training, the impact of formal training cannot be denied. It also underlines the fact that attendance in the lectures is directly correlated with outcomes [7].

The need to have had greater knowledge on ethics was noted by higher proportion of students in the wards and during discussions with colleagues. This reflects a degree of sensitization to ethical dilemmas amongst the students. Table 3 reveals that similar results for UG and PG students with regards to their responses which needs exploring. That medical school dehumanizes students is known [8-9]. It would be reasonable to expect greater empathy, recognition of ethical dilemma and need for knowledge as student's progress from undergraduate to postgraduate studies. The lack of this finding is cause for concern and introspection. The conversion of the expressed felt need to a confidence that translates into higher standards of patient care is the responsibility of the faculty. A formal curriculum would definitely contribute to this end.

It is pertinent to note that most courses do not address ethics from the perspective of student experiences during medical training. Contradictions between what is taught and actually practiced, students' difficulties in adhering to ethical precepts, the silent compulsions of their position in the hierarchal medical structure, temptation to withhold information from patients are some areas not routinely covered [10]. The courses designed need to be relevant and interesting to hold their attention and make a palpable difference in their practice. Several authors have noted that students have definite preference of topics they consider relevant [10-14]. Maturity of a curriculum would be when its' contents satisfy the needs of a learner and the end-beneficiaries – the patient. This strengthens the case for stakeholder participation in curriculum designing.

Another point made by students in this study was with reference to the Media. The media (TV or print) was not seen either as a platform where discussions on ethics happened and neither did students feel the need for knowledge on ethics in that setting. This is a poor commentary on the content of various media modalities that do not deal with topics of ethical interest in a befitting manner. Concern over market share and ratings have resulted in media converting ethical issues into sensational news with more emphasis on blame game and retribution than on the issue itself. However, it is to be accepted that a mature physician would be able to identify the ethical aspects of such media coverage.

CONCLUSION

The study underlines the need for greater extent and depth of training on medical ethics for our students. The medical student is an impressionable mind that we as faculty can embed with ethical values and knowledge that will beget a caring physician. Great hopes are placed on the introduction in the formal curriculum of the AETCOM module. There is an old saying, 'It takes a village to raise a child'. Let us all, physicians, educators, patients and the media, unite to raising a professional, ethical physician for tomorrow.

REFERENCES

1. https://www.mciindia.org/CMS/wp-content/uploads/2019/01/AETCOM_book.pdf Accessed on 12th May 2019
2. Murdoch I. The Sovereignty of Good. 1st Ed. Routledge Classics. London, England: Routledge & Kegan Paul;1970.
3. Scott PA. Role, role enactment and the health care practitioner J Adv Nurs 1995;22(2):323-8.
4. https://www.wma.net/news-post/51st-annual-general-assembly-of-the-world-medical-association/ Accessed on 16th May 2019
5. Hopkins, L, Saciragic L, Kim J, Posner G. The Hidden Curriculum: Exposing the Unintended Lessons of Medical Education Cureus; Palo Alto 2016;8(10):1-5

6. https://www.mciindia.org/CMS/wp-content/uploads/2019/01/AETCOM_book.pdf Accessed on 12th May 2019.
7. Sharma S, Sharma R K Medical College Attendance-Relevance in an Era of E-learning. J Res Med Educ Ethics 2018;8(3):205-10.
8. Geiger HJ. The causes of dehumanization in health care and prospects for humanization. In: Howard J Strauss A, eds. Humanizing Health Care. New York: John Wiley, 1975: 11-36.
9. Haque OS, Waytz A. Dehumanization in Medicine: Causes, Solutions, and Functions. Persp Psychol Sci 2012;7(2):176–86.
10. St Onge J. Medical education must make room for student-specific ethical dilemmas, Can Med Assoc J 1997;56(4):1175-7.
11. Rhodes R, Cohen, D S. Understanding, Being, And Doing: Medical Ethics in Medical Education. Cambridge Quart Healthcare Ethics 2003;12(1):39-53.
12. Musick DW. Teaching medical ethics: A review of the literature from North American medical schools with emphasis on education: Med Health Care Philos 1999;2:239-54.
13. Mijaljica G. Medical Ethics, Bioethics and Research Ethics Education Perspectives in South East Europe in Graduate Medical Education. Sci Eng Ethics 2014;20:237–47.
14. Terndrup C. A Student's Perspective on Medical Ethics Education J Relig Health 2013;52:1073–8.

****

Acknowledgements: *All the students that participated in the study*
Financial grants for this paper: Nil
Conflict of interest: None

Ethical Viewpoint Paper

Electroconvulsive Therapy – Ethical Issues

Pragya Lodha[1] Anoushka Thakkar[2] Avinash De Sousa[3]

[1]Clinical Psychologist, Private Practice, Mumbai.
[2]Undergraduate Student, Psychology, Sophia College, Mumbai
[3]Research Associate, Department of Psychiatry, Lokmanya Tilak Municipal Medical College, Mumbai.
Corresponding Author: Avinash De Sousa
E-mail: avinashdes888@gmail.com

INTRODUCTION

Electroconvulsive Therapy (ECT) is a brain-based treatment modality that falls under the medical treatment methods. It involves a brief electrical stimulation of the brain while the patient is under anesthesia [1]. ECT is typically administered by a team of trained medical professionals that includes a psychiatrist, an anesthesiologist and a nurse / physician assistant. ECT is typically used when other treatments, including medications and psychotherapy, haven't worked. It is used when patients are sole bread winners and need faster recovery and to reduce the number of days spent on a hospital day. In the Indian scenario where there would be only one bread winner for the household, getting back to work faster is a priority. Due to the lack of a prevailing Mental Health Insurance and where the patients pay out of their own pockets, ECT may be sought as a treatment over prolonging pharmacological management [2].

Discovery of ECT

The discovery of ECT goes back to the 1930s, where ECT was introduced and accepted as a better treatment for the treatment of severe psychiatric illnesses. ECT was earlier used unmodified, without anesthesia and muscle relaxants. First used by Italian professionals, Ugo Cerletti and Lucio Bini (1938), ECT has evolved over time to now being administered under anesthesia and with succinylcholine (or its equivalent) modification which is referred to as 'modified ECT'. Surveys indicate that there is considerable practice of unmodified (use of ECT without anesthesia/muscle relaxants) in developing countries and, to a small extent, in the developed world. The myths surrounding electroconvulsive therapy and the misconceptions held by the general public, clinicians and patients have interfered with acceptance of this treatment throughout its history [3].

Certain important clarifications about ECT

- Several documented evidences tell us that the use of ECT was as a means of controlling violent patients and maintaining order in wards. However, it must also be noted that the incident was abuse and misuse of ECT discontinued after the deinstitutionalization movement (Deinstitutionalization movement was a response in rebellion to the institutionalization in which patients would be hospitalized/institutionalized for treatment. It was found that treatment was barbaric and not conducive to patient improvement. The advent of medication also led to Outpatient treatment which was earlier not available. The number of ECTs being given drastically reduced with the rapid advances in psychopharmacotherapy. However, ECT continues to be a widely used treatment algorithm; ECT is also coupled with measures of psychopharmacotherapy and psychotherapy [4].
- The administration of ECT was dangerous as it was administered without the use of anesthesia and muscle relaxants. However, the improvisation of ECT coming as modified ECT as a treatment modality, various flaws have now been mitigated, making it not only safe but also useful and effective. ECT administration is now no more unmodified as per

protocol mentioned in the Mental Health Care Act of India. However, what is clinically prudent to note is that unmodified EC given appropriately can sometimes be safer than modified ECT [5].

- Unrealistic and exaggerated representation of ECT in media, print and the internet, created mammoth myths around ECT and the remnants of the same are still encountered. Media is a medium of the masses, consumed by millions in various fonts. Representation of ECT in Bollywood and Hollywood films has contributed to an amassed stigma towards ECT and a misnomer about it being a 'dangerous' treatment method. Cinema has wrongly portrayed the use of ECT, being used to cripple the patient and barbaric use of repeated ECT to make a patient amnesic which has developed aversion to an important treatment modality in the general community. The use of terms like 'shock therapy' and 'electric current therapy' in itself is extremely stigmatic to the treatment approach and bereft many from benefitting outcomes of ECT [6].
- Misleading public opinion that is not based on comprehensive medical / psychiatric knowledge and understanding creates a buff of mythical understanding. For example- people generally think of ECT being shown as in cinema, which is unmodified ECT and not the case in real-practice, terms like 'shock therapy' in itself create a distance from the treatment modality, people who have known someone undertaken ECT do not realise that some symptoms like blurred memory and speech are temporary symptoms and come back to normal [7].
- The anti-psychiatry movement propagated by Thomas Szasz and colleagues in the 1960s was so severe that the foundational existence of the concept of mental illness was questioned which furthered the disbelief in use of ECT [8].
- Difference in opinion among psychiatrists as a fraternity has also been a contributing factor to lead to ambivalence regarding the use of ECT. The postgraduate courses and trainings may have difference in preference to ECT as a treatment modality based on what does the Head of Department prefer. There are some psychiatrists and hospitals that unhesitatingly believe in the efficacy in ECT treatment.

ECT is a safe treatment

After decades of clinical experiences and research, protocols for safe treatment of patients regardless of their medical status, age and physical state has been warranted and developed successfully. However, despite these improved techniques and practices of ECT, the mechanisms contributing to the effects of ECT are still under investigation and ECT as a treatment has been widely underutilized [9].

ECT's effectiveness in treating severe mental illnesses is recognized by various professionally oriented practitioners and ethically permitted by the medical boards globally. Extensive research has found ECT to be highly effective for the relief of major depression, episodic /acute / atypical schizophrenia (not chronic), bipolar disorder and various other severe mental illnesses. Clinical evidence indicates that for individuals with uncomplicated, but severe mental illnesses, the efficacy of ECT stands between 50%-70%. ECT is sometimes used in treating individuals with catatonia and is also used when the patient presents with active suicidal tendencies and no other modality befits in the shorter frame of time. There are other indications for use of ECT as well such as delirium, acute psychosis, obsessive compulsive disorder and some medical conditions as well [10].

Brief Pulse ECT

The advent and rapid growth of the medical revolution in the 1960s led to the introduction of efficacious psychopharmacological treatment for depression, especially tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) and this consequently led to the decline in use of ECT. Another potential factor that degraded the use of ECT was public reaction reported as cognitive (i.e., memory) side effects, physical discomfort, and the implications of social control associated with the treatment. A notable development is that the recent 'brief pulse ECT' and 'ultra-brief pulse ECT' do not cause cognitive changes like the sine wave ECT which was used

previously. However, with the widespread use of psychopharmacological agents as the first line treatment, there was also a realization that medications were not always found effective for treatment and this led to an increased use of ECT with patients resistant to those treatments [11].

ECT and The Mental Health Care Act in India

Contextually, in the Indian framework, the use of ECT has also been a debatable issue with not being a recommended modality of treatment. Till now there was no prohibition in administration of unmodified ECT in patients of different age group for various psychiatric conditions as per the clinical indication. But now as per the Mental Health Care Act (MHCA), in Section 95 (1)(a) of MHCA, "use of electroconvulsive therapy without the use of muscle relaxants and anesthesia" is a prohibited procedure. According to MHCA, unmodified ECT cannot be administered in patients of any age group. This may neglect the efficacy of unmodified ECT being given which can be beneficial over modified ECT if given with clinical prudence. The act emphasizes patient consent apart from family consent. ECT is usually given three times a week and the usual course is six to eight treatments, though some may require more.

Patient consent (and family consent) for ECT does not always translate into an affirmative one towards ECT given the strong myths about ECT that the patient (and family) may harbor or sheer ignorance of the benefits of ECT- this may defer the essential treatment benefits that the patient may require. In specific times, ECT may be a life-saving treatment that may be consciously denied with non-consent to ECT by the patient or family.

Section 95 (1)(b) of MHCA states that "electroconvulsive therapy for minors" is a prohibited procedure, except in situations, when the treating psychiatrist feels the need to used ECT. Section 95 (2) states that "Not-withstanding anything contained in sub-section (1), if, in the opinion of psychiatrist in charge of a minor's treatment, electro-convulsive therapy is required, then, such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board". Accordingly, if the treating psychiatrist feels the need to used ECT, then, such treatment shall be done with the informed consent of the guardian and prior permission of the Mental Health Review Board (MHRB) [12].

What becomes questionable in such a situation is two things- (1) ECT can be an equally effective a treatment for minors and (2) whether the MHRB is qualified and equipped enough to make this decision- since the board has only one psychiatrist. The availability of the MHRB is also questionable which may be held to question in cases of emergency. It is also important to remember that, as per the section, 94 of MHCA, ECT cannot be given as part of the emergency treatment. The section 94 (3) of MHCA states that "Nothing in this section shall allow any medical officer or psychiatrist to use electroconvulsive therapy as a form of treatment" [13].

A major advantage of using ECT in emergency situations is that it can be live saving which under this section of law may be not available to the patient (and family). The professional and ethical challenge in such a situation is that informed consent that comes through advance directives in the MHCA may be made by the patient who does not understand treatment modalities, may be unaware of the benefits of the treatment and may be warped with stigma [14].

ECT and Pregnancy – critical aspects

Psychiatric disorders are common during pregnancy, affecting 15-29% women. Untreated mental health disorders have negative health consequences for mother and foetus. Electroconvulsive therapy is an effective option for the treatment of severe depression, high suicide risk, catatonia, medication-resistant illness, psychotic agitation, severe physical decline, and other life-threatening conditions even in mothers during pregnancy. The safety and efficacy of ECT in pregnancy has been documented over the five decades. The most common risk to the mother is premature contractions and preterm labor, which occur infrequently and have clearly shown not be caused by ECT. The rates of miscarriages were not significantly different from that of the general population. There have been no associations of ECT with congenital anomalies, either morphologic or behavioral and no neurocognitive disturbances in the child. ECT is a reasonably safe and effective treatment alternative for management of many psychiatric disorders in pregnant patients [15].

ECT in the elderly

ECT has been used in various psychiatric conditions in the elderly. Comorbid medical conditions and cognitive deficits have been the prime concerns for indication of ECT in the geriatric population. The efficacy of ECT has been found in patients with Parkinson's disease and dementia. Pre-ECT evaluation and cognitive evaluation prior and during ECT are inevitable, especially so in this population and so is the determination of right technique, dose, frequency, and assessment of side effects. Owing to risk of cognitive side effects, right unilateral ECT is preferred. In carefully selected indications, ECT may be a superior management modality than pharmacotherapy among the elderly as well [16].

Critical Points for the Future

As any other treatment modality, ECT also comes with its advantages and disadvantages. Electroconvulsive therapy (ECT) is one of the treatment modalities in psychiatry that has stood the test of time for years. Additional research is needed in order to gain a better insight into the basic mechanisms which ECT operates on in order to have therapeutic effects. Critics in the media and medical profession have portrayed ECT as a form of medical abuse. Yet many psychiatrists, and more importantly, patients, consider it to be safe and effective. Electroconvulsive therapy (ECT) is an important treatment in psychiatry; despite the myth that it is a barbaric and outdated practice, it is as relevant today as it was over six decades ago, when it was first introduced [17].
There is need for uniform guidelines and standardized measures when it comes to the use of ECT in patients. These guidelines must be followed by private nursing homes and government hospitals alike and there must also be guidelines for informed consent in ECT from both patients and relatives. This will standardize the procedures in relation to ECT and bring about uniform dissemination of the treatment along with sound psycho-education and reduction of stigma.

REFERENCES

1. Payne NA, Prudic J. Electroconvulsive therapy Part I: a perspective on the evolution and current practice of ECT. J Psychiatr Pract 2009;15(5):346-68.
2. Andrade C, Agarwal AK, Reddy MV. The practice of ECT in India: II. The practical administration of ECT. Indian J Psychiatry 1993;35(2):81-9.
3. Trivedi JK. Practice of ECT in India. Indian J Psychiatry 2002;44(4):313-4.
4. Shorter E. History of psychiatry. Curr Opin Psychiatry 2008;21(6):593-7.
5. Andrade C. Unmodified ECT: ethical issues. Issues Med Ethics 2003;11(1):9-10.
6. McDonald A, Walter G. The portrayal of ECT in American movies. J ECT 2001;17(4):264-74.
7. Fink M. Prejudice against ECT: Competition with psychological philosophies as a contribution to its stigma. J ECT 1997;13(4):253-65.
8. Stefanazzi M. Is electroconvulsive therapy (ECT) ever ethically justified? If so, under what circumstances. HEC Forum 2013;25(1):79-94.
9. Kalinowsky LB. ECT: underused and misunderstood. Psychiatr Serv 1982;33(6):425-8.
10. Chanpattana W, Kunigiri G, Kramer BA, Gangadhar BN. Survey of the practice of electroconvulsive therapy in teaching hospitals in India. J ECT 2005;21(2):100-4.
11. Loo CK, Schweitzer I, Pratt C. Recent advances in optimizing electroconvulsive therapy. Austr NZ J of Psychiatry 2006;40(8):632-8.
12. Narayan CL, Shekhar S. The mental health care bill 2013: A critical appraisal. Indian J Psychol Med 2015;37(2):215-9.
13. Grover S, Avasthi A, Gautam S. Inpatient care and use of electroconvulsive therapy in children and adolescents: Aligning with mental health care act, 2017. Indian J Psychiatry 2019;61(Suppl 2):155-7.
14. Kar SK, Tiwari R. Impact of Mental Health Care Bill on caregivers of mentally ill: Boon or bane. Asian J Psychiatry 2014;12:3-6.
15. Ward HB, Fromson JA, Cooper JJ, De Oliveira G, Almeida M. Recommendations for the use of ECT in pregnancy: literature review and proposed clinical protocol. Arch Wom Ment Health 2018;21(6):715-22.
16. Grover S, Somaiya M. Electroconvulsive therapy in the elderly. J Geriatr Ment Health 2017;4(2):74-81.

17. Andrade C, Shah N, Tharyan P, Reddy MS, Thirunavukarasu M, Kallivayalil RA, Nagpal R, Bohra NK, Sharma A, Mohandas E. Position statement and guidelines on unmodified electroconvulsive therapy. Indian J Psychiatry 2012;54(2):119-33.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Safe Abortion – Ethics in a White Coat

Tejas P. Mhapankar

Intern, Sir J.J. Group of Hospitals and Government Grant Medical College, Mumbai.
E-mail – tejasmhapankar@gmail.com

INTRODUCTION

Globally, induced abortion, whether safe or unsafe, legal or illegal, is a reproductive health service that is a part of the lives of women, couples and communities in both developed and developing nations [1].
The Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971, with the goal of ensuring access to safe abortion [2]. This law however permits only registered allopathic medical practitioners to perform abortion in specified abortion centers as certified under the MTP act. For several years, sections of India's medical community, advocacy groups and government officials have been discussing an amendment to the MTP Act, which was officially proposed by the Ministries of Health and Law in 2014 and is now pending for approval by Parliament, one of which states, "expanding abortion provision to nurses, auxiliary nurse midwives and practitioners trained in the Indian system of medicine with recognized qualifications in Ayurveda, Unani, Siddha or homeopathy [3-4]." Its approval can ensure a rational optimization of the available health workers, address the shortage of specialized health-care professionals and increase the access to safe abortion services.

Several studies have found that certain characteristics of abortion providers and aspects of services are important to women in India and may influence their provider or facility preferences and their perception of the quality of care they receive [5-7]. This is where comes into action, the role of medical ethics, played by these various health professionals. There are a range of moral and ethical issues which arise due to an unintended pregnancy and abortion. In a country like India, the issue of unintended pregnancy and abortion is multi-faceted including social, moral, religious, cultural and economic factors. Exploring the values and ethics on any topic can be complex and confusing and abortion is no exception. For a health-provider, it is imperative to follow the core principles of medical ethics, namely, autonomy, beneficence, non-malfeasance and justice. Whenever we talk about the ethics involved in the clinical practice of providing abortion services, the starting point should always be the point at which a woman presents to the health-provider with a request for induced abortion of an unwanted or unintended pregnancy. The present write up thus focusses on the role of health workers in providing safe abortion with best practice in view of medical ethics involved in abortion service.

Objectives

1. To emphasize the role of health workers in safe abortion care.
2. To discuss the medical ethics involved in care of women requesting induced abortion.

The write up is an extensive review of literature conducted on the already published articles and evidence-based guidelines by the World Health Organization, Royal College of Obstetricians and Gynecologists (RCOG) and the Ministry of Health and Family Welfare, Government of India. The article also contains review of literature conducted on published articles and researches on Abortion in India and globally using various online portals, namely, PubMed, etc. After briefly going through the articles, two aspects of abortion are primarily focused- the role of health-providers in providing abortion and secondly, medical ethics involved in delivering abortion service to women. The present write up focuses only on the health-care provision in India, where

abortion is legal, and thereby safe under the MTP Act of 1971. The health care provision is based on the international guidelines given by the WHO and RCOG. These international guidelines and recommendations have been adapted to the context of health services in India and have tried to ensure that all women considering induced abortion, have an access to a service of uniformly high quality. In the present paper, the role of health-providers and medical ethics is discussed only after considering that the abortion service is safe, legal, meets the criteria of the MTP Act, and not otherwise.

Over the last few decades in India, important advances have been made towards improving the availability and access of safe abortion services. However, the expansion of pool of health-providers who are legally able to be trained in and perform abortion services, other than specialist doctors, still remains to be approved by the Parliament.
According to the World Health Organization (WHO), moving beyond specialist doctors to involve a wider range of health workers is an increasingly important public health strategy [8]. Health workers as defined by the WHO are "All people engaged in actions whose primary intent is to enhance health. This includes physicians, nurses and midwives, but also laboratory technicians, public health professionals, community health workers, pharmacists and all other support workers whose main function relates to delivering preventive, promotional or curative health services."
This is broad-based and inclusive definition of health workers, and many health workers such as advanced practitioners, midwives, nurses and auxiliaries are still inefficiently used in many settings [9-10]. The WHO has provided evidence-based guidelines on the safety, effectiveness, feasibility and acceptability of a range of health workers in the delivery of recommended and effective interventions for providing safe abortion, post-abortion care and post-abortion contraception. Involving all of these health workers makes it more likely that abortion services will be available to women easily which will increase the incidence of safe abortions.

Now, coming to the medical ethics, let's discuss the core principles, to which providing abortion service is no exception-

Autonomy

This principle acknowledges the fact that the patient has a perspective of her interest based on her values and beliefs. The patient has the right to choose or refuse treatment.

Beneficence

A doctor should always have the best interest of the patient as the supreme consideration and ensure a balance of good over harm.

Non-malfeasance

A doctor must make sure that in the first place, he does no harm.

Justice

It is the fair distribution of health resources and the decision of who gets what treatment is fairness and equality.

Now let's move further in addressing the ethical behavior of a health-provider to a woman with a request of an abortion.

Conscientious objection to abortion by the health professional

The Abortion Act of 1967 has a conscientious objection clause, which permits health-providers to refuse to participate in any treatment authorized by the Act if it conflicts with their religious or moral beliefs. Coming to the ethical considerations, it is the duty of the health-provider to explain this to the woman and tell her that she has the right to see another doctor. The health-provider should make sure that all the relevant information about alternative services is available to the woman, as quickly as possible.

Access to the service

An abortion provider should not restrict access on the grounds of age, ethnicity, disability, marital status, number of previous abortions or sexual orientation of the woman. It also includes teenagers,

women with complex social problems, young women from minority groups who have difficulties in accessing healthcare services.

Tailored care
If requested, a female member of the staff should be made available to the woman. The service should be culturally sensitive and if required professional interpreters should be available along with the health-provider.

Information provision
The information should be provided to women requesting abortion in such a way that there is special emphasis on the overall safety of the procedure and in a way that women can understand. Information should be given in a non-judgemental and supportive way.

Initial assessment
To begin with, the health-provider can reduce the stigma around the issue by saying to the woman, "I have treated a number of people with the same problem you have."

Ethical considerations
- Replace the term 'married woman' with 'woman' and the word 'husband' with 'partner', to assure unmarried woman that abortion is legal for all women.
- Respect gender norms by ensuring the presence of female attendant in the presence of male health worker. If requested, make a female health worker as a primary examiner.
- Ensure and assure confidentiality.
- Ensure complete privacy. If the woman is with an accompanying person, reach an agreement as to whether they want this person to be present during the examination.
- Start the clinical interview with issues that are the least sensitive and least threatening.
- Inform the woman about what examination you want to carry out, the purpose and nature of the examination.
- Obtain the woman's consent before examination.

Making the abortion decision
The clinical staff must be sensitive to the different stages of decision making by the woman. It is imperative to identify those women who may require additional support and counselling in making a decision and provide them with necessary aid.
- Present all the relevant information.
- Respond to questions as fully and honestly.
- Help her choose.
- Respect her choice, even if it is not the one you would have wanted them to make.
- wherever possible, women should be given the abortion method of their choice

Information on post-abortion contraception
Effective methods of contraception should be discussed with women and documented.
- Intensive and positive counselling about use of contraception
- Help the woman choose
- Respect her choice
- However do no coerce a woman who is unwilling for contraception

Care after abortion
There are a number of myths about the consequences of abortion. If the woman expresses concern, she has to be reassured about those issues as and when she addresses them.
- Provide a letter with information about the procedure to allow another practitioner elsewhere to manage any complications.

- Provide written information about symptoms they may experience, emphasising those which would necessitate an urgent medical consultation.
- Advise her for routine follow-up if she wishes.
- Referral should be available for any woman who may require additional emotional support or whose mental health is perceived to be at risk.
- Inform her where to seek help if she has any concerns or if she needs further contraceptive advice or provision.

Impact

Much in line with the RCOG Guidelines, abortion service should aim to provide high quality, effective, efficient and comprehensive care which respects the dignity, individuality and rights of women to exercise personal choice over their management. An abortion service should be an integral component of a broader service for reproductive and sexual health encompassing contraception, management of STIs and support. Health-providers working within the service must be appropriately trained. All the aspects of abortion care should be delivered in a respectful and sensitive manner that recognizes women as decision makers.

REFERENCES

1. Stillman M. Abortion in India: A Literature Review, New York: Guttmacher Institute, 2014
2. Government of India, The Medical Termination of Pregnancy Act, No. 34, 1971.
3. Mudur G. Doctor's favor changes in India's abortion law, BMJ 2008;337:1273.
4. Ministry of Health and Family Welfare, The Medical Termination of Pregnancy, (Ammedment) Bill, Government of India, 2014
5. Jeejeebhoy S. Increasing access to safe Abortion in rural Maharashtra: Outcomes of a comprehensive Abortion care Model, New Delhi Population Council, 2011.
6. Acharya R. Knowledge, Attitude and practices of certified providers of medical abortion: Evidence from Bihar and Maharashtra, India. Int J Gynecol Obstetr 2012;118(1 Suppl.):S40-6.
7. Visaria L. Abortion in India: Emerging Issues from the qualitative studies, Economic and Political Weekly 2004;39(46-47):5044-52.
8. Health worker roles in providing safe abortion care and post-abortion contraception., Department of Reproductive Health and Research, World Health Organisation, 2015.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Social Media – The Newest Doctor in Town

Ohsin Behl

Intern, Maharashtra Institute of Medical Education and Research, Pune
Maharashtra University of Health Sciences.
E-mail- officialobehl@gmail.com

INTRODUCTION

What was the absolutely first thing you did this morning? Before you got up from bed even? I have to admit that I did the same thing. In fact, 197 million others are just like you [1]. You probably saw a bunch of 'good morning' and 'good thought' forwards from your relatives. But occasionally there's that one uncle with a self-proclaimed medical degree that'll invariably send forwards like "Cholesterol is good for you". We're obviously too busy to deal with all these nonsense messages so we ignore it. But the less occupied people read it and say "What! I can have that samosa without any guilt? This has to be true", and it goes on in a cascade because of a "non-fact checking" culture, till somewhere a patient of dyslipidemia stops going to his doctor because who likes taking Atorvastatin every day? And it's not just laymen, even the people who are responsible for health policy decisions have been found to be not just unaware, but wrongly aware of facts [2-3]. This is the power of social media. And it's all around us. And it feeds the fundamental human characteristic: gossip. Our brains have been wired to rely on word of mouth, and to be more alarmed by "dramatic things", because there was a time when that was the only mode of communication [3].

What looks more eye catching? "Alcohol consumption leads to liver cirrhosis" (research article) or "10 ways that wine and beer are good for you" (click bait). Not just a simple observation, this is a research based fact that false news spreads much faster than the truth [4-5]. In an international study, in the case of food and nutrition articles, only 5 out of 18 articles studied for credibility received a positive credibility rating [5]. Content in this category was quite varied, but generally articles often took an extreme stand, often exaggerating the benefits and harms of various foods [5]. In the case of articles about vaccines, 12 articles received a positive credibility ratings. We observed that more than half of these articles were reporting outbreaks of vaccine-preventable diseases (mainly measles). These outbreaks were the result of declining vaccine uptake due to anti-vaccination movements. The fact that these articles are popular reflects the general public's concern about this issue. Further underscoring this issue is the World Health Organization branding vaccine hesitancy – mainly due to the anti-vaccination movement – as one of the top threats to global health in 2019 [5]. All 5 vaccine articles which received a negative credibility rating were anti-vaccine in nature, invoking conspiracy theories about public health authorities and pharmaceutical companies, as well as persistent myths about vaccines which have been disproven [5].

In 2018, the number one article shared more than a million times was a piece titled "Federal Study Finds Marijuana 100X Less Toxic Than Alcohol, Safer Than Tobacco – Your Health Guide" [2] was rated a NEGATIVE 1.3 in credibility, meaning that it was not credible and potentially harmful. But is it really a Public health issue? Just like herd immunity and antibiotic resistance, this false news epidemic needs public awareness. And as medical professionals, it becomes our responsibility to not just leave our stethoscope in the hospital. Our responsibility doesn't stop at curing patients. It is our duty to stop this at the root, especially when the branches span to 14% of this country's population [1]. And because false news spreads faster than real facts, we have to be all the more proactive as the knowledge bearers of our community. What use are those 5.5 years

of knowledge if the people around us are being misled by Whatsapp forwards and Facebook posts and Instagram stories.

I have to admit that there have been times when I have found myself questioning whether my own knowledge is credible, and that is how these articles are designed, such as an image of a blister pack of pills, warning recipients to avoid certain brands of the pain reliever acetaminophen because "doctors advise that it contains 'Machupo' virus, one of the most dangerous viruses in the world, with a high mortality rate" [4]. But do not hesitate to refer to the thousands of research articles you can find on PubMed and ResearchGate. Take the time to educate people around you, and correct their knowledge with scientific backing. Our small effort can stop a social media epidemic, even save a few doctors from being harassed by their misinformed patients, and may save a life in time of need.

We have the whole world on our fingertips, and it's up to us to use it for good.

REFERENCES

1. Kumar P. India will have 730 million internet users by 2020, govt says | India News - Times of India [Internet]. The Times of India. [cited 2019Jun18]. Available from: http://www.timesofindia.indiatimes.com/india/india-will-have-730-million-internet-users-by-2020-govt-says/articleshow/57858869.cms
2. Regan J. Federal Study Finds Marijuana 100X Less Toxic Than Alcohol, Safer Than Tobacco [Internet]. Your Health Guide. 2018 [cited 2019Jun18]. Available from: https://web.archive.org/web/20180401034419/http://urhealthguide.com/federal-study-finds-marijuana-100x-less-toxic-alcohol-safer-tobacco/
3. Rosling H, Rosling O, Rönnlund Anna Rosling. Factfulness: ten reasons were wrong about the world and why things are better than you think. Londres: Sceptre; 2018.
4. Sachdev C. Fake Medical News Can Now Be Fact-Checked In India [Internet]. NPR. NPR; 2017 [cited 2019Jun18]. Available from: https://www.npr.org/sections/goatsandsoda/2017/05/12/526687362/fake-medical-news-can-now-be-fact-checked-in-india
5. The Most Popular Health Articles of 2018, a Scientific Credibility Review [Internet]. Health Feedback. 2019 [cited 2019Jun18]. Available from: https://healthfeedback.org/the-most-popular-health-articles-of-2018-a-scientific-credibility-review/#F1
6. Zhang AX, Robbins M, Bice E, Hawke S, Karger D, Mina AX, et al. A Structured Response to Misinformation. Companion of the The Web Conference 2018 on The Web Conference 2018.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

The Need for Preparing Medical Students to be Digitally Responsible in Addition to being Socially Responsible

Aakash Sethi

Undergraduate Student (2nd year M.B.B.S)
SSG Hospital and Government Medical College, Baroda, Gujarat
Email - aakashsethirox@gmail.com

INTRODUCTION

Doctors must be socially responsible when it comes to treating patients. After Tim Berners Lee built the WWW, the way we shared information was revolutionized. The Guy from Harvard, better known as Mark Zuckerberg created the first social network from his dorm room, Facebook as we know today captivated us like nothing has ever before. The internet and social media have shaped the world in a completely different way. As you are listening me speak, one more discovery in the world would have taken place. We are in the peak of our quest to find new things.

Omar N Bredly said - "Ours is a world of nuclear giants and ethical infants." We can very well replace the word 'Nuclear' with 'Technological' considering the pace with we are bring in new technologies in our world. With all these advancements one question remains unanswered- How can we teach Medical students to be more ethically responsible while handling these new Technologies. I have had the privilege to be born in an era stated by many 'as the greatest one to be alive' and will be sharing my thoughts on how technology is shaping a medical students and a doctors life and how can we address that.
The smartphone usage of a college student is about 4-7 hours in a day [1]. This data includes the medical students as well. We, the newer generation of doctors will have technology deep rooted in their daily life. One way in which the new technologies are brought out in the market is 'Bio-Medical Devices'. We can consider that the medical innovations industry has 4 stakeholders- Manufacturer, Regulator, Provider, and Consumer. In future the Students would play the role of the Provider of the innovation. In other words, they would guide and help the patient to choose what's best for him.
The Biomedical devices bring ethical dilemmas with them. Let's take the example of "Electronic Medical Records".

Consider this- You are at the hospital. Using your Identity card the Receptionist access your previous medical records which contain information about the treatments you have received at various health facilities. This record is made available to the doctor whom you are going to consult. As the doctor elicits your new history he/she has in front of him/her all the necessary previous health records. Think for a moment how easier would it get to prevent misinterpretation of half maintained medical records and how creating and maintaining such a system would ease out the work of a medical practitioner? This is not as wonderful as it may sound to you. Remember the Harvard Guy that I spoke to you about in the beginning of my speech? I am sure you would also remember the various Law suits against him because he breached the data privacy laws.

Complete Digitalization of Records would make them vulnerable to the threat of being hacked or misused by people not authorized to that data. The privacy of the patients can be compromised. Mark Zuckerberg said "I think the mistake we made is viewing our responsibility as just building tools, rather than viewing our whole responsibility as making sure those tools were used for good." Thus only creating data privacy laws would not suffice. We as medical students and future doctors

need to learn to handle this data responsible. The concepts of medical informatics can be included in the curriculum to help the students be more familiar with the storage, retrieval and interpretation of the EMR [2]. This would help uphold the principles of `privacy` and `confidentiality`.

When the CDSCO made the Drugs and Cosmetics Act of 1940 they had not foreseen that in less than a century's time Medicines would be dispensed by online pharmacies as well. In an E-pharmacy a prescription is uploaded, and based on that drugs are supplied. To prevent dispensing of drugs on Fake/Photoshoped prescriptions, E- Prescriptions can be given by the doctor and directly uploaded on the E-Pharmacy website. But on the other hand the patient's autonomy in choosing his/her own pharmacy is lost. This might also pave way for E-pharmacies to create monopoly by giving incentives to the doctor. Moving on to another problem posed by E-Pharmacies. Let's suppose you have just bought anti-hypertensive medication. While surfing other websites you see an advertisement for a BP measuring instruments and other products that could be used by a hypertensive. The case would have been different if you were looking a smartphone and ads of Mobile phone accessories were shown. Here your personal data is being given to a 3rd party seller which is using it to show ads of products. Again the issue of breech in personal data privacy is being highlighted.

Contribution of artificial intelligence to diagnosis and treatment has generated ethical dilemmas over the extent of physician reliance on machine intelligence. Artificial intelligence has been used in Radio diagnosis [3-6], Pathology [5], Management of medical records [6] etc. Ethical and regulatory challenges that surround AI in healthcare, particularly privacy, data fairness, accountability, transparency, and liability [7]. Modernized regulatory approval—in the form of ad hoc guidance—is needed to maintain the safety and efficacy of Machine learning in Medicine (MLm) based algorithms. As more diagnostic and therapeutic interventions become based on MLm, the autonomy of patients in decisional processes about their health and the possibility of shared decision-making may be undermined. This would happen, for instance, if reliance on automated decision-making tools reduces the opportunity of meaningful dialogue between healthcare providers and patients or if payers consider MLm recommendations as a precondition for reimbursement and refuse to cover treatments when the MLm recommends against them When using such diagnostic tool the doctors themselves should grasp at least the fundamental inner workings of the devices they use. The students must know more than the machines so they can recognize mistakes and inaccurate information in the computer systems and ensure that decisions made are relative to treatment goals. This would prevent `non- maleficence`. Via proper methods the curriculum should teach students to respect the patient's autonomy at all times over and above all technologies.

The advent of newer and improved kind of treatment options coupled with demands of the patient to be treated faster, have compelled doctors to use diagnostic tools which can be at times costlier. It should be taught to us that the costs of using such modalities should be discussed before performing the tests and not after. "How many of you know about Dr. Lal Path Labs??" It is of India's highest valued and growing diagnostic chain. I had read a very interesting case study about it. During the last three years they have not increased the cost of performing diagnostic tests even with the inflation of 4.14 %. Their CEO has stated that at the heart of this miracle lies improving operational efficiencies and using technology to cut on costs. Thus technology will also benefit the patients. The doctors need to take care that their purchase of health care technology enhances patient care more than it drives up cost. It should be imbibed in the student's mind that the patient's welfare should be the first consideration while making decisions, which is consistent with the principles of `beneficence` and 'autonomy'.

I would like to share with you the reality of Medical students of our generation. From the first year onwards, students sometimes lose interest in dissection. Earlier they still had to go to the Dissection hall to learn anatomy. But nowadays they simply use mobile phone applications and watch videos for clearing anatomy. The extent of availability and accessibility of internet has

increased so much that student's dependency to attend lectures has been decreased. If this trend continues clinical examination would also be learnt over the internet and REAL Doctor patient learning would reduce beyond imagination. There would be a whole generation of doctors who rely on internet over books to read about disease diagnosis, watch educational videos instead of attending workshops thus losing out on 'hand on experience'. This trend can be extrapolated to Future Doctors as well. The ease of learning a new procedure online will increased. This can lead to the physician trying out the new procedure on his patients. Here before the physician applies the newer technique, he should have take appropriate offline training, make full disclosure and discuss the risk/benefits and the alternatives of the procedure with the patient. To prevent this from happening, right from the UG level the Medical colleges should therefore encourage medical students to attend conferences and seminars and take hands on training instead of purely relying on E learning platforms.

As the saying goes `with more power comes more responsibility`. In this technological world if we teach medical students the ethics to handle the great power of heath IT, we can surely achieve the objective of Universal Health Coverage.

RECOMMENDED READING AND REFERENCES

1. Prof. Mohammed Naved Khan. Smartphone Dependency, Hedonism and Purchase Behaviour: Implications for Digital India Initiatives 2018
2. McGowan JJ, Passimentc M, Hoffmand HM. Educating medical students as competent users of health information technologies: the MSOP data. Stud Health Technol Inform 2007;129(2):1414–8.
3. Hosny A, Parmar C, Quackenbush J, Schwartz LH, Aerts HJWL. Artificial intelligence in radiology. Nat Rev Cancer 2018;18(8):500-10.
4. Gulshan V, Peng L, Coram M. Development and Validation of a Deep Learning Algorithm for Detection of Diabetic Retinopathy in Retinal Fundus Photographs. JAMA 2016;316(22):2402–10.
5. Chang HY, Jung CK, Woo JI, Lee S, Cho J, Kim SW, Kwak TY. Artificial Intelligence in Pathology. J Pathol Transl Med 2019;53(1):1-12.
6. Mazzanti M, Shirka E, Gjergo H, Hasimi E. Imaging, Health Record, and Artificial Intelligence: Hype or Hope? Curr Cardiol Rep 2018;20(6):48-50.
7. Vayena E, Blasimme A, Cohen IG. Machine learning in medicine: Addressing ethical challenges. PLoS Med. 2018;15(11):e1002689.
8. Stern RJ. Teaching Medical Students to Engage Meaningfully and Judiciously with Patient Data. JAMA Intern Med 2016;176(9):1397.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

When The Doctor Discriminates

Rahul Rangan

Undergraduate student (3rd year, MBBS),
Krishna Institute of Medical Sciences, Karad, Maharashtra
E-mail id - rahul.rangan98@yahoo.co.in

I urge you to picture a world where caste, creed, religion, money, sex, age, etc. did not hold bar for availing medical services.
A world where patients were treated in an equal and fair manner.
A world where we don't judge the patient before treating.

Can you imagine such a world?

Because in this day and age such a world is left to Utopian Ideology and it is this very minute yet contrasting traits that act as hurdles when we treat someone. The very first thing we are taught during History Taking is that name, age, caste, religion, etc. give us valuable insight on a patient's condition and this information is what predisposes a doctors behavior and attitude towards the patient. I would like to share with you all an example where caste was the deciding factor not only in a patient, but in the education and death of a resident
from our fraternity.

Dr. Payal Tadvi was a post-graduate medical student, who joined a premier institute in Mumbai and was ostracized for the very reason that she came from a lower caste. The harassment and casteist slurs used against her from her seniors went to that extent that she became depressed and on one fateful day after performing two surgeries and calling her family to tell them about the anguish she was undergoing, she was found dead in her room.

Dr. Payal Tadvi's suicide shows how deep caste prejudices run within our profession. The sheer irony being that people say so many things against caste-based reservation but no one has the courage to speak out about the caste-based discrimination that goes on in medical colleges all over India.
There have been numerous propositions on how patients as well as doctors should deal with this kind of harassment. Some of these include confiding in parents and friends, maintaining a diary, collecting evidence of discrimination, and so on. Yet I would argue that individuals shouldn't have to learn to cope with this constant berating. There has to be a shifting tide and this will be achieved only by actively including a diverse set of individuals and providing
them with committees which give equal representation on a large scale to manage overt bigotry. Coming from the medical field we should have the basic knowledge that nobody's blood is different be it patients or our own colleagues.

A recent development which in my opinion should be implemented in the admission process of medical students is the 'Implicit-Association Test (IAT)'. The IAT is a computer-based test that measures how quickly a person can categorize various words and images. It works on the fact that most of us identify words and images more rapidly when they come from closely related categories from our memory. For instance, if you associate librarians with intelligence and boxers with violence, you can probably tell in a split-second that synonyms for intelligence like smart and brainy relate to the dual category "librarians or intelligence," and synonyms for violence like aggression and hostility relate to the dual category "boxers or violence.".

But when the elements are switched around, and the dual category "librarians and violence" is compared to the to "boxers and intelligence"? In this case it will take the person longer to match smart and brainy with the category containing "intelligence," because these dual categories contain elements that are not stereotypically related to each other. Hence, by comparing the speed with which people categorize words or images, the IAT indirectly assesses how closely people associate certain elements with each other.
To examine racial stereotypes, the test might replace librarians and boxers with Whites and Blacks and for religious stereotypes, the test might replace it with Hindu and Muslim or any such indigenous word which is country specific. This will help us to understand whether a person is biased to a certain religion, caste, creed, etc.

Another example I would like to share with you is of one such couple who after meeting with nearly dozen doctors, finally decided to settle on a pediatrician in private practice with nearly 19 years of experience. On the morning of their first appointment, however, the doctor refused to see them. The reason: the couple were a same-sex couple.

The doctor apologized and stated that after much deliberation she felt that she would not be able to develop the personal doctor-patient relationship that she normally did with her patients because her religious faith made it hard for her to be comfortable around same-sex couples.
I actually sympathize for the doctor as she clearly felt that she could not give the level of care that the couple deserved. In fact, a strong doctor-patient relationship is the key to quality health care and if the doctor felt uncomfortable in asking them questions about certain aspects of their personal lives that could affect the health of their daughter, she might overlook pieces of information that were important for the child's therapeutic treatment. The couple too might also pick up on the doctor's unease, and would be less forthcoming about their concerns or opinions. Given this, the doctor might not be the right pediatrician for the child.

Ethically, if the doctor felt that she could not establish the necessary doctor-patient relationship with the couple, she shouldn't have taken them on as patient in the first case and should have been upfront with the couple sooner, rather than waiting until the morning of the child's first pediatric appointment to inform them of her reluctance.

Now we have been informed that a doctor has the right to refuse patients. For the most part, doctors are legally bound to treat patients only once they have entered into a care relationship. A physician must provide a reason for terminating the relationship, if he does so, and must ensure continuity of care through referrals.

According to the Federal Civil Rights Act of 1964, it is illegal to refuse a patient based on race, religion or gender. Sadly, this is not the case for sexual orientation or gender identity.

As I said before, the doctor was not the right pediatrician for the child. But she could be, if she learns to look beyond her personal prejudices and see the couple for who they are: human beings with the same needs, fears, and hopes as her. There has to be an implemented legal framework to get doctors to take that first step for equal treatment without sexual orientation and gender identity bias.

The last instance where health professionals lacked in providing uniform treatment is in the case of Juliann Garey, an author who visited the hospital for an ear infection. When the doctor looked at the list of drugs, she had been prescribed for bipolar disorder, he shut her chart and politely declined to prescribe her medication for her current complaints because he was weary of the medication she had been taking. The very next day her eardrum ruptured and she was left with minor but permanent hearing loss.

On subsequent visits to the hospital, doctors passed snide remarks such as:
"You better get yourself together psychologically or you won't get better physically". Despite suffering from Bipolar Disorder, Juliann had gone through most of her life without anyone ever knowing she suffered from mental illness - except when she had to reveal it to a doctor.

There's a specific term which describes this lack lusture attitude which the doctor showed and it is called: "Diagnostic Overshadowing" and is defined as a process where health professionals wrongly presume that present chief complaints are a consequence of the patient's prior mental illness. As a result, people with serious mental illnesses end up with wrong diagnoses or are undertreated and this is a problem, because ever so often these patients also suffer from chronic conditions like migraines, irritable bowel syndrome and mitral valve prolapse but they aren't treated for the same.

To counter this problem, Columbia University Medical Center started with a premise where health care workers need to start listening to what their patients are telling them, and not just looking at what's written on their charts and this is known as the "Narrative Medicine Program". It focuses on paying attention to the words, the silence, the facial expressions instead of the race, the religion and the economic status or any prior mental health condition because the patient is telling you the diagnosis and not his cultural upbringing.

Finally, I again urge you to see the bigger picture, a world where caste, creed, religion, money, sex, age, etc. does not hold bar for availing medical services.

A world where patients are treated in an equal and a fair manner. A world where we don't judge the patient before treating.
Can you imagine such a world?
Because time has come now to stop imagining and start doing. Let us work together to make that imagination a living reality.

RECOMMENDED READING AND REFERENCES

1. Sonam Joshi - When doctors discriminate; The Times Of India; June 3, 2019;
2. Juliann Garey - When Doctors Discriminate; The New York Times; Page SR6; Aug. 11, 2013;
3. Monique Tello - Racism and discrimination in health care: Providers and patients; Harvard Health Blog; Jan. 16, 2017;
4. Harvard - Implicit Association Test;
5. Holly Fernandez Lynch - Discrimination in the Doctor-Patient Relationship; Bill of Health - Harvard Law School; September 7, 2012;
6. Columbia University - Narrative Medicine Program

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Tackling Public Health in a Culturally Diverse World

Pratik Naxine

Undergraduate Student
Second Year, Bachelor of Physiotherapy,
Datta Meghe College of Physiotherapy, Nagpur (Maharashtra)
Email id - pratiknaxine2699@gmail.com

Change, such a scary beautiful word. We are working for a modern democracy build on the values of human dignity and equality. The conflicts have deepened and new dangers have emerged. Climate change is moving faster than we are, Inequalities are growing and we see horrific violations of human rights. Nationalism and fear of hatred are on the rise and as we begin, I call for unity. I truly believe that we can make our world a more safe and secure. We can settle conflicts overcome hatred and defend shared values.

We can only do that together. Narrow the gap. Bridge the divides. Rebuild trust by bringing people together around common goals. Unity is the path. Our future depends on it. The question arises regarding bridging the healthy equity gap in an unequal culturally diverse world.

Bioethics have an application ranging from birth to end of life. It has an impact at every level of human community.

What is Ethics? Let me first define the word "Ethics." Ethics refers to well-founded standards of right and wrong that prescribe humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues. Ethics is when one knows what is normal between what is right or wrong. For a well-mannered individual, it is easy to think first before you act on something. It is for us to know what our rights are and whether it is right or wrong, to do or not. We should be responsible of our actions or behavior. In the society or community, we can see the diversity on ethics because of differences in race, differences of religion, differences in beliefs and political views.

Ethics is important to every society as it plays important role in shaping the individual's behavior in society. The question is how to bring maturity so that it can make the most helpful contributions? Before making any decision think about what should I do? How should I react? How should I treat others? What are my obligations or responsibilities towards others? What type of person I should be?

Ethical Questions for Individual Practitioners-

- When should communicable diseases be reported to public health authorities?
- Can medical treatment ever be provided against a patient's will?
- Can patients refuse to undergo routine preventive health measures?

Public health Care is commonly cited example of a service that ought to be distributed according to the need [1]. Why be concerned about equity in health care distribution? Part of the answer is that health care serves a significant end in individual's health'. The work of public health professionals is important because public health initiates affect people every day in every part of world. It addresses broad issues that can affect the health and well being of individuals, families, communities, population, and societies, both now and for generations to come.

Culture that is dynamic and evolving. Even when you think you understand one culture it will have evolved or you will have identified exception. Diversity exists within any single culture. The barriers to receiving effective public health treatment are nothing short of intimidating. In public health care we need to recognize cultural differences, individual differences. We need to show respect, speak clearly, be transparent, clarify and ask for clarification when needed.

Practical reasons that can be put forth for attaining greater diversity in Public health care are(3):

- Advancing the cultural competence
- Increase access to high quality health care workforce
- Ensuring the optimal management of Public health care systems'.

The cultural competence denotes knowledge, skills, attitudes and behavior required of a practitioner to provide optimal health care services to person from a wide range of culture and ethnic background' [2]. To do so effectively health care providers must have a firm understanding of how and why different belief systems, cultural biases, ethnic origins, family structures and host of other culturally determined factors influence the manner in which people experience illness adhere to medical advice and respond to treatment'.

Such differences are real and translate into real differences into outcomes of care. Physicians and other health care professionals who are unmindful of the potential impact of language barriers, various religious taboos, unconventional explanatory model of diseases or traditional alternative remedies are not only unlikely to satisfy their parents but more importantly are also unlikely to provide their parents with optimally effective care' [3].

Public Health is more focused on the group even though each individual is affected by Public Health. We all need to resolve public health ethical issues at system level and make organizational decisions. Feel empowered to behave ethically. We all need to get educated in environment that is characteristics of the diverse world they will be called upon to serve.
Throughout the public health code of ethics, the emphasis is clearly and definitively focused on the word "community". The connection between individuals interacting in the community is stressed to show the importance of individual health on the community as a whole. The public health code of ethics is focused more generally on the health care provided to communities and populations and does not focus directly on a specific profession's interaction should be with a patient, but instead broadly stated what "public health" should do.

"Health Care Ethics is a set of moral principles, beliefs and values that guide us in making choices about medical care." Some challenges related to public health research ethics. There is no standardized method of organizing either the ethics of clinical practice, or the public health and biomedical research. Although these distinctive concerns are often dealt with under the broader term of bioethics, sometimes bioethics is presented as the equivalent of medical ethics.

Whichever approach is preferred, a key question remains: what distinguishes public health ethics from medical ethics? The answer lies in the distinctive nature of public health. It is difficult to estimate direct benefits of the majority of public health interventions since some of these interventions target many health problems and many interventions can contribute to reduce the burden of one health problem. Furtherer, it is known that some of health determinants like those associated to environment change naturally. At individual level, it is even more complicated as the efficacy of public health intervention is the absence of a particular health event that is difficult to justify by the intervention

Providing proper health care services to an ever more diverse population is bound to an increasingly difficult challenge. In this issue of ethics in public health we need to choose what we want to be whether a collectivist or individualist.

If collectivist - it focuses on 'WE', it promotes relatedness and interdependence, it has connection to family, it values respect and obedience, emphasize group goals cooperation and harmony, greater and broader influence of group views and values.

If Individualist- that focus on 'I', value autonomy, view ability to make personal choices as right, emphasize individual initiative and achievement. The healthcare team protects the rights, privacy, confidentiality and dignity of its residents.

As a healthcare provider, we must possess the good virtue of honesty, the most important quality we can bring to our job. Since its inception, public health has recognized social conditions as basic causes of illness and disease.

To bridge the healthy equity gap in culturally diverse world that too in public health we need to [4] –

- Monitor health status to identify and solve community health problems.
- Diagnose and investigate health problems and health hazards in community
- Mobilize community partnerships and action to identify and solve health problems
- Assure competent public and personal health care workforce
- Evaluate effectiveness be accessibility and quality of personal and population based health services

We need to Empower, Inform, Educate people about health issues

RECOMMENDED READING AND REFERENCES

1. Culyer AJ. Equity- Some theory and its policy implications. J Med Ethics 2001;27:275-83.
2. Fokunang CN, Tembe-Fokunang EA, Awah P. The Role of Ethics in Public Health Clinical Research. Curr Topics Pub Health 2013; Open Access.
3. Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. Health Affairs 2002;21(5):90102.
4. https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html US Department of Health and Human Services. Centre for Disease Control and Prevention. Accessed on 08 June 2019.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Rethinking Medical Ethics: Artificial Intelligence and Healthcare – Confronting Dr. Robot

Rounak Verma

Undergraduate student (7th semester, MBBS)
Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences (Deemed to be University)
Wardha, Maharashtra
E-mail - rounakkverma09@gmail.com

The ethical guidelines laid out in the Hippocratic Oath nearly 2,500 years ago are about to collide with 21st century artificial intelligence (AI). AI promises to be a boon to medical practice, improving diagnoses, personalizing treatment, and spotting future public-health threats. By 2024, experts predict that healthcare AI will be a nearly $20 billion market, with tools that transcribe medical records, assist surgery, and investigate insurance claims for fraud.

To succeed, though, these systems need access to personal and group health data and use complex algorithms that are difficult, and sometimes impossible, to understand. This creates a potential conflict with current ethical standards for the treatment of patients, which emphasize fairness, consent, and privacy.

Even so, the technology raises some knotty ethical questions. What happens when an AI system makes the wrong decision—and who is responsible if it does? How can clinicians verify, or even understand, what comes out of an AI "black box"? How do they make sure AI systems avoid bias and protect patient privacy?

An artificially intelligent computer program can now diagnose skin cancer more accurately than a board-certified dermatologist [1]. Better yet, the program can do it faster and more efficiently, requiring a training data set rather than a decade of expensive and labor-intensive medical education. While it might appear that it is only a matter of time before physicians are rendered obsolete by this type of technology, a closer look at the role this technology can play in the delivery of health care is warranted to appreciate its current strengths, limitations, and ethical complexities.

Artificial intelligence, which includes the fields of machine learning, natural language processing, and robotics, can be applied to almost any field in medicine, and its potential contributions to biomedical research, medical education, and delivery of health care seem limitless [2]. With its robust ability to integrate and learn from large sets of clinical data, AI can serve roles in diagnosis [3], clinical decision making [4] and personalized medicine [5]. For example, AI-based diagnostic algorithms applied to mammograms are assisting in the detection of breast cancer, serving as a "second opinion" for radiologists [6]. In addition, advanced virtual human avatars are capable of engaging in meaningful conversations, which has implications for the diagnosis and treatment of psychiatric disease [7]. AI applications also extend into the physical realm with robotic prostheses, physical task support systems, and mobile manipulators assisting in the delivery of telemedicine [8].

Nonetheless, this powerful technology creates a novel set of ethical challenges that must be identified and mitigated since AI technology has tremendous capability to threaten patient preference, safety, and privacy. However, current policy and ethical guidelines for AI technology are lagging behind the progress AI has made in the health care field. While some efforts to engage in these ethical conversations have emerged [9-11], the medical community remains ill-informed of the ethical complexities that budding AI technology can introduce. Some of the most exigent concerns raised in this text.

1. Include addressing the added risk to patient privacy. This comes in view when the largest social media platform uses AI to store and act on users' mental health data with

no legal safeguards in place. The upshot of this was demonstrated in late 2017 when Facebook rolled out a "suicide detection algorithm" in an effort to promote suicide awareness and prevention. The system uses AI to gather data from your posts and then predict your mental state and propensity to commit suicide. Of course, this is definitely a positive use case for AI in healthcare. But benevolent intent aside, the fact remains that Facebook is gathering and storing your mental health data. And they're doing it without your consent.

2. Confidentiality, parsing out the boundaries between the physician's and machine's role in patient care, and
3. Adjusting the education of future physicians to proactively confront the imminent changes in the practice of medicine.
4. Additionally, dialogue on these concerns will improve physician and patient understanding of the role AI can play in health care, helping stakeholders to develop a realistic sense of what AI can and cannot do.
5. Finally, anticipating potential ethical pitfalls, identifying possible solutions, and offering policy recommendations will be of benefit to physicians adopting AI technology in their practice as well as the patients who receive their care.

One major theme to be addressed in this text is how to balance the benefits and risks of AI technology. There is benefit to swiftly integrating AI technology into the health care system, as AI poses the opportunity to improve the efficiency of health care delivery and quality of patient care. However, there is a need to minimize ethical risks of AI implementation—which can include threats to privacy and confidentiality, informed consent, and patient autonomy—and to consider how AI is to be integrated in clinical practice. Stakeholders should be encouraged to be flexible in incorporating AI technology, most likely as a complementary tool and not a replacement for a physician. In their commentary on a case of implementing an artificially intelligent computer algorithm into a physician's workflow, Michael Anderson and Susan Leigh Anderson emphasize the importance of user technical expertise in interpreting AI-guided test results and identify potential ethical dilemmas. In a similar case regarding the use of IBM WatsonTM as a clinical decision support tool, David D. Luxton outlines benefits, limitations, and precautions in using such a tool.

Furthermore, in an empirical study, Irene Y. Chen, Peter Szolovits, and Marzyeh Ghassemi demonstrate that machine learning algorithms might not provide equally accurate predictions of outcomes across race, gender, or socioeconomic status. Finally, in responding to a case that considers the use of an artificially intelligent robot during surgery, Daniel Schiff and Jason Borenstein affirm the importance of proper informed consent and responsible use of AI technology, stressing that the potential harms related to the use of AI technology must be transparent to all involved.

A second major theme in this text revolves around the role AI can play in medical education, both in preparing future physicians for a career integrating AI and in directly using AI technology in the education of medical students. Steven A. Wartman and C. Donald Combs contend that, given the rise of AI, medical education should be reframed from a focus on knowledge recall to a focus on training students to interact with and manage artificially intelligent machines; this reframing would also require diligent attention to the ethical and clinical complexities that arise among patients, caregivers, and machines. In a related article, C. Donald Combs and P. Ford Combs explore the use of artificially intelligent, virtual patients (VPs) in medical education. With their exciting applications in teaching medical history taking, such as in psychiatric intake evaluation, VPs offer a readily accessible platform with several benefits over traditional standardized patients; however, the disadvantages and shortcomings are equally important, emphasizing the need for clarity about the role of VPs in medical education.

A final theme addressed in this text elucidates the legal and health policy conflicts that arise with the use of AI in health care. Hannah R. Sullivan and Scott J. Schweikart unveil legal issues such as medical malpractice and product liability that arise with the use of "black-box" algorithms because users cannot provide a logical explanation of how the algorithm arrived at its given output.

Additionally, Nicole Martinez-Martin uncovers a policy gap governing the protection of patient photographic images as they apply to facial recognition technology, which could threaten proper informed consent, reporting of incidental findings, and data security. Finally, Elliott Crigger and Christopher Khoury report on the American Medical Association's recent adoption of policy on AI in health care, which calls for the development of thoughtfully designed, high-quality, and clinically validated AI technology, which can serve as a prototypical policy for the medical system. There is no doubt that AI will have widespread ramifications that revolutionize the practice of medicine, transforming the patient experience and physicians' daily routines. The use of AI in health care can even extend into unexpected areas such as artistic practice, as investigated by Sam Anderson-Ramos, with new dilemmas emerging from the rise of thinking machines in previously human pursuits. Additionally, Elisabeth Miller visually depicts the potential impact of AI on mechanized human bodies. Nonetheless, there is much work to do in order to lay down the proper ethical foundation for using AI technology safely and effectively in health care. Ultimately, patients will still be treated by physicians no matter how much AI changes the delivery of care, and there will always be a human element in the practice of medicine.

Recently, The Bulletin of the World Health Organization will publish a theme issue on new ethical challenges of digital technologies, machine learning and artificial intelligence in public health. This special issue will aim to explore and highlight potential ethical and governance matters that artificial intelligence applications are raising in public health. WHO, as a consequence has welcomed papers covering good research practices, implementation challenges, key normative questions and analysis of ethical challenges that arise in countries dealing with governance, research and implementation of such digital technologies for health. Let us all surge towards a better future together.

RECOMMENDED READING AND REFERENCES

1. Esteva A, Kuprel B, Novoa RA, et al. Esteva A, Kuprel B, Novoa RA. Dermatologist-level classification of skin cancer with deep neural networks. Nature 2017;542(7639):115-8.
2. Ramesh AN, Kambhampati C, Monson JRT, Drew PJ. Artificial intelligence in medicine. Ann R Coll Surg Engl 2004;86(5):334-8.
3. Amato F, López A, Peña-Méndez EM, Vaňhara P, Hampl A, Havel J. Artificial neural networks in medical diagnosis. J Appl Biomed 2013;11(2):47-58.
4. Bennett CC, Hauser K. Artificial intelligence framework for simulating clinical decision-making: a Markov decision process approach. Artif Intell Med 2013;57(1):9-19.
5. Dilsizian SE, Siegel EL. Artificial intelligence in medicine and cardiac imaging: harnessing big data and advanced computing to provide personalized medical diagnosis and treatment. Curr Cardiol Rep 2014;16(1):441-6.
6. Shiraishi J,, Li Q, Appelbaum D, Doi K. Computer-aided diagnosis and artificial intelligence in clinical imaging. Semin Nucl Med 2011;41(6):449-62.
7. Luxton DD. Artificial intelligence in psychological practice: current and future applications and implications. Prof Psychol Res Pr 2014;45(5):332-9.
8. Riek LD. Healthcare robotics. Commun ACM. 2017;60(11):68-78.
9. Luxton DD. Recommendations for the ethical use and design of artificial intelligent care providers. Artif Intell Med 2014;62(1):1-10.
10. Luxton DD. Artificial Intelligence in Behavioral and Mental Health Care. San Diego, CA: Elsevier Academic Press; 2016.
11. Peek N, Combi C, Marin R, Bellazzi R. Thirty years of artificial intelligence in medicine (AIME) conferences: a review of research themes. Artif Intell Med 2015;65(1):61-73.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Who Owns My Tissues

Anna Mary Jose

Undergraduate student (3rd year MBBS)
Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences (DU),Wardha (MS)
Email - annamaryjose0109@gmail.com

When you go to the doctor for a routine blood test, or when you have an appendectomy, tonsillectomy or any other kind of ectomy for that matter, the stuff you leave behind doesn't always get thrown out. Doctors, hospitals and laboratories keep them. Some get consent with admission forms that say something like, I give my doctor permission to dispose of my tissues or use th em in research. Others don't. Some of them don't even know what they are giving consent for and the kind of access the researcher gains with this consent.

John Moore was a man who learned that he had a rare form of Leukemia, and had his cancerous spleen removed. He had to return to UCLA where he was being treated to give tissue and fluid to the lab but decided that he wanted to actually get treated closer to home. The doctor then offered to pay his expenses and would allow for him to stay in a luxury hotel if he decided to continue to come in to give samples. This struck John as weird especially when they had him sign a release form saying "that him nor his heirs would have any right to a cell line developed from his tissues." So John Moore refused to sign the release form and he began to get harassed from the doctor, so he sent it to his lawyers to review. It turns out that the doctor he was seeing at UCLA had developed a cell line from his tissues, Mo, without his consent and without him knowing. So this lead to a lawsuit, for property rights over his own biological material. After a long battle, the court ruled against Moore saying that once the cells are removed from your body consent or not they are no longer yours [1].

- Did you ever think that you would ask yourself this question ?
- Do i even hold ownership to my body and what it produces?
- Because if i don't have that? then what do i really have left to call my own?
- We have always thought of it as a birthright .
- I was born with it, I get to keep it.
- But did you know that your tissues that exist outside the body can't be called yours anymore?

One among the judges who was in favour of Moore stated that the court had given scientists and industrialists "the right to exploit a patient's tissue for their sole economic benefit" and has failed to recognize the patient's "property interest in his own body and its products [1].
Recent court decisions could make it more difficult for scientists to individually secure usage rights for research involving the study of human biological materials.
Tissue ownership and informed consent posed a lot of queries regarding the balance of power between the citizen, the government and commercial interest, and human being's perceptions of themselves and their bodies [2-3]
In short,
What it felt like for the men who enforce the law, was that they were in a quicksand and with every new case came the question, exactly what is granted—and to whom it is granted—when a patient signs an informed consent agreement.

A pattern seemed to take form of researchers exploiting a vulnerable population, a population that didn't seem to understand the power of consent and legislation that did not how to tackle this or create specific boundaries.

A case that is close to my heart, is of Henrietta lacks.
Ring a bell?
Okay let me try this again.
How about HeLa cells?

From our Ananthanarayan ?
Your probably thinking, do not talk about my arch enemy.
That was the past and we need to move on from such hideous moments.
A small reminder that it is because of these very hela cells that India was help to eradicate polio through polio vaccine.

Henrietta Lacks is a magnificent woman, a kind mother, an understanding wife, and a fun sister who went through life in all its ups and downs and braved through them during a time when people of colour were neglected and treated like animals and that is whom we have reduced to this four letter word Hela.
Back then John Hopkins was among the very few hospitals that treated people of colour who were also poor [4].
If someone gives you something for free that means they are upto no good.
Henrietta had cervical cancer for which she sought treatment from Hopkins.
A biopsy was taken, except it was not only used for her diagnosis, it was also used for scientific research which by the way was without her consent. During those days "participation" in the research was considered payback for the free services that was provided at this hospital. Information that this vulnerable population of coloured people were not aware of.

She endured excruciating pain. X-ray's were performed everyday for a month, burning her skin. Henrietta described the side effects of this treatment as "the blackness be spreading inside her". They placed radium capsule on her tumor located on the cervix to kill the cells, and would do this multiple times [3].

What began as a stage 1 cervical cancer ended in an inoperable tumour. Henrietta's body began to be filled with toxins, as she was slowly dying from the inside out. New tumors grew everyday and she was in excruciating pain, but all they said was that "her cells will become immortal.

Notwithstanding the tremendous accomplishments achieved using the HeLa cell line, the case nevertheless evokes serious ethical issues regarding the consent of patients to having their tissue used for research.
Henrietta Lacks's story has brought public attention to a number of ethical issues in biomedical research, including the role of informed consent, privacy, and commercialization in the collection, use and dissemination of biospecimens.

Many reasons that patients should not be allowed ownership of their tissues for fear of decline in the progress of medical research and that the tissue donor would now begin to demand more shares in all the profits gained.

I believe that all this while ,we have been looking at this from the wrong perspective,

Look at it this way,
I get to decide who gets my money after i die, it would not harm me if i died and you gave all my money to someone else. but there's something psychologically beneficial to me as a living person to know I can give my money to whoever I want.

The problem arises when you replace the word money with tissue.
What the Moore case failed to address was this , that those tissues are still yours when attached to your body. If you knew this ahead of time and if your tissues turn out to be valuable, you can control them and play the tissue market as well as any biotech company.

Before I end ,I'd like to tell you about an inspiring man by the name of Ted Slavin, who saw this market coming decades ago.
Slavin was a hemophiliac as a result of which he required multiple transfusion of clotting factors. But the donor blood was not screened for diseases and so Slavin was exposed to hepatitis B virus over and over again.
Upon doing a blood test , it was found that there were extremely high levels of valuable hepatitis B antibodies.
What makes this case special was that his doctor told him about those antibodies, and Slavin realized they were worth a lot of money.
He decided to sell them to laboratories and companies who were helping create the first hepatitis B vaccine.
Slavin wanted money, but more than that, he wanted somebody to cure hepatitis B.
He later on met Baruch Blumberg, a researcher who had won a nobel prize for discovering the hepatitis B antigen and who created the blood test that diagnosed Slavin's disease. Slavin figured that if anybody was going to cure hepatitis B, it would be Blumberg. So he sat down and wrote a letter: Dear Dr. Blumberg, he said, I'd like you to use my tissues to find a cure for hepatitis B. I'll give you all the antibodies you could need. And I'll do it free [2].
That has led to the birth of a vaccine that saved millions of lives and continues to do so.
The difference between Ted Slavin and John Moore wasn't that Slavin owned his tissues and Moore didn't. The difference was information. Someone told Slavin that his tissues were special and that scientists might want them. So, he was able to control his tissues by creating terms before anything left his body. In the end, the question isn't whether people have the ability to control their tissues; it is how much science should be obligated to put them in the position to do so.

RECOMMENDED READING AND REFERENCES

1. https://www.nytimes.com/1990/07/10/science/patient-s-right-to-tissue-is-limited.html
2. https://www.nytimes.com/2006/04/16/magazine/taking-the-least-of-you.html
3. The Immortal life of Henrietta Lacks- Rebecca Skloot

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Health Equity

Gunjan Pandey

Undergraduate student (2nd year MBBS),
Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences (Deemed to be University), Wardha (Maharashtra).
E-mail id - gunjan2411350@gmail.com

Before heading towards the core of the topic we need to know the basics.so starting with it 'what do you mean by equity??' absence or remedial differences among groups of people. Whether those groups are defined socially, economically demographically or geographically.

According to WHO health inequality is not only consider health determinants but also access to the resources needed to improve and maintain health or health outcome and reducing health inequality as it is our fundamental right and that's why its health inequity rather being health inequality, as inequality is merely difference between two measurements of the same indicator while inequity is notion that say's this inequality is unjust or wrong.

Every year 7 million children die all over the world. Among these, every 1 child of out of 5 who are dying are from single country INDIA. Here we know what the problem is right? 7 million children are dying; we know what the solution is …we need more infrastructures more money. We need vaccines more and more health care stuff. Even after getting these things still people are dying. Have you ever wondered why?? It's the implementation. How do we get things to the people who need them? We live in a culturally diverse country .and diverse not only culturally even economically. For a fact, In INDIA there is 1 government allopathic doctor for as many as 10.189 people. One government hospital for every 2,046 people and 1 state running hospital for every 90,343 people, you don't need an epidemic however predictable for public health system to collapse .it is a matter of routine that patients share beds and doctors are overworked. India is little over one million people, of these only around 10% work in public health sectors according to data from National health profile 2017.The shortage of health providers and infrastructure is the most acute in rural areas where catastrophic health expenses push populations to size of united kingdom each year.

Add apathy and you have bodies of the dead being mutilated by dogs in hospital morgues, people carrying home their dead children because the hospital refused them a hearse and tragedies like the hundreds of infant deaths in Gorakhpur's Baba Raghav Das (BRD) Medical College every year. BRD Medical College Hospital's failure to save lives points to a systemic rot in public healthcare delivery, which is saddled with problems of mismanagement and inadequate resources — infrastructure and human.
Despite being routinely flagged. These shortages are seldom corrected. Learning from failure is rare and coarse correction after mistakes is even rarer.
Have you ever wondered why these situations occur mostly with the rural or people who aren't very educated and are poor. Since the middle of the 20th century, national governments and international organizations have committed to eliminating the gap between the most and least disadvantaged. Researchers in global health have been exploring and outlining these differences and policy makers have used the data to attempt to reduce inequalities and inequities. This can be due to low health literacy "the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions." compared to those with adequate health literacy, individuals with low health literacy are more likely to

inappropriately or infrequently use health care services, face difficulty following medical instructions, have worse physical and mental health, and have a shorter life expectancy.

And not only has this situation occurred due to low health literacy it's also due to diversity of cultures within our world's population makes it a challenge for health care providers and system to deliver culturally competent medical care. Culturally competent care can improve patient quality and care outcomes. If providers and health care systems are not working together to provide culturally competent care, patients may have untoward health consequences, receive poor quality care, and be dissatisfied with the care they receive. The quality of patient-health professional interactions is decreased. Lower-quality patient-health professional interactions are associated with decreased satisfaction in the healthcare provider. In fact, African Americans, Asian Americans, Latinos, and Muslims report that the quality of their care was diminished because of their ethnicity or race.

Since now we have come across the problems that lead to a crashed system and poor health care services we need to have an appropriate solution to this problem.

We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care. The fact that the patient is the most important person in a medical care system must be recognized by all those who work in the system. This single factor makes a significant difference to the patient care in any hospital. In developing countries financial constraints often lead to compromised quality of care.

Raising awareness of health issue should be the first step towards improving health outcomes. However, while public health programs have frequently conducted Information, Education and Communication (IEC) campaigns - such as stressing the importance of hand washing, regular ante-natal check ups, institutional deliveries, immunization etc. - they have had little impact. All three projects, therefore, sought to markedly improve the content and quality of health messages and target them at specific tribal groups through the means appropriate to each.

While medical camps have often been conducted in the past, medical camps should also reach to remote tribal populations. Outsourcing of these services to NGOs and medical colleges may prove to be an efficient option, but requires strong monitoring and evaluation systems. The success of mobile clinics depends on effective management of medical personnel, as well as on the availability of drugs, diagnostic facilities and vehicles so that the delivery of services remains assured and consistent. The lack of any one input seriously compromises the efficiency and effectiveness of health care delivery.

These were the few solutions for population where there is lack of health services. But what about different cultures that even have to follow their rituals n also wants to follow health instruction. As we all know there are so many cultures as Buddhism, Christian, eastern orthodox, Hinduism, Islam ,etc. so we see there are numerous cultures even more number of rituals to follow so what can be done so that even there rituals remain .persistent with quality health care services.

Enhancing cultural competency by providing patient-centered care are means by which healthcare challenges are ameliorated. Efforts aimed to improve provider-level cultural enhanced care will go a long way to facilitate cross-cultural communication and respond to patient needs by tailoring healthcare.

Understanding the values and reasons for special requests for healthcare will improve cultural competence and provide culturally sensitive health care that is good for the patient and their families. The culture and religion of an individual can greatly influence their perspectives about healthcare and healthcare providers. Healthcare providers need knowledge and understanding of these patients' background and belief to provide culturally sensitive healthcare. Doctors or say medical practitioners are often judged by their practical implementation but in this scenario it is important to change people prospective towards them and to actually become a bit understanding whether it's a case of different belief due to their culture or due to economic status.

Let us be the ones who say we do not accept that a child dies every three seconds simply because he does not have the drugs you and I have. Let us be the ones to say we are not satisfied that your place of birth determines your right for life. Let us be outraged, let us be loud, and let us be bold.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Unified Ethics Amongst Diversified Cultures

Jerin Varghese Raji

Undergraduate student (First year MBBS)
Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences (Deemed to be University), Wardha (Maharashtra)
E-mail: jerinazero@gmail.com

Every human being, born in this world, after having completed a particular age, gets the wisdom of what is right and what is wrong, irrespective of their caste, color, creed, nationality, cultures, etc…….The only exception to the above said under normal circumstances are the special children(mentally disabled people in worldly terms).They are unaware of the distinction of what is right and wrong, thereby able to maintain their innocence until the very last moments of their lives. This idea of what is right and wrong is exactly what is referred to as ethics.

According to me, "Ethics is a unified and moralized set of understanding of the basic requisite of humanity which cannot be defined within boundaries based on laws, rules or regulations; thus an entity which couldn't be evaluated by comparison."
There are many people out there in this world from various backgrounds, practicing different customs and most importantly caring out their respective roles in this beautiful planet at various places.

These huge lot of variations in the world which we do live in, going simultaneously, is nothing less than a magical co-ordination, which is possible as a result of a universally common ethics applicable to the versatile people out there in this world.
Culture which is a very vast term incorporating different aspects of the life which we carry out, differs from person to person and from region to region. Each and every one of us in this world is born the same way but what a person ends up is as a result of the ways each one do frame their lives.

Just think what would be the scenario if you were born in a country which is neighboring to your present country. Everything would have been upside down from the foods you eat, to the dress you wear, to the way you look, the profession you do choose, etc
It all starts from where you were born and how you were brought up!!

All what you are now is the result of the cultures in which you were brought up. But irrespective of these varied cultures, ethics is one such attribute that remains unified and keeps you in pace with your other fellow beings with whom you do share this planet.

Each and every culture has its own identity, its own ideologies and as we all know its own teachings and practices. One can't say that a particular culture is the best. Everyone has a right to practice their own customs.

But in midst of all these differences we all are equally taught certain similar things. Majority do fade away from these childhood teachings but a mere minority do exist as such as they were before. These people are the life supporters of our world who do hold on to what they were taught in the childhood days because they realize the fact that these are the foundations of a happy living.

Let me give you, a very simple example…Each and every one of us were taught not to tell lies, not to steal, not to cheat irrespective of our cultures. But the thing is how often do we hold on to these

ethical attributes matters the most (I accept the fact that many are also born into such environments were they are taught just the opposite). Being children, we to a good extend sticks firmly to these ethical things taught to us in different ways by different people through different cultures. But as we move ahead in the race of our life, somewhere or the other place we often fail to hold on to these ethics. We know the fact that we are going away from what is right but still we do find excuses to overwrite this inner soul feeling.

A student practicing proxies during lectures has no right to say that corruption should be abolished. If he or she does so, they are only deceiving themselves. The change should start from oneself.

People become extremists due to the lack of such basic underlying principle being not implemented in the day to day life and as a human being become more worse day by day. They earn a lot, to see from outer point of view; everything is perfect in their lives but only they do know the unsatisfactory status they go through.

How many of you who are reading this article didn't cheat even in a single exam? Just think and answer sincerely to your inner ethical being.
Suppose a child steals a pencil of his classmate in kindergarten. If this child is not taught the right, then he would dare to steal much bigger things when he grows up and would even end up being a criminal minded person at a latter part of his life.

Ethics doesn't mean that you always do what the law demands. According to law all patients are equal for a doctor and he or she has to deal with them in a chronological manner on the basic of first come, first consultation basis. But just thing suppose a patient is in a very severe condition and let there be 23 people waiting for consultation of the doctor who are with mild issues, do you think it would be wise to make the serious patient wait until the rest 23 ahead of him gets consulted, just because his number is 24.According to law he should be consulted after the 23rd but according to ethics he should be consulted by the doctor first.

In particular countries one should keep left while driving whereas the scenario of the western countries asks its citizens to do keep right while driving. So, here if we do see then the culture of one country is that people should keep left while driving and of western country being to keep right. Cultures are different but there is one thing in common in both these situations i.e. a person should have the ethics to do follow the rules of the country in which he is driving.

In this ever changing modernized world of technologies where life does get a pause to self-introspect, it's the need of the hour to start finding out some time for oneself and bring out the best in oneself irrespective of the varied culture in which we all were brought up in. This is possible only by holding on to the great ethical teachings which we received during the course of our life.
The particular need as such cannot be pointed out for the following of ethics in our personal day to day life as each and every little aspect of our life is governed by these ethical attributes and these are far beyond the scope of just typing down.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Student Ethical Viewpoint Paper

Bridging The Health Equity Gap : A Case for Using Medical Resources More Effectively

Sujay Chore

Undergraduate student (3rd year, Business Studies)
Double major in Management Information Systems and Business Analytics
Florida International University
E-mail: sujaychore1799@gmail.com

Firstly, hear me carefully, I want you all to rewind your lives back to when you were 17 years old. Now think about a situation where you are sitting impatiently with your father outside the doctor's cabin, in a hospital as big as this, seeing him study your grandmother's reports; your grandmother being 85 years old and having blood cancer. After sometime, the doctor comes out and points out that your grandmother's case is so serious that operating on her at such an age would at best prolong her life by 6 months, and even so, she would be bed ridden for the rest of her life. He also draws attention to all the resources your family would have to spend on her during these 6 months. Given the circumstances, he recommends that she should not undergo an operation. This way, she can subsequently live peacefully for as long as she can. The prospect of simply "letting your grandmother be" seems so absurd in this case, doesn't it? After all, you can't put a price on your loved one's life.

Now rewind your life back by 2 more years. Imagine a situation where you are on a vacation with your family to Africa and while travelling through Nigeria you find out that one of the leading causes of deaths here is something as trivial and easily curable as Malaria. You wonder genuinely, what might be the reason behind this and the answer is quite simply the lack of resources.

Now, knowing what all those resources mean in saving the lives of children in Nigeria, it becomes much more difficult to answer the question of whether you should use the resources to prolong the life of your grandmother or just 'let her be'?

I found myself in this situation less than 4 years ago. The prominence of health equity gap was exemplified in an instant and I started seeking the right answers.

To seek those right answers, I turned to some Scholars of Bioethics. "Well, Bioethics like any ethical stream involves philosophy. In this post-modern, multicultural world, there is no way to objectively give right answers since the decisions undertaken by people are based off of personal experiences", they said.

Many experts still hold this worldview but there is a fundamental flaw in this subjectivism doctrine. We live in a very different world today. Until a century ago, moral philosophy had no direct consequences as such. Philosophy as a whole was looked at solely as an academic field. Today, however, it has very real consequences.

Whether we decide it is ethical to abort a baby in the third trimester or whether it is ethical to kill a person who is terminally ill and no longer wishes to receive treatment or whether it is ethical to donate organs- all of these decisions have very real consequences.

The notion that everything is subjective and we cannot make objective claims about issues in Bioethics is absurd. I would grant that subjective experiences exist, but we surely can make objective claims about those subjective experiences.

To give you an example, we don't know what Mahatma Gandhi was thinking at the time he was shot. That is a very subjective situation and we do not have any data to find the truth. However, we can certainly make the objective claim that he was not thinking about whether or not our 14th Prime Minister be eating mangoes.

Similarly, in the field of Bioethics, we could make such objective observations on subjective experiences and the way to do it is consequentialism. The only reliable way to make more and more ethically sound decisions is to analyze the possible consequences of a given action and then base our decisions on it. There is an urgent need to shift our philosophical thinking from absolutism to consequentialism if we really do intend to bridge the health equity gap in an unequal and culturally diverse world.

In the field of Bioethics, we can look at it from three perspectives. Individual's, medical doctor's and public policies.

On an individual level, Pneumonia used to be called "the old man's friend" because it often brought a swift and relatively painless end to a life that was already of poor quality, which otherwise would have continued to decline. The study, carried out by Erika D'Agata and Susan Mitchell and published in the Archives of Internal Medicine, showed that over 18 months, two-thirds of 214 severely demented patients in nursing homes were treated with antibiotics [1]. We, as individuals, must ask ourselves, whether we should invest all our resources on ourselves and our loved ones, while being aware of the fact that it would not lead to any significant improvement in our quality of life. Even if we assume that antibiotics would prolong the life. The question is, how many people want to prolong their lives? Considering they will be bed ridden and would be needed to be fed by others, with their mental abilities deteriorating irreversibly. If the primary objective is a patient's interests, I am not sure if it's clear that prolonged life is in the best interest of every patient.

From a doctor's perspective, let us take the case of Amillia Taylor. Amillia was termed as the "miracle baby" because she is the most prematurely born surviving baby, born at a gestational age of 21 weeks and 6 days [2]. The baby was understandably weak and it was predicted that she would have severe disabilities while growing up. Instead of discussing the possible option of terminating the baby and taking the nobel active measure, the hospital devoted much of its resources in saving the baby. I am not advocating that all the prematurely born babies with high likelihood of disabilities should be terminated but as doctors, it is their prime responsibility to present these facts, as they are, to parents and let them reasonably decide whether they don't want to take that risk, or put the public to the considerable expense of doing everything possible to ensure the survival of their tiny newborn.

The most important perspective to consider here is the public policy perspective. The medical cost of terminally ill patients with Alzheimer's disease accounted for $160 billion in 2010 in the United States. To put this in perspective, the entire foreign aid budget of the United States in 2005 was $27 billion [3]. Treating dying patients who do not wish to live any longer is a waste of valuable resources, yet only a few countries allow physician assisted suicide or euthanasia in the world.

While looking for solutions, it is quite clear to me that we need to replace the principles of Beneficence and Non-maleficence with the principle of maximizing human wellbeing. To put it in Sam Harris's words, "the problem of ethics and morality is a navigation problem. We live in a space of infinite possibilities, where one possibility is pure suffering with no silver lining and we have to navigate our ways such that we minimize that suffering and maximize human wellbeing."

[4]. It is not evident to me, if the principles of Beneficence and Non-maleficence, if applied in their absolute forms, without taking into account all the possible consequences, would lead to maximum human well-being.

The most crucial solution however, is human conversation. We need to be able to have these conversations amongst ourselves and ask these tough questions to our policy makers if we wish to bridge that health equity gap.

To end this, I apologize to have lied in the very beginning. Neither my grandmother had cancer nor had I been to Nigeria. But I did it to present a point in front of you. I had to begin my presentation with a personal story to establish credibility to be eligible to talk about such a serious topic and that is a problem. The notion of Identity politics of only being eligible to talk on certain topics, if and only if you have gone through such experiences is a huge impediment to human flourishing. To rise above the evils of post modernism and moral relativism in Bioethics, we must first fight identity Politics. My arguments here must be just as compelling despite the fact that my grandmother did not have cancer or I did visit Nigeria. Only then would we be able to look at this world as a whole and bridge the health equity gap.

REFERENCES

1. D'Agata E. Patterns of Antimicrobial Use Among Nursing Home Residents with Advanced Dementia. Arch Intern Med 2008;168(4):357-9.
2. Edemariam A. The extraordinary story of the most premature baby to have ever survived [Internet]. the Guardian. 2019 [cited 13 June 2019]. Available from: https://www.theguardian.com/society/2007/feb/21/health.lifeandhealth
3. Singer P. Ethics in the real world. Princeton University Press; 2016.
4. Harris S. The moral landscape. Free Press; 2014.

****

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil

Scope of the Journal & Instructions to the Authors

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

THE EDITORIAL PROCESS

The manuscripts received shall be peer reviewed for possible publication with the understanding that they are being submitted to only this journal and not simultaneously submitted or accepted for publication elsewhere. The Editors shall review all submitted manuscripts initially. Manuscripts with scientific flaws or vague research designs may often be rejected. The journal will not return any unaccepted manuscripts. The reviewers shall review all papers in a blind review and convey their decision to the Editors. Within a period of 8-12 weeks, the contributors shall receive comments, need for corrections and notice regarding acceptance or rejection of the manuscript. Other journals appropriate for the paper may be suggested in some cases of rejection. Articles accepted would be copy edited for grammar, punctuation, print style, and proofs for correction shall be sent to the author prior to publication. Authors will be asked to sign a copyright form and undertaking for plagiarism in case of accepted manuscripts. Only upon receipt of corrected proofs from the authors and completion of all form required, will a paper be published in the journal.

TYPES OF ARTICLES

- **Original Research Papers or Article:** These papers should only include original research findings from planned research studies such as case–control series, surveys with high response rates, randomized controlled trials and treatment based intervention studies. Meta analyses shall be included in this section. The word limit is 6000 words excluding references and an abstract (structured format) of not more than 250 words with 4-6 key words.
- **Case Reports:** These should contain reports of new, interesting or rare cases of clinical significance or with implications for management. It could also include case reports where novel management methods were used. It has a word count of 1500 words with up to 15 references and an abstract of not more than 150 words.
- **Review Papers**: These are systematic and critical assessments of the literature which will be invited. Authors wishing to submit a review paper will have to contact the editor and seek permission for submission of the review. Only after permission has been sought will the article be accepted for peer review. The review article has a word limit of 8000 words and must be state of the art in every respect. Only invited reviews will be published. However exceptionally interesting topics even if uninvited when submitted may be considered.
- **Personal Subject Related Viewpoint:** These should be experience-based views and opinions on controversial issues that affect the profession. They could also be part of clinical problems that confront people in routine practice. The author should have sufficient experience or must have some unique personal experience based on the subject being considered. The word limit is 2500 words.

- **Announcements:** Information regarding conferences, meetings, courses, awards and other items likely to be of interest to readers should be submitted with the name and address of the person from whom additional information can be obtained (up to 200 words).
- **Book or Movie Review:** Exceptionally readable and good books and movies or documentaries which shall be academic and otherwise in the field of mental health shall be considered in this section. The word limit shall be 1500 words.
- **Poems:** Poems related to various themes in bioethics and allied sciences shall be considered based on their merit for this section.
- The journal is in evolution and newer concepts shall be considered from time to time.

SUBMISSION OF PAPERS

Send soft copy of the manuscript along with a covering letter in Microsoft Word 2007 or 2010. Name and designation of all authors with designation and name of the corresponding author must be mentioned. Copies of any permission(s) to reproduce published material, and to use illustrations or report information about identifiable people must accompany the manuscript.

All the manuscripts should be submitted via e-mail to the editor at email – russell.f.dsouza@gmail.com or avinashdes888@gmail.com
For online submission articles should be prepared in two files (first page file and article file). Images should be submitted separately.

First Page File: Prepare the title page, covering letter, acknowledgement, etc. using a word processor program. All information which can reveal your identity should be here. Use doc/pdf files. Please do not zip the files.

Article file: The main text of the article, beginning from Abstract till References (including tables) should be in this file. Do not include any information (such as acknowledgement, your names in page headers, etc.) in this file. Use doc/pdf files. Do not zip the files. Limit the file size to 400 kb. Do not incorporate images in the file. If file size is large, graphs can be submitted as images separately without incorporating them in the article file to reduce the size of the file.

Images and Tables: Submit good quality colour images. Each image should be less than 400 kb in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 800 pixels or 4 inches). All image formats (jpeg, tiff, gif, bmp, png, eps, etc.) are acceptable; jpeg is most suitable. Do not zip the files. All tables, figures and images must be duly labelled.

Copyright and Contributor's form: If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks from submission. The scanned copyright form can also be submitted via e mail.

PREPARATION OF THE RESEARCH PAPER (MANUSCRIPT)

Please use A4 size (212 × 297 mm) on Microsoft Word, with margins of 1 inch from all the four sides. If sending a hard copy, type or print on only one side of the paper. Use double spacing throughout. Number pages consecutively, beginning with the title page. The language should be British English or American English.

Language

For all purposes the journal shall follow the language pattern of American English.

Title Page

1. Type of manuscript (Original/Review/Case etc)
2. The title of the article, which should be concise, but informative;
3. Running title or short title not more than 50 characters;
4. The name by which each contributor is known with institutional affiliation;
5. The name of the department(s) and institution(s) to which the work should be attributed;
6. The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence;
7. The total number of pages, photographs and word counts separately for abstract and for the text (excluding the references and abstract).
8. Acknowledgements: Specify contributions that need acknowledging but do not justify authorship, such as general support by a departmental chair and acknowledgments of technical, financial and material support. Also mention financial grants received or conflict of interest if any.
9. If the manuscript was presented as part at a meeting, the organisation, place, and exact date on which it was read along with mention of any award it may have received.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (no more than the number of words already specified). For abstract we follow an unstructured abstract format that should not exceed 250 words. Below the abstract should provide 3 to 6 key words.

Text of the article

State the purpose of the article and summarize the rationale for the study or observation in Introduction. For case reports give incidence of similar cases in past. Describe the selection of the observational or experimental subjects clearly in Patients and Methods section. Identify the age, sex, and other important characteristics of the subjects. Identify the methods, apparatus (give the manufacturer's name and address in parentheses), and procedures in sufficient detail. Give references to established methods, describe new or substantially modified methods, give reasons for using them, and evaluate their limitations. Identify precisely all drugs and chemicals used, including generic name(s), dose(s), and route(s) of administration. Reports of randomised clinical trials should be based on the **CONSORT statement** (http://www.consort-statement.org).

When reporting experiments on human subjects, procedures followed should be in accordance with the standards ethical committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2000 (http://www.wma.net/e/policy/17-c_e.html). Do not use patients' names, initials, or hospital numbers, especially in illustrative material. Present the results in logical sequence in the text, tables, and illustrations. Do not repeat in the text all the data in the tables or illustrations; emphasise or summarise only important observations. Use standard guidelines for statistics (See Ann Intern Med 1988;108:266-73).

Emphasize the new and important aspects of the study and the conclusions that follow from them along with implications of the findings and their limitations in the Discussion section.

References

References should be numbered consecutively in the order in which they are first mentioned in the text. Identify references in text, tables, and legends by Arabic numerals in brackets (). References cited only in tables or figure legends should be numbered in accordance with the sequence established by the first identification in the text of the particular table or figure. The titles of journals should be abbreviated according to the style used in Index Medicus. Avoid using abstracts, unpublished observations, and personal communication as references. Please refer http://www.icmje.org for other types of references such as electronic media, newspaper items, etc.

1. Standard journal article: Seshadri L, George SS, Vasudevan B, Krishna S. Cervical intraepithelial neoplasia and human papilloma virus infection in renal transplant recipients. Indian J Cancer 2001;38:92-5.
2. List the first six contributors followed by et al.
3. Personal author(s): Ringsven MK, Bond D. Gerontology and leadership skills for nurses. 2nd ed. Albany (NY): Delmar Publishers; 1996.
4. Chapter in a book: Phillips SJ, Whisnant JP. Hypertension and stroke. In: Laragh JH, Brenner BM, editors. Hypertension: pathophysiology, diagnosis, and management. 2nd ed. New York: Raven Press; 1995. pp 465-78.

Tables

- Tables should be self-explanatory and should not duplicate textual material. Tables with more than 10 columns and 25 rows are not acceptable. Limit the number to minimum required.
- Number tables, in Arabic numerals, consecutively in the order of their first citation in the text and supply a brief title for each.
- Place explanatory matter in footnotes, not in the heading. Explain in footnotes all non-standard abbreviations that are used in each table. For footnotes use the following symbols, in this sequence: *, **, ***
- Obtain permission for all fully borrowed, adapted, and modified tables and provide a credit line in the footnote.

Illustrations (Figures)

- Submit three sets of sharp, glossy, un-mounted, colour photographic prints, with height of 4 inches and width of 6 inches.
- Computerised colour printouts are not acceptable.
- Figures should be numbered consecutively according to the order in which they have been first cited in the text.
- Each figure should have a label pasted on its back indicating the number of the figure, the running title, top of the figure and the legends of the figure. Do not write on the back of figures, scratch, or mark them by using paper clips.
- If a figure has been published, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. A credit line should appear in the legend for figures for such figures.

Reprints

Journal does not provide any free printed reprints. Reprints can be purchased. Articles may be accessed online and pdf format will be sent to the authors. Contact the editor for any queries. Authors wishing to procure a hard copy of the journal may send their requests to the editor via email.

Plagiarism Policy

All articles will be examined by computer software for plagiarism. If it is found that a paper that has been submitted has been copied in parts or fully from an earlier published paper the authors will be duly informed and the paper may be rejected. Action against the erring authors may be taken as per recommendation of the editorial board.

Open Access Policy

The journal grants free, irrevocable, worldwide, perpetual right of access to and a license to copy, use, distribute, transmit, and display the work publicly and to make and distribute derivative works, in any digital medium for any responsible purpose, subject to proper attribution of authorship.