The UNESCO movement for bioethics in medical education and the Indian scenario

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The growing dissension among patients against their physicians has led to numerous incidents of violence against doctors in India. In May 2015, the Times of India reported that over 75% of doctors have faced violence at work. Up to 50% faced violence from patients or their relatives in either the emergency or the Intensive Care Unit. The Indian Medical Association took up this issue, but there is no solution in sight. The growing chasm between doctors and patients, the wishes of many patients to be treated as partners in their care, the commercialization of medicine, and importantly, the rapid breakthroughs in medical technology such as “designer babies,” euthanasia, robotics, and cloning have created an urgent need for an ethical framework to guide the clinician’s behavior and decisions.

Bioethics is a term that has arisen from but is broader than issues of ethics in human research. It addresses ethical issues arising from accelerating technological advances that can potentially threaten human life itself or affect relationships between human beings and their environment. It focuses on protecting the environment and making it safe for future generations.

HISTORY OF BIOETHICS

Fritz Jahr coined the term bioethics in 1926. The American biochemist Van Rensellaer Potter popularized the term using it to indicate “global ethics” - technological advances which yet helped protect the environment and all species linked to an ethical value system. Internationally, the UNESCO Bioethics Program began in 1993, subsumed under UNESCO’s Social and Human Sciences Sector. The program achieved the first milestone with the Universal Declaration on the Human Genome and Human Rights, adopted by the UN General Assembly in 1998. This was followed by adoption of the Universal Declaration on Bioethics and Human Rights by the General Conference on October 19, 2005.

The UNESCO furthers its bioethics programs through standard setting, capacity building, education, and awareness building. It aims to set up common ethical standards across countries of the world. It has established several Chairs to foster bioethics across different technology sectors. The UNESCO Chair of Bioethics Haifa, headed by Prof. Amnon Carmi, was established in 2001 at the International Center of Health, Law and Ethics, University of Haifa “to coordinate and stimulate an International Network of Institutes for Medical Ethics Training (NIMED). NIMED was tasked with associating higher education institutes in both the developed and developing countries and to develop an up-to-date syllabus for medical ethics education which will satisfy the requirements of medical schools in the world.” To this end, Dr. Russell D’Souza, an Indian psychiatrist, settled in Australia and designated head of the Asia-Pacific region for UNESCO Bioethics Chair Haifa, set out to initiate the largest medical bioethics network in the world.

Currently, there are more than 114 Bioethics Chair Haifa Units all over the world from Armenia to the USA to Vietnam and more than 25 such units in India alone. Regular Ethics Teachers’ Training Courses are being held across medical colleges and universities. There is a newsletter (Bioethical Voices) and a free journal with its editorial board in Sri Lanka (Global Bioethics Enquiry). A Youth Bioethics Project for bioethics training in schools was initiated. A Research Board is functioning. The International Forum of Teachers in Bioethics encourages membership from medical teachers who have trained in bioethics. The composite website of UNESCO Chair Bioethics Haifa provides these and several other details. Regular international conferences are held. A dynamic movement is growing under the leadership of Amnon Carmi over the world and Russell D’Souza in the Asia-Pacific.

TEACHING BIOETHICS TO MEDICAL PERSONNEL

UNESCO established Chairs to improve the teaching of bioethics in medical schools. Its position was that bioethics should operate from the bedrock of human dignity and fundamental human rights, and bioethics teachers should be aware of cultural pluralism as well.
Based on research in 1996 and 2001, Prof. Carmi suggested that one of the reasons for deteriorating relationships between doctors and patients was the lack of an ethical framework on which to base this relationship. Many western schools were already teaching ethics but without the desired behavior change. A Steering Committee under UNESCO looked into why ethics education in medical schools seemed not to affect clinical practice. Prof. A. Okasha (Egypt) and Prof. N. Sartorius (Switzerland), both senior psychiatrists, were members of this committee. The committee felt that newer methods were needed to teach the principles of bioethics to make them more practicable. It then decided not only to establish a network of medical universities devoted to “disseminating, improving, and monitoring education in ethics in medical schools” but also to develop a new and responsive curriculum and to train teachers to disseminate this curriculum.[9]

The committee found that standard methods of teaching were no longer effective, considering the growing suspicion harbored against the medical profession on the one hand, and instances of medical misconduct on the other. To this end, “Casebooks” describing cases of actual ethical dilemmas and principles would be most useful. A number of such casebooks illustrating each principle of bioethics are available free on the net (see under Casebook Series, Bioethics Core Curriculum).[9]

WORLD BIOETHICS DAY - FOCUS ON HUMAN DIGNITY AND HUMAN RIGHTS

The first World Bioethics Day was celebrated on October 19 this year. Its theme was Human Dignity and Human Rights. The theme is the first Principle of the Universal Declaration on Bioethics and Human Rights, adopted on October 19, 2005 (Article 3): (1) Human dignity, human rights, and fundamental freedoms are to be fully respected. (2) The interests and welfare of the individual should have priority over the sole interest of science or society.[9]

In the context of the doctor–patient relationship, what signifies human dignity? By virtue of being human, every human being is deserving of concern and respect. Thus, no human being can be a “subject” (Casebook on Human Dignity and Human Rights, UNESCO). No human being should be treated below a certain threshold, just because she/he is a human being. To uphold this innate dignity, basic human rights were formulated. Thus, Article 1 of the Universal Declaration of Human Rights (1948) states that “all human beings are born free and equal in dignity and rights.”[12] A human being should not be respected on individual merit or achievements alone but more fundamentally as a member of the same race. This dignity should be irrespective of culture, religion, sex, behavior, or any other consideration. This also means that no individual should be expected to sacrifice herself for the sake of society or science (Casebook, page xi) except in exceptional and extraordinary circumstances. Fundamental rights arise from this humanness and dignity therefrom. These are inviolable rights to be preserved and protected at all costs except in the most extraordinary circumstances, and there too only with full justification and not as a matter of course.[13]

HUMAN DIGNITY AND PSYCHIATRIC TREATMENT ISSUES - THE INDIAN SCENARIO

India currently has the largest number of bioethics units in a country in the world. Major medical organizations such as the Indian Medical Association, the National Board of Examinations, and the Medical Council of India have recognized its importance and some have formed units. Vice-chancellors of several health universities have also formed bioethics groups and joined the movement. An active student wing is gradually taking shape. The SRM University, Chennai, has formulated an undergraduate curriculum to be taught across 5 years as modules attached to the existing major subjects. The Medical Council of India has a bioethics cell that presently focuses on medical research in India. It has now started organizing symposia and conferences on this subject.

Bioethical issues were continuously addressed in the flagship journal of the Indian Psychiatric Society in the past too. Here, are a few selected examples.

Treating our patients as competent to take decisions unless proved otherwise has been observed more in the breach. Patients or caregivers are frequently not told the diagnosis, duration, risks, and benefits of treatment. Forced treatment against the patient’s will is another problematic bioethical issue which has been debated in psychiatric fora without solution.[14] Covert treatment is a vexed issue in psychiatric practice. Treatment needs to be instituted keeping the rights of the person in mind. A caregiver suggested a novel solution: legalize covert medication.[15]

Euthanasia - or physician-assisted suicide - was addressed by Sinha et al. while Sharma et al. discussed end of life care from a more spiritual point of view.[16, 17] The government has begun to act on the issue of long-term palliative care though its draft bill,[18] upon the Ministry of Health website for suggestions by citizens. It provides for declining (by patients or families) or withholding (by doctors) treatment for terminally ill patients. So far, Indian courts have consistently opposed assisted deaths, even in long-term bedridden cases such as the Aruna Shanbag case.[19]
Research ethics in psychiatry were discussed.[20,21] Doctor–patient communication - which should be a two-way process preserving the dignity and autonomy of the patient - was discussed as far back as 2007.[22]

Another issue that has exercised psychiatrists in India is right to access personal treatment records regarding psychiatric treatment, requested under the Right to Information Act.[23] Currently, legal opinion appears to be in favor of disclosing all treatment information but also protecting the privacy of collateral informants.[24]

An advance directive is another issue, proposed in the Mental Health Care Bill[25] which is exercising the minds of mental health professionals. Right to die - by refusing lifesaving medication or going on a hunger strike - are also issues mental health professionals grapple with.

**FUTURE DIRECTIONS**

A formal network of Bioethics Teachers and Institutions in India needs to be established.

Clinicians in practice need to be trained in bioethics as we cannot wait for trainers to learn and then teach their students. Institutions such as the Indian Medical Association and the Medical Council of India need to spearhead this initiative.

Following the UNESCO mandate, curricula for various medical specialities need to be developed for bioethics teaching. Research, innovation, and publications need to improve.

Most importantly, we need to recognize the autonomy and wisdom of our patients and partner with them rather than dictate to them. The belief of cooperation and collaboration needs to be built into the innermost core of our clinical work.

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