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STUDIA UBB BIOETHICA, LXI, 1-2, 2016 (p.5-7)
(RECOMMENDED CITATION)

EDITORIAL:

WHO SHOULD PARTICIPATE IN BIOMEDICAL RESEARCH?

Assist. Prof. MARIA ALUAȘ PhD

What means *Biomedical Research*? Biomedical Research or experimental medicine consists of basic and applied research aimed at increasing medical knowledge and understanding [1]. It has two main domains: *preclinical research and clinical research*. Preclinical research aims are to generate a better understanding of diseases and new strategies for treatments. Almost all this research are carried out on animals. Clinical research aim is to assess new treatments for diseases. This research is also named *clinical trial* and it is carried out in a group of human participants. Because of some risks and bad consequences of this practice, questions are how to find human participants and how to motivate them to be subjects in research? Or, who should be human participants in research? When we think about Biomedical Research or Experimentation, usually we think in negative terms, like discrimination, violation of rights or ethical rules, something bad, complex and quite difficult to be well understood. And also, because of our background in this field, given by mass-media especially, to the most part of people, the first feeling is that researchers use people for knowledge, they do something bad to sick, or poor, or disabled people. Because we have many histories presented to people! But, actually, the dilemma is that even not participate in research is a bad thing. In this short essay, I will try to argue the situation of HIV patients rejected from research, in the 1980s. I was inspired by the movie *Dallas Buyers Club* (2013), an American biographical drama film. In this movie, we can see the history of an AIDS patient diagnosed in the mid 1980s when HIV/AIDS treatments were under-researched, while this disease was not understood and highly stigmatized.

Why these patients cannot participate as subjects in Human Research, even if they want it? Because they were considered as *vulnerable groups*, and vulnerable groups cannot participate in no research. These are rules and guidelines for researchers. What define a `vulnerable group` in terms of participating in human research? The first thing should be the capacity to understand information and to give the Informed Consent.

Informed consent is a decision to participate in research, taken by a competent individual who has received the necessary information, who has adequately understood the information and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement, or intimidation [2]. Vulnerable groups include children, the mentally disabled, prisoners, minorities and people in developing countries. But even patients with AIDS were considered as vulnerable or pregnant women.

Why these patients are considered as vulnerable groups? They are in a special condition, it is true. But they are able to understand all information and they also can make choices for themselves. Nevertheless, they seem like are discriminated because of their illness or their special condition.

Ethical issues or conflicts are between (1) the duty to protect the vulnerable from abuse and exploitation and (2) the aspiration to benefit them or society through needed research. We need to make sure that the protection is not excessive, or in our case discriminating.

Research participation has to be voluntary. And they wanted to participate. Their participation doesn’t violate their autonomy and does not affect their freedom to choose what they consider to be good for them. If they cannot act for their interests, because the participation is forbidden for their groups, they are discriminated on their illness and on their group membership. Certainly without research, the health condition and the quality of these patients of life cannot be improved. Also, without data to support new treatments, each intervention is an experiment with a single subject.

What these patients did? First, they tried to find their own solutions, as the movie present: they went in Mexico or Japan and brought untested drugs, and used them, in their desperate trying to survive. Then, they asked to authorities for participation access to research. They assailed federal regulations aimed at protecting research participants as obstacles rather than safety measures. Because they viewed protectionism as discriminatory on that it prevented them from getting experimental interventions that they wanted. And the exclusion or limited access to trials is harmful and unjust for them. As a conclusion, research and researchers were perceived not as necessarily harmful but a societal good and as opportunity to treatment [3].

This issue of Studia Universitatis Babeș-Bolyai - Bioethica, presents topics and case reports of bioethical reflection in the different medical research area: legal medicine case reports, pharmacy, patient’s rights, neurology, transplantations, eco-ethics and mentally disabled people issues. All these topics argue about the necessity of ethics, rules, and transparency in our life. Without ethics and thinking, the medical progress is not for all us, but only for some people who use the medical progress in their own purposes. Bioethics issues and all topics in this publication concern all us; they are about our lives and about risks and consequences of medical decisions that do not involve us.

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I. STUDII

STUDIA UBB BIOETHICA, LXI, 1-2, 2016 (p.11-20)
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THE TRIANGLE PHYSICIAN-PHARMACIST-PHARMACEUTICAL REPRESENTATIVE IN THE PRESCRIBING-PROMOTING-DISPENSING DRUG PROCESS – ETHICAL ISSUES

LASZLO-ZOLTAN SZTANKOVSZKY[1], BEATRICE-GABRIELA IOAN[2]*, VASILE ASTĂRĂSTOAE[3], MAGDALENA IORGA[4]

REZUMAT. Triunghiul Medic-Farmacist-Reprezentant farmaceutic în procesul de prescriere-promovare-distribuire a medicamentelor – Probleme etice. Studiul evidenţiază modalitatea în care reprezentanţii companiilor farmaceutice, medicii şi farmaciştii din farmaciile comunitare respectă următoarele principii etice: principiul autonomiei, principiul binefacerii, principiul dreptăţii şi principiul justiţiei sociale, cu scopul de a asigura calitatea vieţii pacienţilor. Lucrarea prezintă, de asemenea, câteva concluzii generale cu privire la procesul de promovare-prescriere-eliberare a medicamentelor, punând în evidenţă cele mai importante riscuri şi propune acţiuni de limitare a consecinţelor negative. Calitatea vieţii pacientului trebuie să primeze, atât în cazul celor implicaţi în politicile de sănătate, cât şi în activitatea desfăşurată de cele trei părţi interesate (reprezentanţii farmaceutici, medicii și farmaciștii) care trebuie să asigure sănătatea pacienţilor.

Cuvinte-cheie*: etică, industria farmaceutică, pacient, calitatea vieţii, politici de sănătate.*

ABSTRACT. The research highlights the way in which, within the activity of drug promotion, prescribing and dispensing, pharmaceutical company representatives, physicians and pharmacists in community pharmacies respect the following ethical principles: autonomy, beneficence, fairness, and social justice in order to assure the quality of life for the patients. The paper presents also some general conclusions regarding the promotion-prescribing-dispensing drug process pointing the main risks and also proposes some actions for limiting the negative

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consequences. The patients' quality of life must come first, for the main three stakeholders (pharmaceutical representatives, doctors and pharmacists) and also for the policy health makers.

Keywords: *ethics, pharmaceutical industry, patient, quality of life, healthcare policy.*

1. Introduction

Patient's satisfaction was always a health care quality metric. Related to this, expenditures and healthcare policies were applied all over the world. Patient's benefits and pharmaceutical companies' profits are not always on the bright side and healthcare policies are meant to guide the process of promoting-prescribing-dispensing drugs in order to assure patient's satisfaction (Fenton *et al*, 2012) and healthcare policies are oriented now to eliminate the waste in health care system (Brody 2010; Berwick& Hackbarth, 2012; Brody 2012; Cassel & Guest, 2012).

Previous research proved that the main 3 stakeholders (pharmaceutical representatives, doctors and pharmacists) are guided by ethical principles but sometimes other subjective factors are influencing their activities (Sztankovszky *et al*, 2015a, 2015b) and differences of opinion between them are influencing the patient's care process (Iorga *et al*, 2015a, 2015b, Sztankovszky *et al*, 2016a, 2016b).

The research analyzed the way in which, within the activity of drug promotion, prescribing and dispensing, pharmaceutical company representatives, physicians and pharmacists in community pharmacies respect the following ethical principles: autonomy, beneficence, fairness, and social justice in order to assure the quality of life for the patients and explain the results to present the current situation in Romania. The main conclusion is that the patients‘ quality of life must come first, for the main three stakeholders (doctors, pharmacists and pharmaceutical representatives) and also for the policy health makers.

2. Material and Methods

To this purpose, following the content analysis of the focus groups organized with physicians, pharmacists, pharmaceutical representatives and the mixed group, the dimensions defining the ethical universe of drug promotion, prescribing and dispensing practices were delineated and we set up three questionnaires which emphasized, for each of the 3 target groups, self-perception and hetero-perception concerning these practices.

The mirroring construction of the questionnaires has taken into account the attempt to accurately identify differences of opinion between the three batches investigated. Though they work together and their activities are complementary with the purpose of ensuring high quality medical services for patients, the results prove that there is obviously a communication niche, especially between pharmacists and the other two medical categories.

In total, 419 subjects from 25 Romanian counties participated in the research: 200 doctors (47.73%), 149 pharmacists (35.56%) and 70 pharmaceutical representatives (16.71%) with the mean age 40 ± 10.48 (minimum age 24 and maximum age 73). A number of 119 subjects are men (28,40%) and 300 are women (71,60%).

The research was approved by the ethical comittee of the University of Medicine and Pharmacy „Gr.T.Popa” of Iasi and was conducted during a period of 5 months. Data have been analyzed using SPSS 17 for Windows.

3. Results and Discussions

The research pointed some important differences regarding the opinions of the three stakeholders. The results are generating more dilemmas and we present some interpretations in order to explain them.

Limiting Factors in the Process of Drug Prescribing

Though, from an ethical viewpoint, patients must benefit from the best treatment for their condition, according to the result of the Physicians' Questionnaire, in more than 50% of cases, physicians are influenced by different aspects when they prescribe a treatment. In prescribing the treatment, physicians take into account other criteria beside the drug considered the most appropriate, such as:

a. the patient's financial resources,

b. health policies – budgetary limitations established by the National Health Insurance House,

c. aspects linked to proximity, to the existence of a certain drug in the given area.

In connection with this problem – the patient's financial contribution – we note that 70% of physicians consider that, in counseling a patient, the pharmacist takes into account his **financial contribution** – this being a more important factor, as they notice directly the patient's resources for purchasing or not a treatment prescribed by the physician.

From the analysis of answers given to the same item addressed to community pharmacists, we observed that 80% of pharmacists take into account the patient's financial resources when dispensing a prescription.

In their turn, health policies, by limitations imposed by the National Health Insurance House (NHIH), influence the drug prescribing and dispensing chain. As the NHIH imposes the prescription of drugs by International Nonproprietary Names, the individualization of treatment is influenced; it is a known fact that, given biological individuality, the individualization of treatment for each patient is important for the final outcome.

Displacement of the Decision to Dispense an INN Drug

Over 80% of doctors prescribe International Nonproprietary Name (INN) drugs (though over 40% also/only mention INNs). Comparing the results with those of pharmaceutical company representatives, over 60% of physicians mention the brand name drug – a fact that explains the pressure from the pharmaceutical industry on prescribers.

The analysis of data obtained from questionnaires distributed to pharmacists shows that approximately 60% of pharmacists frequently dispense only the reference price drug. However, this fact is contradicted by the result according to which 90% of pharmacists claim that they frequently counsel the patient regarding the alternatives of other brand name drugs. We could conclude that, presently, the decision-making process of dispensing a prescription drug with a certain brand name is shifted toward pharmacies, physicians influencing it less and less.

The OTC Drug and Supplement Market

Beside prescription drugs, we have also analyzed the prescribing/ dispensing of OTC (over-the-counter) drugs/supplements. With no limitations from the National Health Insurance House, the prescribing-dispensing chain being direct, the only limitation is the patient's financial potential and the availability of the product in the pharmacy.

Our research emphasizes the fact that 59% of physicians recommend OTC drugs and supplements to complement the treatment administered to a patient. On the other hand, pharmacists declare that in 98% of cases they recommend OTC drugs and supplements to complement the treatment of the given pathology. In accordance with these data, over 75% of physicians and 77% of pharmaceutical representatives consider that the pharmacist recommends OTC drugs and supplements to complement the given pathology.

This number shows us the dimension and potential of the OTC drug/supplement market – there being no price regulations here, but laxity at the level of Direct to Consumer Advertising – it is in the interest of the pharmacy to increase the value of the receipt issued. In fact, several pharmacy chains quantify the number/value of new OTC drug/supplement positions on the tax receipt – additional to the physician's basic prescription - as a criterion of assessment of their staff.

From an ethical viewpoint, this approach is questionable – and a more consistent regulation is needed at the level of the price of OTC drugs and supplements/mass media advertising etc.

The Physician's Dilemma: Between Compliance with Standard Protocol and Experience. The Off-Label (Unauthorized) Prescription of Drugs

The study found that approximately 93% of physicians firstly consider the standard treatment protocol for a particular diagnosis. In order of importance, we identify clinical observations, experience with a particular molecule, information obtained from recent research and, lastly, meta-analyzes published in significant journals. This result is gladdening, taking into account that it underlines the importance of the therapeutic protocols.

In addition, data analysis revealed that physicians consider the information presented by the pharmaceutical company representatives as rather exact, relatively complex and less balanced by comparison with the competition – this last aspect representing an ethical problem at the level of the industry. Nonetheless, this result should be approached with precaution. The data obtained from pharmaceutical company representatives show that, in order of frequency, the pharmaceutical representative uses the following promotion tools in his relationship with the physician: samples, sponsorships, informal gifts – confirmed by 50% of the surveyed physicians. The role of samples is clearly understood by the pharmaceutical industry, the study emphasizing that 59% of pharmaceutical representatives offer physicians samples. The legislation for prescription/OTC drugs is, of course, different from that for supplements. For prescription drugs, samples may be offered only in the first 5 years since the launch of the product on the market, up to 5 units/physician/year. For supplements, however, there is no regulation in this respect.

We may assume that those who do not offer samples promote prescription or OTC drugs which were launched more than 5 years ago on the Romanian market – because the role of samples is essential in creating the physician's experience with a certain product.

According to the study, pharmaceutical representatives believe that physicians use, in 95% of cases, their experience with a certain drug as a criterion for prescribing a treatment. From the analysis of results obtained for the physicians' questionnaire, we find that approximately 93% of physicians firstly consider the standard treatment protocol for a certain diagnosis. In order of importance, the study identifies clinical observations, experience with a particular molecule (where we can still emphasize the role of samples), information obtained from recent research and, lastly, meta-analyzes published in significant journals. The importance of samples is probably overestimated by the pharmaceutical industry – experience with a particular molecule being mentioned only as the third aspect in order of importance, when choosing the optimal treatment for a patient.

The Subjectivity of Prescribing and Dispensing Drugs

The 3 batches were surveyed regarding ways of collaboration with the pharmaceutical representative. Physicians and pharmacists were surveyed regarding the ways in which pharmaceutical companies financially supported them by sponsorships. The pharmaceutical representatives were surveyed regarding his practices of collaboration with the two partners. From his point of view, the pharmaceutical representative uses the following tools for promoting products in pharmacies – in order of frequency: commercial offers, sponsorships for the purpose of continuing education, informal gifts. In the pharmacist's opinion, the pharmaceutical representative uses the following ways of collaboration while promoting products, in order of frequency: commercial offers, informal gifts, sponsorships for the purpose of continuing education. On the other hand, physicians have a different vision, considering that the pharmaceutical representative uses in his relationship with the pharmacist, for instance, as a way of promoting the products of pharmaceutical companies, commercial offers and sponsorships for the purpose of continuing medical education, rather than informal gifts. 57% of pharmaceutical representatives claim they often/always make commercial offers (reduction, discounts) to pharmacists. Concerning the data obtained from the batch of pharmacists, over 83% of them claim they receive commercial offers (reduction, discounts) from pharmaceutical company representatives.

These results obtained by comparing answers prove that commercial offers represent the tool used most often by the pharmaceutical industry in its relationship with pharmacies by means of pharmaceutical representatives, a fact which can be explained by the pharmacists' and pharmaceutical companies' wish to have a sustainable business.

Promotion Ethics – what Lies Between the Interest of the Company and the Interest of the Patient's Health?

The pharmaceutical representative's relationship with the prescriber and the pharmacist is complex, being regulated by codes of ethics of the pharmaceutical industry, relying on the ARPIM (Romanian Association of International Medicine Manufacturers) Code. Beside this code, there are various internal codes of ethics, established by each company.

According to our research, the employing company has an official code of ethics for drug promotion; the pharmaceutical representatives' answers are distributed as follows: 91.4% declare they know about the existence of such a code, 4.3% declare the company has no official code of ethics, 4.3% mention they are not aware of an official code of ethics for drug promotion.

The regulations of the ARPIM Code are matched by internal regulations referring to:

- The way to relate to healthcare specialists – most possible aspects being covered by these regulations;
- Criteria for the selection and sponsorship of healthcare professionals, for participation in courses or events;
- Criteria for offering informal gifts (no more than 150 RON/person).

Our conclusion is that the pharmaceutical industry in Romania has self-regulated sufficiently, but slippages can be identified in certain companies.

To outline physicians' and pharmacists' perspective of pharmaceutical company representatives' practices, we have analyzed and compared the answers of the 3 partners. Both physicians and pharmacists consider, to a lesser extent than pharmaceutical representatives, that there is an official company code of ethics for the promotion of its products. The reflection of promotion practices and tools is important in the perception of an ethical type of promotion. For example, when it comes to informal gifts, the data analysis reveals that over 50% of pharmaceutical representatives claim they never give physicians informal gifts. The physicians' perception is different. From the statistical analysis of answers to this question, we identify that, most often (93.5%), physicians make personal financial efforts to support their activities for continuing education and training, which contradicts pharmaceutical representatives' answers, over 45% of them declaring they often/frequently offer sponsorships to physicians for the purpose of continuing medical education. Though only 15% often/always offer sponsorships to physicians, the other 30% admit they occasionally offer such sponsorships.

Moreover, according to the questionnaire dedicated to pharmaceutical representatives, 67% of them consider that physicians cover the costs of activities related to continuing education and training by sponsorships from pharmaceutical companies.

Pharmaceutical Representative – Pharmacist – Physician Relationships, an Important Factor in Dispensing a Drug

The three parties involved in the process of prescribing and dispensing a drug agree on their mutual influence on dispensing a particular drug. 67% of physicians consider that the pharmacist – pharmaceutical representative relationship is an important criterion, in most cases, for dispensing a prescription drug and 66% of pharmacists claim that the physician's relationship with the pharmaceutical representative is important in prescribing drugs.

A statistically significant difference has been identified depending on the “teaching activity” variable in the batch of physicians. Physicians who also teach consider to a lesser extent than physicians who do not teach that the relationship with the pharmaceutical representative is important in prescribing a certain drug. We corroborate here the data obtained on compliance with protocols and the importance of data obtained from the scientific information flow. It has been observed that physicians who work in academia consider to a lesser extent than physicians who are not that companies employing pharmaceutical representatives have an official code of ethics for drug promotion. In addition, physicians who teach consider to a lesser extent than physicians who do not engage in teaching activities that the pharmaceutical representative uses, in his relationship with the pharmacist, informal gifts and sponsorships for the purpose of continuing education. We may conclude that physicians who also teach value information received from pharmaceutical representatives less, giving more credit to results presented in scientific studies.

Approximately 60% of physicians consider that the relationship between the pharmacist and the physician is important in dispensing a prescription drug; 55% of pharmacists claim that, frequently, the relationship between the pharmacist and the physician is important in this process. Data obtained by this research confirm the studies in the field performed in other countries. Most scholarly studies prove the influence of the pharmaceutical industry on healthcare professionals, but the physician – pharmacist relationship is insufficiently studied and perhaps even undervalued.

4. Perspectives Opened by this Research

This research has addressed a topic which has not been debated so far in Romania. Its conclusions represent, in fact, new research directions, by which future studies may be better guided:

- The physician – pharmacist – pharmaceutical representative relationship,
- The existence of ethical regulations at the level of the pharmaceutical industry; the problems lie in their implementation, because of the fierce competition between various companies, in their pursuit of market share and profit.

Based on the results of our research we can formulate several proposals/ recommendations.

1. A first proposal would be the creation of a Central Fund, where sponsorships from the pharmaceutical industry could be collected,

depending on the turnover of each company. The management board of this body would include: physicians, pharmacists and pharmaceutical company representatives. The sum collected in this manner would be equitably distributed to healthcare professionals for activities related to continuing education and training.

2. Another proposal would be to ensure maximum transparency at the level of granting scholarships and informal gifts to healthcare professionals, by proposing legislative projects for the pharmaceutical industry, for the identification, enclosure and sanctioning of deviations in the system. This process is already advanced – from 2015, both healthcare professionals and pharmaceutical companies have been required to declare sponsorships – but the process can be improved.

3. Finding more effective ways of prescription drug reimbursement, to eliminate financial losses from the healthcare system.

4. The proposal of new regulations related to DTC (direct-to-customer) advertising. The national legislation regarding OTCs is according to European legislation, but there are several loopholes for food supplements. In 2015, there was a draft law aiming at a better regulation of this aspect, but in the end the draft did not obtain the final approval, partly because of its deficiencies – it was not especially directed toward supplements/medical devices – the area where the current legislation is the most permissive – from the marketing authorization to the sales process.

5. Giving more attention to the pharmacist – physician relationship – this being an insufficiently studied aspect and, according to the results of our research, an important factor in dispensing prescription drugs.

6. Improving the patient's quality of life by establishing protocols for therapeutic conduct.

5. Conclusions

Our research underlines the ethical dilemma related to aspects related to the prescribing-promoting-dispensing drug process: doctor’s prescription is influenced by subjectivity and physicians who also teach value information received from pharmaceutical representatives less, giving more credit to results presented in scientific studies. Pharmacists seem to have more power comparing to doctors, regarding the counseling a certain drug. This paper also presents the limiting factors in the process of drug prescribing and shows that health policies and ethical principles must guide the care for the health of patients.

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ETHICAL ASPECTS OF CLASHING TITANS: TRAUMATIC BRAIN INJURY VERSUS AUTONOMY

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REZUMAT. Aspecte etice privind autonomia pacienților cu leziuni traumatice cerebrale. Leziunile traumatice cerebrale (LTC) au devenit o cauza importanta de mortalitate si morbiditate atat in cadrul populatiei civile cat si celei militare, fiind considerate o adevarata epidemie silentioasa, mai ales ca incidenta lor reala este in continua crestere. LTC pot afecta capacitatile cognitive esentiale in exercitarea autonomiei individului. O caracteristica a acestei entitati patologice este aceea ca pacientii pot prezenta capacitati intelectuale normale, aproape-normale sau de limita, fiind insa in acelasi timp certificati ca si competenti psihic si neavand nevoie de un tutore legal, chiar daca s-a obervat ca o capacitate scazuta de a-si evalua propriile comportamente si limite este des intalnita. Pentru a demonstra caracteristica anterioara am elaborat un chestionar care sa reflecte constinta de sine, pe care l-am inaintat atat pacientilor cat si apartinatorilor lor. Acest studiu a fost adresat unei populatii recunoscute ca fiind cu risc crescut de a dezvolta LTC si anume copii, batrani, indivizi cu status economic scazut, persoane necasatorite precum si pacienti cu un istoric anterior de LTC sau boli pshice, distributia pe sexe fiind egala. Rezultatele au aratat o diferenta de opinii intre perceptia pacientilor si a apartinatorilor. In astfel de cazuri, conservarea dreptului autonomiei nu este atat de clara cum s-ar crede in mod obisnuit, in consecinta fiind nevoie de aplicarea unor comportamente si tactici etice particulare. O privire atenta asupra patologiei LTC si a consecintelor sale neurocognitive poate conferi o mai buna intelegere a situatiilor care declina autonomia individuala cu pastrarea drepturilor legale si respectiv a conflictelor etice care decurg din aceasta.

Cuvinte cheie: *autonomie, leziuni traumatice cerebrale, comportament neurocognitiv, drepturi legale.*

ABSTRACT. Traumatic brain injury has become a leading cause of mortality and morbidity in both civilians and military, considered the modern version of a silent epidemic, since its real incidence is on the rise. In the field of medical ethics, “autonomy” represents endogenous determination that does not withstand

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controlling interferences not personal limitations. Traumatic brain injury (TBI) might affect cognitive capacities critical to the adequate exercise of autonomy. The hallmark of this disorder is the possibility of producing survivors who preserve normal, almost-normal or border-line intellectual capacities, certified as being competent and not in the need of a guardian or substitute decision maker, even though an impaired capacity to evaluate their own behaviors and limitations accurately is widely encountered. Aiming to reflect the proposed pattern, a questionnaire echoing self-awareness was apprised by patient and associated family member. The study revealed population at risk for TBI resembling childhood age, elderly, low-come individuals, unmarried people and patients with previous history of TBI or psychiatric pathology, with equal sex ratio distribution. Moreover, a difference of opinions has been noticed when evaluating the arisen topics from the questionnaire. In such cases, conserving the right of autonomy is not such as forthright as one might consider, thus requiring different ethical commitments and tactics. A slight look inside the neurologic pathology of TBI and its neurocognitive consequences seems to yield the basics of understanding situations that decline autonomy with preserved legal rights.

Key words*: autonomy, traumatic brain injury, neurocognitive behavior, legal rights.*

Introduction

In a defiance of the high media coverage and awareness, traumatic brain injury (TBI) is still representing one of the most important leading causes of mortality and morbidity in adults [1], encompassing different social backgrounds, ages and genders [1]. It is characterized by injuries that range from scarce to serious, causing long term disability regarding cognitive behavior. Since the dawn of science, medical ethics has concerned itself with balancing the patient's best interest (both psychological, social and medical) with legal rights and autonomy. As encountered in modern day cultures, these notions are complementary at times and clashing at others. Autonomy has its origins in ancient Greek assembling "autos "and "nomos" [2] with current meaning of "self", respectively, "law", pointing out self-governance as the central conception [3]. From medical point of view, it is considered that any legally competent adult is granted the option of own treatment decisions and outstanding this options have ethical, as well as legal constraints that need to be further assessed [4]. A chosen path of treatment without prior consent, physical and psychological duress are just two examples of medical activities that are not ethically accepted, yet at times are chosen paths of treatment for the patient's best interest. As a consequence, the ethical framework that should guide the actions of medical personnel in their interactions with these patients is not always straightforward and is worth examining more closely. Neuropathology of TBI seconding the neurocognitive changes seems to be the mile stone in understanding situations that decline autonomy with preserved legal rights [5].

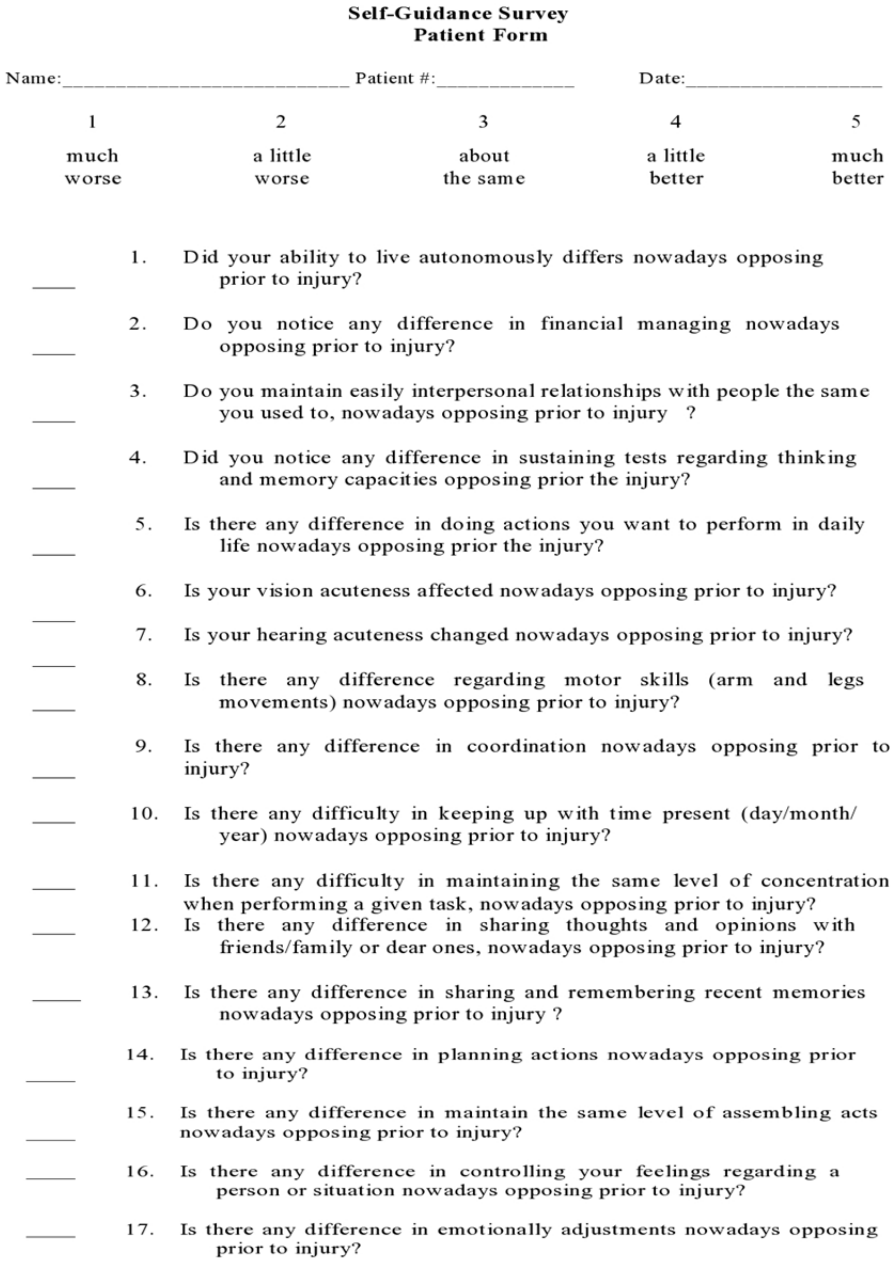
Neuropathology and Neurocognitive Behavior of Traumatic Brain Injury

Despite the high number of studies conducted on this area, the precise pathological mechanisms that tie repetitive or single TBI to abnormal protein accumulation and neurodegeneration are not known entirely [6]. So far, it is a consensus that the initial event taking place in head trauma is mechanical distortion of brain tissue [7]. This is being caused by applying inertial forces upon the axons located in the brain, such as acceleration followed by deceleration. During acute traumatic brain injury, the brain and other components of central nervous system undergo shear deformation producing a transient elongation that selectively injures axons, small blood vessels, and astrocytes [5]. As a suitable scenario one could consider the following schemes: blunt force trauma applied to the cranial surface, vehicle accidents, close contact sports, etc. The sum of injuries is proportional to the severity, intensity and extent of applied force. In the last century, most animal studies regarding single or repetitive head trauma concluded that the initial abnormality of TBI happens due to mechanoporation [8]. Mechanoporation consists of a traumatic defect in the neuronal membrane that occurs at the lipid bilayer of the cell. As a result, various ions can move rapidly into or out of the cell following their pre-injury concentration; potassium moves outside while sodium, chloride and calcium enters the cell. Increased intracellular calcium may stimulate the release of reactive oxygen species (ROS) for mitochondria causing cell membrane and blood vessels destruction leading to diffuse axonal injury, ischemia, neuronal deficits and cell death. The outcome of axonal injury can vary from axotomy (irreversible axonal injury), alterations of electrophysiological function to neurotransmitters concentrations, both acute and chronically [8].

Regarding neurocognitive domain, pathological changes described previously affect the power and executive functions [9]. These impairments are secondary to the diffuse axonal stray inefficiency and contrast the preserved perceptual, motor and intellectual functions [5]. Alterations of basic mental functions are a common symptom registered after TBI relating to mental engagement in current cognitive duty, regardless its nature [8]. Disturbance occurs in arousal (diagnosed first; fastest recovery) and channel capacity (persistent) [10]. This disturbance is characterized clinically by difficulties in three important domains: processing speed, multitasking, and cognitive endurance [11]. Slowed thinking process can be observed in all types of patients recovering from traumatic brain injury [12]. The multitasking reflects as the patient's impossibility to use the complex systems needed for memory and attention while applying external stimuli. Symptomatic TBI patients are often simply unable to sustain any cognitive effort for as long as they did prior to the injury [12]. Related to the reduction in cognitive endurance, patient complains that life in general, and cognitive tasks in particular, require more effort than used to. Furthermore, anticipating, goal selection, planning, initiation, sequencing, monitoring and correcting functions are disturbed [12]. The tasks mentioned previously are key components of the executive functions which give coherence to the human action. The importance of these is based upon one's capacity to accurately assess a given task. The deficit itself varies upon the affected lobe: for traumas occurring in the parietal side of the brain the patients cannot perceive their pathology, contrasting to frontal cases where is seen the loss of capacity to incorporate actual deficit into the global state of disease [11]. In conclusion, autonomy might be perceived as being compromised in both settings, but the underlying brain mechanisms are different leading to different tactics of bioethics appliance.

Material and Methods

The study group consists of 17 patients with a positive diagnosis of traumatic brain injury and conclusive markers of cognition disorder, both aspects determined priory to the examination. Patients were appointed to the Medical Legal Institute of Cluj-Napoca, Romania, during 2011-2015. Inclusion criteria rested on positive history of traumatic brain injury and relevant cognition disorder. Interviews regarding the patient's issues were pursued in a quiet yet comfortable place with the sole purpose of diminishing all possible interferences. The examination was conducted by a forensic doctor accompanied by a neurologist with high numbered years of clinical experience. During the exploration, the patients were asked to fulfill the specific questionnaire by grading questions with the self-opinion regarding arisen topics. The patient's form is similar to the one depicted below in Figure 2. Seconding the patients, a close family member or surrogate decision maker was interviewed by the same method. The survey attributed to the patient's family or tutor is depicted in Figure 3. Both patient and family were blinded from results of the test. Data resulted from both examinations underwent further analysis as depicted in the "Results" segment.



Self-Guidance Survey
Patient Form

Name:__________________________ Patient #:_____________ Date:___________________

1	2	3	4	5
much worse	a little worse	about the same	a little better	much better

____ 1. Did your ability to live autonomously differs nowadays opposing prior to injury?

____ 2. Do you notice any difference in financial managing nowadays opposing prior to injury?

____ 3. Do you maintain easily interpersonal relationships with people the same you used to, nowadays opposing prior to injury ?

____ 4. Did you notice any difference in sustaining tests regarding thinking and memory capacities opposing prior the injury?

____ 5. Is there any difference in doing actions you want to perform in daily life nowadays opposing prior the injury?

____ 6. Is your vision acuteness affected nowadays opposing prior to injury?

____ 7. Is your hearing acuteness changed nowadays opposing prior to injury?

____ 8. Is there any difference regarding motor skills (arm and legs movements) nowadays opposing prior to injury?

____ 9. Is there any difference in coordination nowadays opposing prior to injury?

____ 10. Is there any difficulty in keeping up with time present (day/month/year) nowadays opposing prior to injury?

____ 11. Is there any difficulty in maintaining the same level of concentration when performing a given task, nowadays opposing prior to injury?

____ 12. Is there any difference in sharing thoughts and opinions with friends/family or dear ones, nowadays opposing prior to injury?

_____ 13. Is there any difference in sharing and remembering recent memories nowadays opposing prior to injury ?

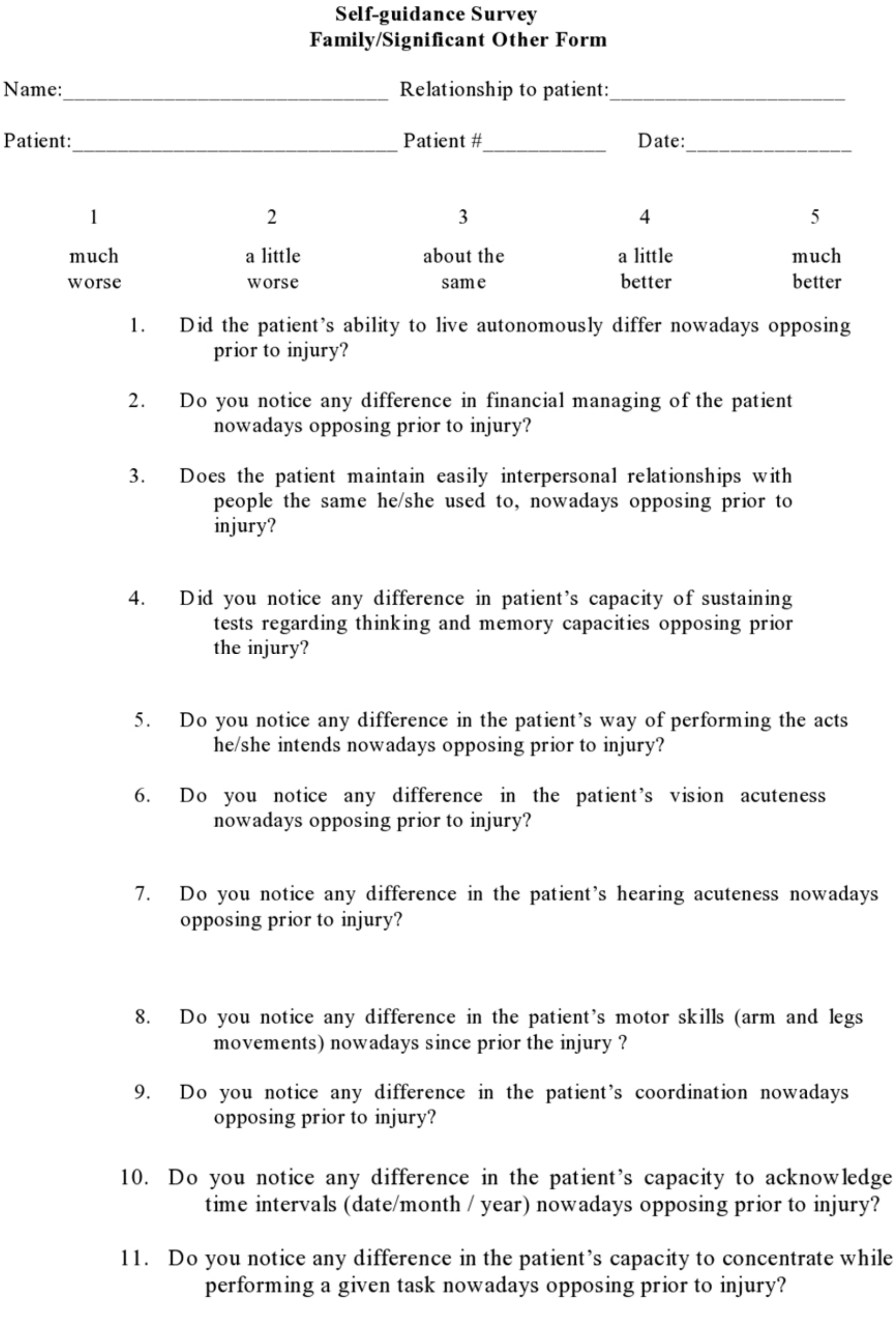
_____ 14. Is there any difference in planning actions nowadays opposing prior to injury?

_____ 15. Is there any difference in maintain the same level of assembling acts nowadays opposing prior to injury?

_____ 16. Is there any difference in controlling your feelings regarding a person or situation nowadays opposing prior to injury?

_____ 17. Is there any difference in emotionally adjustments nowadays opposing prior to injury?

Figure 2. Questionnaire provided to the patient: In order to highlight the patient's opinion and reflections towards its own disease while taking under analysis various tasks that encompass cognition evaluation.



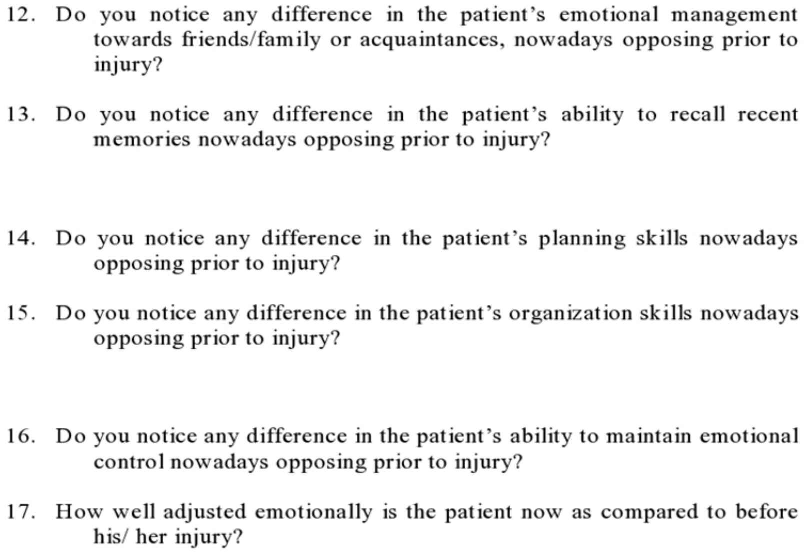
Self-guidance Survey
Family/Significant Other Form

Name:______________________________ Relationship to patient:______________________

Patient:______________________________ Patient #___________ Date:_______________

1	2	3	4	5
much worse	a little worse	about the same	a little better	much better

1. Did the patient's ability to live autonomously differ nowadays opposing prior to injury?
2. Do you notice any difference in financial managing of the patient nowadays opposing prior to injury?
3. Does the patient maintain easily interpersonal relationships with people the same he/she used to, nowadays opposing prior to injury?
4. Did you notice any difference in patient's capacity of sustaining tests regarding thinking and memory capacities opposing prior the injury?
5. Do you notice any difference in the patient's way of performing the acts he/she intends nowadays opposing prior to injury?
6. Do you notice any difference in the patient's vision acuteness nowadays opposing prior to injury?
7. Do you notice any difference in the patient's hearing acuteness nowadays opposing prior to injury?
8. Do you notice any difference in the patient's motor skills (arm and legs movements) nowadays since prior the injury ?
9. Do you notice any difference in the patient's coordination nowadays opposing prior to injury?
10. Do you notice any difference in the patient's capacity to acknowledge time intervals (date/month / year) nowadays opposing prior to injury?
11. Do you notice any difference in the patient's capacity to concentrate while performing a given task nowadays opposing prior to injury?



12. Do you notice any difference in the patient's emotional management towards friends/family or acquaintances, nowadays opposing prior to injury?
13. Do you notice any difference in the patient's ability to recall recent memories nowadays opposing prior to injury?

14. Do you notice any difference in the patient's planning skills nowadays opposing prior to injury?
15. Do you notice any difference in the patient's organization skills nowadays opposing prior to injury?

16. Do you notice any difference in the patient's ability to maintain emotional control nowadays opposing prior to injury?
17. How well adjusted emotionally is the patient now as compared to before his/ her injury?

Figure 3. Questionnaire provided to the patient's family member or substitute decision maker: In order to highlight the family members' opinions and reflections towards their relatives' disease while taking under analysis various tasks that encompass cognition evaluation.

Results

Data gathered in a Microsoft Excel sheet containing age, sex, question's number and graded form of both parts has been taken under analysis. The study groups were omogenously composed, encircecling both female (n=8) and male sex (n=9) with a mean age of 48.7 years old with a standard deviation of 9.1 % years old. Results of our study concluded that men are as likely to undergo TBI as women. The ratio becomes equal when approaching fifth or sixt decade of life, due to increased risk of falling or associated pathology such as gait control, nervous system disturbances and low density of bone structure. Furthermore, the study revealed population at risk for TBI resembling childhood age, elderly, low-come individuals, unmarried people and patients with previous history of TBI or psychiatric pathology. Moreover, a difference of opinions has been noticed when evaluating the arisen topics from the questionnaire. To compress all the information gathered from questionnaires a chart comparing answers from family and patient was created, such as seen in Figure 4.

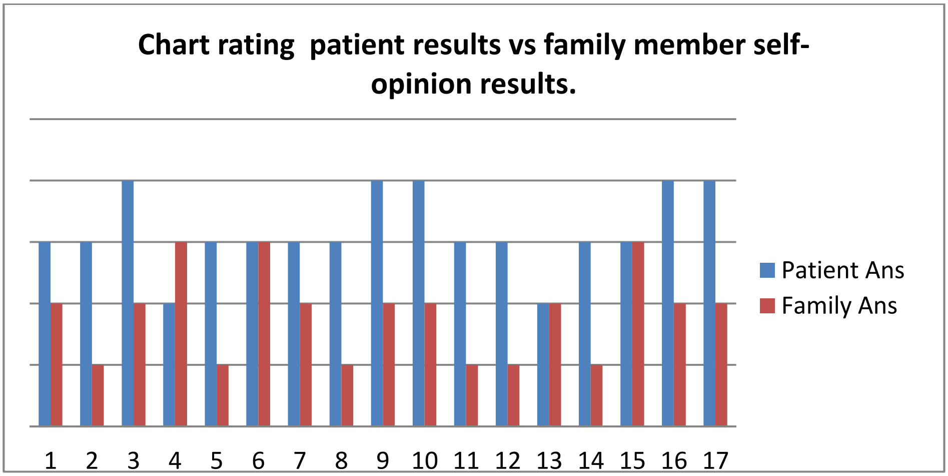


Figure 4. Chart rating the answers of both patient and family member: The chart high points a visibile contrast between the patient self awareness and the opinion of the family regarding autonomous life of patient. The numbers below the chart represent the number of question analysed.

Ethical Aspects

According to the Joint Centre for Bioethics [13, 14] capacity is defined by "the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of a decision". As stated previously, patients with TBI preserve a high part of their prior-injury capacities, which clears them as entitled to own decisions, even though the make-of process is compromised. Therefore ethical issues arise, since a conflict appears between competing values. From a clinician stand point one question speaks louder: should it be taken as granted a patient's TBI decision concerning choice of treatment?

It has been scientifically agreed that even small amounts of trauma occurring over short periods of time produce small deficits that are not easily depicted by modern imaging techniques. Those small shortfalls are not subject to quantification in routine medical practice. Scarce impairments to the frontal lobe results in difficulty of judgment, planning, inhibition, cognitive rigidity, lack of initiative or problems maintaining goal orientation over a long period of time. Emotional flattening or blunting and dulled emotional expressivity is also common when trauma occurs to the frontal lobe [15]. Additionally, small injuries to the temporal lobes causes memory decline, as a result patients have difficulties in retaining, withholding or sharing correct information. Conjointly, the temporal lobes form a part of the limbic system, thus providing emotional symptoms, both understanding and output, causing emotional flooding. The symptoms grow even bigger if there is involvement of the cingulate gyrus that has its main purpose of regulating emotions. A peculiar aspect of injury to this level is the loss of orienting reflex. With small amount damage to the cingulate gyrus habituation to a new stimulus does not occur, hence the individual remains easily distracted by even a constant stimulus in his/her environment [15].

Another fragile to trauma structure is the corpus callosum. Its damage leads to alexithymia. This consists of difficulty identifying and describing the nature of one's own emotional being. Head injured individuals commonly have great difficulty talking about their emotions [15]. All in all, a clean bill of health seconding head trauma may be just a ticking bomb impacting the patient's daily routine, best evaluated by with close family members. The issue arises in the objectivity of relatives.

Besides clinical risk factors, there are aspects that cannot be controlled by an outside force, such as sex, race or age. Scientific based literature [16] has shown that the most prone to traumatic head injury is the pediatric consisting of infants or toddlers aged 4 years old. Second place is granted to the older adolescents aged 15-19 years old. The mature population follows the trimodal distribution with a trend toward trauma in adolescent life followed by decreased risk during adulthood. The prospect of trauma increases with passing time due to gait posture control or associated pathologies. What's more, for every age and race studied males are more prone to accidents than women. Genetic susceptibility and addictions (especially alcohol related) developing in a feeble patient may increase raise the number.

Alongside, the cognitive reserve theory may also play a role in the clinical set-up. It has been stated that a higher cognitive reserve might respond and compensate better, earlier and faster than a meager one [17].

Seconding the first "hit", emerge issues in determining the future medical and lifetime needs of this group of patients. These questions come to withstand the principle accurately stated by Justin Cardozo regarding the self-governance of a patient: "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (Schloendorff 1914) [18]. Moreover, there are extensive models of recovery after brain traumatic injury; one patient might overcome medical expectancy, while others might be entrapped in Vegetative State during life-spam. Trying to solve the ethical maze, another topic troubles waters; the fluctuation of "self" intervals during therapeutic treatment and recovery. Given these situations, medical experts should provide extreme cautions when assessing patient's recovery chances, keeping in mind that personal awareness of the victim is the key point in this decision.

The modern medical practice changed a lot throughout the last decade. Starting with an authoritarian model (the current physician withheld the power to decide course of treatment without prior consent of patient [19]), and reaching, nowadays, to more synergetic doctor-patient communication stipulated by the 2005 version of the WMA "Declaration on the Rights of the Patient" [4] which permits patients to choose proceeding doctor and path of treatment.

Medicine and Law supports competent patients to legal right of autonomy when deciding the preferred course of treatment [4]. Without compromised legal rights all doctors share information with patients in order to augment therapeutic outcome [4]. The dilemma surfacing, regards the patient's ability to fully understand the given situation hence the cognitive process that leads to a decision as being broken. The legal system demands, as one of its fundamental requisites, mental competence. As noted by the scientific literature, being competent depends upon minimal mental, including behavioral and cognitive state, in order to perform certain task that withstands actual civil and criminal law. It is also rendered as a physiological step up in therapeutic formulas for victim's family to seek medical advice and further counseling.

The main question surfacing refers to the exact moment of attributing a decision-maker surrogate. Who should be the appointed guardian? A family member, an outsider - objective member or should it be respected the patient's decision of guardian prior to injury? These questions bare more weight when dealing with patients trapped in vegetative state, as faced the decision to stop or not medical treatment, despite enormous costs and low life quality of the patient. One significant area of debate in VS cases is often whether or not a patient should be made a "DNR" (do not resuscitate) and if so, when. Both scientific and moral arguments have been stated on the ethical differences between withholding versus withdrawing care. To date, noting that withdrawing care reaches a greater level of potential moral and ethical compromise than that of withholding care.

Another ethical clash concerning TBI also comes from the patients' lack of autonomy. Thus, within the judicial system there has been observed that whenever it comes to the possibility of obtaining patrimonial gains, the manufacture and pathological exaggeration of symptoms had been frequently reported in the literature [20]. This is also the case of post-traumatic cognitive disorders. The thorny question that the forensic medical expert is bound to give an answer to, is whether between the incriminated traumatic brain injury, single or repeated and the cognitive disorders might exist or not a link of causality. The answer to this question inevitably gives rise to numerous ethical difficulties of whose right interpretation basically depends the correct forensic evaluation of the case. The ethical difficulties start in most cases from the patient's attitude and that of his caregivers. From their point of view, the acceptance that between the cognitive disorders and the previous brain trauma there would be no connection, is extremely difficult to understand.

From this subjective reasoning start several attempts of simulation or exaggeration of symptoms in order to obtain unjustified monetary benefits. The evaluation of this apparent causality link involves working with a neurologist, the latter being the one who has the power to establish the diagnosis of cognitive disorders. But establishing the existence of a causality link between trauma and the later cognitive disorders burden, lies with the forensic medical expert. Moreover, due to the fact that between the time of occurrence of the cognitive disorders and the traumatic brain injuries a very long period of time had passed, ranging from years to even decades, the assessment of this connection becomes very problematic.

Another distinct and extremely important ethical aspect comes from the way in which the patient's information obtained by the two categories of doctors, physician (neurologist) and forensic medical expert is being used. Up to a point the two assessments are common and overlap. However, since the beginning stands out the distinction between the two types of relationships: in the neurologist's case it is a classic doctor-patient relationship, this implying the obligation of confidentiality. Whereas in the forensic medical expert's case, the obligation of confidentiality cannot be guaranteed, because in many cases the employer of the later is a third party, such as prosecutor, lawyer or even the perpetrator that provoked the traumatic brain injury in the first place.

Discussion & Conclusion

The discrepancy between responses in patients and family members bears in high percentage a scientific explanation regarded to be caused mostly by side effect from the repetitive traumatic brain trauma resulting in diffuse axonal injury, thus risking the integrity of white matter tracts with endangerments of the brain network connection. Additionally, secondary cellular injury mechanisms occurs leading to synaptic dysfunction, cell death and axonal degeneration that are not always picked up by imaging techniques, but they are given out by the patient's reaction to different topics. Likewise, in the whole set-up of a TBI patient it plays an important role the amount, the duration, location of the cerebral traumatic event and most important the patient itself, since its particular features represent circumstances to a better or worst prognostic.

Patients diagnosed with TBI possess complex and various clashes in evaluating competence, since it cannot be clearly determined by scientific methods. Further studies should be performed in order to assess if a person could be rendered as capable or not in pursuing any type of required tasks. To sum all up, there have been numerous studies conducted including debates regarding "for/against" moral arguments, yet no substantial responses nor consensus criteria have been brought to scientific practice. As a final conclusion, ethical dilemmas regarding this topic are hardly solvable to the full satisfaction of all members involved in caregiving.

Disclosure of Interest. The authors declare that they do not have any competing interests.

Abbreviations. TBI - traumatic brain injury; ROS - reactive oxygen species; LTP - impaired long-term potentiation; LTD - long-term depression; VS - Vegetative State; DNR - do not resuscitate.

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BIOETHICAL CONCEPTS RELATED TO HEMATOPOIETIC STEM CELL TRANSPLANTATION IN THE RELIGIOUS AND SOCIO-CULTURAL CONTEXT

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REZUMAT. Concepte bioetice relative la transplantul cu celule stem în contextul religios și socio-cultural. Medicina translațională este o disciplină modernă care își propune să creeze o punte de legătură între cercetarea experimentală, cercetarea clinică și implementarea tuturor acestor date științifice în practica clinică. Medicina translațională presupune, de asemenea, aspecte juridice și socio-culturale care pot avea rol decisiv în rezultatul acestui proces. În transplantul de celule stem hematopoietice (HSCT), cercetarea evidențiază conceptul de celule stem, actualizat continuu, necesare în ameliorarea clinică a alo- și autogrefelor de celule stem hematopoietice.

Între datele experimentale și practica clinică în sine, pot exista lacune, uneori legate de capacitatea de a obține rezultate viabile și utile prin cercetare sau privind abordarea unei medicini care nu este suficient centrată pe pacient. Acest ultim obstacol a fost studiat de autori. Obiectivul principal al lucrării a fost de a stabili dacă convingerile religioase ale pacientului poate influența alegerea pentru terapia cu celule stem. Lucrarea a prezentat patru cazuri de pacienți de la Clinica de Hematologie, Spitalul Clinic Județean de Urgență Arad. Rezultatele au arătat ca pacienții au avut un rol crucial în selectarea terapiei HSCT. Doi pacienți au urmat HSCT; unul dintre ei a refuzat alogrefa din considerente religioase. Una dintre cele mai frecvente motive invocate de către pacienți este refuzul sângelui și a produselor sanguine bazat pe motive sociale, culturale și religioase.

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Cuvinte-cheie: *bioetică, transplant de celule stem hematopoietice (HSCT), transfuzii de sânge, alo-grefare, auto-grefare.*

ABSTRACT. Translational medicine is a modern discipline which aims to create a bridge between experimental research, clinical research and implementation of all these scientific data into clinical practice. Translational medicine also entails legal and socio-cultural aspects that can decide the outcome of this process. In hematopoietic stem cell transplantation (HSCT), research emphasizes the concept of stem cell, continuously updated, necessary for the clinical improvement of allo- and autografting of hematopoietic stem cells.

Between the experimental data and the clinical practice itself, there can be gaps, sometimes related to the capacity of obtaining viable and useful results through research, or the approach to a medicine which is not sufficiently centered on the patient. This last obstacle has been studied by the authors. The main objective of the paper was to establish whether the patient's religious beliefs can influence the choice for stem cell therapy. The paper presented four cases of patients from the Hematology Clinic, Emergency Clinical County Hospital of Arad. The results showed that the patients had a crucial role in selecting the HSCT therapy. Two patients underwent HSCT; one of them refused the allo-grafting for religious considerations. One of the most frequent reasons invoked by the patients is the refusal of blood and blood product transfusions based on social, cultural and religious grounds.

Keywords: *bioethics, hematopoietic stem cell transplantation (HSCT), blood transfusion, allo-grafting, auto-grafting.*

Introduction

Hematopoietic stem cell transplantation (HSCT) is the therapeutic method by which a patient is infused autologous or allogeneic stem cells in order to re-establish hematopoietic function, in the case of pathologies in which the patient's hematogenous marrow or immune system are non-functional or damaged. At present in onco-hematology, modern medicine offers new therapies that can induce complete remission without the need for HSCT, but the indication of HSCT remains absolutely necessary in certain onco-hematological pathologies.

The concept of hematopoietic stem cell is part of the hematological research of recent years. Multipotent stem cells have a research history of over 40 years and have been successfully used until now in treating such illnesses as leukemia. The use of this type of stem cells is to a lesser extent marred by ethical and religious dilemmas, since these cells are naturally found in the body.

However, from a medical point of view, their limited differentiation potential restricts their practical use [8]. Translational research is a recent concept, whose main aim is to categorize practical, outcome-oriented research. In medicine, there are still different definitions, according to the number of phases and other elements of the process [4]. Most current definitions considered it as a process that begins with fundamental research (genetics, molecular biology, proteomics, and so on), and ends at a worldwide level (social healthcare, access to healthcare or education, etc.) [7].

One definition states that translational medicine seeks to create new continuity between research and medical practice, through three phases: fundamental research, clinical knowledge and clinical practice, as well as the therapeutic decision made for each separate patient. In this case, two gaps appear between these phases, one between the laboratory and the patient's bedside, and the other within the attempt to translate medical knowledge to the patient's bedside [3].

Religious issues can be raised in donating tissues or cells [1] and in their acceptance by the donor [5], [6].

Some Legal Aspects Concerning Human Organs, Tissues and Cells Transplantation, in Romania

The issue of human organ and tissue transplantation was officially raised after 1990, the first law to regulate this area being passed in 1998. This referred especially to harvesting and transplanting human tissues and organs for therapeutic purposes. There have been several subsequent normative acts, among which the Law no. 104/2003 on Handling Human Corpses and Harvesting of Organs and Tissues from Corpses for Transplantation Purposes [11], republished in 2014 and amended and supplemented by Law no. 47 of 14 March 2013 [14]. Some of the changes refer to services for using corpses in anatomy subjects at university.

Another legal document is Law no. 95/2006 on Health Reform [12], republished in 2015.

Title VI of this law – Harvesting and Transplantation of Organs, Tissues and Cells of Human Origin for Therapeutic Purposes, establishes in Chapter II the rules on donation and donors of organs, tissues and cells of human origin. Chapter III is entirely dedicated to the Transplantation of organs, tissues and cells of human origin. This chapter mentions that "the transplantation of organs, tissues and cells of human origin is performed with the written consent of the recipient, after having been informed on the risks and benefits of the procedure, according to the form template approved by order of the minister of health". It also indicates the procedures for the case in which the recipient is unable to express consent.

The Order no.1527 issued by Ministry of Health in 2014 [15], established the methodological norms to apply title VI "Harvesting and Transplanting Organs, Tissues and Cells of Human Origin for Therapeutic Purposes" within this law.

An important piece of legislation is the Order of the Minister of Health no. 477/2009 on the establishment of the National Registry of Transplant within sanitary units, designating persons responsible for the management of data from the National Registry of Transplant within health units accredited to perform organ transplantations and establishing the data required for registration of a person for the assignment of the unique registration code from National Transplant Agency, as subsequently supplemented [13].

The latest legislative document is Law no. 9/2016 of 18 January 2016 for ratifying the Additional Protocol to the European Convention for the protection of human rights and human dignity regarding the applications of biology and medicine, with reference to the Transplantation of Organs and Tissues of Human Origin, signed in Strasbourg on 20 February, 2015 [16].

Starting from the aim of the Council of Europe to achieve a greater unity between its members and that one means of achieving that aim is the protection and realization of human rights and fundamental freedoms, the aim of the Convention on Human Rights and Biomedicine, as it is defined, is "to protect the dignity and identity of human beings and to guarantee for everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to its application of biology and medicine" [9].

In conducting transplants one must take into account several aspects such as the ethical, psychological, social and cultural issues related to the transplantation of tissues and organs, the proper use of tissues or organs, so that as not to affect human life or dignity, the conditions under which the transplantation is performed, monitoring compliance with individual rights and freedoms and the prevention of illegal trafficking of organs. All these are aimed at achieving progress in medical sciences, saving lives and increasing the quality of human life. This law regulates, in addition to object and scope, some major issues such as: the transplantation system, harvesting of organs and tissue from live and deceased persons, financial gain, confidentiality etc.

Regarding international agreements on the exchange of organs, the procedures must have a justified distribution among participating countries, taking into account the principle of solidarity within each country.

Likewise, it is very important to provide correct information to the donor about the purpose and nature of harvesting, and about its consequences and risks. The donor must also be informed on the rights and guarantees provided by law for their protection. Also, it should be noted that obtaining any financial gain or comparable advantages is prohibited. In some EU member states there is a donation card by which a person can express donation consent during their lifetime.

Moral, Ethical and Religious Issues Related to Communication with Patients

The idea behind this work came from interdisciplinary collaboration offered in hematologic patient care, by addressing both the moral conscience and ethical norms and relations from a particularly introspective perspective.

Thus, the main problem that arises in the discussion with these patients appeared since communicating the diagnosis, and some of the main dilemmas that we found were those related to the questions “why did I get the disease?” and “what is the healing promise we can get?” This context reminds us how important is the role of confessor (spiritual leader) in human life, which is connected to religion as a guide, helping him discern the path of good or evil.

The study of the history of world culture highlights the fact that the issue of good and evil is present in any ancient culture, being widely debated in the mythology and religion of ancient peoples, long before the emergence of philosophy as a manifestation of human spirituality (a concept proposed by the great Greek philosopher Plato, who situated the idea of “good” at the center of his entire philosophy, and criticized by Aristotle, who believed that there is an asymmetry in the good-evil polarity, with evil being definitive, and good only purporting to be).

A confessor is one who can provide, first of all, support in the patient’s struggle, a struggle which, in a perhaps abstract, and yet so real manner, refers to the very battle between good and evil. Besides support, he can also provide constant objective advice, which does not take into account the fact that, before disease or other individual issues, there are no social classes advice, regardless of the phases through which the individual is going, regardless of context and the time. A confessor is required to be a parent who guides the individual on a good course.

One of the important issues that they have raised is whether the illness occurred due to lack of love in the patient's life, and another question is how can those who want to remain faithful to the Christian belief respond and accept the challenges and opportunities offered by medical progress (Statt's double listening concept). The patient considers the onset of the disease to be a genetic alteration influenced by environmental factors. Is our body a survival and gene multiplication machine (Dawkins' concept), do we function according to a predetermined genetic program that we cannot influence, or is it just the role of divinity in both the occurrence of disease and the outcomes of the treatment?

They also considered it necessary to communicate the truth. From a moral perspective, human relationships based on lies are degrading, having a strong diminishing effect on the human condition. Living a lie influences human relationships to such an extent that it completely cancels the values that underlie and give meaning to authentic human life. Many of those who lie punish themselves and their punishment is, among other things, that a lie always needs another lie to support it, that one has to exert one's memory a lot to remember what they said and worse, the fact that not only are they not believed, but they can no longer believe in anyone. A. Gide said that most detestable lies are those closest to the truth. Therefore we agree with Lucian Blaga, who said it would be terribly unfortunate if the truth were to always be found "in the middle". There are cases where we can talk about a limit to speaking the truth, but mainly the communication of truth has been extremely important for patients.

Regarding the acceptance of the transplant procedure, patients were informed on the therapeutic method involved by the transplantation, be it or allogeneic or autologous.

Ethical and Religious Issues in HSCT Therapy Cases

Allogeneic HSCT has broader indications, because it can provide complete curability in multiple pathologies such as acute leukemia, multiple myeloma, non-Hodgkin's malignant lymphoma, Hodgkin's disease. Autologous HSCT can also be used, but it uses the patient's stem cells, in this case the technique depending on getting a remission of the disease in advance. Rates of mortality and morbidity related to HSCT decreased considerably due to improved conditioning regimes, more efficient HLA typing, supportive therapy and prevention and treatment of serious infections. The types of stem cells that can be used for HSCT are bone marrow, peripheral blood after stimulation with granulocyte colony-stimulating factors, cord blood from related or unrelated donors.

One of the nonmedical issues raised by HSCT is blood infusion by the transplantation itself and the need for supportive therapy with blood preparations in transplant patients. This restriction occurs in patients who, for religious reasons, do not accept blood transfusions or blood preparations.

Modern medicine offers these types of patients, as well as others, a type of HSCT called bloodless transplant [6]. This type of transplant takes particular care that blood components are as much as possible removed by washing and subsequently replaced with albumin in the donor's apheresis product and the use of pretransplant and posttransplant methods to reduce the need for transfusions. Of course, the cytometrical selection of stem cells is done using modern technology, with maximum accuracy.

There are other mindsets of patients, according to the author's experience, which in part are related to the Romanian cultural and social context, according to which the introduction of foreign cells in one's body is seen as a deterioration of the human being. This type of mindset has been noted in patients described in the casuistry of Arad Hematology Clinic.

All patients are informed in advance about the specific HSCT procedure, its benefits and risks, and they sign an informed consent form. According to Law no. 46/2003, correct and complete information of each patient, regardless of religious belief, is part of patient rights and is essential in the therapeutic management of the patient [10].

Regarding the ethical issues that may be raised by HSCT, the patient's decision between a therapy that may be their only salvation or which might even turn out to be fatal is most acute [2]. Questions were also raised about preserving the dignity of the transplanted person. The moral obligation to use live-saving technologies if they are available is another question that HSCT raises. The conclusion of meta-analysis is that, morally speaking, the patient's safety is paramount.

Clinical hematology patients studied in Arad were aged between 23 and 56 years, of the Christian religion. The first case was a 54-year-old woman with acute myeloid leukemia who had two allogeneic HSCTs. The patient hails from an urban background, is highly educated, and had her family by her side at all times (husband). Doctor-patient communication was appropriate, with information from the clinician and answers to all questions asked by the patient and her family. The patient accepted two allogeneic HSCT as the only curative therapy in onco-hematologic disease at the time. Survival was 2 years since the last HSCT.

The second case was a 56 year-old woman with multiple myeloma. The patient came from a rural areas, had completed secondary studies, and family presence during hospitalisation was reduced. This patient's relationship with her carers was not constant. The patient refused allo-transplantation due to the risks involved, the difficulty of finding a compatible donor of hematopoietic stem cells, and religious reasons regarding the acceptance of regenerative tissue from an unrelated donor. Therefore the patient was administered an autologous transplant, with unfavorable outcomes.

The third case is a 23 year-old woman with Hodgkin's disease. The patient comes from the urban area, having completed high school at the time of diagnosis. The patient was accompanied by friends, not family. The patient refused allo-HSCT, citing the following reasons: fear of having foreign cells infused into her body, which could change her identity, indirectly refusing transfusion of blood preparations. This refusal also made self-HSCT impossible, as the conditioning phase and the post-transplant aplastic anemia phases often require the transfusion of blood preparations. The patient had strong religious beliefs, which influenced her conduct and therapy decisions. In addition, the patient refused radiotherapy which is standard protocol in Hodgkin's disease.

The fourth case is a 51 year-old man with acute leukemia. His origin was rural, secondary education, permanently accompanied by his wife. The patient was directed to preparations prior to allogeneic HSCT, but refused it citing uncertainties offered by this therapy, being largely influenced by the outlook of his family and entourage on this therapy.

Conclusions

The patient is a person who does not live in isolation, but is a social being, directly influenced by entourage, family, faith and their own conceptions about life. In conclusion, the patient should always be approached in a complex manner, not just from a biological perspective, but also from a psychological, spiritual, cultural standpoint, in order to be able to offer them health care to the highest standard, but while respecting the dignity and autonomy of the human being.

The HSCT therapy is a complex one and implies a lot of decisions for both physician and the patient. Therefore, in addition to legal and medical aspects that should be considered, often a more important role is played by ethical, moral and religious aspects that can decisively influence the medical act.

The results showed that the patients had a crucial role in selecting the HSCT therapy. Two patients underwent HSCT; one of them refused the allo-grafting for religious considerations. One of the most frequent reasons invoked by the patients is the refusal of blood and blood product transfusions based on social, cultural and religious grounds. The conclusion was that the patient is a person who must be addressed in all his complexity, his decisions being made in accordance with the principle of autonomy and patient's rights, and defining the trajectory towards healing or disease rebound.

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*** Law no. 47 of 14 March 2013 amending and supplementing Law no. 104/2003 on the handling of cadavers and removal of organs and tissues for transplantation from cadavers
*** Order of Minister of Health no. 1527/2014 on methodological norms to apply title VI "Harvesting and Transplanting Organs, Tissues and Cells of Human Origin for Therapeutic Purposes" from Law no. 95/2006 on Health Reform
*** Law no. 9/2016 of 18 January 2016 for ratifying the Additional Protocol to the European Convention for the protection of human rights and human dignity regarding the applications of biology and medicine, with reference to the Transplantation of Organs and Tissues of Human Origin

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WHOLENESS OF THE BODY IN THE CONTEXT OF THE TALKS ON ORGAN TRANSPLANTATION

IULIU-MARIUS MORARIU[1]

REZUMAT. Integralitatea trupului în contextul discuţiilor privitoare la transplantul de organe. În cadrul acestui articol, autorul analizează, pe baza opiniilor unor specialişti în teologie şi bioetică, precum: Înaltpreasfinţitul Irineu al Alba-Iuliei, Thristram Enghelhardt, Mircea Gelu Buta, Maria Aluaş sau alţii, relaţia dintre intrgritatea trupului şi transplantul de organe. Principala întrebare este aceea dacă procesul de transplant, care afectează integralitatea trupului, făcându-l să piardă un organ sau să primească unul străin, este o greşeală, în conformitate cu învăţătura Bisericii Ortodoxe. În cadrul analizei, problema este corelată cu alte procese similare, precum amputarea, sau împărţirea moaştelor, care afectează de asemenea integritatea trupului. Concluzia la care se ajunge în urma cercetării este aceea că, în condiţii normale, procesul transplantului nu este o greşeală, ci un act de iubire pentru aproapele.

Cuvinte-cheie: *Irineu Pop-Bistriţeanul, Thristram Enghelhardt, eshatologie, trup şi suflet.*

ABSTRACT. In this article, the author analyses, based on the opinions of some contemporary theologians and specialists in bioethics like the Archbishop Irineu Pop from Alba-Iulia, Thristram Enghelhardt, Mircea Gelu Buta, Maria Aluaş, or others, the relationship between the wholeness of the body and the transplantation of organs. The main question debated is if the process of transplantation, which affects the integrity of the body is a sin, according to the Orthodox Church teaching. The problem is related with other similar processes like the amputation or the segmentation of relics, which also affect the body wholeness. The conclusion is that, in normal conditions, the process of transplantation is not a sin, in normal situations, but a fact of love for the other.

Keywords: *Irineu Pop-Bistriţeanu, Thristram Enghelhardt, eschatology, body and soul.*

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Introduction

Organ transplantation is an interesting topic of discussion for contemporary researchers, fact proved by her presence in all major treaties bioethics[2], in discussions on legal phenomenon valences[3], abuses or similar matters[4]. Scientists are concerned about both the medical side of it, noting in their works issues relating to donor and recipient profile and moral implications they might have.

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[2] Some of the most important works on this subject are: Vasile Astărăstoae, Almoş Bella Triff, *Essentialia in Bioetica,* Cantes Press, Iaşi, 1998; Irineu Pop-Bistriteanul, *Curs de bioetică (Bioethics handbook),* Renaşterea Publishing House, Cluj-Napoca, 2005; John Breck, Lyn Breck, *Trepte pe calea vieţii – o viziune ortodoxă asupra bioeticii (Steps on the life's road),* translated in Romanian Language by Geanina Filimon, Sophia Press, Bucharest, 2007; H. Tristram Engelhardt Jr., *Fundamentele bioeticii creştine – perspectiva ortodoxă (Fundaments of the Christian bioethics - an Orthodox perspective),* translated in Romanian Language by Cezar Login, Sebastian Moldovan, col. „Philosophia Christiana", Deisis Press, Sibiu, 2005; Maria Aluaş, *Bioetică medicală (Medical Bioethics),* Press of the „Iuliu Haţieganu" University of Medicine and Pharmacy, Cluj-Napoca, 2016; Ana Smith Iltis, Mark J. Cherry (coord.), *La temeliile bioeticii creştine – eseuri critice asupra gândirii lui Tristram Engelhardt jr. (To the roots of the Christian Bioethics - critical essays on the thaught of Tristram Engelhardt jr.),* translated in Romanian Language by Cezar Login, Maria Aluaş, Dumitru Vanca, Renaşterea Publishing House, Cluj-Napoca, 2011; Mircea Gelu Buta (coord.), *Medicii şi Biserica (The Doctors and the Church),* 9th volume -„Bioetica creştină şi provocările lumii secularizate (Christiasn bioethics and the challenges of the secularised world)", col. „Bioetica", Editura Renaşterea, Cluj-Napoca, 2006; Marian Niţă (coord.), *Dicţionar de bioetică, (Dictionary of bioethics)* Aius Printed Press, Craiova, 2009; Gheorghe Scripcaru, Aurora Ciucă, Vasile Astărăstoae, Călin Scripcaru, *Bioetica, ştiinţele şi drepturile omului (Bioethics, the sciences and the human rights,* col. „Bios", Polirom Press, Iaşi, 1998.

[3] Cf. Camil Tănăsescu, *Fundamentele filosofico-juridice ale conceptului de prelevare şi transplant de ţesuturi şi organe umane (mss. dactil., teză de doctorat: The philosophical and juridical fundaments of the concept of transplantation of human tissues and organs),* Bucharest 2005; P. A. Carstens, „The constitutional influence on organ transplants with specific reference to organ procurement", in *Potchefstroom Electronic Law Journal,*XVII (2014), Issue 1, pp. 208-210; Gheorghe Scripcaru, Simona Damian, „Către o nouă ramură juridică, biodreptul (dreptul comparat și aculturația juridică) (Throw a new juridical branch, the bio-law – the comparated law and juridic aculturation", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, pp. 33-35.

[4] Cf. Maria Cristina Voinic, *Traficul ilicit de organe, ţesuturi şi celule umane – prevenire şi combatere (Illicit trafficking in organs, tissues and cells - preventing and combating),* Sitech Press, Craiova, 2009; Ştefania Kory Calomfirescu, *Moartea cerebrală şi transplantul de organe (The cerebral death and the transplantation of organs),* Ecou Transilvan Publishing House„ Cluj-Napoca, 2014; Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009; Iancu Tănăsescu, *Transplantul și prelevarea (The transplantation and prelevation),* C. H. Beck Press, Bucharest, 2008.

Bioethics, science and history quite recent, located at the crossroads of many sides of contemporary investigation, assured the friendly meeting and dialogue between different specialists. Contemporary bioethical discourse has become so big concerns synthesis of all devoted to the subject. Among these concerns, include one regarding the relationship between transplant and completeness of the body, which we will analyze in the following lines, drawing large publishers aspects of literature older or newer, theological or secular[5].

Wholeness Of The Body - a Barrier to Organ Transplantation?

Definition

As can be inferred from the very name of the concept, completeness body is the term used to define the quality of the human body, living or dead, to be composed of all its organs at the place where, biologically, they found since the birth of their owner[6]. This may be disrupted either because of diseases that lead to loss by amputation of some organs or following transplantation. Teeth or hair loss does not affect the integrity, just as the loss of the different layers of the skin after its regeneration, as in their case, it is natural phenomena that produce it.

Contemporary Bioethicists, Transplant and Completeness Body

Transplantation requires, as noted, there is a donor and a recipient. The trial itself raises many questions theological, medical, legal, etc. Some theologians such wonders whether the man is a unit „dies in pieces"[7]. Analysis lawyers are concerned both legislative provisions concerning transplantation and abuses attributed to the procurement of the necessary bodies, while doctors are interested in all these aspects, but also the underlying medical phenomenon.

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[5] Cf. Dominique Martin, „Professional and Public Ethics United in Condemnation of Transplant Tourism", în rev. *American Journal of Bioethics,* X (2010), Issue 2, p. 18; Maria Aluaș, „Trafficking in organs and transplant tourism. Ethical and legal issues in the romanian context", în Ioana Vasiu, Florin Sireteanu (eds.), *Crimes, Criminals and the New Criminal Codes. Assesing the Effectives of the Legal Response. In Honorem Professor George Antoniu,* Accent Press, Cluj-Napoca, 2014, pp. 170-178.

[6] In fact, according to the *Explicative Dictionary of the Romanian Language,* "integrality" is defined as being: " state, situation of what is comlete". Cf. Romanian Academy, "Iorgu Iordan" Institute of Lingvistics, *Dicționar Explicativ al Limbii Române (DEX) (Explicative Dictionary of Romanian Language),* 2nd edition, Univers Enciclopaedic Publishing House, Bucharest 1996, s. v. „integralitate".

[7] Cf. Ioan Chirilă, „Omul - o unitate care moare pe părți? (Man – a unit split dies?)", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, pp. 25-26.

Among theologians, some voices are against transplant, claiming that the entirety of the body, important condition for human existence in its spiritual meaning is affected through this process. Moreover, and legally, it stipulates that „the human body is sacred, untouchable, should be respected both during life and after death, and can not be subject to any trade"[8], paragraph willing to emphasize the importance of the body and its relationship and dignity. The idea completeness body was found in a veiled way to theologians as Enghelhardt and is expressed directly and clearly by His Eminence, Archbishop of Alba Iulia today, in two of his works. At first, it is presented in a less directly, but rather the respect to be given to the body as part of the human being:

> „In all cases, bodies, human organs and tissues must be given respect. Through baptism, Christians faithful were clothed in Christ and united with Christ (Gal. 3, 27)" and they received the Eucharist Christ in themselves. Their bodies became temples of the Holy Spirit. This may provide grounds directly against the killing of a human body brain dead, but otherwise living (eg never inject a lethal drug to cause a biological dead). The bodies of all (the Holy Spirit blows where He wills), but especially of faithful Christians should be respected as we respect the body relics of a saint[9].

At the second, original ideas are outlined in volume that wants a little treatise on bioethics, and more clearly in the second. And he aware that respect for the human body is a prerequisite even in the transplantation[10], analyze this aspect is concerned. An interesting contribution it brings to confer keep eschatological dimension of the whole problem. Thus, when talking about this medical approach, he states that:

> „Many Orthodox oppose a strong resistance to organ transplants because their conception of character and the human body, about sickness and

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[8] Gheorghe Scripcaru, Aurora Ciucă, Vasile Astărăstoae, Călin Scripcaru, *Bioetica, științele și drepturile omului (Bioethics, the sciences and the human rights),* p. 140. In other place, they show that: " As whe have allready show, nore the human place in its integrality, must not be the boject of a commercial activity (with the exception of the donation of blood, which, in the majority of the states, is for free)". *Ibidem,* p. 141.

[9] H. Tristram Engelhardt Jr., *Fundamentele bioeticii creștine – perspectiva ortodoxă (The fundaments of the Christian Bioethics - the Orthodox perspective),* p. 433.

[10] " Sampling means sometimes go to the lack of respect and consideration for fellow body. We are wondering if it still is respected the dignity of this body where there are missing the eyes, the hart, the lungs, the liver, the kidneys, the pancreas, a few bones and a few meters from the gut (what is called multi-organ sampling and it is considered the most cost). Maybe, in this case, we are all right to be opponents of such a materialist and utilitarian reductionism, which is now predominating and which is transforming the body in an object and in and in removable and interchangeable parts". Irineu Pop-Bistriteanul, *Curs de bioetică (Handboo of bioethics,* p. 69.

> healing and about death. In Orthodoxy, man is never found without his body, either during the biological life or thereafter. After death, the man retains a kind of biological imprint of his body. You will need to account for how it has used, or what has become of those they suffered: „He who sins against his own body (I Cor. 6, 18), „The Lord keepeth all their bones, none of them will crush (Ps. 33, 19 şi In 19, 36). Finally, when the Saviour says: „And if thy hand or thy foot offend you, cut it off and throw it from you, it is better for thee to enter into life maimed or lame, than to be burned in the eternal fire" (Mt. 18, 8-9), do not let us understand that: 1) the body and destiny are part of the elements of personal judgment after death; 2) the fact of the matter is currently before you judge with integrity or amputated body?
>
> In Scripture, mention organ of the body is made primarily by their function relationship which marks or deviating („who has ears to hear, let him hear"). For the Orthodox, no organ is isolate each part of a system that links it to all the other organs of the body, the body which itself is the temple of the Holy Spirit Church member and member of the body of Christ. What prevents the Orthodox to accept the easy removal of organs from a body„ "is undoubtedly the conception we have about death and about the first days after it"[11].

In a study published four years later in the journal Bioethics of the University of Cluj, he shall recompose speech, expressing in a much more readable, aided by an artifice rhetorical conception dance on the relationship between the completeness of the body, perceived as whole and the complex phenomenon of transplantation. Here's what he says:

> „But where is it and what remains of dignity when he lacks eyes, heart, lungs, liver, kidneys, pancreas, some bones? How will present him before the judgment seat?"[12]

Concept dance, as well as other professionals you quotes[13], it is one that is based on a serious and may be, somehow, citing scriptural. However, it raises questions similar to those which it put other specialists from recipients behaviour analysis asks whether transplantation and kinship brings the two

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[11] *Ibidem,* pp. 61-62.

[12] Irineu Pop-Bistrițeanul, „Un gând creștin asupra transplantului de organe (A Christian think about the transplantation of organs)", in *Studia Universitatis „Babeș-Bolyai",* series "Bioethica", LIV (2009), nr. 1, p. 22.

[13] Mark Andronikof, „Un punct de vedere ortodox asupra transplantului de organe (An Orthodox point of view about the transplantation of organs", in *Revista Teologică (Theological Review),*New Series, VIII (1998), nr. 1-2, p. 102 et passim.

actors[14]. It is one that is based on a serious and may be, somehow, citing scriptural. However, it raises questions similar to those which it put other specialists from recipients behaviour analysis asks whether transplantation and kinship brings the two actors. However, when it comes to an amputation surgery, the aim of which is the salvation of man, even without retaining entirety, no protest, does not consider the process as one being unethical and does not provide arguments scriptural against him. Researchers dealing with prevention of amputation[15], trying to find solutions, but where this is not possible, however, call this process, without any qualms, more than that if they try to oppose, through such assumptions, by the Church, it would be heavily criticized and it claims that preaches death and not life as Christ asks! Why is it that when it comes to amputation therapeutic role, theologians are quick to talk about the need for completeness body, and when it comes transplant, she relies on in order to provide an argument against this?

True, if the amputation of a body, this is because the one who loses would not be able to use it and storing it in the body could lead to disruption of the function of the other and, ultimately, death. Transplantation, organ functioning, and in addition, the integration of another body would of course raise serious questions about the relation of the body with him. Will make the body of the old body? Will it be part of the new body? How will report the body receives from him? Questions which could be its knead those concerned about the moral dimension of the process. Sometimes, however, the theory is solved by doing. In the present situation it is the same. When if it is a healthy organ is transplanted, the one who donates body can function without him[16], while the body of the recipient uses to prolong life and to function parameters similar to those before. It's true, we can discuss here the quality of life of the

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[14] Cf. Sebastian Moldovan, „Transplantul – o înrudire? (Transplantation - a kinship?)", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, pp. 108-128; Viorica Bindea, „Se întâmpla în 2008 (It hapened in 2008)", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, p. 225.

[15] Cf. Malgorzata Zdzioch, "Preventing amputation... This reflective account is based on NS796 Thomas E (2015) Preventing amputation in adults with diabetes: identifying the risks" in *Nursing Standard,* XXX (2016), Issue 25, pp. 61-62.

[16] Cf. Cristina Gavrilovici, Beatrice Ioan, Mihaela Vicol, Vasile Astărăstoaie, „Aspecte etice în procurarea de organe (Ethical aspects in the procurement of organs", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, p. 79.

two and how it is affected, however, we believe that future advances[17], can improve this aspect.

We believe therefore that the main dilemma that should knead specialists should not be so, but the approach should be based on other premises, such as love of neighbour and help him. In addition, there are more important issues that should be considered, such as body abuses arising from the practice etc.

On the other hand, the reader might ask whether this body is fully valid only during life and lapses after its finality. In the press, the news and other sources is often mentioned as the relics of certain saints were offered but some communities or individuals, especially from ecclesiastical space[18]. The relics are nothing but bodily remains of some saints, usually remaining incorrupt and usually they smell nice. Their existence is a prerequisite for the process of canonization[19].

However, dividing the pieces of these churches which have as protectors on certain saints or certain hierarchs of the Church does not affect the completeness of the body. Why then would affect the entirety transplantation?

The matter is therefore an issue only in the context of the entirety of the body is correlated with dignity owner and abusive practices. Given that there is such situations, when death will fully brings transplant donor should definitely avoid making the practice of transplantation. Under normal circumstances, however, as the Tristram Enghelhardt:

> „When there is a determination proper death, even a determining proper death of the entire brain, you should be banned Orthodox Christians or their families to give their consent to such donations after establishing brain death, if they do this in love for others.
>
> When there is a reliable determination of death, transplant does not involve the killing or maiming of a living person. Indeed, even living donation of an organ or tissue not essential to life vividly show none of the signs of mutilation sinful,

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[17] Cf. Ştefan Iloaie, „Transplantul sau suferința ca șansă pentru mântuire (Transplantation or the sufference as a chance for the salvation)", in Mircea Gelu Buta (coord.), *Medicii și Biserica (The Doctors and the Church),* 7th volume, „Perspectiva creștin-ortodoxă asupra prelevării și trasplantului de organ(Christian-Orthodox perspective about the prelevation and transplantation of organs)", Renașterea Publishing House, Cluj-Napoca, 2009, pp. 165-183.

[18] Cf. http://biserica-sfantul-silvestru.ro/biserica-sfantul-silvestru-a-primit-moastele-patronului-ei-spiritual, accesat 24. 05. 2016; http://www.crestinortodox.ro/stiri/ziarul-lumina/parohia-ostia-primit-particica-moastele-sfantului-calinic-la-cernica-96126.html, accesat 24. 05. 2016; http://mitropolia.md/particele-din-moastele-sfintilor-si-o-bucata-de-lemn-din-crucea-pe-care-a-fost-rastignit-hristos-au-fost-aduse-la-sfanta-manastire-suruceni/, accesat 24. 05. 2016.

[19] For more information about this subject and about the conditions that must be fulfilled for a canonisation, see: Ioan N. Floca, *Drept canonic ortodox – legislaţie şi administraţie bisericească (Orthodox Canon Law – legislation and administration of the Church),* 2nd volume, Press of the Biblical and Missionary Institute of the Romanian Orthodox Church, Bucharest, 1990.

> they were determined canons in non-therapeutic castration convictions. We are not ungrateful for the body that God gave it to us. Do not try to remove the differences between man and woman. We accept goodness human nature. Instead, we get back, loving, helping others, as long as it does not involve risk certain death (as, for example, by donating the heart), such acts of love, depending on the circumstances, not only tolerable but also commendable"[20].

It is therefore Orthodox perspective on organ transplants. Seen as an act of love and help to our neighbor, practiced as such, it does not come with any of the canons of the Church but rather strengthens learned from the Fathers.

Conclusion

As you can see from our research page, completeness body is not a problem for organ transplantation, as long as it is not about any „sinful mutilation"[21], or is not motivated by criminal intent. Clearly, God sees things in depth and understand the act of love beyond the requirements of a law that can kill (II Cor. 3, 6), giving it a new meaning by His Holy quickening. So, theologians concern is based only in the context of the problem is related to other similar matters and tends to escalate, placing it outside the context of ethical dialogue. In other cases, more important issues such as cloning and euthanasia, supported recently by some contemporary theologians[22], ought to preoccupy contemporary theological exponent's space and lead them to find solutions.

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[20] H. Tristram Engelhardt Jr., *Fundamentele bioeticii creștine – perspectiva ortodoxă (The fundaments of the Christian Bioethics - the Orthodox perspective),* pp. 432-433.

[21] *Ibidem,* p. 432.

[22] Cf. Hans Kung, *La mort heureuse,* trad. Jean-Louis Schegel, Editions du Seuil, Seuil, 2015; Hans Kung, *My Struggle for Freedom. Memoirs,* Eerdmans, Grand Rapids, Michigan, 2003 (Novalis, Ottawa 2003; Continuum, London 2003); Hans Kung, *Disputed Truth. Memoirs*, vol. II, Continuum Publishing House, London, 2008.

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ETHICAL CONSIDERATIONS ON THE USE OR THE ABUSE OF CT-SCAN INVESTIGATIONS

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REZUMAT. Considerații etice cu privire la uzul sau abuzul investigațiilor de tip CT. Investigațiile imagistice de tipul radiologiei clasice, examinările de tip *Computer Tomograf* (CT), *rezonanță magnetică nucleară* (RMN) sunt investigații esențiale pentru realizarea unui diagnostic de acuratețe, fiind indispensabile practicării unui act medical de calitate. Investigarea de tip CT reprezenta, în urmă cu numai un deceniu, o practică a medicinii de vârf, devenind în prezent una dintre tehnicile de investigație uzuale, fiind adesea preferată în locul radiologiei clasice. Avantajele pe care le prezintă acest tip de investigație sunt însă costisitoare și totodată expun pacientul la un grad ridicat de iradiere. Nefiind o investigație de rutină, nu este justificată în toate situațiile. Urmările negative ale realizarii unor investigații inutile se reflectă pe de o parte asupra sistemului sanitar, prin costurile suplimentare antrenate, și pe de altă parte asupra pacientului, care este iradiat, fără a exista un beneficiu real pentru sănătatea sa. În acest articol, autorii încearcă: 1) să evalueze dimensiunea problematicii excesului de investigație CT, plecând de la analiza unui caz, 2) să identifice principalele cauze care duc la acest exces, 3) indicând totodată și posibile consecințe negative ale uzului exagerat al acestor practici.

Cuvinte-cheie: *CT- scan, abuz de investigații, iradiere medicala, consimțământ informat, educația pacienților.*

ABSTRACT. The imagistic investigations such as classical radiology, *Computed Tomography* (CT) examinations, *nuclear magnetic resonance* (NMR) are essential investigations for carrying out a diagnosis of accuracy, being indispensable to the practice of a medical act of quality. The CT type of investigation represented, one decade ago, a practice of the high medicine, becoming in present one of the usual techniques of investigation being often preferred instead of classical radiology. The advantages of this type of investigation are however expensive and also expose the patient to a high degree of irradiation. As it is not a routine investigation, it is not justified in all situations. The negative consequences of carrying out unnecessary investigations are reflected on the one hand on the sanitary system

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by the additional costs involved, and on the other hand on the patient, who is irradiated, with no existence of a real benefit for his health. In this article, the authors attempt: 1) to evaluate the dimension of the problematic excess of CT investigations on the basis of the analysis of a case, 2) to identify the main causes which lead to this excess, 3) pointing also possible negative consequences of the exaggerated use of these practices.

Keywords: *CT- scan, Abuse Investigations, Medical Irradiation, Informed Consent, Patients Education.*

CASE REPORT

At the consulting cabinet in the Medical Forensic Department a young patient, age 32 years, went and claimed that she was aggressed in a pub. At the objective medico-legal examination she presented a purplish bruise on the back side of her left hand. The doctor asked her if she had another investigation and she gave him a CT examination paper attesting a specialized investigation with spiral acquisition of the entire body. This type of investigation implied a 10 mSv irradiation. At the doctor's question if she has any medical problems, she mentions that she is 5 weeks pregnant. The legist doctor asks her if the CT investigation was carried out at the request of the clinician doctor in the Emergency Room, but she claims that she took the investigation at her own initiative. The doctor wanted to know if she was informed that this kind of investigation is not recommended for pregnant women, as it affects the embryo or the fetus, but she claimed that she didn't know about that and that she wasn't asked by the previous doctor if she is pregnant or not. When the doctor asked her if she wants to keep the baby, she confirmed, being a wish. The legist doctor recommended the patient to talk with her obstetrician doctor for counseling. The patient decided to interrupt the pregnancy as a result of the counseling with the obstetrician and of the analysis of risks.

THE CASE ANALYSIS

To analyze this case and to set out the eventual committed errors and also the ethical and legal aspects that should be taken into consideration in these situations, we should punctually answer to the following sets of questions:

1. What does it mean the CT investigation?
2. Who does and were these investigations are done?
3. Is there any real abuse of indication of the CT investigations? What may be the causes?

4. What are the negative consequences associated to the abuse of the CT-scan?
5. Who should recommend these investigations and why?
6. Has the patient the right to be informed regarding the specific of the CT investigation?
7. Who has to inform the patient on the risks and benefits of such examination?
8. What should be done if a patient comes to a medical investigation center asking for such examinations at his own initiative?

DISCUSSIONS

1. What does it mean the CT investigation?

Since the first radiographic image realized by Wilhelm Rontgen (1845-1923), the one of his wife's hand, in 1895, 121 years of evolution of the medical imaging have passed. Nowadays all the County Emergency Hospitals have or have access to a computed-tomography. This investigation became a usual one, being recommended even in situations in which the classical radiology, such as radiography and radioscopy, could solve them, considered by the specialists as easy to practice, reproducible and least invasive[1]. On the other hand, this investigation is considered by the patients as a kind of "uncrowned queen" of the medical examinations, the doctors being frequently asked by the patients or by the dependants for a referral ticket to a computed-tomography. There are also situations in which the supplier of medical services is a private company and the patients may directly require and for charge, at own initiative, the carrying out of such investigations with no previous medical prescription.

The radiation dose the human body absorbs has cumulative effects during the life and is measured in mSv (milisiverti). The average dose an American citizen absorbs in the course of a year is of 6.2 mSv and most part of the radiation comes from the atmospheric gases (37%), on the second place being the computed tomography medical investigation (24%), followed by the nuclear medicine (12%), by interventional fluoroscopy (7%) and by conventional radiography and fluoroscopy (5%) [2]. Not the entire population is exposed to a medical irradiation. It is found that the radio imagistic and radio therapeutic medical activities occupy together 48%, practically doubling the average dose of the radioactivity the general population is exposed. It is observed also the big difference between the contribution to the irradiation of the population through CT and through classical radiology.

In Romania, an ordinary individual who is exposed to some additional sources, natural or artificial, of ionizing radiations receives annually a dose of natural radiation of 2-3 mSv, according to the results of a study published by the National Agency for the Protection of the Environment [6].

The administered ionizing radiations, be they from the classical radiologic investigations, weather from CT-scan techniques are added to those 2-3 mSv from the natural radiation.

With regard to the differences from the view point of the dose of administered ionizing radiations, they are:

Skull radiography: 0.01-0.03 mSv. Cranial CT: 2 mSv
Thoracic radiography: 0.02-0.06 mSv. Thoracic CT: 8 mSv
Pelvis radiography: 0.7 mSv Pelvis CT: 10 mSv. [3].

It is easily noticeable that a CT-scan investigation of the pelvis exposes the individual to a dose equivalent to the natural irradiation corresponding to 3 to 5 years!

The French Code of the Public Health specifies that, with regard to the exposure to ionizing radiations for medical and medico-legal purposes should be applied principles of justifying the investigations by establishing the benefit of such examinations in relation with the risks which it incumbents and by optimizing them to obtain information useful to the diagnostic using the smallest possible dose [4].

In Romania, the radiologic norms of security in the practices of radiology, diagnostic and interventional radiology [5] states in art. 60 align. (1) that: "The requirements for radioprotection regarding the justification of practice, the limitation of the doses and protection's optimization and constraints of the dose, drawn in mind. IV from NFSR is applied in radiology taking into account the details specified as follows.

(2) Justification – All the practices that imply the medical exposure to X-ray radiations must be justified weighing the diagnostic benefits these practices can bring with the detrimental the X-ray radiations could cause, being taken into consideration the benefits and risks of the available alternative techniques, but which do not imply the exposure to X-ray radiations. […].

(4) Optimization of the radioprotection

a) For the medical exposures in the purpose of diagnostic, the optimization of the protection is realized by maintaining patient's exposure to a minimum necessary to realize the objective of the requested diagnostic."

Similar formulations and principles are found in the French and Romanian norm.

The consequences of the exposure to ionizing radiations appear on long-term and short-term. In case of high exposure to radiations it may appear sterility and the so-called disease of irradiation, which can evolve to death, situation not carried on in cases of exposure to medical irradiation. For example, at 6000 mSv were exposed the workers from the nuclear central from Chernobyl, who have died within a month.

In case of exposure to smaller and repeated doses, such as the irradiation from the imaging medical procedures, the effects are on long-term and consist in the appearance of an oncologic pathology or of some genetic defects, the probability of their occurrence increasing once with the dose [7]. In case of pregnant women, the most exposed is the fetus whose maximum sensitivity to radioactivity as teratogenic factor (mutagen) is between 2 and 15 weeks of pregnancy [8]. In this period of pregnancy by the exposure to small or medium ionizing radiations it is the risk of the appearance of some malformations of the future new-born. On the doses of radiation the mother was exposed and the period of pregnancy the obstetrician could recommend preventive interruption of pregnancy.

2. Who does and were these investigations are done?

The CT exam is realized with a *device* that uses photoreceptors to detect the attenuation of roentgen rays emitted by an X-ray tube which is rotating around the body over multiple diametric pathways in the axial plane. The information acquired is processed by a computer and the result is a series of images with slices aspect of the examined body [10].

The examinations are carried out in the areas of imaging-radiology of state sanitary unities – emergency county hospitals or the municipal hospitals or in specialized clinics with private capital. According to the emergency degree and to available funds, these examinations are paid either by the Health Insurance House or by the patients in question. In many situations, especially, in clinics with private capital, there is no radiologist with CT competence to interpret the results, sending them to a specialist in a different locality who will interpret it without direct relation with the patient. For example, the private centers providing such services from Bistrița cooperate with specialists from Târgu-Mureș or from Cluj, because in Bistrița-Năsăud there were no radiologists with CT competence. The patients do not get in touch with the doctor, the ones who carry out the positioning of the patient and the handlings of the device were the nurses or the technicians. They insure also the communication with the patient, the anamnesis and the training, patient's informing on the type of the investigation and in what it consists. Also they give the results after the specialist interpreted the images. This practice is contrary to the Ethical Code of the Radiology and Medical Imaging Society from Romania, which states that: "Radiologists must set such a relationship with their patients that allow them to interpret the images and to decide on the interventions in the context of the general medical situation of the patient. They must ensure that all the relevant information regarding the medical history of the patient and the previous results reached them optimally." [11].

The medical deontology code of the Romanian doctors adopted in 2012, art.24 emphasizes on: “The unmediated character of the relation doctor-patient: except of some exceptionally objective situations and impossible to remove, any medical decision will be based firstly on personal and unmediated examination of the patient by the doctor concerned.” And in art.31is referred to “the medical act from distance”, thus: “The investigation or the medical intervention from distance, in any existent forms and modalities, is allowed only in when the patient is directly assisted by his doctor and the purpose of the investigation and procedures the patient is supposed to is to help the doctor to set the diagnostic, to establish the treatment or to use another medical procedure to finish the medical act or medical intervention in case of surgery. The emergency situations are the exception.” [5].

In the interpretation of these stipulations will result that the practice referred to above is not in accordance with the deontological norms from Romania.

3. Is there any real abuse of indication of the CT investigations? What may be the causes?

The possible causes of the excess of computed-tomography investigations were identified as patients urgings, professional uncertainty (doctor’s hope that the CT could highlight something else), the material co-interest carried out by the contracts in cooperation signed by the providing companies of such services with the doctors, the desire to document to a maximum the case in the condition of the defensive medicine practice.

One raised problem is the one of the ethics of a payment carried out by the doctor on behalf of a recommendation to an investigation involving risks for the patient, even when not potentially lethal or immediately pathogen. There is also the possible idea of the existence of the risk a doctor may be tempted to recommend this type of investigation in spite of other investigations more harmless, which in some cases (obviously, not in all) it would lend as well as outlining the diagnostic.

Beyond the letter of the radiology security norms in the radiologic diagnostic practices and interventional radiology which foresee that always should be recommended the investigation with the smaller dose of irradiation, appears also the analogy with the letter a) from art.383 of the Law no. 95/2006, “the pursuit of the profession of doctor is incompatible with: a) the quality of an employee or a collaborator of the unities of production or of distribution of pharmaceutical products or sanitary materials;” and with art.23 from the Medical deontology code. Therefore, “it represents a serious touch brought to the independent character of the medical profession the following acts:

a) Except the situations provided by the law and the previous announcement of the profession's organs, association or collaboration, under any form and modality, direct or indirect, between the doctor and a person which produces or distributes medicines; […]

c) The involvement, directly or indirectly, in the distribution of medicines, medical devices, medical or of other products for medical use;"

The reasons for which the legislator provides this incompatibility are that a doctor, employee or collaborator of a unity of distribution or production of the pharmaceutical products may be tempted to prescribe preferentially the products of the company which materially co-interests him. Consequently, neither the co-interest of the doctor to recommend certain investigations seems recommendable. We find ourselves in each of these two situations, both the one of the doctor-pharmacist and the one of the doctor prescribing investigations by which he receives the share in a superposable situation over one of the definitions of the conflict of interests, namely the case in which the personal interest comes into conflict with the professional obligation to support the interest of another part, compromising the expectations relating to a reasonable objectivity and impartiality with respect to the other side[9].

Another problem is related to the allocation of resources. The CT-scan investigation is one of high accuracy, but much more expensive than the classical radiological investigation, in so as far as in the case of carrying it out in the private health system where is directly paid by the patient or it is settled on by the Health Insurance House. Supposing that the only problem is the recommendation of a CT when it is sufficient a radiography or a fluoroscopy, the system's resources were already abused, by recommending an expensive investigation instead of a cheaper one which gives the same diagnostic. The abuse of such resources takes a new dimension when we are speaking about the situations in which occurs the lack of justification of any type of imaging investigation.

Generally, it can be noticed an affinity of the general population to the computed-tomography investigation, which they require both when they were patients and for their relatives, when they were dependants, the perception on this investigation being high idealized. A negative phenomenon is that some patients, especially those traumatized, when the emergency specialist, neurologist, neurosurgeon or surgeon does not consider necessary the CT investigation, chose to go by their own to the unities carrying out such medical services, paying them from own funds.

4. What are the negative consequences associated to the abuse of the CT- scan?

The abuse of CT investigation may have negative consequences on the patients, on the personnel working in such unities and on the health system.

The effects on the patients consist firstly in their exposure to doses of ionizing radiations with no benefit to the real diagnostic. As mentioned, the ionizing radiations have cumulative effect, their effects occurring depending on the total dose an individual was exposed to during his life and the CT investigation involves exposure to a high dose of radiations with possible mutagen effects (the occurrence of malformations at descendants) or with the increase of the risk of the occurrence of oncologic pathology. In the situation in which the patients are those at the initiative of which is carried out the investigation, the negative effect is also the pecuniary one, the costs being paid by them. Another problem is the one relating to the excessive confidence of the patients in this investigation, which may cause a feeling of false safety: the patient to whom this investigation has not revealed any kind of pathology is willing to give up to other investigations, being convinced by the infallibility of this method. There are also situations in which the examination does not reveal any pathologic, which does not mean that there is no pathology: the brain contusion, for example, becomes visible for the CT only after an evolution of 4-48 hours.

The effects on the personnel can be negative by the exposure to ionizing radiations. The personnel of these services wear a check box for the monitoring of the radioactivity they were exposed and the modern equipment has a good radioprotection, but the risks are not totally removed.

The negative effects on the health system can have the abuse of indication by the specialists of this type of investigation, taking into account the expensive costs and the limited financial resources.

5. Who should recommend these investigations and why?

The carrying out of the CT investigations is performed theoretically by the specialist in order to elucidate the diagnostic. There are many ways to carry out this type of investigation – CT with spiral acquisition, CT with contrast substance etc., and on the type of investigation can only decide usually the treating doctor or, preferably, the treating doctor after consulting with the radiologist with CT competence. Therefore, in the conditions of suspecting the existence of formations with subcentimetric dimensions – of the type of cerebral hemorrhage or of tumor type – it will be agreed on a certain set of images of slices type more frequent or for spiral acquisition with small step (which involves a high dose of irradiation, but does not allow the formation to get between sections and should not be visible). Under the existence of a known formation of larger size whose evolution is monitored, the images can be done in “slices” thicker, the irradiation being much more reduced. The investigation carried out at the patient’s request is one at least unprofessional.

6. Has the patient the right to be informed regarding the specific of the CT investigation?

Taking into consideration that this investigation is presenting risks and possible negative consequences for the patient, the patient has the right and the doctor has the obligation to inform him and to obtain the informed consent to carry out the CT type exam.

As idea of principle, any treatment or examination which presents risks for the patient and for his life involves patient's consent for the medical act. *The informed consent* is the decision taken by a **competent** individual by whom he agrees to partake of a research or to take a treatment his doctor proposed. This implies that the individual **has received the necessary information,** that he **understood it** and that he **took the decision without being the subject of some coercion, induced influences, incites or intimidations** [12].

Patient's consent is the connection between the obligation of the doctor to treat and the personal right of the patient to manage his own health and life.

According to art.6 of *The universal declaration of bioethics and human rights* released by The United Nations Educational, Scientific and Cultural Organization (UNESCO), in 2005, "*any medical intervention which has a preventive character, diagnostic or therapeutic must not be initiated only with the previous consent, free and expressed of the person in question, based on sufficient information*"[13].

The doctor should inform his patient taking into consideration patient's level of understanding and of the condition in which he is at that moment. Therefore, according to the *Law no.95/ 2006 on the reform in the health system,* art.649 (3), the patient will be informed about: the diagnostic, the nature and purpose of the treatment, the risks and their consequences, the prognostic of the disease without applying the treatment.

The consent does not extend on other interventions than the ones the patient was informed about and gave his consent.

The doctor has the professional obligation to respect the stages of the procedure of obtaining the informed consent, taking into consideration the characteristics of the patient's condition, as well as the condition of anxiety, the features of his personality, giving him the necessary explanations. One of the difficulties the doctor encounters frequently is the one of giving pertinent information to his patient and adequate to his level of understanding.

7. Who has to inform the patient on the risks and benefits of such examination?

As a basic rule, the patient should be always informed by his treating doctor. It is one of the essential rights of the patient, right found in all international and intern legal regulations relative to the patient's rights. To be informed to this right allows the construction of a relationship of quality with the treating doctor and the other professionals involved in the medical act.

The patients are more informed and more interested to actively partake of the medical act which reflects on health, on projects of life and quality of their life. In quality of citizens, holders of rights we benefit of this right, but not sufficient informed to take decision in full knowledge of facts? The answer is affirmative, when the medical information is given by the treating doctor or by the specialist and when he fulfills his obligation to inform the patients on: the diagnostic, nature and the purpose of the treatment, the risks and the consequences of the proposed treatment, viable alternatives of treatment, the risks and their consequences, the prognostic of the disease without applying the treatment, according to *Law no.95/ 2006 on the reform in the health system* states in art.649 (3). In our case the information could not come from a treating doctor or specialist, as there were no doctors in such private unities. Therefore, the question is to what extent the medical personnel which receives the patients is sufficient trained to compensate the absence of the doctor and of the pertinent information coming from someone who knows the risks and which are the alternatives. From what can be seen in our case, it seems that the medical personnel from the private unity where the woman has done this investigation did not fulfilled this exigency, thing that led to the serious consequence produced (interruption of pregnancy).

8. What should be done if a patient comes to a medical investigation center asking for such examinations at his own initiative?

Patient's confidence in the CT examination has positive valences, rarely encountered the situation in which those concerned have the feeling that they've been carried out an useless investigation, even the case in which because of lack of funds from the public health system they paid their own money. There are also situations in which the patient comes to the private imagistic clinic and requires a CT examination without having the recommendation of a specialist. Some of the private providers of such medical services have a firm policy in not accepting to carry out investigations in the absence of a referral ticket. In practice are encountered, frequently, patients coming to the medico-legal examination with an analysis report containing the interpretation of a CT examination which does not reveal any kind of internal injuries and which was carried out at the patient's request, in private centers. Usually, these practices of the private clinics should be discouraged, eventually by including in the legislative norms of interdiction of carrying out investigations which involve the use of ionizing radiations, inclusively in private regime, when there is no recommendation of a doctor with the right of free practice.

CONCLUSIONS

The computed-tomography investigation offers a large quantity of information of outstanding accuracy in the conditions in which is adequately used, having as disadvantages high costs and high dose of irradiation of the patient. It can be noticed the tendency of the general population to ask as last diagnostic argument the CT-scan investigation. When the case allows similar diagnostic results the use either of the classical radiology, or of the computed-tomography examination, it is recommended the radiography as the dose of irradiation on the patient is up to hundreds smaller than the dose given by CT-scan. The price of the computed-tomography is generally much higher than the one of the radiologic investigations. In the conditions in which approximately half of computed-tomography investigations analyzed in the medico-legal documents taken in the evaluation have no justification by the symptomatology prism, of the objective examination, of the anamneses or other clinical data, we could appreciate that there is a certain degree of abuse of compute-tomography investigation in the health system from Romania. The possible causes of excess recommendations of carrying out the computed-tomography examination may be patient's pressures, doctor's professional insecurity, practice of medicine defensive and last but not least the material co-interest of the doctors in recommending that investigation. The consequences of computed-tomography examination in excess are of two types. Some of the possible consequences on long term on patients' health, irradiation of an individual during his life being cumulative and the probability that these develop an oncologic pathology being proportional to the sum of all doses of radiations to which he was exposed and other are immediate on the health insurance system, which is exposed to some expensive and useless costs.

The practice of the imaging clinics deprived of accepting to carry out such investigations with ionizing ray at the simple request of the patients, without asking a referral ticket from a specialist, is engraved by risks especially for the patients who can be irradiated useless. It is imposed a regulation to bring these companies closer the health services area and more far from the market one.

The ethical problems raised by the analysis of our case are related to some clear regulations regarding the carrying out such investigation in the private regime and by the lack of patient's informing on the risks these examinations suppose. At the same time patients should be informed on the existent alternatives in such cases and, firstly, the patients should be advised to consult a doctor to recommend them the necessary, not to address by their own to such unities/centers. The steps a patient has to follow when facing some problems, such as those presented in our case, should be established by certain guidelines which should be applied both in the public medical unities/centers and in the private ones and the patients should not be encouraged or shall not be recommended shortcuts or alternatives by those who are not their doctors and assume some negative consequences such as those presented in our case.

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THE NECESSITY OF THE NEW RISE OF THE ECO ETHIC

DEJAN DONEV[1]

REZUMAT. Necesitatea apariției unei noi eco-etici. Civilizația modernă este în criză. Lacunele sunt numeroase și profunde! Impreună cu noile și marile descoperiri științifice, omenirea, în același timp, nu s-a elevat. Acest lucru ne-a condus la o dezorientare morală în diverse domenii ale vieții. În pe sfârșitul anilor 60 și începutul anilor 70 a secolului trecut, primele semne premonitorii ale acestei evoluții s-au dovedit încurajate, în special, de amenințarea poluării mediului. Dezvoltarea umană nelimitată dovedește un prim impact negativ asupra lumii în care trăim, natura care ne înconjoară. Omul modern devine mai conștient de faptul că poate distruge barca plutitoare, casa în care trăiește. Textul tratează despre nevoia crescută de a răspunde la două întrebări de bază în acord cu noua arie de cercetare etică, i.e. comportamentul uman în raport cu natura. *Prima întrebare* este – avem noi într-adevăr, pentru rezolvarea acestei probleme, o strategie științifică postulată pe elementele fundamentale ale ecologiei ca știință a mediului și transformată în decizie socială și politică (ca biopolitici la nivel internațional și național), sau avem nevoie de o nouă etică pentru mediu care va fi stabilită ca o strategie științifică și, prin urmare, ca biopolitici? *Al doilea aspect* este de a ști dacă natura și protecția mediului sunt interesante pentru noi doar la nivel instrumental sau noi credem că natura are o valoare intrinsecă, deci poate exista chiar și fără om?

Cuvinte-cheie: *eco-etică, natură, mediu, ecologie.*

ABSTRACT. Modern civilization is in crisis. The gaps are numerous and deep! Along with new and great scientific discoveries, the humanity at the same time isn't increased. This led us to moral disorientation in various areas of life. In the late 60th and early 70th of the last century, the first premonitory signs of this development showed especially encouraged by the threat of environmental pollution. Human unlimited development showed the first negative impact on the world in which we live, the nature that surrounds us. The modern man becomes more aware of fact that it can destroy the flying boat, the house in which lives. The text deals with the increased need for answering two basic questions according to the new area of research in ethics, i.e. **human behavior towards nature**. The *first question* is do we need indeed, for resolving this problem, a scientific strategy

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postulated on the basics of ecology as a science of the environment and transformed into social and political decision (as biopolitics on international and national level) or do we need a new ethics for the environment that will be established as a scientific strategy and therefore as a biopolitics? The *second issue* concerns whether the nature and environmental protection are interesting for us only on an instrumental level or we believe that nature has intrinsic value, so it can exist even without man?

Keywords: *eco-ethics, nature, environment, ecology.*

INTRODUCTION

Modern civilization is in crisis, the downfalls in it are numerous and deep. Will it survive or as like the previous civilizations, will vanish in time? Many doctors, bowed over her bed, are searching for that answer.

... one of its many serious diseases is the moral disease. The moral is undoubtedly an important part of every civilization. If the moral is sick, what are the consequences for the human, for the civilization, for the society? This particularly, because along with new and great discoveries in science, the humanity in people had not increased at the same time, but more and more we come to a moral disorientation in various areas of life[2].

In this constellation, the economy affects even more on the whole human life, because of the simple fact that the money for the scientific discoveries comes from the economy. With this conductions in business and generally in economy, world becomes solitous. In this context, the neocapitalism from the 80tees in the U.S., is a tipical example, i.e. capitalism of the Regan's era with the slogan of the neocapitalists of Walt Street: "*To get rich is to borrow, so to spend and enjoy*". All this resulted in a moral crisis, primarily in the West, and then wider in the world[3].

At the same time, from the many of the ethical issues related to science, and which disturb the public, some of them can be directly and justifiably placed upon the original scientific research or scientific conclusions. This is so because most of the issues are concerning the society which actually monitors and

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[2] R. Wisser, *Odgovornost u mijeni vremena*, Svjetlost, Sarajevo, 1988, str. 283-318.

[3] There are different indicators of this crisis. For example, in developed societies from West, indicators of this crisis are internal political and social pecks. In our region, it is obvious the behavior of Europe and the world toward wars on Balkan. It is politics in which on the first place is the interest and calculation, political pragmatism, and on the second place there are justice and actions for peace.

funds scientific researches and decides on the application of scientific results. In this conflict between political and scientific interests, science always loses and it is always put on the dock, for example, for the atomic bomb, for the Chernobyl disaster, for the destruction of rain forests, for the emergence of greenhouse and ozone holes ...

Moreover, today's democratic governments misled by the rapid enrichment, invest less in science, and more in antiintelectual movements. Paradoxically and symbolically, but true, the money earned from dynamite, are partly financing the Nobel Peace Prize today! It shows that society and politics are increasingly reinforcing the impact of the choice and range of scientific research. The development of science today depends on the programs of governments, not of the issues that today's scientists meet as strange and unknown questions. Instead of this, man investigate how from the originally acquired knowledge to come to a greater wealth and thus to satisfy the growing need for exclusive material desires of modern civilization. Today's technological revolution progresses through selectively developed applied sciences. Science is capricious and unstable alliance of the political actions!

In this context, in the late 60ees and early 70tees of the last century, the first premonitory signs of this development emerged, and with that, the need to answer these questions, increased. It was especially encouraged by the threat of environmental pollution. The human unlimited development impacted firstly on a negative way for the world in which we live, and the nature that surrounds us. Modern strongman becomes more aware of the possibility of destroying the boat in which it sails, the house in which he lives.[4]

So "the interest in nature within philosophical circles of contemporary thought grew again, especially with the thinking through the crisis of the dialectics of techniques, which brought at the surfice the experience that progress of scientific and technical culture leads to the destruction of man and his environment".[5] So the question is: Are we just owners or agents of the Earth that we have, like *boni patres familias*, and we should put it in better condition for future generations?

THE RISE OF THE NEED FOR ECOLOGICAL ETHICS

The momentary culmination with the cumulative problems of the mankind called the ethics on stage again, but this time it brought expansion in terms of its area, i.e. expanding of all spheres of human life - in terms of itself and

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[4] For further inquiry see Rudi Supek, *Ova jedina zemlja*, SNL, Zagreb, 1978, str. 79-83.

[5] I.Koprek, "Etika", in *Etika - Priručnik jedne discipline,* I.Čehok & I. Koprek (eds.), Školska knjiga, Zagreb, str. 186.

its needs, in terms of the Other and other people, in terms of community, nature and universal existence. For all these mentioned new areas of moral, within the ethics there are new relevant disciplines developed, i.e. social ethics, the ethics of social communication, political ethics, economic ethics, medical ethics ...

Among them, as a special, new area, appears **human behavior towards nature**.[6] Although man is a natural being, up till' the present era it didn't thought ethically much about nature, in which, the feeling of the effects of the consumption of resources begun, of the industrialization and of the pollution. The utilization of the resources of the Earth increased, depletion of natural resources, enormous spending large amounts of energy, increasing the overall temperature, pervertation of climate, the occurrence of bad weather conditions, excessive use of oxygen and water, irrational cutting of large areas of forest, throwing garbage everywhere..., all of these are the acts of man. An economic greed, war, overloaded planet with a large population, made life becoming more difficult for living, survival began hanging over every head.

The actions and the negative consequences of its irrational and bad behavior led, once again, to today's need of ethical awareness and understanding of human activity in a unit, with a vision for survival. Hence, the two questions. **First**, whether to resolve this problem do we need a scientific strategy postulated on the basics of ecology as a science for environment and translated into social and political decision (as biopolitics on international and national level), or we need a new ethics for environment that will be a base not only for the the scientific strategy, but as well as for the biopolitics? In other words, it is about the question wheather the key challange of the new era, one of the hottest issues, can be solved pragmatically, or we need one general ethical and philosophical-religious reorientation, a transition from antropocentric ethics, religion and philosophy, to ecocentric? The **second** question refers onto whether the nature and the environment protection is of an instrumental interest for us (as a means to further survival of humanity) or we consider that nature has intrinsic value, that would exist even without the man?[7]

The answers to both of the questions are hiding in the facts that speak for our actions in the past 80 years, i.e. from the time when the first warnings from Karl Jaspers appear, tied to environmental problems and population. "Certain problems such as population, (...), tooth or misuse of natural and human resources and genetics, must not be adrifted to a blind destiny. It is time when the human race not only can, but must take the intelligant control of their own fate", warned Jaspers, concerned about the growth of the world population.[8]

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[6] Д. Донев, „Еко-етичките проблеми како круцијален дел на биоетичките дилеми„, *Филoсофија*, бр. 31, јуни 2011, стр. 57-67:59.

[7] P. Singer, *Praktična etika,* Signature, Beograd, 2000, str. 270-290.

[8] K. Jaspers, *Duhovna situacija vremena,* Matica Hrvatska, Zagreb, 1998.

This testifies that ever before, in the past 80tees, we only spoke about the dominant Western tradition, according to which God has given dominion to the people over the natural world and he does not care about how people will act. Human beings are the ones that are only morally important members of this world. Nature itself has no value by itself, and the destruction of plants and animals can not be wrong if it does not harm human beings.[9] In other words, this dominant Western tradition does not exclude our care for nature, but only if it refers on human welfare. It's a tradition, an ethics in which moral frameworks refer to the man, while the preservation of the natural environment is not a value of the highest importance.

BIOCENTRISM VS. ANTHROPOCENTRISM

Hence, until the last century, mankind had only acknowledged two forms of ethics: ego-centered and homocentric form of ethics, which tells about the domination of man over all, in another words, they were basically anthropocentric views. Given all the negative actions that people have taken in relation to the environment, these two forms of anthropocentrism are no longer sufficient today for rehabilitating the consequences.

Somewhere in the second half of the 20th century, the need for domination of the so-called ecocentrism appeared, i.e. biocentrism over anthropocentrism as a possible solution to environmental problems. This is because some believe that the exit in the general reorientation of the view on the world, and actions taken toward this, i.e. the creation of eco-ethics - is a final and complete replacement of the anthropocentrism with ecocentrism, not just kind of replacement. In addition to this the fact that we had, up till' now, a traditional, religious, philosophical, antroposentric ethical teachings, even older than two thousand years, that have not stopped, not only the ecocide, but homocide, ethnocide, and wars.

Both thesis, i.e. anthropocentrism and biocentrism lead in many contextual questions in relation to the same requirements. For biocentrics position the change in posture is important. Ethics is not depleting in establishing norms. It also owns the ethos, i.e. the emotional attitude that motivates proper treatment. Therefore, it is not enough solely aesthetic attitude towards nature. It is a danger to reduce the treatment of nature only by the matter of subjective taste.

Biocentric thesis requires a position that arises from the aesthetical toward ontological value of nature, which recognizes and values it. Instead of thinking, according to which nature is only a means for satisfying human interests, it should take the model of cooperation. Thus the man should take

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[9] P. Singer, *Praktična etika,* Signature, Beograd, 2000, str. 270-290.

into account the nature, with which he grow up to its goals, because the man is a being of the community, a being directed towards the others. The ecological crisis forces us also to look in the human community. It should be realized that we are heavily depended from other organisms, so we should admitt their contribution for us, **but only if we have respect for their interests and needs**.

The human priviliged position is not being jeopardized by this, but only more pronounced.[10] Biocentrism does not mean naturalism because the distinction between subject and object of morality is still being emphasized. By respecting the aims of the nature and looking at it as a partner, for the man this means taking responsibility for himself. In terms of anthropocentrism, the man is still a part of the nature. He is not separated from nature. As a spiritual and physical being, he is part of nature and as such, is determined by the laws of material life. That's why the humanity today calls so much for ecocentrical ethics!

BIOCENTRISM AND THE LIFE WHO WANTS TO LIVE

All this iniciates the issue for ecological ethics, which develops along with the degradation of the environment and the living conditions for the other living creatures.[11] Inversely proportional to the decline of living conditions, the awareness about the importance of good conditions for real life rises and grows. This is best reflected in the statement: "*We are all victims and we are all guilty*." The main issue is how to save nature if this saving is not a part of the ethical values of all, if everyone does not contribute, if we do not consider our actions?

Therefore we need an ethics that will arise from the deep respect of life, on which Albert Schweitzer and Paul Taylor called, which will erase the line of the old ecological ethics that outlines and thus closes the sphere of moral action on those beings who are able to feel, leaving all the other beings out of that round. The treatment of ancient forests, the disappearance of certain species of animals and plants, the destruction of several complex eco-systems, the stopping of the wild rivers ... it should all be taken into account! Therefore, the question arises: whether it is possible to make a break with the traditional position and create ecological ethics that will accept the intrinsic value of what will come in a wider circle of moral action.

Hence, it is not difficult to sense the main outline of a true ecological ethics. At its foundation, this ethics should build respect for all sensitive beings, including future generations! It should be followed by an aesthetic of respect for

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[10] See also J. Đurić et al. *Životna sredina: Moralni i politički izazovi*, Službeni glasnik & Institut za filozofiju i društvenu teoriju, Beograd, 2012 and Džozef de R. Žarden,. *Ekološka etika: Uvod u ekološku filozofiju*, Službeni glasnik, Beograd, 2006.

[11] Also see T. Krznar, *Znanje i destrukcija*, Pergamena, Zagreb, 2011.

wild and unadulterated nature. This ethics should advocate for small families, to reject the ideal of a materialistic society, in which success is measured by the accumulated funds. This new ethics should promote temperance, which would contribute to reducing pollution, and to multiple usage of what was previously used. Towards this, leads us and the call of "green consumers", which are calling for recycling and buying those products that do not pollute the environment. We need to redefine our term of extravagance and call for national solidarity against visible immediate dangers.

In this context, because the man, as an expression of the whole, has impact on life, can not bear a sense of responsibility for its own environment until realises that it is a part of the nature. The range of this responsibility should first determine the negative, in the way of respecting certain limits of its own technical operation and disposal. Under this negative limitation of technical and rational attitude towards nature, there is the necessity hidden in the positive constraint: *call for allowance - to be*! That view is called awe of life.[12] Ecological ethics has to start from the human mind: *I am a life that wants to live, implied by life which wants to live*.

CONCLUSION

According to the previous, we need a **complete attitude towards nature**, and then consistently, a full ecological ethics.[13] Ecological ethics must start from this fact, to assume **the awareness of the whole**. It must offer a framework that will regulate the instrumental mind not becoming a pure no-mind. This means that, all the relevant spiritual and social-scientific stakeholders of technical action, must be included in finishing the future ecological ethics.

It is about an ethics that does not exhaust in mediating between deontological and teleological ethical theories, between the ethics of moral actions (dedication) and ethics of responsibility (consequessialism). Ecological ethics should also mediate the emotional attitude, the ethos, that motivates the doing of good. It means a new ethics, not only in content, but also according to essence. It is the sharpest ethics so far in humanity, with generally good thought, with rigid liability, with absolute idea to refrain from violation of the others, and with the ultimate awareness of the universality of the consequences of actions.

If the task of philosophy is to maintain awareness of the whole in all, then she has to unite, direct and spread the thought of love for wisdom up to successful, good life. It should be calling for awareness that the aim of mankind is not having a bad life, even not life by itself, but the good life. Perhaps the philosophy showed the biggest dissapointment for this issue so far!

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[12] H. Jonas, *Princip odgovornosti,* Veselin Masleša, Sarajevo, 1990, str. 13-44.

[13] К. Темков, *Етиката денес*, Епоха, Скопје, 1999.

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ETHICS AND SUICIDE PREVENTIONS. CASE REPORT

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REZUMAT. Etică și prevenirea suicidului. Analiză de caz. Tratând o astfel de problemă individuală și complexă din punct de vedere social, legiști se pot confrunta cu numeroase provocări etice pe care trebuie să le rezolvăm. Cazul de față prezintă situația unei femei de 26 de ani care suferea de anxietate severă, angoasă și stres, precum și de atacuri de panică repetate timp de un an și jumătate, comițând suicid prin spânzurare într-o clinică de psihiatrie. Ceea ce face acest caz unic sunt dilemele etice prezentate; în plus, autorii subliniază consecințele dilemelor etice precum și posibilele soluții.

Cuvinte-cheie: *suicid, bioetică, principiile autonomiei, beneficiență, non-maleficiență și echitate.*

ABSTRACT. Dealing with such a complex individual and societal issue, forensic pathologists may face numerous ethical challenges which we must find solutions. This case is about a 26 year old woman who suffered from severe anxiety, anguish and distress as well as repeated panic attacks since one and a half years ago and she commits suicide by hanging in an inpatient psychiatric clinic. What makes this case unique are the ethical dilemmas presented, furthermore, the authors point out the consequences of the ethical dilemmas as well as possible solutions.

Keywords: *suicide, bioethics, principles of autonomy, beneficence, non-maleficence and justice.*

INTRODUCTION

Suicide is an issue that has long raised ethical, moral, religious and cultural discussions and debate. According with statistic data adult women's suicide attempt rates are higher than adult men's attempt rates.[1] The ratio of

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suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly.[2]

Medical professions, through multiple human relationships that are committed during and for making medical act, were involved from the start with a rich professional ethical conduct content.[3] Professional ethics in the field of medicine is a system of moral norms and rules governing the behavior of the doctor and of health workers. The medical moral as any moral professional is socially determined, not only by doctor's personal qualities, but also the character of the social system, the dominant health care system, the social prestige of medical workers and their working conditions.

The medical act must primarily be conducted in the direction to help and protect the patient, i.e. legally, nominally and personally. The organization or the institution offers legal protection but the nominal and personal protection is given by our personal values and common dictated professional values. Legal protection is covered by laws, regulations and protocols and nominal protection e.g. human rights, principles and professional codes. For the protection of the patients ethical codes are given and are based on the classical principles of autonomy, beneficence, nonmaleficience and justice[9].

Bioethics has developed responsibilities which are based on the principle of autonomy such as: respect for individuals based on patient rights; telling the truth and giving all the details; confidentiality, fidelity. Autonomy advertises respect, dignity and choice.

The principles are there but they are not sufficient to solve dilemmas in everyday professional life. We need personal protection of the patients. Personal protection is under the umbrella of our personal values which are dictating our contact with the patients. Good examples are: awareness, understanding, integrity and respect for patients' rights, honesty, and trust, maintaining a good relationship with the patient, empathy, listening skills, and patience.

Watson said in 2006 that "the values of the organization are dictated by economics, technology, medical sciences, administration". The organization protects mainly its own interests. [5]

The ethical dilemma begins where there is a conflict between loyalty to the organization / institution (upper hierarchical structures), to the patient, to oneself or sometimes to the rules of the group. It is important to note that legal is not equal to ethical. In most cases, laws only provide the minimum standard of attitude- ethics claims for more. [6]

CASE REPORT

1. Facts: Anna, a 26 year old female from Sweden, commits suicide by hanging in an inpatient psychiatric clinic on the 20th of September 2014.

Personal history: Anna suffered from severe anxiety, anguish and distress as well as repeated panic attacks since one and a half year ago. She was diagnosed with anorexia neurosa (on and off psychological help as a teenager) at the age of 15, but in the last one and a half years the eating disorder has become worse with features of bulimia. In order to lose weight she has intermittently used drugs (amphetamine, heroin). She has made 4 suicidal attempts within a period of one and a half years and been admitted to the ER, and ICU, because of drug intoxication and hanging attempts and to the department of surgery (was found unconscious with compartment syndrome after overdose) and several times to psychiatric clinics as inpatient and outpatient.

Medical history: she used antidepressants, anxiolytics, antipsychotic, sedatives, tranquilizers, and analgesics. [7]

Social and professional history: Anna has been working as an assistant optician and renting an apartment till one and a half year ago when she became ill and moved in with her parents.

Marital status: Single. Anna had a boyfriend who died of a heroin overdose half a year ago.

2. Discussion

2.1. Ethical dilemmas among health care personnel in issues of loyalty in case of suicidal patients. Loyalty to the patient versus loyalty to the organization/state authorities

AUTONOMY

Confidentiality/Secrecy law - waiver of confidentiality? Anna's mother was denied access to information. To keep suicidal risk as a secret can be fatal. As clinician you feel it is important to disclose the risk of suicide or other dangerous behavior, but may not be allowed due to confidentiality. The involvement of close relatives may contribute to the understanding of the patient[8]. In Anna's case some members of the staff tried to emphasize the importance of the mother's involvement, but the organization refused. The organization is very often more interested to secure its own interests than the patients'.

Fidelity**:** Clinicians must be faithful to their patients[9]. The risk of suicide must be taken seriously and recognized as the primary problem and the cause must be investigated thoroughly. Unfortunately financial resources for therapy sessions and investigation are not prioritized. The physician usually wants to spend more time to investigate the young patient's situation, but administration and organization work takes a lot of a physician's time and the resources for this type of activity are small[10].

Respect for personal rights**:** Suicide is the result of psychological deprivation of emotional and mental strength[11]. Deep depression with anxiety and aguish are common features in individuals who are suicidal. If one extends the autonomy to those who are suicidal it may facilitate the recognizing its vulnerability, i.e. showing empathy, understanding, human affection and involving the next to kin by getting information which can be of great importance in the help of the patient.

Major: from 18 years of age. Parents are excluded if the patient is not giving the consent.

There were occasions when Anna was in such a psychological distress that she couldn't give her consent. She was often left alone without surveillance. Her mother was begging to be with the daughter but was refused. Anna committed suicide while she was alone in the toilet of the ward.

BENEFICIENCE

Clinicians must act for the well-being of the patient**.** When the physician is diagnosing the patient as suicidal it is of crucial importance that he/she is not sacrificing beneficence to autonomy of the patient[12]. Very often beneficence is equated with treatment but beneficence is more than this **-** it also means caring!

NON-MALEFICENCE

Clinicians must have the goal to protect patients from harm**.** In non-maleficence is included every measure to assure a patient's life. Anna was left alone in the inpatient psychiatric ward without surveillance, although it was well known that she was severely suicidal, and hanged herself with a sheet in the toilet handle.

A very good example in Anna's case is the decision which was made by the social services for compulsory treatment for drug addicts. The physician who examines her didn't agree and he managed to convince the social services to withdraw the decision. Very often it happens that the physician has a different opinion from the social or health authorities and it is not easy to change it. In Anna's case the physician saw that treatment under force would trigger the patients' suicidal thoughts. In Anna's case one physician actually got involved and listened thoroughly to her story.

Loyalty to the values of the self is very much corresponding to the loyalty to the respected values of the patient. Example of values are: conscience, understanding, respect for the patient's integrity and rights, honesty, trustworthiness, maintenance of good relation to the patient, empathy, listening to the patient, patience, mindfulness in the presence of the patient[13] [14].

2.2. Ethical questions/dilemmas in cooperation conflicts within the hierarchical structure:

These types of questions are raised especially in a situation where the behavior of the team towards a patient is not agreed by a member. A dilemma is created in a given situation between the patient, the team and the self[15]. In Anna's case one member of the team did not agree with the rigid and disrespectful way she was approached and spoken to. Despite this the specific member didn't want to go against the group or members of the group. The member chose loyalty to the group and colleagues instead of to the patient and to his/her integrity.

Very often when a physician is criticizing a decision, because it is against his/her values or judgments, he/she is met by the voice of the superior reminding him of his/her position within the hierarchy.

2.3. Consequences of ethical dilemmas**:**

For the patient the consequences can be described in terms of: disappointment, helplessness, loneliness, neglect, disrespect

For the caregiver other types of emotions can be evolved as, bad conscience and the feeling of guilt, moral stress, insecurity, doubts, the fear not to be able to help the patient enough, angst for the consequences.

2.4. Possible and most common solutions to the dilemmas:

- Acceptance: due to powerlessness because the position of the individual in the hierarchy-He/she is aware of the conflicting values, but does not adopt them.
- Submittance: when the values of the individual are compromised to that degree that the caregiver feels the need to quit.

2.5. Optional solution:

- Innovation: to take control of the situation work creatively and inter-relational
- Disscusions during breaks and between colleagues
- Debates on an organisational level
- Forums-working groups, training courses
- Cooperation within the hierarchy- support by superiors
- Moral support from the team and team leaders
- Introduction of others forums: e.g. Church, mass-media.

The clinical psychologist Kay Jamison, said very truly "*I have been struck by how little value our society puts on saving the lives of those who are in such despair as to want to end them.*"[7]

CONCLUSIONS

Each involved in Anna's case may not have had the whole picture, but each caregiver has an individual responsibility to think and act with an open heart to give maximum empathy, understanding and love to the patient. It is a choice he or she has to make.

The codes of conduct guiding clinicians are often inadequate in addressing duty to those who are at risk of becoming suicidal or who are suicidal.

Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood changes.

It is everyone's responsibility to prevent suicide!

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BETWEEN MARGINALIZATION AND ACCEPTANCE - MENTALLY DISABLED PERSONS IN SOCIAL CONTEXT

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REZUMAT. Între marginalizarea și acceptarea persoanelor cu handicap mental în context social. **Scopul studiului** este de a identifica opiniile studenților cu privire la persoanele cu deficiență mentală. **Material şi metode**: 85 de studenţi au fost incluşi în cercetare. Dintre aceștia, doar 26% au declarat că au avut experienţe anterioare cu persoane cu deficienţă mentală. Instrumentul folosit a fost un chestionar cu răspunsuri deschise care a investigat următoarele dimensiuni: conceptul de deficiență mintală (perspectiva cognitivă vs perspectiva globală), imaginea persoanelor cu deficiență mintală (caracteristici, capacități, dizabilități), integrare în societate (percepția socială, măsuri de sprijin, instituții de sprijin, opțiuni vocaționale), educație (tipuri de școlarizare, probleme de adaptare, relaționale, comportamentale, educative și perspective post-absolvire). Transcrierea interviurilor a fost urmată de analiză calitativă efectuată cu ajutorul programului QDA Miner 4 Lite. **Rezultate**: cele mai multe dintre problemele asociate sunt legate de comportament (82%) și 92% dintre subiecţi asociază deficienţa mentală (DM) cu incapacitatea de integrare socială şi autonomie. Un total de 58% corelează DM cu degradarea cognitivă; 52% dintre participanţi susţin că instituţiile publice ar trebui să aibă grijă de persoanele cu DM. **Concluzii**: Participanții tind să evalueze personalitatea deficientului mintal mai mult global, cu o centrare pe diversitatea aspectelor personalității sale, și mai puțin schematic, centrat doar pe aspectele cognitive specifice deficienței mintale, accentuând diversele aspecte cognitive nefuncționale în cazul deficienței mintale.

Cuvinte-cheie: *dizabilitate mentală, discriminare, vulnerabilitate, studenţi.*

ABSTRACT. The aim of the study is to identify opinions related to mentally disabled people among students**. Material and method**: 85 students were included in the research; only 26% declared that they had experience with

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mentally disabled (MD) people. The instrument used was an open-answer questionnaire, which investigation of the following dimensions: the concept of mental disability (the cognitive vs. global perspective), the image of mentally disabled people (characteristics, capacities, disabilities), social integration (social perception, support measures, support institutions, vocational options), education (types of schooling, adjustment problems, relational, behavioral, educational problems and perspectives after graduation). The transcription of interviews was followed by a qualitative analysis performed with the freeware version of the QDA Miner 4 Lite software. **Results**: The most frequent issues revealed by our study have been the behavioral ones (82%) and 92% of subjects associates MD with loosing social integration and autonomy. 58% of the participants correlate MD with the cognitive impairment; 52% sustain that public institutions must take care of mentally disabled persons. **Conclusions**: The subjects tend to assess the mentally disabled personality globally, focusing on the diversity of aspects of the mentally disabled personality, and less schematically, focusing only on cognitive aspects specific to mental disability, emphasizing the various non-functional cognitive aspects of the mentally disabled individuals.

Keywords: *mental disability, discrimination, vulnerability, students.*

INTRODUCTION

Mentally disabled people were always situated on the limit of the society. Over the years, the society had tried to support them and to eliminate discrimination. But travelling, public transportation, social integration, housing, schooling or poor living conditions still affect this vulnerable population. Disability is spatially, as well as socially, constructed (Kitchin, 1998) so that we have to construct the space for disabled people if we want to integrate them in society. The access to health care is also a difficult issue. Some researchers from the past proved that even healthcare professionals are having negative attitudes towards mentally disabled people (Anthony, 1972; French, 1994) and mentally disabled people are less positively view comparing to physically disabled people (Furnham & Pendred, 1983). On the other hand, disability is a construct related to the type of society, and taking care of a disabled person is the mark of the society (Shakespeare, 1994).

The social perception of mentally disabled people has undergone changes within the community, in that public policies, information, research in the field, a change in the generation of professionals who take care of these people have led, on the one hand, to a more accurate understanding of the concept of mental disability and have formed, on the other hand, more favorable attitudes toward these individuals.

The aim of our study is to identify opinions related to mentally disabled people, taking into account variables such as age, the type of education subjects are employed in, their gender and their degree of interaction with mentally disabled people.

MATERIAL AND METHOD

The qualitative research was performed between February-March 2015. The instrument used was an open-answer questionnaire, which included the investigation of the following dimensions: the concept of mental disability (the cognitive vs. global perspective), the image of mentally disabled people (characteristics, capacities, disabilities), social integration (social perception, support measures, support institutions, vocational options), education (types of schooling, adjustment problems, relational, behavioral, educational problems and perspectives after graduation).

The questionnaire was applied to 85 students aged between 18 and 50. A total of 95% are women and 5% are men. Concerning the level of education, 66% of subjects had a high school education, 2% had a post-secondary education and 32% had a higher education; 10% of them are already employees. Regarding the environment variable 67% of subjects are from urban areas and 33% from rural areas. A total of 26% declared that they had previous experience with mentally disabled people (in their families or while volunteering) and 74% of the surveyed subjects claimed they had never had interactions with mentally disabled people.

The transcription of interviews was followed by a qualitative analysis performed with the freeware version of the QDA Miner 4 Lite software, downloaded from its official website.

RESULTS

The concept of mental disability

The first assessed dimension was the concept of mental disability, as it is understood by the members of the community. Most answers offered a didactic perspective, rather than a personal one, most respondents giving definitions taken from scholarly papers:

Mental disability is a global disability, which affects the individual's whole personality: his structure, organization, intellectual, affective, psychomotor and behavioural - adaptive development. The defining mark for mental disability is represented by the alteration of the general component, bio-

physiological and psychological integrity being, in fact, a differentiated form of organization for personality.

The significant decrease in psychic faculties, which determines a series of disorders in the individual's adaptive reactions and mechanisms for facing the constantly changing environmental conditions and standards of social cohabitation of a particular culture area, places the individual in a situation of incapacity and inferiority, expressed by a state of disability in relation to the other members of the community he is part of.

Those who opted for the cognitive perspective of the term resorted to scientific definitions less often.

Impaired intellectual development.

Mental disability characterizes a person who does not have a normal intellectual development.

The most frequent answers to this dimension refer to the global perspective of the concept; thus, mental disability is regarded as a suffering which alters the individual's whole personality.

The research of Dweck (1989), shows that people are willing to assess any component of reality which has become an object of knowledge by adopting two different strategies: either by focusing on a global assessment, with emphasis on the diverse aspects of that reality, or by focusing on a more simplistic, reductionist assessment, while, most often, capturing essential features of the assessed reality. In our case, we note the activation of both implicit theories of personality related to mental disability. The results show that subjects tend to assess the mentally disabled personality globally, focusing on its diversity of aspects, and less schematically, focusing only on cognitive aspects specific to mental disability.

Characteristics, capacities and disabilities associated with mental disability

Another dimension analysed was that of the image mentally disabled people have within the community, in terms of characteristics, capacities and disabilities associated with their condition. Most surveyed people mention insufficient development at a cognitive level, such as:

- The common feature is the incapacity to carry out activities involving operations of thought at the level of their performance by individuals of the same age, because psychic functions (especially cognitive ones) develop at a slower pace and stay at a low level, by comparison with those of normal individuals of the same age.

- Mentally disabled people are characterized by low IQs and limited adaptive functions.

- Characteristics specific to these people are: a limited vocabulary, little knowledge about the outside world, the inability to support themselves.

- A delay in language development. A delay in intellectual development.

There were, however, respondents who pointed out characteristics from the affective range, from the range of social relations, or physical features.

- They are introverted, they do not communicate, they look down, they're almost always sad, agitated or nervous, they communicate with difficulty and they're negativistic.

- These people may be characterized by their lack of cooperation, their inappropriate behavior in certain situations, by low intelligence, resulting in failure at school.

- These people may easily be distinguished from normal individuals by their broad forehead, large eyes, their sign communication, etc.

- These people experience states of delirium, they have a limited vocabulary and sudden emotional changes; they are unable to adapt to situations.

- High emotiveness, puerile behavior, feelings of inferiority and anxiety, limited emotional control.

Table 1. The frequency of answers regarding characteristics of mental disabled people

Characteristics	Frequency
physical	6%
affective	8%
relational	28%
cognitive	58%

Most subjects emphasized non-functional cognitive aspects in the case of mental disability. Nevertheless, it is important to mention that the emphasis on the mentally disabled individual's issues with social relations is significantly stronger than the emphasis on the individual's emotional or physical issues. This shows that subjects perceive intelligence as defined by Jean Piaget (1973), in the sense of adaptation, and the main issues beyond those of adaptation to physical, objectual reality are those of communication, of relating to one's peers, of social insertion.

In what concerns capacities, all respondents considered that mentally disabled people might reach a certain degree of personal autonomy, be it lower or higher. Most subjects referred to self-service abilities, but there were also some answers referring to mentally disabled people's artistic endowment:

- It depends a lot on the level of disability. Overall, bringing together several degrees of mental disability, people who have it may take care of themselves and may be somewhat independent (average mental disability), they may graduate from a special school if encouraged and directed correctly and intensively (moderate disability).

- These people can be integrated in society, as long as society allows it. It depends on these people's reactions, but also on people in our society.

- They can write, read, count, calculate, they have personal autonomy (they can get dressed and eat by themselves), they can travel within certain limits.

- They can develop some senses, in their favor. They can draw or have a more developed artistic level: in painting, dancing, singing and other fields.

- These people are very affectionate and they can create many handmade products.

- There are cases in which these individuals may have a particular talent, regardless of their mental problem, and thus they can be appreciated for what they do.

The study emphasizes the subjects' optimism related to the mentally disabled individual's capacity to progress in terms of personal autonomy. What is surprising is that some participants take this optimistic tendency further and consider that, beyond mental disability, there is the possibility that some talents (skills), especially artistic ones, can be discovered and valorised in the mentally disabled person.

Concerning disabilities, most answers target mentally disabled people's inability to integrate into society and to reach an optimal level of personal autonomy:

- They cannot have a job, like normal people.

- They are incapable of supporting themselves, they must be monitored constantly.

- They cannot perform certain daily activities which a normal person performs.

- These people cannot go to a regular school, they cannot get a higher education or integrate into society like a normal person and they cannot go to a job.

- They cannot have important state functions; they cannot easily socialize with others; they cannot express themselves in a logical-mathematical speech; they are not capable of perseverance.

There were also answers pointing out disabilities emphasized by these people being discriminated against by other members of the society:

- These individuals cannot ride a bike or skateboard, they cannot swim, handle a ball or a tennis racket, they cannot make friends, because they are seen by

other people as weird. They can only, for instance, walk around town, eat, watch TV or spend time on a computer, and only with the assistance of a capable (normal) person.

- If the intellectual potential and skills of disabled people is not highlighted, they cannot become resources of their environment. This fact implies an effort required of all society members, who must offer disabled individuals a chance: the chance to show there are things they can do successfully.

A few answers targeted, in particular, physical disabilities attributed to people with mental disabilities:

- Some cannot walk, cannot talk, cannot write, they perform certain activities, but without understanding them.

- It depends on the degree of disability: they may show obvious behavioral disorders and physical anomalies; their vocabulary is limited; they are unable to support themselves; physical malformations; movements lacking precision; paralyses.

Table 2. The frequency of answers regarding the type of disability

Disabilities	
social integration and autonomy	92%
physical	2%
emphasizing discrimination	6%

Despite the optimism related to the mentally disabled individual's capacity to evolve positively when it comes to personal autonomy, deficient personal autonomy is considered, realistically this time, the mentally disabled individual's main handicap, compared to the average individual. Most subjects consider that the wrong perception of mentally disabled individuals' possibilities causes them to be hindered from taking a walk unaccompanied, from riding a bike, playing tennis or ball games, etc. Changing our perception of mentally disabled individuals, these subjects believe, may lead to progress regarding their social insertion and, by default, to their better personal autonomy.

Discrimination

Regarding the way in which mentally disabled people are perceived by the community, most respondents show that they are discriminated against and/or ignored. Some of the answers are the following:

- Society and its members have always been "disturbed" by these special people, because an absurd emphasis is placed on physical and intellectual beauty, aspiring to perfection; these people are sometimes even violently rejected by society.

- Society generally ignores such cases.

- They are perceived as people who are not right in the head, people with whom one cannot talk, weird people.

- They are most often ignored and people avoid including them in social activities.

- These people suffer because we do not give them a chance to show us they're like us. Just like us, they need to feel the protection and acceptance of society, family and of their group of friends. They are perceived as a shortcoming of society, as those "defective" people.

- These people are isolated, marginalized, considered incapable; they cause a feeling of pity.

Only a few answers point to a social perception with positive aspects.

- They are well regarded by society for their effort to complete a task, especially as not many disabled people are employed.

- Some people see they are different and treat them differently; others try to help and treat them like normal people.

- From my point of view, they are people with big hearts and keen on affection! They're normal people, they're people like us!

Table 3. The frequency of answers regarding the social perception type

Social perception	
positive	10%
negative	90%

Most surveyed subjects (90%) think that mental disability is perceived negatively and that mentally disabled people are discriminated against. This result is in accordance with research in the fields of ethology and evolutionary psychology. Ethologists have reported that superior animals (e.g. chimps) completely reject the members of the group that show signs of disease, running away from them (Standford *et al*, 1994; Williams, 2002). Evolutionary psychologists consider this behavior a defensive one. Many diseases are contagious, so it is normal for animals to instinctively stay away from everything that seems weird, strange, and anomic. Man is no exception. The Bible records the social isolation of the insane among tombs; lepers were required to ring a bell in order to signal their presence and, in addition, the social behavior during the great plague, cholera or typhus epidemics is notorious.

Social measures implemented by the community

Most respondents consider that Romanian society has implemented enough support measures for mentally disabled people, answers containing mainly arguments of a legislative nature or related to the theory of protection and fewer practical arguments, which refer to the way in which these measures are applied. However, some of the subjects consider either that the state does not offer enough support measures, or that they are not suitably applied:

- Unfortunately, our society doesn't really protect these individuals, just by a disability pension, that's all.

- The rights of these people are protected by law and refer to non-discrimination and to the personalization of these rights, which apply to all people, regardless of the disability criterion. In Romania, the care centers where children with special needs are protected have been assessed. Alternative services and support services have been created to respond to the needs of the child, the family and the community.

- Our society protects these people with: specialized psychotherapies, speech therapy, visits to a psychologist, a very well established schedule, varied activities (which stimulate creativity, outdoor games, trips, etc.), avoiding their social labelling.

- These people are not protected. There are a few centers for disabled people, but the state cannot provide financial support; instead, it expects families including this sort of people to pay for taking them to the center. Conditions are not quite adequate. There are too few centers for such people. And, in order to receive a disability certificate, there are way too many steps to take and they're much too tormenting for the people concerned, from the point of view of both time and space. And their pensions are much too low for the huge medication prices.

- Society ensures the participation of all children in education; the school integration of children with liminal intellects is possible if the curriculum is differentiated and individualized, if the emphasis is placed on forming and consolidating the child's social competencies.

Regarding the institutions from which mentally disabled people may request help, the most frequently mentioned have been state institutions (departments of social protection, employment agencies, special schools, day care centers, councils for combating discrimination), followed by medical institutions (psychiatric hospitals, medical recovery centers), psychological clinics and NGOs.

- Social assistance institutions, institutions for mental health and care for disabled people.

- Institutions, hospitals or psychiatric wards, recovery and neuropsychiatric rehabilitation centers, medical-social centers and foster care centers.

- Specialized institutions for mental disabilities, psychological and psychiatric clinics.

- For help and counselling, one can turn to county employment agencies, departments of social protection, various nongovernmental organizations.

- These people may ask for help from the City Hall, from psychologists, speech therapists, teachers specialized in this field.

- Clinics that offer special therapies for them.

- They can resort to psychotherapists, occupational therapies.

Table 4. The frequency of answers regarding the institutions providing support for mental disabled people

Support institutions	
State institutions	52%
Medical institutions	18%
Psychological clinics	16%
NGOs	14%

The answers reflect the fact that the state is considered the main supplier of assistance for mentally disability, especially if we add the percentage obtained by hospitals, supported by the state. The fact that the involvement of NGOs and psychological clinics is considered the smallest shows that there is a lot to do in this respect.

Schooling and labor market integration

Concerning the professions which mentally disabled people may choose, most answers refer to occupations that imply physical exertion, but there have also been respondents who have mentioned occupational alternatives, associated with people with less severe mental disabilities:

- Caregivers in specialized centers.

- They can have professions which do not require too much thinking.

- They can practice professions like plumbing, house painting, livestock farming.

- Vocational education is represented by vocational schools where the development of psychological and physical features is continued, with a focus on learning trades (in Romania, mildly disabled individuals are prepared to become plumbers, carpenters, house painters, livestock farmers, cooks, confectioners.

- Some people whose IQ is below 51 cannot practice any profession; people whose IQ is between 51-70 can take care of themselves and perform daily work; people whose IQ is between 71-80 can graduate from an elementary school successfully; people whose IQ is between 81-90 can successfully graduate from an elementary school and become established in manual trades and professions.

- There are cases in which these people work in IT.

- If they have a developed artistic sense, they can work as painters, singers, dancers. If not, they can have the same type of professions as normal children.

- They can have a talent for tailoring, music, design.

- They can practice any profession (generally, IT).

- I think they can become painters, musicians, carpenters.

- We consider the perception about the mentally disabled individual's possibilities to choose a profession realistic. Even when fields have been mentioned which normally require a high IQ, we believe that the respondents refer to the fact that those professions have not been chosen at random; it is a known fact that, in the artistic and IT fields, except for high-end programming and computer-aided design, there are occupational areas where less intelligence is necessary and repetitive skills are involved, that can be learned mechanically (creating handmade products, the algorithmic use of software, etc.).

In what concerns schooling, most respondents listed as options public schools with an adjusted curriculum, support staff or special classes. Special schools also frequently appear in the answers offered. Only a few subjects mention the lack of education or home-schooling:

- School, by its contribution to the mentally disabled child's training, is an important socializing environment, but also the place where his public image can be corrected. The ways of integrating mentally disabled children can be the following: differentiated classes, integrated in regular school structures, groups of two-three disabled children included in normal classes, individual integration of these children in the same normal classes.

- They are schooled depending on the degree of their mental disability; thus, those with severe mental disabilities benefit from special education, and those with liminal and mild mental disabilities benefit from inclusion in mass education.

- In Romania, from the total number of people with mental disabilities, only a third benefit from education.

- In mass education in kindergarten, in primary school, or in special schools.

- They stay at their initial stage. They participate in classes and activities, but they cannot be active like other children.

- They can attend special schools, public schools, integrated special groups or classes, they can be homeschooled or attend a therapeutic pedagogy center; it all depends on the degree of disability.

- Depending on the degree of disability, they are taken to special centers, where special learning takes place.

- Mentally disabled children have their special schools, with a specialized curriculum, adapted to their requirements and needs.

Table 5. The frequency of answers regarding the type of schooling recommended for mental disabled people

Type of schooling	
Public schools	63%
Special schools	35%
Other options	2%

The large percentage of subjects who mention public schools as the main option for the education of a mentally disabled child reveals a positive attitude regarding the social integration and positive evolution toward his personal autonomy. We believe this fact correlates with the previously mentioned optimism related to the mentally disabled individual's attainment of personal autonomy.

Problems related to mental disability

Regarding the adjustment problems mentally disabled children may face throughout their schooling; these have been split into behavioral, relational and educational problems. The most frequent issues found in the analyzed answers have been behavioral (82%), followed by educational (76%) and relational ones (72%).

- They can have inappropriate behavior at school and can create problems.

- Because they're marginalized, these people exhibit aggressive behavior.

- There are some children who are quiet, despite their mental disabilities, but there are other children who have certain behavioral disorders, manifested through screams and striking.

- For mentally disabled children, teachers will have to modify the content of their lessons and their teaching strategies, depending on these children's level of comprehension.

- They don't pay attention to instructions, they start acting right away, they don't ask for clarification, don't foresee difficulties, which leads to failure; they show negativism when given flat orders (in order for them to collaborate, they need to receive suggestions, they react negatively to flat orders because of their limited capacities). They have a hard time finding the meaning from a context; their sentences have a reduced number of words and poor grammar.

- They cannot develop relationships with those around, because they have trouble expressing themselves and relating to others.

- They don't like to communicate; most often they react negatively to the teacher's requests.

It is normal for a mentally disabled individual's behavioral problems to be mentioned first, because they are the most visible form of the disability; relational and communication problems are also behavioral problems, if we stretch the definition a bit. Anyway, the differences are not so great as to claim that there are significant distinctions between these three types of investigated problems.

According to the respondents, post-educational perspectives for mentally disabled people are split between integration into the labor market (most frequently mentioned) and continuing education by vocational courses. There were also subjects who mentioned the lack of any perspectives for these individuals, the future being seen from the perspective of their permanent dependence on the state or the family environment:

- After leaving school, these people can lead a normal life and be part of society, like everyone else.

- Most of them stay in certain centers they belong to or go away for work, but this often happens because many of them become homeless drug addicts (junkies), drink alcohol, etc.

- After leaving school, they can continue with certain courses that can help them more in their chosen path. It's important for them to continue their professional development, but also their family or social development.

- If the degree of disability is not high, they can continue their studies or look for a job. If the degree of disability is higher, they will continue attending special classes in order to try to develop certain abilities.

- They can be integrated in workshops or can function within a special center for their problem. They can practice what they learned at school and get a job (it depends on the seriousness of their health status).

- I don't know, but I suppose they don't really do much. They stay at home, in the care of one of their parents.

- After leaving school, they usually stay in their own families, they're excluded from society.

- They go to specialized centers.

- Usually, they can't find a job and they receive minimal aid from the state.

- Unfortunately they become homeless, and if they don't receive proper medication, they become physically violent.

Table 6. The frequency of answers regarding the perception of students about chances for mentally disabled people

The perception of students	
Labor market integration	69%
Continuing education	11%
Full dependence	20%

Most answers show optimism related to the perspective of the mentally disabled individual's attainment of personal autonomy. Thus, most answers, more specifically 80%, mention that mentally disabled people can be integrated into the labor market and/or can continue their studies.

CONCLUSIONS

Our study shows that the subjects tend to assess the mentally disabled personality globally, focusing on the diversity of aspects of the mentally disabled personality, and less schematically, focusing only on cognitive aspects specific to mental disability, emphasizing the various non-functional cognitive aspects of the mentally disabled individual. The mentally disabled person's social relating is emphasized significantly more than his emotional or physical problems. 90% of subjects consider that mental disability is negatively perceived, that mentally disabled people are discriminated against and that public institutions represent the main source of assistance. The high percentage of subjects mentioning public schools as the main educational option for the mentally disabled child reveals a positive attitude regarding social integration and a positive evolution toward personal autonomy. We believe this fact correlates with the optimism connected to the mentally disabled individual's attainment of personal autonomy.

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CASE STUDY ON RISK ASSESSMENT OF ACCIDENTS AND PROFESSIONAL DISEASES FOR AUTO MECHANIC WORK WITHIN A SMALL AND MEDIUM ENTERPRISES

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REZUMAT. Studiu de caz privind evaluarea riscurilor de accidentare și îmbolnăvire profesională pentru locul de muncă mecanic auto din cadrul unei intreprinderi mici si mijlocii. Una dintre cerințele legale privind sănătatea și securitatea în muncă este ca angajatorul să identifice și să evalueze riscurile de accidentare și îmbolnăvire profesională pentru toate locurile de muncă existente în organizație. Scopul evaluării riscurilor este ca angajatorul să ia măsurile tehnice, organizatorice, igienico-sanitare și masuri de altă natura în vederea prevenirii accidentelor de muncă și îmbolnăvire profesionale la locurile de muncă organizate de către angajator.Metoda de evaluare a riscurilor profesionale, utilizată în cadrul acestei lucrări, este o metodă implementată la INCDPM București[3], începând cu anul 2006, fiind o metodă de succes în ceea ce privește prevenirea accidentelor de muncă și a îmbolnăvirilor profesionale. In prezenta lucrare s-a efectuat un studiu de caz prin implementarea metodologiei menționate într-un service auto, la locul de muncă „mecanic auto”, nivelul de risc global calculat fiind egal cu 3,175. S-au identificat un număr total de 26 factori de risc dintre care 5 factori de risc depășesc, ca nivel parțial, limita maxim admisă. Pentru riscurile care au depășit nivelul risc s-au propus măsuri de eliminare sau diminuare a efectelor acestora.

Cuvinte-cheie: *sănătate și securitate în muncă, factori de risc, nivel de risc, evaluare risc, măsuri propuse, INCDPM.*

ABSTRACT. One of the legal requirements on health and safety at work is that the employer to identify and assess risks of accidents and professional diseases for all existing jobs in the organization. The purpose of risk assessment is that the employer takes appropriate technical, organizational, sanitary and other measures to prevent accidents and occupational illness in workplaces organized by the employer. Professional risk assessment method used în this paper is a method implemented in INCDPM Bucharest, since 2006, which is a successful method in terms of preventing accidents at work and occupational diseases. In this paper was carried out by implementing a case study methodology set out in a garage at work "auto mechanic", the overall risk is calculated equal to 3.175. They identified a total of 26

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risk factors including 5 risk factors which exceed, as part level, the maximum allowed. Concerning the risks that exceeded the risk level were proposed measures for eliminating or minimizing their effects.

Keywords: *health and work safety, risk factors, risk level, risk assessment, proposed measures, INCDPM.*

INTRODUCERE

Conform legislației privind sănătatea și securitatea în muncă din România, una din obligațiile angajatorilor este de a identifica și de a evalua riscurile de accidentare profesională pentru fiecare loc de muncă. Baza legală este articolul 7 din legea 319/2006, în care angajatorul în cadrul obligațiilor sale, trebuie „să evalueze riscurile pentru securitatea şi sănătatea lucrătorilor, inclusiv la alegerea echipamentelor de munca, a substanţelor sau preparatelor chimice utilizate şi la amenajarea locurilor de munca", [2]

Din multitudinea de metode utilizate pe plan mondial şi naţional pentru evaluarea riscurilor, cea mai frecvent utilizată în România este metoda de evaluare a riscurilor de accidentare şi îmbolnăvire profesională elaborată de I.N.C.D.P.M București, experimentată până în prezent în majoritatea ramurilor industriale, [5].

Această metodă face parte din categoria metodelor analitice, semicantitative, şi constă, în esenţă, în identificarea tuturor factorilor de risc din sistemul analizat cu ajutorul unor liste de control prestabilite, urmată de cuantificarea dimensiunii riscului pentru fiecare factor de risc în parte, pe baza combinaţiei dintre gravitatea şi frecvenţa consecinţei maxime previzibile. Nivelul de risc global pe loc de muncă se determină ca medie ponderată a nivelurilor de risc parţiale. Aplicarea metodei se finalizează cu două documente centralizatoare pentru fiecare loc de muncă: fişa de evaluare a riscurilor şi fişa de măsuri propuse, [4].

Evaluarea riscurilor presupune identificarea tuturor factorilor de risc din sistemul analizat şi cuantificarea dimensiunii lor pe baza combinaţiei dintre doi parametri: gravitatea şi frecvenţa consecinţei maxime posibile asupra organismului uman, [5]

EXPRIMAREA NIVELULUI DE RISC

După obținerea nivelului de risc pentru fiecare element al sistemului de muncă (executant, sarcina de muncă, mijloace de producţie/echipamente de muncă şi mediu de muncă) se calculează nivelul global de risc pentru locul de muncă evaluat. Formula de calcul a nivelului global de risc, conform metodei elaborate de INCDPM Bucureşti, este [5]:

$$N_r = \frac{\sum_{i=1}^{n} r_i \bullet R_i}{\sum_{i=1}^{n} r_i} \qquad (1)$$

în care:

N_r = nivelul global de risc pe loc de muncă;
r_i = rangul factorului de risc "i";
R_i = nivelul de risc pentru factorul de risc "i";
n = numărul factorilor de risc identificaţi la locul de muncă.

Pentru a obține nivelul global de risc se calculează media ponderată a nivelurilor medii de securitate determinate pentru fiecare loc de muncă analizat din componența macrosistemului organizației, [5].

STUDIU DE CAZ

Locul de muncă analizat şi evaluat, în care a fost implementată metoda INCDPM București, este cel de mecanic auto din cadrul departamentului Mecanic auto, secţia "Atelier auto" de la unitatea S.C. Service Auto SRL Oradea, procesul de muncă constând în executarea operaţiilor de mecanică auto.

Elementele componente ale sistemului de muncă evaluat:

a) **Mijloace de producţie/echipamente de muncă:**
   - autocamioane;
   - compresoare;
   - echipamente tehnice (elevatoare);
   - dispozitive, transpaleţi;
   - unelte manuale;
   - ustensile pentru efectuarea curăţeniei în zona de lucru.

b) **Sarcina de muncă:**
   - să efectueze operaţii specifice de mecanică auto conform cerinţelor din cartea tehnică şi instrucţiunilor de lucru;
   - să acţioneze utilajelor şi dispozitivelor auxiliare conform instrucţiunilor de lucru;
   - să utilizeze echipamentul de protecţie adecvat postului de lucru.

c) **Mediul de muncă:**
   - ''Mecanicul auto'' își desfășoară activitatea în atelierul service;
   - Locul de muncă este racordat la instalația de energie electrică, rețeaua de apă potabilă, canalizare și este dotat cu instalație de climatizare.

După identificarea elementele componente ale sistemului de muncă evaluat s-a trecut elaborarea şi întocmirea Fişei de evaluare a locului de muncă (Tabelul 1). Aceasta cuprinde factori de risc identificaţi şi forma concretă de manifestare a factorilor de risc (descriere, parametri). Factori de risc identificați au fost clasificaţi şi grupaţi în 7 categorii:

a. factori de risc mecanic;
b. factori de risc electric;
c. factori de risc termic;
d. factori de risc chimic;
e. suprasolicitare fizică
f. acţiuni greşite;
g. omisiuni.

Pentru fiecare factor de risc a fost previzionată consecinţa maximă, clasele de gravitate şi de probabilitate, precum şi nivelul de risc. Au rezultat, în final, un număr de 26 de factori de risc.

Tabelul 1. Fişa de evaluare a locului de muncă

Unitatea: S.C. SERVICE AUTO SRL Oradea Secția: Atelier auto Departamentul: Mecanic auto Număr persoane expuse: 5 Durata expunerii: 8 ore						
Componenta sistemului de muncă	Factori de risc identificați	Forma concretă de manifestare a factorilor de risc (descriere, parametri)	Consecința maximă previzibilă	Clasa de gravitate	Clasa de probabilitate	Nivel de risc
Mijloace de producție	Factori de risc mecanic	1. Prinderea membrelor în echipamentele tehnice cu care se lucrează (organe de maşini în mişcare)	INV [1] gr. III	4	2	3
		2. Vătămări corporale, pierderi de vieţi omeneşti din cauza utilizării inadecvate a mijloacelor de ridicat;	DECES	7	1	3
		3. Afecţiuni ale ochilor din cauza jetului de ulei la fisurarea accidentală a elementelor circuitelor hidraulice aflate sub presiune	INV gr. III	4	2	3
		4. Afecţiuni ale feţei, ochilor din cauza proiectării de corpuri sau particule (anvelope, furtun)	INV gr. III	4	2	3
		5. Răniri ale membrelor cauzate de contactul cu suprafeţe tăioase sau înţepătoare	ITM [2] 3-45 zile	2	2	2
		6. Loviri, striviri ale corpului cauzate de lovirea de către	DECES	7	1	3

Unitatea: S.C. SERVICE AUTO SRL Oradea
Secţia: Atelier auto
Departamentul: Mecanic auto
Număr persoane expuse: 5
Durata expunerii: 8 ore

Componenta sistemului de muncă	Factori de risc identificaţi	Forma concretă de manifestare a factorilor de risc (descriere, parametri)	Consecinţa maximă previzibilă	Clasa de gravitate	Clasa de probabili-tate	Nivel de risc
		mijloace de transport care circulă pe căile de circulaţie internă sau atelierul auto				
		7. Loviri prin cădere de la înălţime prin cădere în gol, alunecare, dezechilibrare (în canalele de acces auto din atelierul de revizii şi reparaţii)	DECES	7	1	3
	Factori de risc electric	8. Electrocutare prin atingere directă (prize deteriorate accidental) sau indirectă (deteriorarea accidentală a izolaţiei, cabluri neizolate, defecte)	DECES	7	2	4
		9. Electrocutare prin atingere indirectă sau prin apariţia unor tensiuni (legături la împământare, izolaţii străpunse accidental).	DECES	7	2	4
		10. Electrocutare cauzată de intervenţii neautorizate la instalaţia electrică	DECES	7	2	4
	Factori de risc termic	11. Arsuri cauzate de explozii în timpul încărcării bateriilor	DECES	7	2	4
		12. Arsuri cauzate de incendii generate de prezenţa materialelor combustibile	ITM 3-45 zile	2	2	2
		13. Arsuri cauzate de explozii datorită recipienţilor sub presiune în zona de lucru sau în vecinătatea desfăşurării activităţii	DECES	7	1	3
	Factori de risc chimic	14. Iritaţii ale pielii din cauza substanţelor inflamabile	ITM 3-45 zile	2	2	2
		15. Afecţiuni respiratorii din cauza gazelor, vaporilor, aerosolilor toxici proveniţi de la funcţionarea motoarelor termice în incinta atelierelor in timpul reparaţiilor auto)	ITM 3-45 zile	2	5	3

Unitatea: S.C. SERVICE AUTO SRL Oradea
Secţia: Atelier auto
Departamentul: Mecanic auto
Număr persoane expuse: 5
Durata expunerii: 8 ore

Componenta sistemului de muncă	Factori de risc identificaţi	Forma concretă de manifestare a factorilor de risc (descriere, parametri)	Consecinţa maximă previzibilă	Clasa de gravitate	Clasa de probabilitate	Nivel de risc
MEDIUL DE MUNCĂ	Factori de risc fizic	16. Afecţiuni respiratorii din cauza condiţiilor de lucru în sezonul rece (bronşite, pneumonii, degerături)	ITM 3-45 zile	2	5	3
		17.Oboseală auditivă din cauza funcţionării compresoarelor	ITM 3-45 zile	2	5	3
SARCINA DE MUNCĂ	Suprasolicitare fizică	18. Pozitii de lucru forţate şi vicioase la executarea unor operaţii	ITM 3-45 zile	2	5	3
		19. Afecţiuni osteoarticulare din cauza - manipulări repetate prin ridicare, tragere, împingere, purtare	ITM 3-45 zile	2	5	3
EXECUTANT	Acțiuni greșite	20. Fracturi, loviri, striviri din cauza neasigurării echipamentelor suspendate	DECES	7	1	3
		21. Loviri, striviri, fracturi din cauza executarea de intervenţii sub mijloacele de transport auto atunci când motorul este pornit	DECES	7	2	4
		22. Vătămări corporale cauzate de utilizarea echipamentelor de muncă care nu corespund din punct de vedere tehnic, defectuoase, improvizate	DECES	7	1	3
		23. Loviri, fracturi cauzate de căderea de la acelaşi nivel prin împiedicare, alunecare	ITM 3-45 zile	2	5	3
		24. Loviri, striviri, fracturi din cauza nerespectării instrucţiunilor proprii pe linie de sănătate şi securitate în muncă	DECES	7	1	3
	Omisiuni	25. Vătămări ale corpului cauzate de neutilizarea echipamentelor de protecţie colectivă / individuală	DECES	7	1	3
		26. Vătămări ale corpului cauzate de nerespectarea semnalizării de securitate	DECES	7	1	3

1) INV – Invaliditate; 2) ITM - Invalididate Temporară de Muncă

În figura 1 sunt ilustrate sub formă grafică nivelurile de risc pentru cei 26 de factori de risc identificaţi la locul de muncă analizat. Se poate observa că 5 factori de risc depăşesc, ca nivel parţial, limita maximă admisă, situându-se în categoria factorilor de risc pentru care trebuie luate măsuri de eliminare sau diminuare a efectelor acestora. Aceştia sunt prezentaţi sintetic în Tabelul 2.

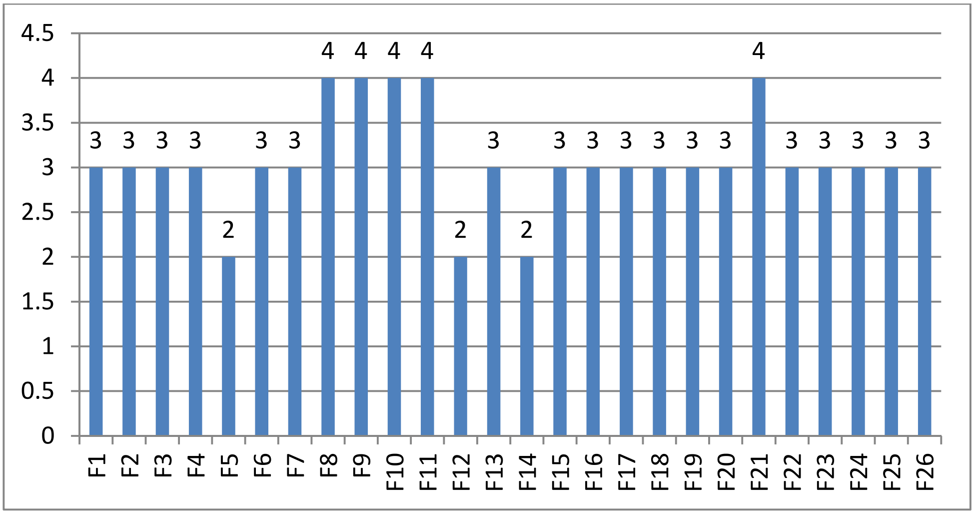

Fig. 1. Reprezentarea grafică a factorilor de risc pentru locul de muncă mecanic auto

Tabelul 2. Factori majori de risc identificaţi la locului de muncă „mecanic auto"

Indice factor	Descriere
F8	Electrocutare prin atingere directă (prize deteriorate accidental) sau indirectă (deteriorarea accidentală a izolaţiei, cabluri neizolate, defecte)
F9	Electrocutare prin atingere indirectă sau prin apariţia unor tensiuni (legături la împământare , izolaţii străpunse accidental)
F10	Electrocutare cauzată de intervenţii neautorizate la instalaţia electrică
F11	Arsuri cauzate de explozii în timpul încărcării bateriilor
F21	Loviri, striviri, fracturi din cauza executării de intervenţii sub mijloacele de transport auto atunci când motorul este pornit

Având în vedere nivelului de risc cuantificat în cadrului Tabelului 1, pentru fiecare element al sistemului de muncă, prin înlocuire în relaţia (1) de calcul a nivelului global de risc se obţine:

$$N_{rg} = \frac{\sum_{i=1}^{26} R_i \cdot r_i}{\sum_{i=1}^{26} r_i} =$$

$$\frac{0\cdot(7x7)+0\cdot(6x6)+0\cdot(5x5)+5\cdot(4x4)+18\cdot(3x3)+3\cdot(2x2)+0\cdot(1x1)}{0x7+0x6+0x5+5x4+18x3+3x2+0x1} = \frac{254}{80} \qquad (2)$$

ceea ce conduce la un nivelului global de risc:

$$N_{rg} = 3{,}175 \qquad (3)$$

valoare ce nu depăşeşte limita maximă acceptabilă de 3,5. Aceasta înseamnă că locul de muncă evaluat „mecanic auto” se încadrează în categoria locurilor de muncă cu nivel mediu de risc de accidentare şi îmbolnăvire profesională.

După o analiză atentă şi detaliată a locului de muncă şi a cauzelor care pot conduce la apariţia şi favorizarea celor 5 factori de risc a căror nivel parţial depăşeşte limita maximă admisă, s-a elaborat şi întocmit "Fişa de măsuri propuse pentru locul de muncă "mecanic auto"" (Tabelul 3). Aceasta prezintă sintetic factorii de risc major / locul de muncă, împreună cu nivelul de risc şi măsurile propuse pentru evitare/diminuare.

Tabelul 3. Fişa de măsuri propuse pentru locul de muncă „mecanic auto”

Nr crt	Factori de risc / locul de muncă	**Nivel de risc**	Măsuri propuse (nominalizarea măsurii)
1	F8. Electrocutare prin atingere directă (prize deteriorate accidental) sau indirectă (deteriorarea accidentală a izolaţiei, cabluri neizolate, defecte);	**4**	1. Verificarea periodică a echipamentelor electrice de către personal autorizat şi instruit in acest sens (electrician); 2. Verificarea vizuală a integrităţii legării la pământ; 3. Comunicarea imediată a deficienţelor constatate către conducătorul locului de muncă.
2	F9.Electrocutare prin atingere indirectă sau prin apariţia unor tensiuni (legături la împământare, izolaţii străpunse accidental).	**4**	
3	F10.Electrocutare cauzată de intervenţii neautorizate la instalaţia electrică;	**4**	1. Instruirea mecanicului auto privind faptul că intervenţia la echipamentele electrice se va face numai de către personal autorizat şi instruit în acest sens (electrician); 2. Respectarea regulilor de securitate electrică;

			3. Utilizarea, după caz, a sculelor cu mâner electroizolant de către personalul autorizat (electrician).
4	F11. Arsuri cauzate de explozii în timpul încărcării bateriilor	**4**	1. Respectarea regulilor de securitate privind activitatea de încărcare a bateriilor; 2. Încărcarea bateriilor se va efectua de către personal autorizat și instruit.
5	F21. Loviri, striviri, fracturi din cauza executării de intervenţii sub mijloacele de transport auto atunci când motorul este pornit;	**4**	1. Intervenția se va efectua de către personal instruit; 2. Intervenţia sub mijloacele de transport auto se va efectua atunci când motorul este oprit.

CONCLUZII

În urma analizelor şi studiilor efectuate la locul de muncă „mecanic auto” s-au identificat un număr total de 26 factori de risc, dintre care 5 factori de risc depăşesc, ca nivel parţial, limita maximă admisă, situându-se în categoria factorilor de risc pentru care trebuie luate măsuri de eliminare sau diminuare a efectelor acestora.

Nivelului global de risc N_{rg} calculat a avut valoarea de 3,175 (valoare ce nu depăşeşte limita maximă acceptabilă de 3,5), fapt ce încadrează locul de muncă evaluat în categoria locurilor de muncă cu nivel de risc mediu de accidentare şi îmbolnăvire profesională.

S-a elaborat, întocmit şi propus o Fişă de măsuri pentru locul de muncă "mecanic auto", în care sunt nominalizaţi cei 5 factorii de risc major / loc de muncă, împreună cu nivelul de risc şi măsurile necesare a fi luate pentru evitare/diminuare.

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PSYCHOLOGICAL REASONS AND ETHICAL ISSUES RELATED TO EARLY DIAGNOSIS AND INTERVENTION IN CHILDREN WITH AUTISM SPECTRUM DISORDERS

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REZUMAT. Rațiuni psihologice și probleme etice cu privire la diagnosticul și intervenția în cazul copiilor cu Autism. În ultima decadă, incidența cazurilor de autism a crescut, la nivel mondial, la valori foarte ridicate. Totuși, acest traiect accelerat nu poate fi cauzat doar de creșterea numărului de persoane care suferă de autism, ci poate fi atribuit și altor factori. Această lucrare prezintă problematica creșterii ratelor de autism și oferă o scurtă descriere a semnelor timpurii din primul și al doilea an de viață. Intervenția comportamentală timpurie este prezentă ca fiind o metodă eficientă de intervenție pentru copiii care prezintă această tulburare. Câteva aspecte etice și psihologice sunt menționate pentru a sublinia importanța și necesitatea intervenției timpurii.

Cuvinte cheie: *tulburări din spectrul autist, diagnostic timpuriu, intervenție timpurie, etica.*

ABSTRACT. In the past few years, the reported incidence of autism has increased at a remarkably high rate across the world. However, this accelerating trend may not be due to an actual increase in the number of people who exhibit behaviors characteristic of autism, but may be attributed to other factors. This paper presents the problematic of the increased rates in Autism Spectrum Disorders and offers a brief description of early signs during the first and second years of life. The early intensive behavioral intervention is presented as being an effective method for young children with Autism Spectrum Disorders. Some psychological and ethical aspects are presented in order to point the importance and the necessity of early intervention.

Keywords: *autism spectrum disorders, early diagnosis, early intervention, ethics.*

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1. INTRODUCTION

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM, 5th Edition), the diagnostic criteria for the autism spectrum disorder include: a) persistent deficits in social communication and social interaction across multiple contexts and b) restricted, repetitive patterns of behavior, interests, or activities. The heterogeneity of the spectrum involves the severity of the condition, developmental level, chronological age, and associated conditions (mental retardation, language impairment) and challenging behaviors.

This heterogeneity constitutes a challenge for the development of a comprehensive early detection strategy. Nevertheless, it is essential to develop effective approaches to identify and diagnose children with ASD as early in life as possible. Early identification and diagnosis help reduce the confusion about the diagnostic and strange behaviors, the level of distress among parents who do not understand the reasons for their child's behavior; the early diagnostic leads to early intervention programs aimed at helping children modify their behavior and for parents to learn new skills.

In the last decade there has been a growing interest in ASD due to increased number of reported cases of autism at a very high rate across the world (Hertz-Picciotto & Delwiche, 2009; Nygren et al, 2012; Baxter et al, 2015). In a literature review published by Matson and Kozlowski (2011) the authors presented studies aimed at identifying the frequency of ASD in general population and concluded that the numbers are increasing rapidly and in a relatively few number of years.

The *World Health Organization* (*WHO*) reported, at the beginning of 2016, that 1 in 160 children has an ASD and could be higher, as reported by well-controlled studies (although autism prevalence in many countries remains largely unknown). Also, *Centers for Disease Control and Prevention (CDC)* published combining data for a period of twelve years, presented in *Table 1*.

Table 1. Prevalence of ASD (2000-2012) Combining data provided by Centers for Disease Control and Prevention (https://www.cdc.gov/ncbddd/autism/data.html)

Surveillance year	Birth year	Number of ADDM Sites reporting	Prevalence per 1000 children (range)	This is about 1 in X children …
2000	1992	6	6.7 (4.5 – 9.9)	1 in 150
2002	1994	14	6.6 (3.3.-10.6)	1 in 150
2004	1996	8	8.0 (4.6-9.8)	1 in 120
2006	1998	11	9.0 (4.2-12.1)	1 in 110
2008	2000	14	11.3 (4.8-21.2)	1 in 88
2010	2002	11	14.7 (5.7-21.9)	1 in 68
2012	2004	11	14.6 (8.2-24.6)	1 in 68

This growing prevalence is alarming and researchers have focused on finding the possible causes However, this accelerating trend may not be due to an actual increase in the number of people who exhibit behaviors characteristic of autism, but may be attributed to differences of, or changes in: eligibility criteria, subjective judgments in the assessment process, non-response bias, changes in service availability, varied case finding methods, the diagnosis of very young children, accuracy of diagnosis, cultural practices, more knowledge of the parameters and awareness of autism, better trained clinicians, and possibly false-positives diagnoses (Posserud et al, 2010; Baxter et al, 2015; Eriksson et al, 2013). Moreover, accurate prevalence rates of autism are challenging to achieve, as autism can occur along with other disabilities (Kopetz & Endowed, 2012).

Calculating prevalence is often the first step toward launching government and nonprofit mental health services. Numbers can also lead to scientific insights on the genetic, environmental and cultural underpinnings of autism. Researchers continue their work in order to learn more about the condition's etiology, its impact on families and on national economies, methods to accommodate demonstrated behavioral concerns and approaches that can best inform the public and teachers who assist individuals affected by autism.

The increase in ASDs has important public health and policy implications, particularly given that most people living with ASDs today are adults and this will continue to be the case (Baxter et al, 2015).

2. EARLY SIGNS OF ASD

The worldwide concern for the increase of ASDs determined researchers and practitioners to focus on early diagnosis and intervention. Although ASD is increasingly thought of as having a genetic basis (Sokol & Lahiri, 2011; El-Fishawy & State, 2010), there are no biological markers for it. Also, despite the fact that there is a growing number of instruments used for diagnosing and documenting autistic symptoms, to date the "gold standard" (Volkmar, 2005) in diagnosis is clinical judgment based on behavioral manifestations.

Usually, ASD is diagnosed around 3 years old or even later (Fountain et al, 2011; Jo et al, 2015). According to Watson et al (2003) symptoms include (taking into account several domains): *affective development* (limitations in facial expression, fewer facial expressions, ambiguous facial expressions, a lack of social smiling), *sensory processing, attention, and self-regulation* (hypersensitivities to sound, aversion to social touch, avoidance of certain food textures, lack of response to pain, poor orientation to visual stimuli, and over focused attention or preoccupations with various sensory features of objects), *praxis and imitation* (imitation deficits, difficulty forming internal representations of visually modeled actions), *communication* (impaired key aspects of nonverbal behavior that typically support the mapping of language onto real world objects and relations, less babbling and gesturing during early development, limited range of preverbal communicative intentions), *play* (less proximity to peers, reduced levels of social initiations, fewer responses to social overtures, and more solitary activities), and *motor features and stereotyped/repetitive behaviors* (lags in gross motor development, unusual postures, clumsiness, and motor planning problems).

Given that some of the primary symptoms of autism may not manifest themselves unequivocally before the age of 3, it is interesting that a number of researchers are convinced that a meaningful diagnosis can be made in children younger than 12 months, on specific areas such as *movement*, *social behaviors*, *attention*, *communication*, *orientation/response to name* and *paradoxical reactions to sounds and/or semblance of deafness* (Lemke et al, 2013; Zwaigenbaum et al, 2013; Hutman et al, 2012; Guinchat et al, 2012).

Although significant progress has been made in the direction of identifying ASD as soon as possible, a clear diagnostic in the first year of life might prove difficult in terms of reliability. The signs become increasingly evident with increasing age and might not be fully manifest until later in life, particularly in children who have IQ and language skills within the normal range. Ethical aspects are important due to the fact that some vulnerable population are presenting higher risks to delay the time of diagnostic. Among them we pointed ethnicity and migrants as important factors (Valicenti-McDermott et al, 2012).

Chawarska et al. (2007) found evidence for short-term stability of the autism diagnosis assigned in the second year of life, while the study of Kleinman et al. (2008) indicate diagnostic stability at acceptable levels at age 2. Studies aimed at identifying symptoms of ASD in the second year of life help to further clarify patterns of early indicators as they become more pronounced.

In a study of Wetherby et al. (2004) were identified nine red flags for ASD:

- lack of appropriate gaze,
- lack of warm, joyful expressions with gaze,
- lack of sharing enjoyment or interest,
- lack of response to name,
- lack of coordination of gaze, facial expression, gesture, and sound,
- lack of showing,
- unusual prosody,
- repetitive movements or posturing of body, arms, hands, or fingers,
- repetitive movements with objects.

Chawarska et al. (2007) identified a series of symptoms specific for children with autism in the second year that overlap on those found by Wetherby et al. (2004), but they also include limited response to joint attention bids and delays in functional and symbolic play. Severl years after this study, Landa, et al (2007) found that children classified as having an early ASD diagnosis (14 months) showed abnormalities in joint attention (similar to Chawarska et al.), in initiation of communication with others, and in the variety of vocal and nonvocal forms used to express communicative initiations by 14 months of age, and that these abnormalities persisted through 24 months of age.

Some other studies pointed that children usually failing on three key elements (proto-declarative pointing, gaze-monitoring, and pretend play) are at risk of receiving a diagnosis of autism at 18, respectively 24 months (Robins et al, 2001; Baron-Cohen, 1992). Zwaigenbaum et al. (2009) warn us that, although there have been significant advances in our ability to detect early signs of ASDs, diagnostic evaluation in children younger than the age of 2 remains challenging.

Matson et al (2008) note that early diagnosis is a good development only if the diagnoses are reliable, have good predictive validity, and prove useful in assisting in better care and prognosis. Development of specific approaches to infants and very young children is an important research priority and is essential in understanding the boundaries of the disorder in relation to broader autism spectrum conditions.

3. THE IMPORTANCE OF EARLY INTENSIVE BEHAVIORAL INTERVENTIONS (EIBI) AND TO PROVIDE EQUAL CHANCES TO HEALTH AND EDUCATIONAL SERVICES

There is general consensus that ASDs should be identified as early in life as possible, with a view to ensuring that intervention can start as quickly as possible (Fernell et al, 2013). Due to the fact that more children under the age of 3 years are being diagnosed with ASD, early interventionists face the challenge of identifying appropriate programs to meet the unique needs of very young children with ASD and their families. The increased numbers and the earlier age at diagnosis are having a dramatic impact on early intervention providers. Any child would benefit from appropriate early interventions building on her or his behavioral strengths and remedying any weaknesses (Poling & Edwards, 2014). As such, early diagnosis and information are needed in order that an autism friendly environment be "created" around affected individuals (Fernell et al, 2013).

Roberts and Prior (2006), reviewing the international literature in order to provide guidelines for best practice for early intervention programs for children with ASDs, stress the following key elements:

1. provide an autism specific curriculum content focusing on attention, compliance, imitation, language, and social skills,

2. address children's need for highly supportive teaching environments,
3. include specific strategies to promote generalization of new skills,
4. address children's need for predictability and routine,
5. adopt a functional communication approach in addressing challenging behaviours,
6. support children in their transition from the preschool classroom,
7. ensure that family members are supported and engaged in a collaborative partnership with professionals involved in the delivery of treatments.

As we improve our ability to identify toddlers with ASDs, the need for research on the efficacy of very early intervention approaches becomes critical. There is strong evidence that early intensive behavioral intervention (EIBI) programs are effective in changing the natural long-term outcome for many individuals with an early diagnosis of autism (Estes et al, 2015; Nah et al, 2014).

The core elements of EIBI involve (Reichow et al, 2014):

1. a specific teaching procedure referred to as discrete trial training,
2. the use of a 1:1 adult-to-child ratio in the early stages of the treatment
3. the implementation in either home or school settings for a range of 20 to 40 hours per week across one to four years of the child's life.

Lovaas (1987) suggested that 47% of the autistic children included in his study achieved normal intellectual and educational functioning and maintained these gains when assessed at 7-year follow-up. Adapting this model proposed by Lovaas, several studies proved that there is an improvement in the adaptive behavior, increases for IQ scores and outperformance for visual-spatial skills, language, and academics (Eikeseth et al, 2012; Howard et al, 2005). Other studies using EIBI in other formats than Lovaas suggest higher adaptive functioning and higher cognitive skills, improvements in language, daily living skills, and positive social behavior (Flanagan et al, 2012; Remington et al, 2007).

Matson et al (2012) conclude that studies on EIBI routinely demonstrate good or superior effectiveness and positive effects. The results consistently showed that children with autism improve significantly with early intervention. These improvements are stable over the years. The findings highlight the importance of ensuring that children begin intensive therapy as soon as possible after the diagnostic.

Early intervention is very important for the future development of a child with ASD. Strategies adapted to each case may increase the rate of developing skills in order to diminish the negative aspects related to the problem. On the other hand, early intervention will help parents to cope with stress determined by the child's behavior and they will be more skillful to interact and to communicate with their child.

Ethical aspects must not be ignored when it is about a vulnerable population: children in need. They must be assisted with dignity and to provide equal chances to health services, with no ethical, racial, economical, religious, ethnical or educational reasons. Seventy-five of approximately 120 countries in which an ASD-specific organization has been established are low or middle income (Daley et al, 2013). Many ethical dilemmas were preferring to the aspects of developing studies or the level of literacy of the investigated population or understanding the informed consent in case of parents with a low level of education.

Also, due to the fact that low or income countries are presenting a high number of cases of children with ASD, an international strategy must be adopted in order to provide equal chances for children living in poor countries to access health and educational services.

4. CONCLUSIONS

As worldwide awareness of autism gains momentum, there is a need for research advances from more countries. Continued international research in assessment and treatment may help extend work from older and more able individuals to the first years, if not the first months, of life. Psychological aspects and ethical reasons must be considered due to the fact that religion, ethnicity, migration or parents level of education represent important factors for a proper diagnostic and an early intervention.

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LEGAL REGULATIONS ON PATIENT'S RIGHT TO REFUSE MEDICAL TREATMENT

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REZUMAT. Reglementări legale privind dreptul pacientului de a refuza tratamentele medicale. Refuzul tratamentelor, a intervenţiilor de către un pacient este o realitate a practicii medicale, care duce deseori la dileme etice datorită conflictului dintre datoria medicului de a trata pacientul şi cel de a-i respecta dreptul la autodeterminare. Tema aceasta este importantă şi actuală prin faptul că pacientul secolului al XXI-lea tinde să decidă şi să acţioneze în mod autonom, într-un mod mult mai accentuat decât o făceau predecesorii săi, iar coordonatele relaţiei medic-pacient sunt regândite şi fundamentate şi pe alte criterii decât cele clasice. Astfel, este nevoie de o bună descriere, de o capacitate de analiză şi de o putere de sinteză a informaţiilor şi a argumentelor pentru a cunoaşte modul optim de acţiune şi de a proceda în consecinţă, cu scopul de a identifica punctele neelucidate, problematice. Scopul acestui articol este acela de a prezenta și de a analiza modalităţile de implementare a dreptului la autonomie al pacientului conform reglementărilor legale internaționale și naționale în vigoare, printre care și dreptul de a refuza tratamentele.

Cuvinte-cheie: *refuzul tratamentelor, autonomie, consimțământ informat, refuz informat.*

ABSTRACT. Refusing treatments, interventions by a patient is a reality of medical practice, which often leads to ethical dilemmas because of the conflict between the duty of the physician to treat the patient and the patient s right to self-determination. The topic is important and actual, because the patient of the XXI century tends to decide and act autonomously, much more pronounced than their predecessors, and coordinates doctor-patient relationship are redesigned and based on other criteria than the classic ones. Thus, it needs a better description, capacity for analysis and synthesis information and arguments in order to know how is best to proceed and to identify points unclear or problematic. The aim of this paper is to present and to analyze how patient's right to autonomy is implemented in international and national legal regulations in force, including the right to refuse treatment.

Keywords: *treatments refusal, autonomy, informed consent, informed refusal.*

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INTRODUCTION

In some cases of the medical practice exercising this profession is limited due to patient's decision not to join the proposed treatment. Informed consent is a patient's right required before starting medical act. It is actually a choice, an informed choice between two possibilities: acceptance or rejection of the proposed treatment or consultation by a medical doctor. Principles of medical ethics assume that each person is respected as a value in itself, and this respect assumes the recognition of the individual autonomy. The medical ethics recognizes the fundamental principle of patient's autonomy, which in practice should be combined with other principles: beneficence, nonmaleficence and equity (1). From the legal point of view, the principle of autonomy translates as the patient's right to self-determination. He/she has the right to be informed, to act according to his/her will and faith, should not benefit from treatment if it decides so. Internationally this right of the patient is known under different names, and in the domestic Romanian legislation, the patient has the right to refuse treatments, including the lengthy and expensive ones, even when the refusal will result in death (2). In the following paragraphs we will present the international and national context on the right of refusing treatments and its consequences in the legal and medical practices.

INTERNATIONAL ENVIRONMENT. DELIMITING TERMS

1. The individual's right to self-determination

Patient's autonomy is protected by his/her right to self-determination, a concept introduced in the Lisbon Declaration on Patients' Rights, first in 1981 (3). This right was adopted by the international law and practices and refers to a patient who can freely decide to participate or not in a clinical trial or a medical act, and within the medical act to accept or to decline the proposed medical interventions. He/she has the right to take part in the therapeutic decision, which is conditioned by the Informed Consent. The right to self-determination is regulated only for those who, in the legal sense, are able to take a decision, to make a free choice. The factors that must be evaluated to determine the ability of making an informed decision are: understanding consequences of the decision, the patient's condition when he/she is taking the decision (ex. the terminally ill) and the process of the decision (4, 5).

2. Patient's right to treatment

The Universal Declaration of Human Rights (1948) in the article 25 provides the right of all persons to health care: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (5). This right is taken also by the Romanian legislation. Thus, the Romanian Constitution stipulates in the article 34 "the right to protecting the health" (6). The Law no. 46/2003 regarding patient rights, updated in 2014, provides, in the chapter 6, articles 29-36, the patient rights to treatments and health care (7).

3. Patient's right to refuse treatments

The Helsinki Declaration on Ethical Principles for Medical Research Involving Human Subjects adopted in 1964 stipulates in the article 26, for the first time in a formal framework and unanimously, the patient right to refuse treatment, with a specific purpose, the experimentation. The statement was made under the influence of the Nuremberg trials, where defendants of Nazi Germany were convicted and sparked discussions that impacted on the development of international criminal law, resulting in the Universal Declaration of Human Rights (8). The Helsinki Declaration provides the right to information of the subject, prior the experiment, giving him/her objective information about methods, benefits and dangers. The subject must be informed on his/her right to refuse participation in experimentations, on the possibility of abandoning anytime the clinical studies. Then he/she gives the free and informed consent to the medical doctor or researchers. In this process, the physician should pay particular attention to the possibility that the subject should not be coerced or forced to consent (9).

Later, in 1984 it was adopted the European Charter of Patients' Rights, which states that: "A patient's right to be informed about the diagnosis, therapy and prognosis". Another legal framework is the New York City Health and Hospital Corporation "Patient Rights", which establishes the right of the patient "to accept and refuse (in terms of correct) treatment and to participate in his election. In case of refusing treatments proposed by the physician, the patient should be advised of possible medical consequences of this refusal" (1). The law provides the right of patients to refuse treatment in the most parts of the world, a special question being the limited denial. The Oviedo Convention on the Protection of Human Rights and Human Dignity to the Application of Biology and Medicine of the Council of Europe adopted in 1997, the article 5 states besides respecting patient's autonomy the patient's right to receive information or to refuse to receive information, and the right to withdraw consent previously given “data subject may at any time withdraw their consent freely” (10).

4. Forms of treatment refusal

The right to the Informed Consent includes also the right to informed refusal. Such refusal shall be stated under the laws of the country, in writing, by signing a standard form of assuming the decision. If the patient wants to dispose of the right to self-determination when he/she became incompetent to make decisions, he/she can draw up a living will or an advance directive (4), as a plan of further treatments.

Advance directives

Advance directives are documents that people, as future patients will manifest in advance, expressing their will to not receive certain treatments that would aim maintaining them alive (11). Basically, we are talking about refusing treatments or medical interventions that the future patient deemed useless or dangerous or unwilling to undergo such interventions, such as, for example, transplantation of an organ or the amputation of a member. The Oviedo Convention (1997) provides in the article 9, advance directives as “previously expressed wishes”. Thus, “when the patient is not in a state to enable it to express their will there will be taken into account previously expressed wishes relating to a medical intervention”. In Romania there is no specific law regulating advance directives. But Romania has ratified the Oviedo Convention of the Council of Europe (1997) by the Law no. 17/2001, so the text of the Convention is the benchmark for medical practice in Romania. The Deontology Code of Physicians (2012) also states in the article 16 the implied consent that “in the interests of the patient are valid and will be taken into account authorizations and wishes expressed previously regarding a medical intervention by a patient when at the new intervention it is not in a state to afford to express will or if the medical by nature has a specific sequence and repeatability” (13). Advance directives can be used only by patient who was once competent, and has, usually, two forms: drawing up a living will or delegating someone it trusts to decide in its place (14). Controversies and counter-arguments of this right are brought because the patient decides in some circumstances that could be very different when these documents are implemented or taken into account by physicians or close relatives. Some argue that the person who decides is no longer the same person at the time of the implementation will. (4)

THE RIGHT TO REFUSE TREATMENTS IN THE ROMANIAN LEGAL CONTEXT

1. Regulations concerning the doctor-patient relationship. Rights and Obligations of Parties

The relationship between the doctor and the patient starts by requiring the doctor (medical services) by the patient. To be born this relationship, it is legally required that the doctor accept to see the patient. In legal terms, medical staff and patient agreement is a covenant between the two parties. This relationship is not a contract in the traditional sense, but because it is an agreement of wills between two sides, according to article 942 of the Romanian Civil Code, it is a kind of contract. To be born this contract, the first step is done by the patient, who must see Primary Medical Assistance Service, which in turn gives access to the secondary care, of the medical specialist. The doctor will make contract offer, the second step being that the patient is accepting the offer. Only by written request from the patient may be arised healthcare contract. In Romania, the National Health Insurance's unique ticket fulfills the role of reference document acknowledging the request of the person that requires health services. The healthcare contract needs four key elements in order to be valid: the capacity of the parties to consent, an object of the contract and a cause (13). The Law No. 95/2006 on Healthcare Reform, republished in 2015, provides in the article 649 align. (3) that the information given to the patient must refer to: diagnosis, nature and purpose of the treatment, the risks and consequences of the proposed treatment, viable treatment alternatives with risks and consequences, the prognosis without treatment (15). The medical doctor incurs with the patient an obligation of means, not of results, and on patient's side paying medical fees will be the object of the contract. Exceptions to the birth of such contract are described in situations where the patient's decision-making capacity is absent or partial damaged, and the patient needs a legal guardian. Also medical emergencies are a particular case (13).

2. Interrupting doctor-patient relationship

According to Law no. 95 of 2006, the article 653, the relationship between physician and patient could be interrupted in the following situations:

a. once the disease is cured,
b. by the patient or
c. by the doctor, only in two specific situations, such as:

(i) The patient is sent to another doctor, providing all the medical data obtained, which justifies the assistance of another physician with competent skills;

(ii) The patient manifested hostility and/or disrespectful towards his/her doctor.

The patient could decide to interrupt the medical relation with his/her doctor at any time without requiring any condition to do so. Thus, because the doctor-patient contract is concluded in the patient's interest and it is patient who chooses the doctor, makes it possible for the patient to dispense of the doctor's attributes when they no longer meet with his expectations (13). The medical liability in case of the interruption of medical care at the patient's request will be judged in terms of civil, criminal or disciplinary action, as appropriate.

3. Patient's right to refuse treatment

According to the Law no. 46/2003, the article 13, it is entitled to refuse or to stop a medical intervention, assuming responsibility for this decision in writing. Consequences of refusing or stopping medical documents must be explained to the patient. Decision of refusal can be made only by competent person (6). The physician has the obligation in this case to ensure that the patient's decision is informed, clear, and free, so informing patient must have the same standard as in the case of the Informed Consent, providing as much information about the consequences. Thus, the doctor must understand that the decision of refusal is not just the responsibility of the patient, but also a professional one in case of informing patient not in a properly way, and the patient could not figure out the risks and injuries of a such choice (13).

5. Patient's right to refuse or stop terminal care

According to the Law No. 46/2003, the patient can refuse any medical intervention, provided by recording this in writing, and explaining the consequences deriving thereof, specified in the article 13. Therefore, we understand that the patient can refuse also the terminal care (6). Terminal care means the care provided to a patient when it is no longer possible to improve the fatal prognosis of the disease state and the treatment given near death (16). The article 190 of the Romanian Criminal Code forbids Euthanasia practices in Romania: "The murder committed at the explicit serious, conscious and repeated request of a victim who was suffering from an incurable illness or serious disablement medical attested, causing him permanent and unbearable suffering, shall be punished with imprisonment from 1 to 5 years" (17).

6. Exceptions of the right to self-determination

Incompetent patient

According to the Romanian Civil Code, the article 43 is unable to take a decision a minor under 14 years and those who are declared incapable by court order. For those who do not have the legal capacity, ends legal acts on their behalf their guardian or legal representative, as provided by law (18). Minors may express their consent in the absence of their parents or legal representatives in cases of emergency when parents or representatives can not be contacted and the child has the ability to understand his/her medical condition, and in cases involving issues of sexual and reproductive request, the minor over 16 years could decide by him/herself (19). According to the article 16 of the Law no. 46/2003, where is required the legal representative's consent, patient should be involved in the decision as far as it has the ability of understanding (7).

Surrogate decision. Nominating guardian

According to the Code of Deontology, the article 13, "Where, under the law, a major because of a mental disability illness or a similar reason has not the capacity to consent to an intervention, it can not be done without the consent of his/her representative or without the authorization of authority or a person or agency appointed by law" (20). The patient may be represented by a legal guardian, a representative of the health system, close relatives, in the following order: spouse, son/daughter, parent, grandparent, grandchild, a close friend (14). Persons who decide for the patient must be informed of the medical act, consequences and its benefits, alternatives and risks.

According to the article 17 of the Law No. 46/2003, if the representative refuses to give consent and the physician determines that the patient needs assistance concerned, the decision will denied to an arbitration panel specialist (7).

FINAL CONSIDERATIONS

In this paper we tried to acquaint all those working in the medical field on the national and international legal context on patient's right to autonomy, including the right to refuse medical treatment. Analysing the legislation we have seen that the principle of patient autonomy is the foundation for both the patient act of consenting to treatment proposed by his doctor, but also to refuse the proposed treatments. However, the acceptance of treatment is much better regulated in legal terms, than the procedure of refusal of treatments. On refusal, the legislation merely says that it must be in writing, without indicating any specifications that these forms must contain, unlike the Consent Forms, where are indicated marks on what the patient needs to be informed. Our suggestion is to respect the principle of symmetry; so the Refusal Forms should contain the same elements as the Informed Consent. This is supported by the existence of refusal forms already present in medical practice of some countries, like USA or UK.

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II. INTERVIEW

STUDIA UBB BIOETHICA, LXI, 1-2, 2016 (p.121-125)
(RECOMMENDED CITATION)

TEACHING BIOETHICS IN PERU

Interview with Yordanis ENRÍQUEZ CANTO PhD on Bioethics, Associate Professor of Bioethics at the Universidad Católica Sedes Sapientiae, Lima, Perú done by Maria ALUAȘ

Question 1: "What is, in your opinion, the definition of a bioethicist? What exactly does a bioethicist do in the South-America context?"

It is difficult to give a definition that in any way clarifies the identity of the bioethicist. However, it is possible to assert that the activity of the bioethicist has a philosophical nature. This is because the questions that a bioethicist asks about technosciences are philosophical in nature. These topics have to do with the meaning of the construction of human identity within the technological action. On the other hand, it is possible to point out two important characteristics. The first is that their work is expressed as critical conscience. What is this "critical conscience"? A critical conscience provides a clarification of a specific practical and theoretical content introduced by technosciences. This "conscience" also tries to understand the historical condition of contemporary man - regardless of its geographical location - and, from it, make value judgments. The second characteristic is relative to the method with which it works and which is expressed in an *esprit de finesse*. That is, in its ability to use language precisely and to make distinctions between notions.

Regarding the second part of the question, that is, what a bioethicist does in the context of South America: it is necessary to indicate a main characteristic of the Latin American context and in particular of the Peruvian one. Although in many aspects it manifests itself as conservative with regard to several issues (such as concerning the protection of the beginning of life and the characteristics of a family). However, the first symptoms of a crisis are beginning to be observed. Which is not primarily economic, but on the contrary reveals a face that we could call anthropological. What is the fundamental characteristic of this anthropological crisis? Today, it is not self-evident what is fair with respect to a great number of fundamental questions, which in some cases can become a law. Precisely with regard to the question of how it is possible to recognize what is right, today more than ever, it is hard to find the answer. This also in the Latin American context, nevertheless, the depth of our knowledge and the increase of our capacities.

In this context, which may seem to be adverse, it is therefore useful to recall what Hannah Arendt said about the value of a crisis: „A crisis forces us to ask questions again and demands new or old answers, but in any case direct judgments. A crisis becomes a disaster only when we respond to it with pre-established judgments, that is, with prejudices. Such an attitude sharpens the crisis and also prevents us from experiencing reality and takes away the opportunity to reflect that reality gives us" (Arendt, Hannah. 1977, *Between Past and Future*). Precisely the work of a bioethicist is closely linked to these last two points: to the possibility to experience reality and to help to reflect about reality. My work in Latin America is closely connected to the possibility of helping others to reflect. A reflection that is not unrelated to the possibility of trying to solve concrete problems. Above all, bearing in mind, that the solution of the problems that life poses each day does not occur directly facing the problems, but deepening in the nature of the subject that faces them. In other words, the particular is solved by deepening the essential. This is the great challenge faced by the Peruvian university in the face of the great contemporary educational emergency.

Question 2: "What kind of difficulties you met in a multidisciplinary team at work? What are the most usual challenges of this work?"

In the work of a multidisciplinary team, professionals must achieve a balance that takes into account responsibilities, values, knowledge, skills and especially the goals related to patient care. This balance is not always easy to reach. Sometimes it can be precarious or, in the worst case, has a formal type. In many cases, to reach it is necessary, to leave aside personal opinions that can go against the decision making shared.

It is possible to identify some of the main difficulties that arise in multidisciplinary work teams. On the one hand, and from a practical point of view, because many physicians in particular are accustomed to an environment of clinical practice in which decisions are "taken" by the physician and "carried out" by others professionals, it is sometimes difficult for doctors to adjust to a team approach. However, the deference for a more expert opinion, unanimity or consensus may be more appropriate methods in decision making, than an autocratic decision.

On the other hand, as far as the issue of decisions is concerned, the challenge lies in the process of arriving at agreements. It should be borne in mind that, in the current social context, there are widespread convictions. The first one, in this decisional process must be based on a content-free ethics that can be used among moral strangers. (For Engelhardt: „Moral strangers are people who do not share sufficient moral premises or rules of evidence". The Foundations of Bioethics. New York: Oxford University Press; 1996: 7.) Expression used to refer to ethics in the public sphere which by its secular nature can not aspire to anything other than being a set of rules. The second is the thesis that faced with a widespread ethical pluralism; a single ethic would not be possible today because it would claim to be absolute.

This situation requires a solution anyway. How to deal with conflicts that arise in a multidisciplinary team? Especially since, as some claim, when there is a plurality of visions among "moral strangers", a single perspective is unable to find sufficient consensus, because it is reducible to a particular worldview. Instead of this worldview, it would seem opportune to introduce a perspective that is respectful of individual decisions, empirically concrete and, in any case, less binding in practice. Faced with the variety of opposing interests and the pluralism of views, only those decisions that can be subjected to a public exchange of reasons and arguments can claim validity.

The first strategy of collaboration is to recognize procedures for working together. This strategy would offer those separated by different visions the possibility of obtaining authority not from God, not from reason, but from agreement. In order to find the basis for cooperation between these individuals, a neutral structure (some secular structure) should be sought to ensure it through the establishment of procedural instances such as the Hospital Ethics Committees (HEC).

The HEC are delineated as a „dialogical instance", the place where, using bioethics as a frame of reflection, the interests of different groups of „moral strangers" come together; the practical articulation of the representation and the representativeness that allows the meeting „face to face". One point should be clarified, given that one of the risks is to make the committee appear to a small parliament, where the discussion cancels the ethical reflection. On the other hand, the people who participate in the committees can be chosen in such a way that they represent only the interests of a „community of moral strangers". From this point of view the „delegates" could promote the debate and discuss with certain reasons in support of the group to which they belong. Such a dynamic can only concretize the evolution of political negotiation groups, moving more and more away from a space for ethical reflection.

Question 3: "What are the most discussed bioethics topics in the Peru universities?"

One of the subjects of greater discussion is the argument of the so-called „new rights". Today, Peruvian universities and the media are discussing about the right to marry and to adoption among persons of the same sex, the right to have a child, the right to own gender identity, the right of the child not to be born if is not healthy and the list could be expanded. Many perceive these „new rights" as a provocation or a real attack on the values on which Western civilization has been founded for centuries, and in particular Peruvian society. Many of these new rights exert a great attraction on people, while they are feared by others as factors of destruction of society. It is precisely around these issues of Bioethics and public ethics that the deepest social fractures and the most heated political controversies are created. However, the interesting question is where these "new rights" originate. It is essential to recognize that each of them ultimately born of deep human needs. These demands are the affective need, the desire for motherhood and paternity, the fear of pain and the search for one's identity.

Each of these „new rights" has its roots in the structure that constitutes human existence. On the other hand, the multiplication of individual „new rights" expresses the expectation that the legal order, in some way, can solve human dramas and ensure satisfaction to the infinite needs of the human heart. They all have as a common feature to place at the center a man who claims absolute self-determination at every stage of life; a self-determination that manifests itself in deciding whether to live or die, whether to suffer or not to suffer, whether to have a child or not to have, whether to be male or female. It is a self that is conceived as absolute freedom, without limits and that does not tolerate any kind of conditioning. The contemporary self is like an eternal teenager: does not want to hear about limits. Being free means in fact to be able to always access new possibilities, trying to reduce desire to enjoyment. This culture carries within itself the conviction that the attainment of „new rights" is the way for the realization of the person. It is thought that in this way could avoid making unnecessary the debate on the fundamentals of life.

Question 4: "In your opinion, what could be the most appropriate way to introduce ethical and bioethical debates in our hospitals, universities, and societies?"

In my opinion, on the one hand, it is necessary to rethink and revive the values that lie at the basis of the debates in Bioethics. In fact a value, which is a good, it is not possible to protect it only with laws as this is the current trend in some Latin American countries. On the contrary, it is necessary to start from another point. It is necessary to take up the question from the very base: which means to introduce into the debate the problem of man and the yearning for fulfillment that constitutes us. That is, to reintroduce the theme of the deep need that constitutes us. In this way it would be possible to rewrite, rethink and revive values (for example human dignity or the good of existence at any point in its development) that are at the basis of bioethical debates.

Another important point to establish a dialogue on many bioethical issues could be the rediscovery of elements that from the anthropological point of view accumulate us as a species. One thing about dialogue is that it should not be limited to an exchange of ideas or words. This is a fairly frequent trend in academic debates or in our lessons, ie a high level of controversial abstraction. Ideas, in fact, remain abstract until when one does live them or feel them as part of oneself. The ideas, although sublime and expressed in the best possible way, do not educate if they are not welcomed in the experience of our life.

Returning to the common anthropological point for dialogue, that is, the set of ultimate demands that define the structure of every human being. To discover it within our own experience we must, above all, seriously establish our human problem. For this reason we must first of all open ourselves to ourselves, that is, to give full account of our experiences and to look with sympathy at the human in us. We must take into consideration what we truly are. What does it mean to take seriously what we experience? It means to consider *everything*, to surprise *all* its aspects looking for *all* their meanings. Otherwise, we impose on the experience categories and explanations that block it presuming to solve it. For example, the myth of scientific progress that will one day resolve all our desires is the modern formula of this presumption. A violent presumption that does not consider our true desires and does not know what they are.

Numerous problems with bioethical nature reveal this reduction of man: the lack of awareness of the nature of his desire, of the structural disproportion between what he wants and what he can achieve with his own strength. The reduction of desires or censorship of some demands is the weapons of power. The dominant mentality that surrounds us produces in us strangeness with regard to ourselves. We are at the mercy of many reduced images of desire and we hope utopically that the solution to the human problem, which is the basis of the debates in Bioethics, comes from some rules.

In this way, the awareness of a common factor to all men is seen as an interesting path that can open the way in the search for certainties shared at all level (universitary or social). In this sense, we can understand why the solution to life's problems - and bioethical issues in particular - does not come about directly by addressing problems, but rather by deepening the nature of the subject that confronts them.

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RECENZII – BOOK REVIEWS

Medicii și Biserica vol. XIV: Valorile creștine ale educației pentru sănătate, volum coordonat de Prof. Dr. Mircea Gelu Buta, Editura Renașterea, Colecția Bioetica, Cluj-Napoca 2016, 778 p.

Binecuvântarea oferită de Înaltpreasfințitului Andrei, Arhiepiscopul Vadului, Feleacului și Clujului, Mitropolitul Clujului, Maramureșului și Sălajului pentru recentul volum, *vol. XIV,* al seriei *Medicii și Biserica*, vine cu un *Cuvânt de Învățătură* în care se justifică tematica aleasă prin sublinierea importanței educației religioase pe plan spiritual fără de care ființa umană ar fi infirmă, după cum se amintește a fi fost spus de filosoful Petre Țuțea.

Ca parte introductivă a acestui volum, în continuarea „Cuvântului de învățătură", Prof. Dr. Mircea Gelu Buta vine cu o scurtă prezentare „Spiritualitatea actului medical"; mai apoi este reprodusă alocuțiunea ÎPS Andrei Andreicuț cu ocazia înmânării distincției „Crucea Transilvaniei" D-lui Prof. Dr. Pavel Chirilă și răspunsul de mulțumire; însă este transcrisă și conferința „Abgar, primul om vindecat prin imagine" susținută de Acad. Sorin Dumitrescu. „Spiritualitatea actului medical" aduce în discuție dificultatea medicilor de a oferi tratamente eficiente acelor boli care, teologic vorbind, își au originea în „căderea în păcat", fapt pentru care rândurile următoare aduc în prim plan necesitatea unei atenții sporite față de partea biopsiho-socială și spirituală a vindecării. În medicina actuală, secularizată, este resimțită nevoia însoțirii tăcute a celui aflat în suferință, după cum prietenii lui Iov au fost părtași la suferința acestuia timp de șapte zile fără a-i adresa vreun cuvânt. Acad. Sorin Dumitrescu vorbește despre vindecarea prin imaginea iconică ca putere delegată. În acest context apare istoria regelui Abgar al Edessei care, suferind de ciumă și având convingerea vindecării sale prin vederea chipului lui Hristos, îi încredințează unui slujitor al său misiunea de a desena chipul Mântuitorului. La răspunsul deznădăjduit al celui care încerca, fără izbândă, să-L deseneze, Hristos își lipește fața de o năframă pe care rămâne imprimat Chipul Său. Astfel se naște această imagine vindecătoare, nefăcută de mână omenească - *Acheiropoietos*, a Mântuitorului ce va traversa veacurilor servind drept model tuturor reprezentărilor iconice ulterioare. Trecând de la incursiunea privind reprezentarea vindecătoare chipului Mântuitorului, se află cele șase secțiuni ale publicației care abordează următoarele tematici: „Valoarea spirituală în alimentație", „Educația terapeutică a pacienților", „Educația pentru sănătate în școli", „Nevoia de consiliere psihologică și/sau spirituală în actul medical", „Secțiunea de artă sacră: suferință, jertfă și pătimire – ipostaze plastice și iconografice ale artei creștine", iar ultima abordează tema „Religia în școli".

Cea dintâi secțiune menționată, „Valoarea spirituală în alimentație”, aduce în atenție problema alimentației în contextul consumerismului actual în cadrul unei piețe pline de reale pericole prin metodele de producere și procesare a hranei. Tematica este deschisă prin articolul Prof. Univ. Dr. Dan L. Dumitrașcu care discută despre importanța alegerii unei alimentații sănătoase și echilibrate în menținerea sănătății, prezentând, totodată o serie de tipuri de alimentație restrictivă pentru care nu au fost derulate cercetări științifice în care să fie dovedită eficiența lor. Iar, aici s-ar găsi un rol educativ important Bisericii determinarea individului de a adopta unui stil de alimentație sănătos. Și mai mult decât atât, părinții să nu-și supună copiii la un stil alimentar lipsită de diversitatea necesară a nutrienților. Pe lângă pericolul unei diete stricte, în centrul atenției sunt aduse, prin articolul următor, tulburările de comportament alimentar: anorexia și bulimia. Aceste două probleme își au originea în ceea ce, spiritual vorbind, se cheamă *filautie* (iubirea de sine). Astfel, în acest context, colaborarea preot-psiholog poate, conform terapeuticii duhovnicești specifice ortodoxiei, contribui semnificativ la vindecarea acestor tulburări prin succesiunea unor etape ce împletesc consilierea, mărturisirea, rugăciunea și răbdarea și a căror încheiere are loc doar în momentul în care pacientul ajunge la o înțelegere corectă a iubirii de sine. Suportul social oferit prin frecventarea bisericii poate aduce o reechilibrare persoanelor singure aflate în momentele dificile asociate cu tulburări de comportament alimentar. În strânsă relație cu tulburările de regim alimentar se aflâ o altă problemă pregnantă a societății contemporane: consumerismul. Câteva din studiile acestei secțiuni relevă faptul că deși modul de viață al acestor zile impune consumul semipreparatelor și utilizarea intensivă a cuptorului cu microunde, analiza ultimelor decenii evidențiază un interes crescând pentru alimentația sănătoasă. Iar efectele acestui tip de alimentație sunt corelate cu beneficiile socializării – ale unei mese luate împreună cu familia, prietenii sau colegii. Și, pe lângă rolul pe care Biserica îl poate avea în oferirea unui suport adecvat astfel încât individul să aleagă o alimentație sănătoasă, ea ar mai avea capacitatea și, totodată, datoria de a trage un semnal de alarmă autorităților privind posibilele efecte ale unei alimentații slab nutritive sau modificate genetic, a căror efecte negative s-ar putea observa și la două sau trei generații după. Asta, dacă este să se ia în considerare faptul că efectele foametei olandeze din anii 1944-1945, pe lângă decesele survenite la acel moment, au putut fi observate și la nepoții femeilor gravide din acea perioadă.

Următoarea secțiune, „Educația terapeutică a pacienților”, este axată pe subiecte ce aduc în atenție necesitatea educației pacienților în vederea ameliorării relației medic-pacient și, finalmente, a calitățile serviciilor medicale oferite prin o mai bună corespondență cu expectanțele acestora. Se discută, însă, și despre nevoia oferirii unei educații terapeutice pacienților implicate în comportamente periculoase: masochism, abuz/dependență de alcool și/sau alte droguri. Aceste două problematici legate de stilul de viață al individului impun o metodologie specifică de identificare, evaluare și terapie. Astfel, în cazul masochismului, probabil născut în urma abuzurilor suferite în copilărie sau a experiențelor traumatice datorate tensiunilor de autoritate din sânul familiei parentale, individul trebuie să urmeze terapii prin care să ajungă a fi capabil să înțeleagă consecințele comportamentului deviant, să simtă rușinea specifică, să ajungă a crea o conexiune între acest comportament și un eveniment neplăcut pe care să încerce a-l evita. În schimb, în cazul abuzului sau dependenței de alcool/droguri, accentul este pus pe ședințele de consiliere. Mai întâi este efectuat un screening prin utilizarea diferitelor teste ce evidențiază existența unei astfel de probleme în viața pacientului, fiind, apoi, necesară efectuarea unei evaluări care să evidențieze gravitatea problemei. Pe baza datelor obținute, pot fi făcute recomandări specifice privind forma pe care ar trebui să o ia terapia. Totodată, dacă este necesar, sunt efectuate și unele intervenții prompte precum în cazul deciziei de internare la secția de dezintoxicare sau direcționarea pacientului spre un centru rezidențial specializat, pentru cazul în care intervențiile în ambulatoriu ar rămas fără rezultate. Însă, desigur, munca nu este încheiată la această fază, fiind necesară monitorizarea pe o perioadă mai lungă de timp dat fiind faptul că „schimbarea comportamentului este un proces care implică și procedeul încercare-eroare.” (p. 213) Cu toate acestea, educația terapeutică nu se limitează doar la pacienții cu devieri comportamentale, ci, conform definiției date de Organizația Mondială a Sănătății, aceasta „este destinată a ajuta pacienții să dobândească sau să mențină abilitățile de care au nevoie pentru a gestiona optim o boală a lor” (p. 183), fapt ce este de asemenea atins în lucrările acestui capitol.

Cea de-a treia secțiune a volumului, „Educația pentru sănătate în școli” aduce în discuție, prin articolele sale, derularea unor acțiuni cu un scop oarecum analogic educației terapeutice, însă, în acest context, în obiectiv sunt luați copiii și adolescenții. Astfel, interesul educației pentru sănătate este mai mult de a forma comportamente de viață sănătoase în rândul minorilor și de a-i învăța elemente de profilaxie specifice. Iar când vorbim de profilaxie, este imperios a aminti programele de vaccinare implementate prin strânsa colaborare cu instituțiile de învățământ. Cu toate că se regăsesc unele probleme majore ale implementării Calendarului Național de Vaccinare a populației din România, precum lipsa unei producții autohtone de vaccinuri, conform statisticilor derulate, vaccinarea, alături de folosirea antibioticelor, se consideră ca fiind principala cauză a creșterii populației pe glob după 1945 prin eficiența în lupta cu boala. Alte două aspecte abordate de articolele acestei secțiuni sunt rolul iubirii în educarea copiilor, cât și rolul spiritualității sau al religiei în determinarea atitudinii și comportamentului sexual la adolescenți. În ceea ce privește educația copiilor, se poate observa, conform studiului realizat de Prof. Dr. Hadrian V. Conțiu, faptul că aceștia *învață ceea ce trăiesc și trăiesc ceea ce învață*. Or, iubirea precede formarea și disciplinarea, un copil iubit fiind, prin iubire, cu mult mai ușor de disciplinat. De aceea criza creată între generații prin sustragerea implicării propriu-zise a părintelui în viața copilului poate fi remediată doar prin urmarea cuvintelor părinților Bisericii care văd necesitatea asumării prin iubire a fenomenului educațional și de a urma exemplul lui Hristos. Apoi, strânsa legătură a adolescentului și a părinților săi cu Biserica și viața religioasă, creează un cadru ce îi este acestuia un ghid în dezvoltarea unui comportament orientat spre sănătate fizică și psihică, înfrânându-l în dezvoltarea unei atitudini și a unui comportament sexual ce contravine scalei valorice urmate și promovate în comunitatea religioasă de apartenență.

Secțiunea ce are ca temă „Nevoia de consiliere psihologică și/sau spirituală în actul medical” este focusată asupra unor problematici precum cele specifice consumului de alcool/droguri, tendințelor suicidare sau altor situații grupate în arealul psihiatric și a posibilelor terapii asociate. Astfel, Conf. Dr. Ion Copoeru face o scurtă expunere a fundamentului cercetărilor recent desfășurate la Cluj-Napoca în cadrul unui proiect european ce aveau ca obiectiv dezvoltarea unor activități inovative de învățare în sprijinul adulților aflați în recuperare din adicție. Ideea de bază a articolului este faptul că „adicția relevă modul de raportare al individului la lume, iar recuperarea, reconectarea lui cu lumea" (p. 310). În acest context, adicția apare ca un fenomen cultural al unui stil de viață fundamental diferit în întreaga complexitate a sa: blocat în lumea trăită, individul este rupt de realitatea cotidiană, erodându-i-se chiar capacitatea de a se reconecta la aceasta. Apoi, pe lângă lucrarea ce face o scurtă prezentare a marilor teorii morale cu relevanță în bioetică și cel care prezintă valențele spirituale ale terapiei prin artă, majoritatea articolelor acestei secțiuni încearcă să aducă în atenție potențialul consilierii religioase și al citirii problemelor pacientului din prisma relației acestora cu religia/teologia creștin-ortodoxă. Iar doamna asistent social Nicoleta Amariei merge, în articolul său, până la a sugera o serie de acțiuni și activități derulate în cadrul bisericii ce ar putea avea o contribuție semnificativă în sprijinul persoanelor cu abuz și/sau dependență. Printre sugestiile enumerate se regăsesc: oferirea de pliante, lipirea de afișe specifice pe ușa bisericii și la avizier, însă chiar și introducerea unor tematici de predică ce relevă consecințele băutului și a altor comportamente nocive înscrise în această sferă, venind, în același timp, cu câteva cuvinte de încurajare pentru cel prins în această luptă. Observând propunerile doamnei Amariei, devine evident rolul pe care îl poate juca Biserica, prin însăși specificul activităților religioase, în consolidarea eforturilor depuse de consilier și personalul medical în procesul de vindecare.

Cât despre cea de-a cincea secțiune, „Secțiunea de artă sacră: suferință, jertfă și pătimire – ipostaze plastice și iconografice ale artei creștine" conexiunea acesteia cu actul medical se pierde puțin în mirajul esteticii iconografice al martiriului. Totuși, reprezentarea suferinței în icoana ortodoxă ar puterea face mai vizibile frânturi din trăirile umane ale traumei.

Dacă cea de-a treia secțiune aducea în atenție valențele parteneriatului dintre clerici și laici în dezvoltarea unor programe de educație pentru sănătate prin introducerea unei perspective moral-creștine, ultima secțiune „Religia în școli" duce și mai mult accentul asupra necesității unei educații în care predarea valorilor creștine să-și primească considerația cuvenită. Pe lângă faptul că istoria și valorile perene ale poporului român, după cum afirmă Pr. Dr. Mihai-Iulian Necula, nu ar putea fi niciodată pe deplin înțelese în lipsa oricărei cunoștințe privind valorile religioase, introducerea religiei în curricula școlară a fundamentat inițierea unor piste de cercetare prin acceptarea relației spiritualității cu științele medicale. Astfel, chiar dacă din perspectiva medicului nu pot fi complet elucidate și cuantificate efectele credinței și ale rugăciunii, beneficiile acestora ca adjuvante nu pot fi trecute cu vederea: chiar dacă un pacient nu primește răspunsul dorit la rugăciune prin mult-așteptata vindecare, survine de multe ori o transformare de ordin moral, iar pacientul, în multe cazuri, face față cu mult mai bine dificultăților impuse de boală.

Tematica acestui volum reușește să creeze o rețea puternică între educație, religia creștină și medicină. În acest context, accentul este pus pe evidențierea valențelor pozitive pe care le poate avea introducerea programelor educaționale ce să promoveze valori creștine în dezvoltarea unor atitudini și comportamente sănătoase, cât și orientare vădită spre profilaxie. Astfel, lectura acestui volum reușește, prin actualitatea temelor abordate, să ofere cititorului o imagine suficient de clară asupra rolului pe care îl poate juca Biserica, prin valorile și modelele promovate, în ameliorarea acțiunilor sociale orientate spre menținerea și îmbunătățirea sănătății populației. Totodată, ni se relevă faptul că în absența oricărei conexiuni cu valorile creștine, individul, lipsit de o motivație puternică, ușor va putea cădea pradă comportamentelor și atitudinilor nocive (atât pentru el, cât și pentru comunitatea din care face parte). Iar, aici, putem vorbi despre abuz/dependență de alcool sau droguri, însă și despre comportamente sexuale deviante sau despre tendințe suicidare – cazuri în care Biserica poate, de asemenea, aduce contribuții semnificative în procesul de recuperare.

Iulia Andreea SOMEȘAN

STUDIA UBB BIOETHICA, LXI, 1-2, 2016 (p.133-134)
(RECOMMENDED CITATION)

DIN ACTIVITĂŢILE CENTRULUI DE BIOETICĂ

- Seminarul anual de la Bistriţa, *Medicină și Teologie,* ediţia a XV-a, a avut loc în acest an în zilele de 9 şi 10 Mai 2016, în saloanele Hotelului Metropolis, fiind organizat de Arhiepiscopia Ortodoxă Română a Vadului, Feleacului şi Clujului, Facultatea de Teologie Ortodoxă a Universităţii Babeş-Bolyai din Cluj-Napoca, Consiliul Judeţean Bistriţa-Năsăud prin Centrul Judeţean pentru Cultură, Biblioteca Judeţeană Bistriţa-Năsăsud împreună cu Societatea Română de Bioetică, Uniunea Medicală Balcanică din România, Asociaţia Medicală Română - Filiala Bistriţa-Năsăud și Spitalul Judeţean de Urgenţă Bistriţa. Tema generală a seminarului a fost: „Tendințe și politici demografice ale României într-o Europă unită” și „Tendința în arta creştină europeană a secolului al XX-lea. Redescoperirea icoanei”.
- A doua zi, după un Te Deum oficiat de Mitropolitul Andrei, s-au continuat discuțiile cu privire la conferinţele „Minorităţi şi majorităţi în Transilvania, din Evul Mediu până în zilele noastre” – susținută de Acad. Prof. Dr. Ioan Aurel Pop; „Antropologia integrală: chestiunea genurilor şi viaţa” susținută de Pr. Prof. Dr. Ioan Chirilă și „Creştinism accesibil şi creştinism iconic” susținută de acad. Sorin Dumitrescu.
- Ideea organizatorului acestui eveniment amplu, prof. Mircea Gelu Buta, directorul Spitalului Judeţean de Urgenţă, este aceea de a trata pacientul ca întreg, atât din perspectivă sufletească-duhovnicească-teologică, cât şi din cea medicală propriu-zisă, temele abordate fiind teme importante ale societăţii noastre.
- În holul Hotelului Metropolis a putut fi admirată și expoziția de icoane pe sticlă, a studenţilor şi masteranzilor Facultăţii de Teologie Ortodoxă din Cluj-Napoca.
- În data de 21 mai 2016 a avut loc primul Simpozion de bioetică medicală, organizat de Disciplina de Abilități-Științe Umaniste și Istoria Medicinii a Universității de Medicină și Farmacie Iuliu Hațieganu din Cluj-Napoca și de Centrul de Bioetică al Universității Babeș-Bolyai, împreună cu Cercul de Bioetică și cu Asociația Studenților pentru Etică Medicală din Cluj. Agenda Simpozionului a cuprins prezentări pornind de la aspecte etice în cercetare și publicare până la aspecte morale și deontologice întâlnite în practica medicală de zi cu zi. Astfel, simpozionul a cuprins trei secțiuni: etica în cercetarea științifică, etica medicală și etica clinică. Etica în

cercetarea științifică s-a bucurat de prezența a doi invitați: Marius Farcaș și Andrada Urdă de la UMF Cluj, care au prezentat aspecte legate de Conduita greșită în cercetare (Scientific Misconduct) și cele de țin de autorat (Authorship. Peer Review). Secțiunea de etică medicală a cuprins temele: confidențialitatea datelor pacienților și realizarea consimțământului informat, fiind invitați David Domițian Bolduț, de la Facultatea de Drept, UBB Cluj și Maria Aluaș, UMF Cluj. La secțiunea etica clinică s-au trecut în revistă teme precum: Direcții de abordare a Bioeticii în Republica Moldova, tema fiind prezentată de Ludmila Rubanovici de la UMF Chișinău; Teme etice în psihiatria infantilă, prezentate de Bianca Săndica Andreica, UMF Cluj; Aspecte etice în chirurgia pediatrică, prezentate de Voicu-Mihai Negrea, UMF Cluj; tema spunerii adevărului pacientului, prezentată de Cristian Costea, medic rezident la Institutul Regional de Gastroenterologie și Hepatologie „Prof. Dr. Octavian Fodor”, Cluj-Napoca; tema dreptului pacientului de a refuza tratamentele, prezentată de Maria Raika, studentă în anul VI, UMF Cluj. Evenimentul a fost destinat, în general, studențiilor clujeni și, de asemenea, și medicilor rezidenți, specialiști și primari care se confruntă cu astfel de aspecte în practica medicală curentă.

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