STUDIA UNIVERSITATIS
BABEŞ-BOLYAI

BIOETHICA

1-2/2018

STUDIA
UNIVERSITATIS BABEŞ-BOLYAI
BIOETHICA

1-2/2018

EDITORIAL BOARD OF
STUDIA UNIVERSITATIS BABEŞ-BOLYAI BIOETHICA

EDITORIAL OFFICE: 68th Avram Iancu Str., Cluj-Napoca, Romania, Phone: +40 264 405300,
centruldebioetica@yahoo.com, http://studia.ubbcluj.ro/serii/bioethica/index_en.html

YEAR **Volume 63 (LXIII) 2018**
MONTH **DECEMBER**
ISSUE **1-2**

S T U D I A
UNIVERSITATIS BABEŞ-BOLYAI
BIOETHICA

1-2

STUDIA UBB EDITORIAL OFFICE: B.P. Hasdeu no. 51, 400371 Cluj-Napoca, Romania,
Phone + 40 264 405352

CUPRINS – CONTENT – SOMMAIRE – INHALT

EDITORIAL

I. STUDII

II. INTERVIU - INTERVIEW

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 5-8)
(RECOMMENDED CITATION)

Editorial:

ETHICAL JUSTIFICATION OF BIOMEDICAL RESEARCH

MARIA ALUAŞ

What is biomedical research and why biomedical research concern all us? Before starting to talk about contemporary ethical concern regarding biomedical research, let's define the concepts. According to the Stedman's Medical Dictionary[1], "research" refers to the "organized quest for new knowledge and better understanding, the natural world or determinants of health and disease".

Biomedical research or experimental medicine is an applied research with the purpose to increase medical knowledge. Medical research has two arm: *preclinical* research and *clinical* research. *Preclinical* research aims to generate a better understanding of diseases and new strategies for treatments, *clinical* research evealuates new treatments for safety and efficacity[2].

This kind of research generated many ethical concerns and critics from its very beginnings as a method, because participants in this research were enrolled in fraudulent ways wuthout telling them the whole truth about what will happen to them during the research phases.

The main question focus in our editorial is on the difference between medical practice and research. Robert J. Levine[3] (2008) discusses several ways in which the two fields conflict. He mentions a list of conflicts between Medical

---

[1] Stendman's Medical Dictionary for the Health Professions and Nursing. 7th Edition. Wolters Kluwer Health, Lippincott Williams & Wilkins, 2012, p. 1450.

[2] J. Pierce, G. Randels, *Biomedical Research*, in "Contemporary Bioethics", Oxford University Press, 2010, pp. 487-506.

[3] R. L. Levine, *The Nature, Scope, and Justification of Clinical Research*, in "The Oxford Textbook of Clinical Research Ethics", Oxford University Press, 2008, pp. 211-222.

Practice and Research. Thus, the practice of medicine is not scientifically based, the physicians practice model is the authority; the researcher practice is to learn and to tell the truth. In the tradition of medicine, the physician does not tell the truth to the patient about diagnosis or prognosis, unless he/she is certain that this is good for the patient. The physician should keep the confidentiality of what the patient told him/her. Instead, the researcher's motivation is to publish findings of their research. The physician treats the patient, the researcher should respect the protocol and the randomized controlled study. The researcher enrolls the participant in the study only after the participant gave the Informed Consent. In the medical practice, there are some situations when the physician should treat the patient even without Informed Consent (i.e. emergencies).

We consider that the researcher has always a hypothesis of the research, he/she is looking to confirm or not this hypothesis, but the physician does not have a hypothesis. He/she always should listen and talk to every patient without presumptions or hypothesis. In the end, we can see a difference between the Institutional Review Board (IRB) in research and in medical practice: the approval of the IRB in a clinical study is always mandatory, but in the medical practice, the ethics committee or ethics consultant's opinion is not mandatory, having only a role to orientate the physician.

Both, the participant in the biomedical research and the patient should be informed about the meaning and the pourpose of their participation or treatment, they should understand exactly what kind of treatments they are doing and also they should agree with the treatment or the reseach freely. But, both medical practice and biomedical research still face many issues and concerns and we are far from finding a good solution for everyone interested in these fields.

This issue of Studia Universitatis Babeş-Bolyai – Bioethica cover topics both from medical practice and research and all articles are focused on developing new idea, understandings and realities. Our conclusion is that we need to find more professionals from the biomedical field interested on ethics and how to manage ethically their everyday practice.

Bibliography:

Stendman's Medical Dictionary for the Health Professions and Nursing. 7th Edition. Wolters Kluwer Health, Lippincott Williams & Wilkins, 2012, p. 1450.

J. Pierce, G. Randels, *Biomedical Research*, in "Contemporary Bioethics", Oxford University Press, 2010, pp. 487-506.

R. L. Levine, *The Nature, Scope, and Justification of Clinical Research*, in "The Oxford Textbook of Clinical Research Ethics", Oxford University Press, 2008, pp. 211-222.

I. STUDII

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 11-25)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.01

ETHICAL AND SOCIAL ISSUES RELATED TO STUDENTS' ACCESS TO HEALTHY FOOD IN THE UNIVERSITY CAMPUS. A THEORETICAL APPROACH

LAVINIA-MARIA POP[1], MAGDALENA IORGA[2*], BEATRICE-GABRIELA IOAN[3]

ABSTRACT. University years represent a critical period in terms of establishing eating patterns and adapting to a new environment. The largest gain in weight occurs at age 18-29 and can have negative consequences on students` health status. The access of students to a healthy diet represents an ethical and social problem little studied in our country. The present paper wanted to examine the main causes that can lead to unhealthy patterns among students. The theoretic analysis showed that nutritional education, knowledge about food, health beliefs, academic schedule, campus food environment, financial incomes and meals' costs - all these factors can have positive or negative influences on students' eating habits. In addition, international students represent a more vulnerable population and one of the main sources of stress of acculturation among international students is represented by the type of food from hosting culture. Given the above, universities must take an attitude and contribute to the development of a healthy university food environment. Implementation of dietary programs to improve the nutritional health of students will inform the student who will be more aware of the consequences of unhealthy foods, poor in vegetables and fruits on mental and physical health, later in life. In conclusion, there are many factors that affect the eating habits among students, It is really useful to know about these factors in order to provide effective education and nutritional care so university must offer equal access to healthy food to all of its students.

Keywords*: student, nutrition, ethics, university, health, vulnerability, dietary habits, international students*

[1] Master's degree student, Nutrition and Dietetics Department, Faculty of Medicine, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania

[2] Associate Professor, PhD, Department of Behavioral Sciences, Faculty of Medicine, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania

[3] Professor, PhD, MD, Faculty of Medicine, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania

* Corresponding author: Magdalena Iorga, PhD, Universitatii 16, 700160, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania, +40722800936

REZUMAT. Probleme etice şi sociale privind accesul studenţilor la alimentele sănătoase în campusurile universitare. O abordare teoretică. Anii universitari reprezintă o perioadă critică în ceea ce priveşte stabilirea tiparelor alimentare şi adaptarea la un nou mediu. Cel mai mare câştig în greutate apare la vârste cuprinde între 18-29 de ani şi poate avea consecinţe negative asupra stării de sănătate a studenţilor. Accesul studenţilor la o dietă sănătoasă reprezintă o problemă etică şi social, puţin studiată în ţara noastră. Din acest punct de vedere, această lucrare a dorit să examineze principalele cauze care pot duce la tipare nesănătoase în rândul studenţilor. Analiza descrisă în acest articol arată că educaţia nutriţională, cunoştinţele despre alimente, credinţele în sănătate, programul academic, mediul alimentar din campus, veniturile financiare şi costurile meselor - toţi aceşti factori pot avea influenţe pozitive sau negative asupra obiceiurilor alimentare. Studenţii internaţionali reprezintă o populaţie şi mai vulnerabilă, iar una dintre principalele surse de stres aculturativ în rândul studenţilor internaţionali este reprezentată de tipul de mâncare din ţara gazdă. Universităţile trebuie să ia atitudine şi să contribuie la dezvoltarea unui mediu alimentar universitar sănătos. Implementarea programelor alimentare pentru îmbunătăţirea sănătăţii nutriţionale a studenţilor vor contribui la informarea studentului care va fi mai conştient de consecinţele alimentelor nesănătoase, sărace în legume şi fructe, asupra sănătăţii mintale şi fizice, ulterior în viaţă. În concluzie, există mulţi factori care afectează obiceiurile alimentare în rândul studenţilor şi este foarte util să cunoaştem aceşti factori pentru a oferi studenţilor educaţie şi îngrijire nutriţională eficientă iar universităţile să faciliteze accesul egal al studenţilor la o mâncare sănătoasă.

***Cuvinte cheie**: student, nutriţie, etică, universitate, sănătate, vulnerabilitate, tabieturi alimentare, studenţi internaţionali*

Introduction

Nutrition plays a very important role in the healthy development of children and youths and it is one of the most important aspects of a lifestyle *(Barzegari et al., 2011).* Eating patterns of university students became a subject of interest because the largest gain in weight occurs at age 18-29 and university years is a critical period in terms of weight gain *(Yu & Tan., 2016)*. At the same time, students need to adapt to a new environment that is often away from home and when they fail to adapt properly, this fact can have negative consequences for their health and subsequent weight status *(Deliens et al., 2014)*. It was found that exists even greater risk for weight gain for people aged

18 to 29 years with some college education, considering that obesity rates rose from 10.6% to 17.8% between 1991 and 1997 in this population (*Mokdad et al., 1999*). Also, many types of research show that eating patterns established during university years will transform into behaviors and these behaviors will shape the future related to the health of a student *(Steptoe et al., 1990–2000; Von Bothmer & Fridlun, 2005).*

Many studies show that students do not comply with healthy eating recommendations as outlined in the dietary guidelines. This fact is probably due to the typical sedentary lifestyle of these young adults and frequently, the sedentary hours are spent in front of a television or a computer (*Gallè et al., 2019*). At the same time, due to the lack of parental influence or parental control, students might have a faster and more practical diet characterized by a high amount of processed foods, rich in fat and calories and a large consumption of salt and alcohol.

Additionally, students' diet is low in vitamins, nutrients, and antioxidants because they consume too little fruits, vegetables, legumes and grains which often can lead to nutritional imbalances *(Monteiro et al., 2019).* Not to mention that students do not follow the physical activity recommendations of the World Health Organization (WHO), registering differences according to gender meaning that women can often have a normal weight but practice less sport than men (*Gallè et al., 2019*). Therefore, starting to the fact that healthy habits are essential to prevent diseases in adult life, it is important to know the main causes that can lead to unhealthy patterns among students.

Nutritional education, knowledge about food, health beliefs and gender differences

Maternal education, family-related habits to nutrition and parental income have a greater impact on dietary patterns of a young adult among which is the practice of skipping breakfast (more common among females than males). A study carried out in Southern Nigeria found that there is a significant association between the levels of education of students' parents and food diversity of students meaning that students whose parents had a tertiary level of education had a highest dietary diversity compared with respondents whose parents had a primary level of education. Also, it seemed that the proportion of overweight or obesity was higher among students whose fathers had a tertiary level of education *(Omage & Omuemu, 2019).*

From the perspective of a nutritionist, nutrition knowledge represents knowledge of nutrients and nutrition (a quantitative science). Consumers seem

to be aware that nutrition includes even more than simply information about nutrients. It is about food safety, food additives, effects of vitamins on skin, ways to lose weight or even to prevent cancer and the list can continue. What is more important for a consumer to know is the energy content of food, the source of vitamins and minerals and the roles of fat, proteins, and carbohydrates.

It is also good to know that the knowledge of nutrition principles can influence or even change food behavior (term which can include many types of behavior) *(Worsley, 2002).* Young adults often do not possess the necessary experience and knowledge to make adequate decisions related to healthy food or about weight-control practices and tend to develop unhealthy habits such as skipping breakfast (more common among girls who lived away from home), increasing consume of snack food which can even replace regular meals (more prevalent in smoking students than other students) or increasing intake of soft drinks (*Neslişah & Emine, 2011*).

And yet is surprising the fact that recent studies from United States (11), Europe (4), Australia (4), New Zealand (2), Africa (1), Asia (1), and the Middle East (1) show us that some faculties are not devoted to the nutrition, do not have extensive nutrition programs and in this way medical students are not well trained in nutrition and could have difficulties in counsel patients on healthy eating (*Abbasi, 2019*). Other scientists reveal that a single course on nutrition was effective in improving the nutritional knowledge of students who are in their final year of college and this fact is very important because in order to be able to understand and apply the recommendations of dietary guidelines certain nutritional knowledge is required. A study realized in Canada found that students who took a nutrition course consumed less fat than those without nutritional education so that the impact of nutritional education on fat consumption is important (*Mazier and McLeod, 2007)*.

In another study was found that gender is a factor that influences the nutritional attitudes in the meaning that female students have better nutritional attitudes than male students. Consequently, those women will not tend to skip breakfast so frequently, will not consume so many alcohol and soft drinks and will eat more fruits and vegetables (*Wong et al., 1999*). Gender differences are discovered when it comes to food choices meaning that women seemed to pay attention to label information or healthiness of their choice and men seemed to be very little interested and implicated in food decisions *(Levi et al., 2006*). Also, another issue related to reading the food label was discovered in a study among 553 Canadian students aged 18-34 years. It seems that this group of the population considers nutrition less important than age older groups and perhaps students use food labels less frequently than the average Canadian adult. Those who read the food label pay more attention to the nutrition information panel than to the

nutrient claims or ingredient list. However, this study indicates that university students, who are in general more educated than the rest of the population, are more likely to use food labels than those without education *(Smith et al., 2000).*

Academic schedule and perceived lack of time

Time turned out to be a very valuable issue when it comes to students' food practices so they claimed that they would rather spend their time doing other activities than cooking, especially when they must cook only for themselves (*Deliens et al., 2014*). Being so tight with a busy academic and social schedule, a student gets very difficult even to find time to go to the market and to purchase the food items and ingredients, not to mention about finding time to prepare and cook a good meal *(Omage & Omuemu, 2019).*

A study conducted among freshmen students by multiple methods (first - keeping an audio diary for two weeks, second – keeping a daily written journal for the same period, and third – using focus group discussions) revealed that these students are implicated in many activities like coursework, extracurricular activities, part-time jobs, organizational memberships and so on and as a consequence that struggle with time management hindered these students to maintain healthy eating habits. Moreover, some participants of this study claimed that not just once happened to forget to eat or to miss their meal plan hours because of their back-to-back class schedules *(Childers et al., 2011).*

A study carried out among medical students in Saudi Arabia highlights that the busy schedule of these students affects their eating habits meaning that during the period exams students wanted to spare as much time as possible studying and this made it difficult for them to comply with a healthy meal schedule. Consequences are related through an improper intake of healthy foods or simply by choosing unhealthy foods (*AlJaber et al., 2019*). The problem of a busy schedule which did not give time to the student to eat healthy foods or to cook so they ate instead convenience food was mentioned in another study (*Alakaam et al., 2015*).

However, students` control of a chaotic schedule became a major problem for them, very difficult to tackle. It seemed that dining halls hours are often missed by the students because these are not placed at a convenient time for them. Offering different solutions such as changing dining hall hours or 24-hour dining halls, could solve the problem, but this involves costs from all points of view. Also, excessive alcohol drinking, late-night eating, and increased sleeping

the following day are other problems mentioned which are associated with the students` schedule *(Childers et al., 2011).*

Living in campus – access to unhealthy food

Eating disorders are frequently diagnosed in adolescence and young adulthood - a stage in life associated with stressful events, such as leaving for college *(Yu & Tan, 2016).* Transition to an unfamiliar environment can be a critical moment when unhealthy weight problems can occur, problems mainly caused by changes in eating habits *(Childers et al., 2011).*

Besides the influence exerted by the students' university schedule on eating habits, it seems that these habits also depend on the food environment inside or near the university campus *(Gazibara et al., 2013)*. Willis and Buck *(2007)* defined the food environment as a collection of multiple factors among which the place where to get food, food prices, community characteristics, proximity to the restaurant, market availability and other factors that influence food choices and eating habits are mentioned.

The campus food environment can have both positive and negative effects on weight gain; this hypothesis is demonstrated by the fact that livelihood in student dorms that have a dining room improves the quality of men's diet, but promotes weight gain for women *(Horacek et al., 2013).* Regarding the students' attitudes towards the food services offered by the university canteens, these were generally positive; the students were satisfied with the food services in the canteens, but they think that the cooking methods should change, such that the food should be fried less, there should be more fresh vegetables and fruits and fewer recycled or even overcooked foods *(Liang, 1992).*

The literature shows that the quality of accommodation directly influences students' health and well-being; the students who lived in their own home, with their family members were the most satisfied with the accommodation (also having lower levels of stress, anxiety and depression) unlike to those who lived in rental accommodation or student hostels, who were least satisfied *(Yue, Lê, & Terry, 2014).*

Students living on the university campus tend to eat at irregular hours, make poor food choices (such as frequent fast-food consumption) and have an inadequate nutrient intake, but nonetheless, university canteens have been associated with positive effects on students' eating habits since they provide a student with all three main meals.

Unlike them, students living in apartments outside the university campus are required to purchase and prepare their own food, and this can be quite difficult for some of them if they do not receive the necessary guidance before leaving home and this is very important because more frequent food preparation is associated with lower fast-food consumption and increased consumption of fruits, vegetables, dairy products and whole grains *(Gresse et al., 2015).* Besides, the students who lived outside the university campus were worried that this could be dangerous for their safety considering delinquency`s and other potential dangers (especially if they were walking at night), while students living on campus felt that they save time and money and have easy access to campus facilities, such as libraries, canteens, transport, security and community *(Yue, Lê, & Terry, 2014).*

It has also been noted that student residence affects food intake and physical activity, students off campus having healthier diets than those students who live on campus *(Brevard and Ricketts, 1996).* This is probably explained by the fact that the students stored in their dorm rooms salty snacks, cereal or granola bars, desserts or candy sugar-sweetened beverages and items that had been purchased by parents for the students which are often richer in calories and fat content than items purchased by students themselves, estimating a number of approximately 23,000 calories per dorm room *(Nelson and Story, 2009).*

The snacks and drinks sold on the university campus create a food environment with limited healthy options. Likewise, the university campus offers a food environment with a number of commercial spaces, most of which are not in line with dietary recommendations for the prevention of obesity, having "healthy" foods of limited quality as well as convenience stores or fast food products *(Horacek et al., 2013).* Previous studies have found that large stores and chain stores are more likely to market healthy foods and also to offer foods at lower prices in contradistinction to smaller stores. As well, the increased availability of supermarket chains was associated with lower weight gain, while the availability of smaller grocery stores or convenience stores was likely to be associated with a higher risk of overweight *(Powell et al., 2007).* However, convenience plays a major role in the choice of food given the fact that students prefer food that is particularly convenient, easy and quick to cook. In addition, unavailability of foods that are seasonal may contribute to a lower intake frequency because you cannot consume food if it is not available *(Omage & Omuemu, 2019)*.

If we refer to the products traded in the campus or university vending machines, a study evaluated their content to determine the nutritional quality of the snacks and drinks sold. The results show that most snacks sold were salted snacks (chips, pretzels) and sweets (candy and candy bar), most of them

low in fiber, high in calories, fat and sugar (just about half), while the slots for beverage machines contained more sugar-sweetened drinks than non-calorie drinks, none of which mentioned not being rich in nutrients. Of all these machines, it seems that only within two institutions were sold both milk and 100% juice, the portion of snacks and drinks sold being on average over 200 cal. In conclusion, this study's findings suggest that vending machines provide limited healthful choices (*Byrd-Bredbenner et al., 2012*).

Students at risk. Financial incomes and meals' costs

Besides the factors mentioned above, food choices are also determined by the cost of food and, by implication, student incomes. Thus, the most expensive foods are often the least nutritious, which becomes a problem for students. Also, it is known that the food that requires the shortest time for preparation is unhealthy, which makes students with limited resources and little time to be slightly forced to eat unhealthily (*Reyes, 2010)*. Similarly, another study found that students living in dorm rooms reported missing meals due to insufficient funds, as well as significantly lower consumption of fruits, vegetables, and dairy products because of the same reason, leading to poor dietary practices *(Gresse et al., 2015).*

A Canadian study found that male students consumed more alcohol and more water and spent more money on campus for food *(Jackson et al., 2009).* From this point of view, poor eating behaviors tend to get crowded, because people who engage in poor eating behavior generally engage in other poor eating behaviors, such as increases in fast food consumption and lower physical activity (*Reyes, 2010)*. Also, the high intake of sweet snacks served by students with insufficient funds to buy healthy food alternatives indicates that many students follow a diet high in refined carbohydrates and low in fiber *(Gresse et al., 2015)*.

Studies show that hours spent on campus, weekly budget for food, maternal education, family income and not only have an impact on the eating behaviors of students (*Reyes, 2010).* Dietary diversity increases with the increase of the monthly allowance, being closely linked to accessibility: if the student has money it means that the respondent can afford healthy foods or varied food groups with some balanced nutrient content *(Omage & Omuemu, 2019)*. Another study found a relationship between financial resources and students' perception of nutritional balance, reporting that students who were primarily supported by family finances were less concerned about their income than those who were

supported by other sources, such as savings, own job, scholarships or financial loans *(Yue, Lê, & Terry, 2014).* The allowance seems an appropriate way for students to afford healthy foods with a balanced nutrient content, but it does not always seem to have the expected positive effects as students with a higher monthly allowance tend to skip breakfast and spend more money on frivolities, which can have adverse effects on their nutritional status *(Omage & Omuemu, 2019)*.

The data showed that most students would eat healthier if money and/or time were not factors affecting their food choice (*Reyes, 2010)*. Individuals expressed concern about the cost of food at the canteen and for some students, the lack of money was a reason that led them to bring food from home to college *(Tyrrell et al., 2015).* Finally, the data show that the price of healthy eating disproportionately affects working students and those in the lower middle class (*Reyes, 2010)*.

International students – a vulnerable population facing cultural, religious and food-related restrictions

Changing the cultural environment is one of the most traumatic events a person can face, most students experiencing different degrees of cultural shock *(Kim, 2001).* One of the main sources of stress of acculturation among international students is represented by the type of food from hosting culture. It was observed that for the migrant students, the food from the country of origin, through its familiarity, is soothing, nourishing and stabilizing, being able to alleviate stress and loneliness and transposing students in a place and at a time that made them feel in safety (*Brown et al., 2010*). Losing familiarity causes anxiety but serving meals in a group of friends and the comfort created by maintaining or making new ethnic connections can be a powerful antidote to culture shock *(Kim, 2001).*

International students represent a more vulnerable population facing healthy and tasty food issues in the host country. Specific meals which are sometimes difficult to find or prepare, ingredients needed to prepare a traditional meal could be missing from the hosting culture, climate differences may sometimes not facilitate access to ingredients, restaurants where traditional meals are served may be difficult to find - these are just a few of these problems. Moving to a new culture can have, in many cases, negative effects on diet and health, such as increased alcohol intake, altered dietary practices, and an increased

body mass index (*Edwards et al., 2010*). Brown *(2009)* found that the adverse reaction to local food is even greater as the original food culture differs more from the food available in the new culture.

A study conducted in the United States among international students found that the main foods that participants ate were associated with an American diet (generally meat, foods high in fat and sugar and poor in fresh fruits and vegetables). In their defense, students reported that fast and convenient food is cheaper, and this makes them consume more products of this kind (*Alakaam et al., 2015*).

Similar results were found in a study targeting the behavioral changes of Portuguese students enrolled at universities in London: Portuguese participants reported a significant decrease in weekly frequency of consumption of raw vegetables, fish, vegetable soup and red meat and an increase in the frequency of consumption of tasty snacks, fast food - this eating pattern was similar to the English students pattern`s *(Vilela et al., 2014).* Also, the taste of the food in the host country is another problem encountered by international students because it was less tasty compared to food consumed at home (*O'Sullivan & Amirabdollahian, 2016*).

Another research conducted in USA identified that migrant students noticed that traditional foods are different in the United States than in the country of origin: these foods are modified or processed (for example, these have too much salt and sugar) and it is difficult to find traditional food ingredients in most local stores from the United States (traditional grocery stores could only be found in big cities, two to three hours away). In addition, traditional foods are more expensive and of poor quality (*Alakaam et al., 2015*). In another study, the majority of the students considered that the local food is boring and tasteless, and this confirms the importance of the cultural distance in the degree of shock the migrant faces (*Brown et al., 2010*).

Students from the Middle East and Asia said meat and vegetables are at the same prices in the United States (which causes them to buy more meat products), while vegetables in the country of origin are cheaper than meat. Also, the unavailability of traditional food has led some students to ask parents to send traditional ingredients from their home country every couple of months, even if the shipment was expensive for their parents (*Alakaam et al., 2015*).

Culture and religion increase the level of stress regarding student's access to food and meals. Cultural habits and religious restrictions could cause a lot of distress among migrant students. Religious factors have a strong influence on international students` food selection because they can avoid certain types of meat, a good example in this case being Muslim students: due to the limited

access to Halal food (meaning foods that are allowed under Islamic guidelines) in the United States, these students consume less meat, eat less in restaurants and on campus. (*Alakaam et al., 2015, O'Sullivan & Amirabdollahian, 2016*).

On the other hand, religion can have a positive influence on international students, being a source of spiritual support that can help students overcome adjustment problems and better tolerate their situation. However, adaptation to the host country was very slow and not at all easy because the characteristics of the host country such as religion, language and many others are different from the country of origin of the students *(Mehdizadeh & Scott, 2005).*

University challenges to provide healthy food for students

Many studies mentioned above pointed out that students living in campus are more prone to consume unhealthy food. This means that universities are the main responsible stakeholder and must take attitude and promote and provide access to healthy nutrition of students. So, the triad inform-educate and provide healthy nutrition knowledge must be a main goal for university policy makers.

The development of a healthy food university environment could be done by implementing dietary programs to improve the nutritional health of students. A more informed students will be aware about the consequences of unhealthy food, poor in vegetables and fruits on psychological and physical health later in life. Especially for female students (more importance even for those being pregnant), for students suffering from chronic diseases and for maintaining a good health, a balanced diet is necessary.

Another strategy is bringing together local farmer's markets with food service companies on campus. Moreover, the university could collaborate with businesses in the area to provide its students with more flexible spending options for the meal plan, in which students could use the allocation of university food to local stores (*Alakaam et al., 2015*).

Another strategy could be to eliminate the availability of unhealthy foods even for short periods to increase sales of healthier products and reduce their prices. Food demonstrations supported by financial commitments from campus administrators or partnerships with corporate health organization sponsors can be effective in creating opportunities for students to taste a healthier choice *(Levi et al., 2006*). International students should be informed about healthy food choices and availability of healthy foods during their stay in a different cultural and food environment *(Perez-Cueto et al., 2009).*

Also, universities could offer packed lunches or lunches that promote healthy eating, which gives freshmen a good opportunity to try eating fresh fruit and vegetable smoothies.

Last but not least, health promoters, including student wellness centers and counseling services, need to make more efforts to help students critically analyze socio-cultural influences, including advertising, how to make healthier food selections, to resist the negative social pressures and to develop social support for healthy eating.

Also, students should be educated to analyze their own eating patterns, to set realistic goals for changes in their eating behaviors, being monitored at the same time by qualified staff *(Levi et al., 2006*). Besides education, providing quality exercise facilities and proximity of the grocery store with complete services can have a beneficial effect on the students' health *(Childers et al., 2011).*

Students associations must be encouraged by the university staff to organize and promote campaigns for educate students to eat healthier.

Conclusions

Student population represents an important point of interest because they constitute a large population of developing adults who are expected to play influential roles in society as teachers or policy makers. The transition to another environment is likely to change eating behaviors *(Tanton et al., 2015).* What causes students to eat unhealthily is not only the choice of food, but there are structural forces that make it difficult for students to consume healthy foods and the main barriers felt by students are time and money. Besides these, there are many factors that affect the eating habits among students, among which: the differences of social class, the cost of food, the knowledge of food, the time of food preparation, the family structure, culture and so on, some of these factors can even be multiplied, considering lives of many students (*Reyes, 2010).*

It is really useful to know about food choices and preferences, as well as the factors that influence students' eating habits in order to provide effective education and nutritional care by promoting healthy eating, a high-fiber diet, whole grains, dairy products and foods with a low energy consumption (*Alakaam et al., 2015; Gazibara et al., 2013)*. Also, there is a growing demand for global health strategies that would encourage the body's image and healthy figure, initiatives that should mobilize society at national and international levels (*Gazibara et al., 2013)*.

References:

Abbasi, J. (2019). Medical Students Around the World Poorly Trained in Nutrition. *JAMA*.

Alakaam, A. A., Castellanos, D. C., Bodzio, J., & Harrison, L. (2015). The factors that influence dietary habits among international students in the United States. *Journal of International Students*, *5*(2), 104-120.

AlJaber, M. I., Alwehaibi, A. I., Algaeed, H. A., Arafah, A. M., & Binsebayel, O. A. (2019). Effect of academic stressors on eating habits among medical students in Riyadh, Saudi Arabia. *Journal of family medicine and primary care*, *8*(2), 390.

Barzegari, A., Ebrahimi, M., Azizi, M., & Ranjbar, K. (2011). A study of nutrition knowledge, attitudes and food habits of college students. *World Applied Sciences Journal*, *15*(7), 1012-1017.

Brevard, Patricia B and Crystal D. Ricketts. 1996. Residence of College Student Affects Dietary

Brown, L. (2009). The role of food in the adjustment journey of international students. In A. Lindgreenand M. Hingley (eds) The New Cultures of Food: Marketing Opportunities from Ethnic, Religious andCultural Diversity. London: Gower

Brown, L., Edwards, J., & Hartwell, H. (2010). A taste of the unfamiliar. Understanding the meanings attached to food by international postgraduate students in England. *Appetite*, *54*(1), 202-207.

Byrd-Bredbenner, C., Johnson, M., Quick, V. M., Walsh, J., Greene, G. W., Hoerr, S., ... & Horacek, T. M. (2012). Sweet and salty. An assessment of the snacks and beverages sold in vending machines on US post-secondary institution campuses. *Appetite*, *58*(3), 1143-1151.

Childers, C. C., Haley, E., & Jahns, L. (2011). Insights into university freshman weight issues and how they make decisions about eating. *Journal of Consumer Affairs*, *45*(2), 306-328.

Deliens, T., Clarys, P., De Bourdeaudhuij, I., & Deforche, B. (2014). Determinants of eating behaviour in university students: a qualitative study using focus group discussions. BMC public health, 14(1), 53.

Edwards, J. S. A., Hartwell, H. L., & Brown, L. (2010). Changes in food neophobia and dietary habits of international students. *Journal of human nutrition and dietetics*, *23*(3), 301-311.

Gallè, F., Sabella, E. A., Da Molin, G., Liguori, G., Montagna, M. T., Orsi, G. B., ... & Napoli, C. (2019). A cross-sectional study investigating lifestyle and weight perception of undergraduate students in southern Italy. *BMC public health*, *19*(1), 1316.

Gazibara, T., Tepavcevic, D. B. K., Popovic, A., & Pekmezovic, T. (2013). Eating habits and body-weights of students of the University of Belgrade, Serbia: A cross-sectional study. *Journal of health, population, and nutrition*, *31*(3), 330.

Gresse, A., Pietersen, J., & Steenkamp, L. (2015). The influence of student accommodation on NMMU students' dietary patterns, activity and alcohol consumption. *South African Journal of Higher Education*, *29*(6), 93-105.

Horacek, T. M., Erdman, M. B., Reznar, M. M., Olfert, M., Brown-Esters, O. N., Kattelmann, K. K., ... & Shelnutt, K. P. (2013). Evaluation of the food store environment on and near the campus of 15 postsecondary institutions. *American Journal of Health Promotion*, *27*(4), e81-e90.

Intake, Physical Activity, and Serum Lipid Levels. *Journal of the American Dietetic Association*, 96 (1): 35–38.

Jackson, R. A., Berry, T. R., & Kennedy, M. D. (2009). The relationship between lifestyle and campus eating behaviours in male and female university students. *College Student Journal*, *43*(3), 860-872.

Kim, Y.Y. (2001). Becoming intercultural: an integrative theory of communication and cross-cultural adaptation, Thousand Oaks, CA: Sage

Levi, A., Chan, K. K., & Pence, D. (2006). Real men do not read labels: The effects of masculinity and involvement on college students' food decisions. *Journal of American College Health*, *55*(2), 91-98.

Liang, H. Q. (1992). Dietary practice and nutrient intake of students living in the college accommodation of Wollongong University.

Mazier MJ, McLeod SL. University science students' knowledge of fats. *Can J Diet Pract Res.* 2007;68(3):154–9.

Mehdizadeh, N., & Scott, G. (2005). Adjustment problems of Iranian international students in Scotland. *International Education Journal*, *6*(4), 484-493.

Mokdad, A.H., Serdula, M.K., Dietz, W.H., Bowman, B.A., Marks, J.S. & Koplan, J.P. (1999). The spread of the obesity epidemic in the United States, 1991-1998. *Journal of the American Medical Association, 285(23), 2973.*

Monteiro, L. Z., Varela, A. R., Lira, B. A., Junior, G., de Oliveira, D., Souza, P. D., ... & Bonardi, J. M. T. (2019). Physical activity and nutritional habits among Physical Education undergraduates: a crosssectional study in Brasília. *Revista Brasileira de Cineantropometria & Desempenho Humano*, *21*.

Nelson, Melissa C. and Mary Story. (2009). Food Environments in University Dorms: 20,000 Calories per Dorm Room and Counting. *American Journal of Preventive Medicine*, 36 (6):523–526.

Neslişah, R., & Emine, A. Y. (2011). Energy and nutrient intake and food patterns among Turkish university students. *Nutrition research and practice*, *5*(2), 117-123.

O'Sullivan, N., & Amirabdollahian, F. (2016). Loyal tongue, liberal mind: International students' experiences on dietary acculturation in England. *Journal of International Students*, *6*(1), 107-127.

Omage, K., & Omuemu, V. O. (2019). Factors associated with the dietary habits and nutritional status of undergraduate students in a private university in Southern Nigeria. *Nigerian Journal of Experimental and Clinical Biosciences*, *7*(1), 7.

Perez-Cueto, F., Verbeke, W., Lachat, C., & Remaut-De Winter, A. M. (2009). Changes in dietary habits following temporal migration. The case of international students in Belgium. *Appetite*, *52*(1), 83-88.

Powell, L. M., Auld, M. C., Chaloupka, F. J., O'Malley, P. M., & Johnston, L. D. (2007). Associations between access to food stores and adolescent body mass index. *American journal of preventive medicine*, *33*(4), S301-S307.

Reyes, A. M. (2010). Influences on College Students' Eating Habits.

Smith, S. C., Taylor, J. G., & Stephen, A. M. (2000). Use of food labels and beliefs about diet-disease relationships among university students. *Public Health Nutrition*, *3*(2), 175-182.

Steptoe A. Wardle J. Cui W. Bellisle F. Zotti A.M. Baranyai R. Sanderman R. Trends in smoking, diet, physical exercise, and attitudes toward health in European Universities students from 13 countries, 1990–2000. *Prev. Med.* 2002, *35*, 97–104.

Tanton, J., Dodd, L. J., Woodfield, L., & Mabhala, M. (2015). Eating behaviours of British university students: A cluster analysis on a neglected issue. *Advances in preventive medicine*, *2015*.

Tyrrell, R. L., Townshend, T. G., Adamson, A. J., & Lake, A. A. (2015). 'I'm not trusted in the kitchen': food environments and food behaviours of young people attending school and college. *Journal of Public Health*, *38*(2), 289-299.

Vilela, S., Santos, S., Padrão, P., & Caraher, M. (2014). Length of migration and eating habits of Portuguese university students living in London, United Kingdom. *Ecology of food and nutrition*, *53*(4), 419-435.

Von Bothmer M.I, Fridlund B. Gender differences in health habits and in motivation for a healthy lifestyle among Swedish University students. *Nurs. Health Sci.* 2005, *7*:107–18.

Willis, M. S., & Buck, J. S. (2007). From Sudan to Nebraska: Dinka and Nuer refugee diet dilemmas. *Journal of nutrition education and behavior*, *39*(5), 273-280.

Wong Y, Huang YC, Chen SL, Yamamoto S. Is the college environment adequate for accessing nutrition education: A study in Taiwan. Nutr Res 1999;19:1327-37.

Worsley, A. (2002). Nutrition knowledge and food consumption: can nutrition knowledge change food behaviour?. Asia Pacific Journal of clinical nutrition, 11(s3).

Yu, Z., & Tan, M. (2016). Disordered eating behaviors and food addiction among nutrition major college students. *Nutrients*, *8*(11), 673.

Yue, Y., Lê, Q., & Terry, D. R. (2014). Transition to an unfamiliar environment: International students' living experiences in an Australian regional area. *Journal of the Australian and New Zealand Student Services Association (JANZSSA)*, (23), 10-20.

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 27-46)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.02

ETHICAL ISSUES RELATED TO THE EVALUATION OF FACTORS THAT INCREASE THE RISK FOR ADVERSE CHILDHOOD EXPERIENCES

ANAMIKA JAIN[1], TIM CARR[2], MAGDALENA IORGA[3*]

ABSTRACT. Adverse childhood experiences are the results of traumatic events that children are passing till their eighteen years old. Many factors are influencing the development of adverse childhood experiences (ACE) and risk factors were also identified by many researchers. Family-related problems, environment, socio-economic status, abuse, etc. are all determinants of ACE. Many studies showed that there is a strong link between ACE and psychological and physical health problems in adult life, meaning that ACE should be treated as public health problem. But some ethical problems arise from identifying ACE during childhood. Accordingly, to the theory of Loftus, negative memories could be implanted. The evaluation of ACE should be done with a lot of responsibility, considering all ethical issues in order to assure a proper psychological recovery and to avoid adulthood health problems.

Keywords: *adverse childhood experiences, physical health, psychological health, chronic disease, parents, victimisation, ethics*

REZUMAT. Probleme etice privind evaluarea factorilor care cresc riscul experienţelor adverse din copilărie. Experienţele adverse din copilărie (EAC) sunt rezultatul unor evenimente traumatice prin care copiii trec până la vârsta de optsprezece ani. Mulţi factori influenţează dezvoltarea acestora şi de asemenea, factori de risc au fost identificaţi de foarte mulţi cercetători. Factori legaţi de familie, mediu, statut socio-economic, existenţa unui abuz etc, toţi sunt factori determinaţi ai evenimentelor adverse din copilărie. Multe studii au

[1] Medical Student, Faculty of Medicine, University of Medicine and Pharmacy, "Grigore T. Popa", Iasi, Romania
[2] Medical Student, Faculty of Medicine, University of Medicine and Pharmacy, "Grigore T. Popa", Iasi, Romania
[3] Associate Professor, PhD, clinical psychologist, Faculty of Medicine, Department of Behavioral Sciences, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania
* Corresponding author: Magdalena Iorga, PhD, Universitatii 16, 700160, University of Medicine and Pharmacy "Grigore T. Popa", Iasi, Romania, +40722800936

arătat faptul că există o strânsă legătură între EAC și problemele de sănătate psihică și fizică în perioada adultă. Dar câteva probleme de natură etică se nasc din încercarea de a identifica EAC. Conform teoriei lui Loftus, amintirile negative pot fi plantate în memoria subiectului. Evaluarea EAC trebuie să fie făcută cu multă responsabilitate, ținând cont de toate aspectele etice cu scopul de a asigura o bună recuperare psihologică și pentru a Evita problemele de sănătate în viața adultă.

***Cuvinte cheie**: experienţe adverse în copilărie, sănătate fizică, sănătate psihică, boală cronică, părinţi, victimizare, etică*

Introduction

Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being. (Feliti et al., 1998). Some studies focusing on the impact of negative experiences during childhood on adult life showed that children exposed to adverse psychosocial experiences were at elevated risk of depression, high inflammation levels, and clustering of metabolic risk markers. The study of Danese et al. (2009) found that children who had experienced socioeconomic disadvantage, maltreatment or social isolation had elevated age-related-disease risks in adulthood.

The *Adverse Childhood Experiences Study* was the pioneer study conducted in the field of ACE's. (Dube et al., 2003). Felitti et al. were seeking to help patients lose weight, and found that a significant number of his patients were dropping out. On further investigation, many of those who dropped out were in fact the ones who were losing weight. The explanation for this seeming paradox was found in the discovery that unhealthy (risk) behaviours, such as overeating food and smoking were coping strategies for the subconscious stress they were experiencing and the trauma from their childhood. (ACE Reporter, 2003). These findings have since opened a large field of research in which important links were discovered between chronic disease, mental health problems and preventable disease to adverse events experienced in early development of the individual. The factors highlighted by this ground-breaking study laid the foundation for future research, which continues even until today.

Many studies pointed out that there are different factors which contribute to the development of ACE and that there are also some risk factors that make some individuals to be more exposed and vulnerable to ACE: age of exposure,

the duration of exposure to the traumatic even, gender, family related factors like socio-economic status and level of education of parents, the physical and mental health of parents and caregivers, family type (single parent, adopted child), environment, exposure to psychological, emotional, physical, sexual abuse.

Factors related to the development of ACE

Risk behaviours

A risk factor is defined as something that increases the vulnerability of a person or increases the likelihood of developing a disease or mental health problem. (Grizenko & Fisher, 1992) Stressful events such as conflicts between family, peers, school, ending romantic relationships and abusing drugs are major contributing factors in mental illness as well as a lack of emotional nurturance and physical or sexual abuse during childhood.

An illicit drug is identified as a substance that has multiple detrimental health outcomes such as sexually transmitted diseases, cardiac problems, domestic violence, disability and crime.

Based on data taken by the National Surveys on Drug Use and Health (2009-2014) it was found that 1 in 8 children (8.7 million) lived in a household where a parent has a substance abuse disorder. (Lipari & Van Horn, 2017). Where a child was subject to a parent having SUD, these were more often in households of low SES, dysfunctional families and families with academic and social problems. These children reported higher levels of behavioural and mental disorders (Peleg-Oren & Teichman, 2006) and had a higher chance of developing SUD themselves. (Bederman et al., 2001) This may be because the child has had an early exposure to drugs and witnessed their parents using it as a coping mechanism, they may follow in their footsteps and become addicted.

In a study of 8613 adults attending a primary care clinic in California, it was found that each ACE increased the chances of early drug usage 2-4 times and compared to those who had no ACES, respondents reporting 5 or more ACES were 7-10 times more prone to illicit drug use. (Dube et al., 2003) A plausible reason for early initiation during adolescence may be due to the accessibility, in a national survey including children aged 12-17 years old, 55% claimed that marijuana was easy to find. (*Substance Abuse and Mental Health Services Administration, 2001*)

Children growing up in environments where at least one parent is an alcoholic have an increased risk of having a dysfunctional family life and are prone to experiencing ACEs (emotional, physical, sexual abuse and parental divorce). Studies have shown that children of alcoholic parents are likely to develop coping styles such as inappropriate emotional expression, manipulation and personality disorders.

Research has presented a marked increase in children witnessing domestic violence in alcoholic households. A survey conducted by 8629 HMO members revealed the probability of men having a battered mother when growing up was 13 times higher when both parents were abusing alcohol. (Dube et al., 2002) A possible reason for this is due to the pharmacological effects alcohol has on the brain, leading to an aggressive behaviour.

In another study of 139 undergraduate and graduate students studying psychology or sociology, it was found that those brought up in families without alcoholism or mental illness had significantly higher self-esteem than other groups as well as a lower amount of depression and anxiety. (Williams et al., 1992)

In a national epidemiological survey involving 43,000 participants, respondents having 2 or more ACEs were almost 1.4 times more likely to have an alcohol addiction compared to those that had 1 or no ACEs. (Pilowsky et al., 2009) From this, it can be deduced that children growing up with alcoholic parents are at a higher risk of experiencing ACEs, they may then end up having an alcoholic dependence and this will in turn affect their children; therefore, it will be a cyclic effect.

Suicide is a health problem affecting people worldwide, it is the second and third leading cause of death between ages 10-19 in Canada and US. Before puberty, suicide is rare, but the rate peaks at ages 19-23. (Shaffer et al., 2001) This may be because of the level of planning and mental maturity needed for a suicidal attempt. (Brent, 1993).

In adolescents completing suicide, it was found in Canada that more than 90% of adolescents suffered from a mental health disorder. (Shaffer et al., 2001) *The Youth Risk Behaviour Survey* (Grunbaum et al., 2001) reported that 19% of high school students considered attempting suicide and 17% of randomly selected undergraduate and graduate students had a history of self-harm. (Withlock et al., 2006). In a physiological autopsy of 120 successive suicides aged less than 20 years, factors found to be contributing to the suicide were problems at school, a family history of suicidal behaviour, poor parent-child communication, dysfunctional families and stressful life events. (Gould et al., 1996)

There are studies presenting strong evidence linking attempted suicides with ACES. In a study of 17,337 adult members attending primary health care, 1.1% of respondents, who had a minimum of one suicidal attempt, stated no ACES; however with those reporting 7 or greater, the suicidal attempt increased to 35.2%. (Chapman et al., 2007) A possible reason for this can be explained by a study of 49 women aged 18-45 who reported child abuse. The women who reported child abuse and were diagnosed with major depression showed a six times higher adrenocorticotrophic hormonal response to stressors compared to the control group. It is believed that high levels of adrenocorticotrophic hormone over activate the autonomic nervous system and affect the functionality of the hypothalamic-pituitary-adrenal axis and so increases the risk of depression. (Heim et al., 2000) These results suggest that child abuse may lead to modifications in the brain's function and result in lasting consequences. (Chapman et al., 2007).

Lower rates of alcohol consumption, substance abuse and an increase in antidepressant prescription have shown a decline in suicidal rate for the young population in US. (Brent et al., 1991; Olfson et al., 1998). Canterbury, Canada reported the greatest drop in suicidal rates linked to an increased prescription of SSRI (a type of antidepressant) in that area. (Joyce, 2001)

Environment

A caring and supportive environment is vital for aiding the development of a child. There are millions of abandoned children worldwide that are left with limited opportunities and little assistance. The Bucharest early intervention project found that children raised in Romanian institutions aged 12-31 months had a much higher rate of reactive attachment disorder in which they were unable to secure a healthy relationship with their caregivers. (Zeanah et al., 2005) These children also displayed higher rates of reduced physical growth, cognitive delays and bad behaviours. (Snyke et al., 2002; Snyke et al., 2007) Raised levels of inattentiveness and hyperactivity for adopted children in Romania and children living in care in the UK have been reported. (Tizard et Hoges, 1978; Rov et al., 2000)

A study of 65 children in London found that children who were previously in institutions and afterwards returned to their birth families or were adopted did not suffer the negative emotional outcomes that those staying in institutions suffered. (Tizard et Hoges, 1978) Therefore, it can be said that

the greater the time a child spends in institution, the more likely the child is to develop behavioural problems. (Tizard et Rees, 1975)

A research conducted on Eritrean war orphans suggested that the management of children in institutions plays a significant contribution on mental health and cognitive development. The results showed that orphanages where children are encouraged to become independent by communicating with the staff and learning how to make decisions for themselves were less likely to have behavioural problems and emotional distress compared to children in institutions where they must abide by a set of strict rules, schedules and where all decisions are made by staff members. (Wolff & Fesseha, 1998)

Another determinant in how the children are cared for is in the culture and religious beliefs of that family or country. In some countries the child of a deceased parent is not accepted by the extended family and treated harshly, whereas in other countries the child will be treated as if they were their own. (Whetten et al., 2009)

It is believed that adolescents from authoritative homes have better academic achievements in school. (Dornbusch et al., 1997) Strict parenting can also affect the behavioural development of the child with children having better work ethics, better class participation, spend more time on homework, have higher goals and optimistic feelings of school. (Lamborn et al., 1991)

Parenting styles were assessed in 1.198 15-18 yr old Brazilians. Adolescents coming from authoritative families incorporated 5 principles into their children: universalism, benevolence, compliance with social standards, tradition and security. The results showed similarities in the priority given to these principals between adolescents from indulgent and authoritative parents, but adolescents from neglectful families placed these values with a lower priority. Adolescents with permissive parenting had higher family self-esteem and performed equally in academics, social aspects and physical self-esteem compared to those with authoritative parents. Adolescents from neglected families performed lower in those categories. From this study, it can be concluded that where the child experiences affection, support, approval and attention, they are able to obtain on par results without the need for elevated discipline. (Martinez & Garcia, 2008)

Many children change schools each year for multiple reasons, in America, 20% of the population (6 million children) aged 5-13 move locations each year. Levine (1966) and Bloom (1978) proposed that changing schools may have an adaptive problem.

Data taken from the 9914 subjects aged 6-17 years in a national health survey found that 23% of children who relocated often had repeated a year in education compared to 12% that repeated who never or rarely moved. 18% that repositioned consistently had 4 or more behavioural problems compared

to 7% who never or rarely moved and these children having behavioural problems were 35% more likely to fail a grade, but growth development and learning disabilities were not found to be linked. (Wood et al., 1993)

In a survey of 250 students who completed education till the 9th grade, there were no significant differences in GPA and attendance with students between grades 1-8, however between the transition of 8th grade to high school there was a significant effect on the student's academic achievements. The student's GPAs reduced by greater than half a letter grade and there was a significant rise in absences between grades 8-9, students absent from school for more than 20 days rose from 23% to 45% on progression to high school. Black students presented no significant difference in their academic achievement, which suggests a racial involvement in this study, but overall it was found that white students coped better in the transition to high school. It can be concluded from this study that transition to high school may be particularly hard for students to adapt to possibly due to new anticipations from teachers, a greater likelihood of judgement among peers, and the stress of important decisions to be made during this time. (Felner et al., 1981)

It is known that gang members tend to commit violent crimes, are more likely to carry a gun and partake in both selling and abusing drugs. The inability to complete school and early sexual activity were factors found to increase the likelihood of gang involvement in females. (Bjerregaard & Smith, 1993).

In a research, 808 children were followed up from age 10 till 18. 15.3% of the sample admitted to being part of a gang between ages 13-18 with the greatest frequency being age 15 and male. The results indicated that adolescents living with one parent or no parents had up to a 3 times greater odd ratio of joining gangs compared to those living with both parents. Parental encouragement towards violence between ages 10-12 also foreshadowed later gang associations as well as a sibling's anti-social behaviour. Being classified as mentally disabled or having low academic performance had up to a 3 times greater odds ratio of later being involved in gangs. Early influence of drugs has shown to be a predictor of future gang involvement. 29.7% of children admitting the abundant availability of drugs when they were aged 10-12 became gang members compared to 10.6% who joined gangs after reporting the unavailability of marijuana aged 10-12. Adolescents in the top quartile area for marijuana availability were found to have a 3.6 times greater odds ratio of becoming part of a gang than other neighbourhoods. Therefore, the results present that parental behaviour, antisocial siblings, drug availability and learning difficulties in childhood increase the likelihood of the child being affiliated with gangs in the future. (Hill et al., 1999)

Parents with mental illness or physical disability

In 2008, it was estimated that 3 million children from the EU live in a household where this is a mentally ill parent (Pretis and Dimova, 2003)

These mental health problems can be short-term or long-term and are sometimes combined with alcohol and drug abuse. A parent having a mental illness may find it difficult to effectively carry out their role as a caregiver and this could impact the relationship with their child.

The attachment theory is built on the infant's first attachment (usually with their mother) that moulds their emotional and cognitive development (Bowlby, 1969) and later relationships that child forms. (Ainsworth & Marvin, 1995) A parent that is nurturing and fulfils the child's needs forms a feeling of security. (Chase-Lansdale et al., 1995) However, due to a parent's illness or addiction to drugs and alcohol, the child may feel neglected. This leads to an avoidant or insecure attachment. (Erwin, 2013)

Research has shown that children growing up with parents having mental illnesses have greater levels of psychosocial stress, learning difficulties, suicidal and antisocial behaviours and oppositional defiant disorder. (Klimes-Dougan et al., 1999; Leadbeater et al., 1996; Cantwell & Baker, 1984)

A research conducted in the UK involved 65 individuals working in the health, social care and voluntary sector who were asked to comment on their views about young carers. They believed the biggest difficulty faced by young carers is social isolation. Many children living with parents having a mental illness find it hard to assimilate with their peers due to their involvement in caring responsibilities, this may make it hard for their inexperienced peers to understand their struggles. The children also reported being too tired to join in social events or play with classmates and hence their ability to maintain friendships was affected. (Gray et al., 2008)

A study conducted by the Young Carers Research Group (YCRG) at Loughborough University, UK investigated 40 parents with a severe mental illness whose children were looking after them. 87% were mothers with depression or bipolar disorder and 90% of these mothers were cared for by their daughters (with an average age of 12). These children were adapted to having responsibilities associated to that of an adult such as domestic and nursing duties like toileting and bathing parents. (Aldridge & Becker, 1993; Deardem & Becker, 2004)

The children also emotionally supported parents, namely in episodes of self-harm and psychosis. Consequently, they can be described as having a role reversal where the child is taking on responsibilities of a parent. There was no evidence found of the parents physically abusing or neglecting the child despite self-harming themselves, this suggests children that have a parent with mental

illness are not negatively affected. It is possible the parent-child relationship may be strengthened as the child cares, is attentive and is understanding of the condition their parent suffers. (Aldridge, 2006; Aldridge & Becker, 1993)

Having a newly handicapped parent can be of particular distress to a child as they experience pitying comments from teachers, friends and peers; they are less likely to ask for help from fear of being ridiculed. (Romano, 1976) Furthermore, the education of the child may suffer with them taking time out from school e.g. if the parent is hospitalised after a suicidal attempt, which would also debilitate the focus of that child on studies. This has been proven with reports of children who have dropped out of school or avoided university to look after their parent.

Socioeconomic status (SES)

By joining the household income and the highest level of education received by parents, the socio-economic status is calculated.

Various studies conducted have related children growing up in a low SES to have a higher incidence of physical health problems, mental health problems, learning difficulties and poor career advancement compared to children that are richer. This could be due to a lack of educational resources offered in the household, less mentally stimulating activities that help to develop the brain and an increased exposure to toxins or allergens.

McEwan investigated the link between stress and health outcomes. His work concluded that during allostasis, the body must learn to adapt to its' environment and as a result compensates to reach this equilibrium. This could explain why a low SES in childhood has shown links to poorer health in adolescence and adulthood. (Friedman & McEwan, 2004)

Studies have shown that smoking mothers are more prevalent among families with low socio-economic statuses and this has been linked to low birth weight and a 40% higher neonatal mortality rate. (Comstock et al., 1971) Researchers at MacArthur Foundation Network of SES and health have said for the development of a particular organ system, there are "critical periods" and alterations during these periods are permanent. Therefore, a low birth rate could lead to complications such as an undeveloped pancreas and kidney leading to type 2 diabetes and hypertension. (Lee et al., 1988)

A study in New Zealand involving 1000 students, aged 26, who grew up in a low SES household discovered they were more likely to have cardiovascular health problems, periodontal disease and substance abuse regardless of their current SES. (Poulton et al., 2002)

Another study involved 4089 new-born infants in Stockholm, the children were followed up for 4 years. The results found that children from low SES had a higher incidence of asthma, rhinitis and eczema. (Almqvist et al., 2005)

When it comes to the relation of SES and education, underprivileged children are 2 times more likely to drop out from school and 1.5 times more prone to have a learning disability. (Duncan et al., 1994) In a sample of 80 countries, 12% of children in high-income households dropped out from school and 38% of children from low-income households dropped out from school. (Bruneforth, M., 2007)

Ludwig and Sawhill (2007) compared families in the lower 5th of the socio-economic population. Affluent families were more likely to have access to a laptop, have three times as many books and read more consistently. At a very early age, these contrasts had a large impact on test scores and were shown to have non-cognitive outcomes such as physical aggression, teenage pregnancy and involvement in crime.

The Child–Parent Center Program in Chicago enrolled over 1500 low-income children in an ongoing program from kindergarten to 3rd grade. A follow-up found that children in this program were more likely to attend college, have full time employment and less likely to be arrested and show signs of depression. (Reynolds et al., 2007) Therefore, these studies show that a low SES has an impact on a child's educational achievement, career progression, criminal convictions and mental health.

Marital status of parents

Marital status can be categorised into single, married, remarried, widowed, divorced and married but separated.

Divorce rates have increased significantly over the years and with this many families are raised in single-parent households.

Studies have shown that children brought up in households with divorced parents are more likely to have health problems. In Norway, a study found that children of divorced parents were 54% more likely to be overweight compared to that of married parents. (Biehl et al., 2014) This might be because of less time available to cook home-made foods and so the family resorts to processed foods of lower nutritional value. Another possibility is the child is eating to help manage their emotional stress. (Yannakoulia et al., 2008)

An unhappy marriage as well as parental depression has shown to affect a child's mental health. Children who have a depressed parent have greater

emotional and behavioural problems and children brought up in a household of marital dissatisfaction have greater distress levels. (Fishman & Meyers, 2000) Another study in Sweden showed results of a higher suicidal attempt rate in children in single-parent households. (Weitoft et al., 2003)

When it comes to the negative influence on children, divorce has different impacts considering the gender of the child. In the United States, a study assessing the effects of divorce and remarriage on the academic achievement of high school seniors found that females were more affected than males in divorce and remarriage of parents. (Ham, 2004)

The state level analysis of "*single households and children's educational achievement*" by (Amato et al., 2015) indicated that with the increased proportion of children from single parent households, the more poorly they scored in mathematics. Mathematics grades were found to be on average lower in the states in which there was a comparatively greater percentage of single-parent households. (these findings were confirmed by data). An explanation for this was hypothesised based on the theory developed by (Becker,1981) that parents invest both time and money into their children. And that in the case of a single parent household, one parent must meet the financial demands involved in raising the child, housekeeping and such, therefore in order to cover this they must spend more hours working in order to receive more wages to financially support the household. This would result in the parent being busier and not having time to offer to the child to meet his/her needs.

On the contrary, some studies show that children living in a single-parent household are more mature than those living with two parents. In a research program, 200 single parents were interviewed. The results determined that children who grew up in the absence of a parent were better at making decisions about the household and on family matters. A single parent working full time is more likely to share household responsibilities with their children for example at 8 years old they are hoovering and at 10 cooking, which may make it easier to look after themselves as they grow older. Parents working long hours may use harsher discipline and have less time to talk matters through with their child. (Walberg & Marjorikbanks, 1976) This lack of communication with their parents may make it hard to build future meaningful relationships.

It was reported that children from single-parent households are more likely to show authority towards their family. Adolescents have seen the vulnerabilities of their parents and are made aware and worried for problems such as a lack of income reaching the house. This led to feelings of uncertainty and a strong will to be self-sufficient. (Weiss, 1979)

Victimisation

Children are the most vulnerable for becoming victims of abuse, they are not able to adequately defend themselves physically or emotionally and a reciprocation may lead to further consequences for the child victim.

Emotional abuse is said to be a 'hidden form of child abuse' as it is less informed about, but the effects may be more harmful than physical abuse or neglect. Emotional abuse involves: rejection with the adult not understanding the child's worth or needs, terrorising or bulling where the adult verbally insults the child and instils fear, ignoring by showing no attention towards the child, isolation by cutting the child from social experiences or preventing friendships, corruption by teaching sexually exploitative conduct and showing the child that 'bad is good' and finally placing extreme pressure for the child to achieve beyond their abilities. (Garbarino et al., 1986) The brain systems are affected by early experiences, it is possible that ACEs change limbic reactivity and children growing up with ACEs are less able to regulate their emotions. This leads to disorders such as depression, bipolar disorder, borderline personality disorder, substance-abuse, eating disorders (Berking & Wupperman, 2012) and the children are at a higher risk of reactive aggression. (Lopez-Duran et al., 2009)

In sub-Saharan Africa, there are reports of poor physical and mental health with an increased risk of HIV infection, depression and suicidal thoughts. In a study with 3515 children aged 10-17 years, 35.5% stated a lifetime of emotional abuse, 56.3% a lifetime of physical abuse and 14.8% reported a lifetime of sexual harassment. Sexual abuse involved forcing children to watch pornography, non-consensual touching, kissing and genital touching which were most frequently mediated by peers and intimate partners. Younger children were more likely to face physical abuse and older children had a greater likelihood of reporting sexual or emotional abuse. The main sources of abuse were primary caregivers, teachers and relatives. (Meinck et al., 2016)

Having a secure attachment by caregivers is necessary for the development of emotional regulation. In a study of 76 maltreated children and 45 healthy controls aged 8-12, it was found that maltreated children had greater levels of emotional dysregulation, aggression and less social competence. (Shields et al., 2001) A possible consequence of emotional abuse was provided by a study of 230 adults completing the Dex/CRH test, the results showed a significant reduction in cortisol response in cases of reported child abuse. (Carpenter et al., 2009)

Research has shown that children that are sexually abused by family are at a higher risk of developing emotional and behavioural dysregulation. A study was conducted involving 21 sexually harassed girls aged 6-12 years, the results demonstrate that maltreated girls had a significantly lower emotional understanding

and lower emotional regulation than non-maltreated girls. Sexually abused girls reported stopping feelings of anger more so than non-abused girls, this could be because they expressed a greater fear of conflict if they showed their anger. (Shipman et al., 2000)

In a survey involving 487 men aged 19-84, the average age for first encountering the sexual abuse was 10.26 years. 61.5% reported the perpetrator being a clergy and 38.5% of participants reported the sexual abuse happening more than 20 times. The mean number of ACES was 1.87 with the most common reported ACE physical abuse at 45.4%. (Easton, 2012)

Therefore children can be victims of sexual, emotional and physical abuse which can induce later consequences in that child's overall wellbeing and health.

Ethical issues when evaluating ACE

As humans, we are able to intensify, maintain or reduce negative and positive emotions in a conscious or unconscious state, this may stimulate or inhibit the resulting behaviour. (Gross, 2002; Ochsner et al., 2002) We can change our reaction to emotions e.g. being distracted in an emotional situation can decrease the strength of the negative emotion or increase the strength depending on which part of the situation was focused on. In this way, the ultimate meaning of the thought can be changed in a situation. An example of where this is used for the benefit of patients is in cognitive behavioural therapy which is used to change the way we perceive situations and can help patients suffering from anxiety and depression. (Gross, 2002)

77 undergraduate participants were examined on how well they remembered past emotional childhood events such as getting lost, getting into a serious fight with another child, serious medical procedures and animal attacks. 88.3% remembered a true event and the results showed that 26% showed a full memory of a false event and 30% presented a partial memory of the false event. (Porter et al., 1999) These results indicate as Loftus' theory showed, that childhood memories can be implanted. According to Loftus' theory some studies are starting to show us how these false memories may arise. One reason is the increased pressure researchers place on the participants to remember a scenario and another may appear when someone is having difficulty remembering something, so they build an event from their imagination. False memories are created using both real memories and information received from others which may cause confusion. (Loftus & Palmer, 1974)

In a study of 129 women, 38% did not report the sexual abuse that had been documented in hospital records. And in some cases, they repeatedly denied any sexual maltreatment. In the case of one woman, the original account of the abuse recorded that the participant (aged 4), her cousin, (aged 9) her play mate (a little boy aged 4) were sexually abused by the uncle. The participant told her mother about the abuse and her mother informed the playmate's mother (a little boy) who stabbed the uncle. However, the participant answered that she had never met her uncle and he had died before she was born. She recalled that he molested a little boy and the mother of the little boy ended up killing the uncle. (Williams, 1994) Therefore, this shows that memories can be altered following tragic events.

Women aged 4-6 at the time of abuse were 62% more likely to have no recollection of the incident. This may be because of the emotional trauma suffered, being unable to comprehend the meaning or severity of the abuse as well as the limited cognitive development capacities altering the memories and resulting in the adults forgetting. It was found that women that had a close relationship with the offender were more likely to forget the abuse. (Everson & Boat, 1989)

Research shows that 4-8% of sexual abuse reported is imaginary. In a sample of 64 children, who were originally admitted to the emergency room under accusations of sexual harassment, 6% of these cases were deemed to be untrue. (Peters, 1977) In a study of 576 complaints of sexual abuse, 53% were confirmed, 17% were suspicious, 21% did not have enough evidence and 8 allegations made by 5 children were false. 4 of the girls who had false allegations had a history of sexual abuse and their symptoms suggested them having a post traumatic disorder. (Jones & McGraw, 1987)

Conclusion

Adverse childhood experiences cause a lot of negative effects on a child's life. Psychological or physical traumas are influencing an individual's life in adulthood. As studies proved, physical problems are strongly related to the presence of adverse experiences during childhood. So, identifying ACE could be seen more than an individual problem, but a public health-related concern. Apart from personal, family-related, social or educational issues related to ACE, ethical approaches should always be considered in order to help the subject to recover.

References:

Ainsworth, M.D. and Marvin, R.S., 1995. On the shaping of attachment theory and research: An interview with Mary DS Ainsworth (Fall 1994). *Monographs of the society for research in child development*, pp.3-21.

Aldridge, J. and Becker, S., 1993. Punishing children for caring: the hidden cost of young carers. *Children & society*, *7*(4), pp.376-387

Aldridge, J. and Becker, S., 1993. *Children who care: Inside the world of young carers*.

Aldridge, J., 2006. The experiences of children living with and caring for parents with mental illness. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect*, *15*(2), pp.79-88.

Almqvist, C., Pershagen, G. and Wickman, M., 2005. Low socioeconomic status as a risk factor for asthma, rhinitis and sensitization at 4 years in a birth cohort. *Clinical & Experimental Allergy*, *35*(5), pp.612-618.

Amato, P.R., Patterson, S. and Beattie, B., 2015. Single-parent households and children's educational achievement: A state-level analysis. Social science research, 53, pp.191-202.

Anda, R.F., Whitfield, C.L., Felitti, V.J., Chapman, D., Edwards, V.J., Dube, S.R. and Williamson, D.F., 2002. Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric services*, *53*(8), pp.1001-1009

Berking, M. and Wupperman, P., 2012. Emotion regulation and mental health: recent findings, current challenges, and future directions. *Current opinion in psychiatry*, *25*(2), pp.128-134

Biederman, J., Faraone, S.V., Monuteaux, M.C. and Feighner, J.A., 2000. Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics*, *106*(4), pp.792-797.

Donkor, H.M., Grundt, J.H., Júlíusson, P.B., Eide, G.E., Hurum, J., Bjerknes, R. and Markestad, T., 2017. Social and somatic determinants of underweight, overweight and obesity at 5 years of age: a Norwegian regional cohort study. *BMJ open*, *7*(8), p.e014548.

Becker, G.S. and Becker, G.S., 2009. A Treatise on the Family. Harvard university press.

Bjerregaard, B. and Smith, C., 1993. Gender differences in gang participation, delinquency, and substance use. *Journal of Quantitative Criminology*, *9*(4), pp.329-355

Bowlby, J., 1969. *Attachment and Loss: Attachment; John Bowlby*. Basic books

Brent, D.A., Perper, J.A., Allman, C.J., Moritz, G.M., Wartella, M.E. and Zelenak, J.P., 1991. The presence and accessibility of firearms in the homes of adolescent suicides: a case-control study. *Jama*, *266*(21), pp.2989-2995.

Brent, D.A., 1993. Depression and suicide in children and adolescents. *Pediatrics in review*, *14*(10), pp.380-388

Bruneforth, M., 2007. Characteristics of children who drop out of school and comments on the drop-out population compared to the population of out-ofschool children. *Background paper for the EFA Global Monitoring Report*.

Cantwell, D.P. and Baker, L., 1984. Parental mental illness and psychiatric disorders in" at risk" children. *The Journal of clinical psychiatry*

Carpenter, L.L., Tyrka, A.R., Ross, N.S., Khoury, L., Anderson, G.M. and Price, L.H., 2009. Effect of childhood emotional abuse and age on cortisol responsivity in adulthood. *Biological psychiatry*, *66*(1), pp.69-75.

Chapman, D.P., Dube, S.R. and Anda, R.F., 2007. Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals*, *37*(5).

Chase-Lansdale, P.L., Wakschlag, L.S. and Brooks-Gunn, J., 1995. A psychological perspective on the development of caring in children and youth: The role of the family. *Journal of Adolescence*, *18*(5), pp.515-556

Comstock, G.W., Shah, F.K., Meyer, M.B. and Abbey, H., 1971. Low birth weight and neonatal mortality rate related to maternal smoking and socioeconomic status. *American Journal of Obstetrics & Gynecology*, *111*(1), pp.53-59.

Dearden C, Becker S. 2004. Young Carers in the UK: The 2004 Report. Carers UK: London

Dornbusch, S.M., Ritter, P.L., Leiderman, P.H., Roberts, D.F. and Fraleigh, M.J., 1987. The relation of parenting style to adolescent school performance. *1987*, *58*, pp.1244-1257.

Dube, S.R., Anda, R.F., Felitti, V.J., Edwards, V.J. and Croft, J.B., 2002. Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive behaviors*, *27*(5), pp.713-725.

Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H. and Anda, R.F., 2003. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*, *111*(3), pp.564-572.

Duncan, G.J., Brooks-Gunn, J. and Klebanov, P.K., 1994. Economic deprivation and early childhood development. *Child development*, *65*(2), pp.296-318

Easton, S.D., 2012. Understanding adverse childhood experiences (ACE) and their relationship to adult stress among male survivors of childhood sexual abuse. *Journal of prevention & intervention in the community*, *40*(4), pp.291-303

Erwin, P., 2013. *Friendship in childhood and adolescence*. Routledge.

Everson, M.D. and Boat, B.W., 1989. False allegations of sexual abuse by children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *28*(2), pp.230-235.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S., 2019. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *56*(6), pp.774-786.

Felner, R.D., Primavera, J. and Cauce, A.M., 1981. The impact of school transitions: A focus for preventive efforts. *American Journal of Community Psychology*, *9*(4), pp.449-459.

Fishman, E.A. and Meyers, S.A., 2000. Marital satisfaction and child adjustment: Direct and mediated pathways. *Contemporary Family Therapy*, *22*(4), pp.437-452.

Friedman MJ, McEwan B. Posttraumatic stress disorder, allostatic load, and medical illness. In: Schnurr PP, Green BL, eds. Trauma and Health: Physical Health Consequences of Exposure to Extreme Stress. Washington, DC: American Psychological Association; 2004.

Garbarino, J., Guttmann, E. and Seeley, J.W., 1986. *The psychologically battered child* (p. 8). San Francisco: Jossey-Bass.

Gould, M.S., Fisher, P., Parides, M., Flory, M. and Shaffer, D., 1996. Psychosocial risk factors of child and adolescent completed suicide. *Archives of general psychiatry*, *53*(12), pp.1155-1162.

Gray, B., Robinson, C. and Seddon, D., 2008. Invisible Children: Young Carers of Parents with Mental Health Problems-The Perspectives of Professionals. *Child and Adolescent Mental Health*, *13*(4), pp.169-172

Grizenko, N. and Fisher, C., 1992. Review of studies of risk and protective factors for psychopathology in children. *The Canadian Journal of Psychiatry*, *37*(10), pp.711-721

Gross, J.J., 2002. Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology*, *39*(3), pp.281-291

Grunbaum, J.A., Kann, L., Kinchen, S.A., Williams, B., Ross, J.G., Lowry, R. and Kolbe, L., 2002. Youth risk behavior surveillance—United States, 2001. *Journal of School Health*, *72*(8), pp.313-328.

Ham, B.D., 2004. The effects of divorce and remarriage on the academic achievement of high school seniors. *Journal of Divorce & Remarriage*, *42*(1-2), pp.159-178

Heim, C., Newport, D.J., Heit, S., Graham, Y.P., Wilcox, M., Bonsall, R., Miller, A.H. and Nemeroff, C.B., 2000. Pituitary-adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood. *Jama*, *284*(5), pp.592-597

Hill, K.G., Howell, J.C., Hawkins, J.D. and Battin-Pearson, S.R., 1999. Childhood risk factors for adolescent gang membership: Results from the Seattle Social Development Project. *Journal of research in Crime and Delinquency*, *36*(3), pp.300-322.

Jones, D.P. and McGraw, J.M., 1987. Reliable and fictitious accounts of sexual abuse to children. *Journal of interpersonal Violence*, *2*(1), pp.27-45.

Joyce, P.R., 2001. Improvements in the recognition and treatment of depression and decreasing suicide rates. *New Zealand medical journal*, *114*(1145), p.535.

Klimes-Dougan, B., Free, K., Ronsaville, D., Stilwell, J., Welsh, C.J. and Radke-Yarrow, M., 1999. Suicidal ideation and attempts: a longitudinal investigation of children of depressed and well mothers. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(6), pp.651-659

Lamborn, S.D., Mounts, N.S., Steinberg, L. and Dornbusch, S.M., 1991. Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child development*, *62*(5), pp.1049-1065.

Leadbeater, B.J., Bishop, S.J. and Raver, C.C., 1996. Quality of mother–toddler interactions, maternal depressive symptoms, and behavior problems in preschoolers of adolescent mothers. *Developmental Psychology*, *32*(2), p.280

Lee, K.S., Ferguson, R.M., Corpuz, M. and Gartner, L.M., 1988. Maternal age and incidence of low birth weight at term: a population study. *American journal of obstetrics and gynecology*, *158*(1), pp.84-89.

Lipari, R.N. and Van Horn, S.L., 2017. Children living with parents who have a substance use disorder. *The CBHSQ Report*.

Loftus, E.F. and Palmer, J.C., 1974. Reconstruction of automobile destruction: An example of the interaction between language and memory. *Journal of verbal learning and verbal behaviour. 13(5), pp.585-589.*

Lopez-Duran, N.L., Olson, S.L., Hajal, N.J., Felt, B.T. and Vazquez, D.M., 2009. Hypothalamic pituitary adrenal axis functioning in reactive and proactive aggression in children. *Journal of abnormal child psychology*, *37*(2), pp.169-182.

Ludwig, J. and Sawhill, I., 2007. Success by Ten: Intervening Early, Often, and Effectively in the Education of Young Children. Discussion Paper 2007-02. *Hamilton Project*.

Martinez, I. and Garcia, J.F., 2008. Internalization of values and self-esteem among Brazilian teenagers from authoritative, indulgent, authoritarian, and neglectful homes. *ADOLESCENCE-SAN DIEGO-*, *43*(169), p.13

Meinck, F., Cluver, L.D., Boyes, M.E. and Loening-Voysey, H., 2016. Physical, emotional and sexual adolescent abuse victimisation in South Africa: prevalence, incidence, perpetrators and locations. *J Epidemiol Community Health*, *70*(9), pp.910-916.

Ochsner, K.N., Bunge, S.A., Gross, J.J. and Gabrieli, J.D., 2002. Rethinking feelings: an FMRI study of the cognitive regulation of emotion. *Journal of cognitive neuroscience*, *14*(8), pp.1215-1229.

Olfson, M., Marcus, S.C., Pincus, H.A., Zito, J.M., Thompson, J.W. and Zarin, D.A., 1998. Antidepressant prescribing practices of outpatient psychiatrists. *Archives of general psychiatry*, *55*(4), pp.310-316.

Peleg-Oren, N. and Teichman, M., 2006. Young children of parents with substance use disorders (SUD): A review of the literature and implications for social work practice. *Journal of Social Work Practice in the Addictions*, *6*(1-2), pp.49-61.

Peters, J.J., 1976. Children who are victims of sexual assault and the psychology of offenders. *American Journal of Psychotherapy*, *30*(3), pp.398-421

Pilowsky, D.J., Keyes, K.M. and Hasin, D.S., 2009. Adverse childhood events and lifetime alcohol dependence. *American journal of public health*, *99*(2), pp.258-263.

Porter, S., Yuille, J.C. and Lehman, D.R., 1999. The nature of real, implanted, and fabricated memories for emotional childhood events: Implications for the recovered memory debate. *Law and human behavior*, *23*(5), pp.517-537.

Poulton, R., Caspi, A., Milne, B.J., Thomson, W.M., Taylor, A., Sears, M.R. and Moffitt, T.E., 2002. Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. *The lancet*, *360*(9346), pp.1640-1645.

Pretis, M. and Dimova, A., 2016. *Early intervention with children of mentally ill parents*. E. Reinhardt.

Reporter, A.C.E., 2003. *The Effects of Adverse Childhood Experiences on Adult Health and Well Being.*

Reynolds, A.J., Temple, J.A., Ou, S.R., Robertson, D.L., Mersky, J.P., Topitzes, J.W. and Niles, M.D., 2007. Effects of a school-based, early childhood intervention on adult health and well-being: A 19-year follow-up of low-income families. *Archives of Pediatrics & Adolescent Medicine*, *161*(8), pp.730-739.

Romano, M.D., 1976. Preparing children for parental disability. *Social Work in Health Care*, *1*(3), pp.309-315

Roy, P., Rutter, M. and Pickles, A., 2000. Institutional care: risk from family background or pattern of rearing?. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *41*(2), pp.139-149.

Shaffer, D. and Pfeffer, C.R., 2001. Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(7), pp.24S-51S.

Shields, A., Ryan, R.M. and Cicchetti, D., 2001. Narrative representations of caregivers and emotion dysregulation as predictors of maltreated children's rejection by peers. *Developmental psychology*, *37*(3), p.321.

Shipman, K., Zeman, J., Penza, S. and Champion, K., 2000. Emotion management skills in sexually maltreated and nonmaltreated girls: A developmental psychopathology perspective. *Development and psychopathology*, *12*(1), pp.47-62.

Smyke, A.T., Dumitrescu, A. and Zeanah, C.H., 2002. Attachment disturbances in young children. I: The continuum of caretaking casualty. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(8), pp.972-982.

Smyke, A.T., Koga, S.F., Johnson, D.E., Fox, N.A., Marshall, P.J., Nelson, C.A., Zeanah, C.H. and BEIP Core Group, 2007. The caregiving context in institution-reared and family-reared infants and toddlers in Romania. *Journal of Child Psychology and Psychiatry*, *48*(2), pp.210-218.

Tizard, B. and Hodges, J., 1978. The effect of early institutional rearing on the development of eight year old children. *Journal of child psychology and psychiatry*, *19*(2), pp.99-118.

Tizard, B. and Rees, J., 1975. The effect of early institutional rearing on the behaviour problems and affectional relationships of four-year-old children. *Child Psychology & Psychiatry & Allied Disciplines*.

Walberg, H.J. and Marjoribanks, K., 1976. Family environment and cognitive development: Twelve analytic models. *Review of Educational Research*, *46*(4), pp.527-551.

Weiss, R.S., 1979. Growing up a little faster: The experience of growing up in a single-parent household. *Journal of Social Issues*, *35*(4), pp.97-111

Weitoft, G.R., Hjern, A., Haglund, B. and Rosén, M., 2003. Mortality, severe morbidity, and injury in children living with single parents in Sweden: a population-based study. *The Lancet*, *361*(9354), pp.289-295

Whetten, K., Ostermann, J., Whetten, R.A., Pence, B.W., O'Donnell, K., Messer, L.C., Thielman, N.M. and Positive Outcomes for Orphans (POFO) Research Team, 2009. A comparison of the wellbeing of orphans and abandoned children ages 6–12 in institutional and community-based care settings in 5 less wealthy nations. *PLoS One*, *4*(12), p.e8169.

Whitlock, J., Eckenrode, J. and Silverman, D., 2006. Self-injurious behaviors in a college population. *Pediatrics*, *117*(6), pp.1939-1948.

Williams, L.M., 1994. Recall of childhood trauma: a prospective study of women's memories of child sexual abuse. *Journal of consulting and clinical psychology*, *62*(6), p.1167

Williams, O.B. and Corrigan, P.W., 1992. The differential effects of parental alcoholism and mental illness on their adult children. *Journal of clinical psychology*, *48*(3), pp.406-414.

Wolff, P.H. and Fesseha, G., 1998. The orphans of Eritrea: Are orphanages part of the problem or part of the solution?. *American Journal of Psychiatry*, *155*(10), pp.1319-1324.

Wood, D., Halfon, N., Scarlata, D., Newacheck, P. and Nessim, S., 1993. Impact of family relocation on children's growth, development, school function, and behavior. *JAMA*, *270*(11), pp.1334-1338.

Yannakoulia, M., Papanikolaou, K., Hatzopoulou, I., Efstathiou, E., Papoutsakis, C. and Dedoussis, G.V., 2008. Association between family divorce and children's BMI and meal patterns: the GENDAI Study. *Obesity*, *16*(6), pp.1382-1387.

Zeanah, C.H., Smyke, A.T., Koga, S.F., Carlson, E. and Bucharest Early Intervention Project Core Group, 2005. Attachment in institutionalized and community children in Romania. *Child development*, *76*(5), pp.1015-1028.

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 47-61)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.03

MORAL RESPONSABILITY ON BODY, NOWDAYS. THEOLOGICAL REFLECTIONS

GABRIEL NOJE[1]

ABSTRACT. The purpose of this study is to present the principles on which the moral responsibility for the body is based from an Eastern theological perspective. The idea that the man is responsible for the redeeming works of each divine Person on his life and especially on his body is highlighted. Afterwards, there are several ways in which the responsibility can be fulfilled. The moral principles that guide man's responsibility in relation to his body are the following: moral purity, the attainment of holiness and the possibility of being deified. These are the principles the text tries to highlight in order to counterbalance the permissive and, unilaterally, hedonist principles that distort the contemporary responsibility towards the body. Even if the moral theological principles do not refer directly to it, are also applicable in the Bioethics area as it states that the purpose of the body is not to undergo any alteration by all means of its biological form, but it aims its spiritual transfiguration, through the action of the divine grace.

Key words: *responsibility, body, individual, post-duty society, postmodernity, Holy Trinity, Divine Persons, spiritual life, holiness, deification*

REZUMAT. Responsabilitatea morală a trupului, în zilele noastre. Reflecţii teologice. Scopul acestui studiu este să prezinte principiile pe care se fundamentează responsabilitatea morală faţă de trup din perspectivă teologică răsăriteană. Este subliniată ideea că omul este responsabil faţă de lucrările mântuitoare ale fiecărei Persoane divine manifestate asupra vieţii acestuia şi în special asupra trupului acestuia. Sunt trecute apoi în revistă mai multe modalităţi în care această responsabilitate poate fi împlinită. Principiile morale care ghidează responsabilitatea omului în raport cu trupul său sunt: puritatea morală, dobândirea sfinţeniei şi posibilitatea acestuia de a fi îndumnezeit. Aceste principii textul încearcă să le scoată în evidenţă în scopul de a contrabalansa principiile permisive şi, unilateral, hedoniste, ce denaturează responsabilitatea contemporană faţă de trup. Chiar dacă nu fac referire în mod direct, principiile teologice morale au aplicabilitate şi în sfera Bioeticii, întrucât

[1] PhD Candidate, Faculty of Orthodox Theology, Babeş-Bolyai University, Cluj-Napoca, Romania. Email address : gabriel.noje15@gmail.com

sugerează că menirea trupului nu este aceea de a fi supus unor alterări cu orice preţ a formei sale biologice, ci menirea vizează transfigurarea spirituală a lui, prin acţiunea harului divin.

Cuvinte cheie: *responsabilitate, trup, individ, post-duty society, postmodernitate, Sfânta Treime, Persoane Treimice, viaţa spirituală, sfinţenie, îndumnezeire*

1. Some contemporary understandings on body responsability

Nowadays, there is the tendency for man to claim an exclusive concern or responsibility for the governance of his body, which culminates with the individualistic right to control the body at its own will. This fact has, we consider, some explanations. Once, in the European societies' case where the Christian spirituality and culture were predominant, the relationship of the man and his body, the attitudes he has to adopt towards his own body were, mainly, regulated and legitimated through a moral and social code from a transcendental religious instance, a revealed God. Today, the declared failure of the greatest political and religious transcendences[2], that led to a meaningless of life, and the context of the emergence of a new post-moralist order that glorifies the body, will, individual and its own wellbeing[3], leads the contemporary individual to assume more frequently its freedom to dictate one's own duty regarding its corporality. In other words, while the man's behavior towards body was once prescribed or guided by a transcendental moral law, nowadays it represents the option of an autonomous, religious uprooted human will. Surprisingly, although these new moral duties for the body reflect the patterns of a secular thinking, the man still tends to perceive the responsibility toward body in religious, even quasi-soteriological, terms, as a nowadays observer states that the man of our days fells "called to answer for his body, just as he once did for its own soul"[4].

[2] See this idea in ISABELLE QUEVAL, "Le corps et la performance", in: *Actualité et dossier en santé publique*, nº 67, juin 2009, p. 43; and also, DAVID LE BRETON, *Antropologia corpului şi modernitatea*, coll. *Cartier istoric*, translation from French byLiliana Rusu, Cartier, Chişinău, 2009, p. 290.

[3] See more broadly the features of thispost-moral order at GILLES LIPOVESTKY, *Amurgul datoriei. Etica nedureroasă a noilor timpuri democratice*, coll. *Sophia*, translation and preface by Victor-Dinu Vlăduţescu, Editura Babel, Bucureşti, 1996, pp. 61-67.

[4] ANNE MARIE MOULIN, "Corpul în faţa medicinei", in: ALAIN CORBIN, JEAN-JACQUES COURTINE, GEORGES VIGARELLO (coord.), *Istoria corpului. III. Mutaţiile privirii. Secolul XX* (volum coordonat de Jean-Jacques Courtine), coll. *Cărţi cardinale*, translation from French by Simona Manolache, Mihael Arnat, Muguraş Constantinescu, Giuliano Sfichi, Editura Art, Bucureşti, 2009, p. 18.

Through the continuous impropriation of the contemporary society, the man has lost the sense of existence the Christian revelation conferred, but this process has not succeeded to remove also the idea of salvation inscribed in the human nature. Thus, the void left by the disappearance of a universe of Christian meanings and values had to be somehow filled or revalued. In this context, the nowadays individual has replaced the concern for his soul's salvation with the concern and excessive attention for the "salvation", here and now, on earth, of his body.

From a Christian perspective, the responsibility the contemporary individual tents to assume towards his body is based on the principles and values of a permissive and relativizing morality, promoted by the globalizing ethos. French sociologist Gilles Lipovestky highlights in his analysis how perennial moral values and principles, how the body's moral purity, chastity, virginity, body integrity, natural beauty are seen now – in what he calls the post-duty society – old-fashioned or irrelevant. Instead, these became imperative, especially through their inoculation by the consumerist rhetoric, bodily desire, sensuality, eroticized body, alteration or modification of the body, absolute liberty in choosing and manifesting the sexual identity etc.[5] What happened differently so clearly in terms of morality was a sharp decline of the virtue and virtuous life understood as a way of disciplining or mastering the body and senses.

A hedonistic morality specific to the post-modernity states, therefore, the twilight of Puritanism and rigorous norms and proclaims the right of each individual to pleasure and comfort[6]. The Christian principles and values that concern the human body are cleared in post-modernity, and other subjective, ephemeral, related to immediate satisfaction of carnal desires are brought into light and considered today as the ones that really matter[7]. From this perspective, the decline or loss of the meaning of values mentioned above leads to the desecration of the body's purpose and of the moral responsibility towards it. In fact, this desecration of the body explains many of today's people behaviors

[5] GILLES LIPOVESTKY, *Amurgul datoriei…*, pp. 46-52, 70-92. See also GILLES LIPOVESTKY, *Fericirea paradoxală. Eseu asupra societății de hiperconsum*, coll. *Plural M*, from French by Mihai Ungurean, Editura Polirom, Iași, 2007, pp. 213-214.

[6] According to an Orthodox thinker, we have witnessed in the last century "to the unilateral exaltation of the principle of pleasure" – see OLIVIER CLÉMENT, *Viitorul Bisericii*, translation by Vasile Manea, Ciprian Vidican, Editura Patmos, Cluj-Napoca, 2014, p. 15.

[7] "The classical «meanings» [including religion] less and less effect on the contemporary subject. Other values take over: the individual, the pleasure, the body, the sex, the money... The perverse society would be this ultra-liberal, libertine and permissive society, which leaves the subject at the impulses' will under the poor supervision of a permissive superego" – ZYGMUNT BAUMANN, TIM MAY, *Gândirea sociologică*, translation in Romanian by Mihai C. Udma, Editura Humanitas, București, 2008, pp. 31-33.

towards their bodies, a body that is no longer seen as a part of the man that must be sanctified and deified, but, generally, as a source par excellence of pleasures. A body that, in the society of consumption, craves and that must be lusted for, according to a contemporary American sociologist[8].

In another registry, the human rights, highly invoked in everyday rhetoric, became for some contemporary the philosophical-legal shield of various personal uses or responsibilities of the body. For example, in the name of a right to freely master its own body, the phenomena of the human body marketing (the prostitution phenomenon, the case of surrogate mothers, illegal trafficking of organs) or parts of it (the sale of sperm or ovum) it's spreading in various countries, a situation that raises the ethical problem of the way in which the man of the post-modern society understands the responsibility for his body, he decides to rent or sell for a certain sum of money.

The biomedical intervention the body can be subjected at, nowadays, also raises the question of the responsibility the man has related to its corporality. Through a diversified range of options and body medical procedures (cosmetic surgery, blepharoplasty, liposuction, rhinoplasty, prosthesis, cloning, in vitro fertilization, vulvas rejuvenation, liposculpture, brain chip implants etc.) it's aiming the amplification of the body's functions, the increase of its capabilities and endurances, the desire to make it conform to the best body standards dictated by the current society, the requirement to be more reliable and flexible or to respond optimally to the "user" requirements[9]. The ethical question is how far it can go following the path of such medical procedures that alter, in one way or another, the human body. If the human body is more than a simple biological material that – today, thanks to these technical and medical possibilities- can be corrected, modified, improved.

2. The resposibility for body in front of God-Trinity

The Eastern Christin tradition and theology have always highlighted the truth that living *in the body,* being a *spiritual being in the body,* or a *living* being is a great responsibility for the man. In the order of priorities, the first moral instance the man has to answer for his body and for the way he cared for it in

[8] MIKE FEATHERSTONE, „The body in Consumer Culture", in: *Theory, Culture and Society*, I (1982), pp. 21-22.

[9] *Cf.* PETRUȚA TEAMPĂU, „Corp trăit, corp gândit. Ipostaze teoretice în științele socio-umane", in: LAURA GRÜNBERG (coord.), *Corp – artă – societate: reflecții întrupate*, Editura UNARTE, Bucharest, 2010, p. 15

his earthly life is the Trinity God. Although, generally, man's responsibility to God for his bodily existence is unique, we could say, however, that the responsibility is expressed differently from each Trinity Person, due to the role these divine Persons had during the entire history of man's salvation.

a. Man's responsibility to *God-The Father* is based on that He is the One who proved, regarding the creation and shaping of the human body from earth (clay), much appreciation and love to create an adequate organ to manifest the spiritual life of man[10]. It results that, by its material nature, the human body created by God is a good in itself and receives the ability to support the dynamism of the spiritual life of the human being. Given that the man has by the act of his creation a dichotomous composition, in the command "Grow" (Fac 1, 28), God gave to the first people immediately after bringing them to life, we could see – through extrapolation – a first responsibility of man from God-Father regarding the physical, bodily growth, *in good*, so that the body remains permanently able for the moral and spiritual perfection of the man. Therefore, the responsibility for the growth of the body involves or implicitly sends to the idea of protection or guarding of the body given to man by God to remain alive and subject to man's soul.

In an interpretation of Psalm XIV, "Lord, who shall abide in thy tabernacle and who shall dwell in thy holly hill?", St. Basil the Great highlights the moral responsibility the man, by creation, has towards his body consisting of. He says that as the men lease the land and work the field according to the landlord's will, also God gave us the care for the body and we need to care for it according to God's will and to give the body back to the Lord as a place in which Lord could dwell[11].

---

[10] The theologian Constantin CALLINICOS mentions: "The dust of the earth was kneaded and shaped, according to the anthropomorphic scriptural expressions, by God's hands. It lifts the man above any other body in which life exists" – *The Foundations of Faith. An in-depth explanation of the Eastern Orthodox Creed*, translation and revision by Rev. George Dimopoulos, Scraton, Christian Orthodox Edition, 1975, p. 66. The fact that in the creation of the human body, God involves personally and with a special care – in contrast to the other things brought to life by the divine word "to be" – shows that He prepares the body even from its creation to be adequate to the spiritual principle that it will ensoul. God gives the body a sublime purpose when it prepares it to be supporter of carrier of the spiritual life. See Dumitru RADU (coord.), *Îndrumări misionare*, Editura Institutului Biblic şi de Misiune al Bisericii Ortodoxe Române, Bucureşti, 1986, p. 180, 186.

[11] SAINT BASIL THE GREAT, "Homily I to Psalm XIV", 1, in: *Omilii şi cuvântări*, in coll. *Părinţi şi Scriitori bisericeşti 1*, New series, translation from Greek and introduction by Dumirru Fecioru, text revised and note on edition by Constantin Georgescu, notes by Dumitru Fecioru, Constantin Georgescu and Alexandru Mihăilă, Editura Basilica a Patriarhiei Române, Bucharest, 2009, p. 398

On the other hand, starting from the words of St. Macarius the Great: "as God created the heaven and the earth for man to dwell in, so He created man's body and soul for a dwelling for Himself, to inhabit and take His rest in the body as in His own house"[12], we see that the man's responsibility for his body towards God-Father is also detached from the great destiny inherited by the body through the act of creation, but it will be ushered only in the eschatological plan[13].

The human being is, therefore, responsible for its body towards God-Father, as Creator, He has endowed our body with all necessary to be a collaborator to the soul. In this sense, the man fulfills this responsibility through his actions by which he strives to maintain his bodily integrity, to avoid those privileges or life situations that harm the body and place it in the impossibility to be a worthy servant of the soul.

b. To *God-Son,* man's full responsibility for his body arises from that the embodied Son of God, from love and mercy towards the fallen humanity and overthrown by sin, took the human condition by Himself with all its affections, apart from sin, in order to achieve in His body, whipped, crucified, passed through death, raised and lifted to heaven, our reconciliation with God placing in His body the premises of the resurrection of all people with their bodies at the end of centuries. Therefore, we are responsible before Jesus Christ, Son of God made man, because, as St. Athanasius the Great shows, "prin înrudirea Lui cu noi după trup, am devenit şi noi temple ale lui Dumnezeu şi ne-am făcut fii ai lui Dumnezeu"[14]. Through all He has done *in His body*, Son of God, who has come in close proximity to man in the historical person of Jesus Christ, has redeemed us from the bondage of corruption and death. Therefore the word of Scripture that presents Jesus as the one "who gave Himself for our sins, to rescue us from this present evil age" ("Cel ce S-a dat pe Sine pentru păcatele noastre, ca să ne scoată pe noi din acest veac rău de acum") (Gal 1, 4) represents for each of us an awareness of a great responsibility towards the fruits of Christ's sacrifice gained through His crucifixion with the body for humans.

On the other hand, Christ is the One who restored the human nature, with whom through incarnation He fully identified Himself, thus offering the

---

[12] See SAINT MACARIUS THE GREAT, „Cele cincizeci de omilii duhovniceşti", 49, 4, in: *Omilii duhovniceşti*, coll. *Părinţi şi Scriitori Bisericeşti*, Vol. 34, translation from Greek by Constatin Corniţescu, introduction, indexes and notes by Nicolae Chiţescu, Editura Institutului Biblic şi de Misiune al Bisericii Ortodoxe Române, Bucureşti, 1992, p. 280.

[13] CĂTĂLIN PĂLIMARU, *Teologia experienţei în Corpusul macarian*, coll. *Monografii 4*, Editura Renaşterea, Cluj-Napoca, 2014, p. 118.

[14] SAINT ATHANASIUS THE GREAT, *Cuvântul întâi împotriva arienilor*, XLIII, in: *Scrieri. Partea I*, coll. *Părinţi şi Scriitori Bisericeşti*, Vol. 15, translation, introduction and notes by Dumitru Stăniloae, Editura Institutului Biblic şi de Misiune al Bisericii Ortodoxe Române, Bucharest, 1987, pp. 207-208.

man the possibility to rise with his whole being – body and soul – to the richness of the perfect life that comes from God – Holy Trinity. Thus, Christ gave the human being the possibility of deification in body, which is why Apostle Pavel draws our attention to the responsibility we have for conforming our lives to the Christian lives: "Viața lui Iisus să se arate în trupul nostru cel muritor" (2 Co 4, 11). On the other hand, we have a moral responsibility towards Christ, Son of God, because He at the Las Super, before His Passions, He instituted the Holy Eucharist so that through His Blood and Body for us to have fellowship to His eternal life. Therefore, since through the Mystery of Baptism we have been incorporated in the Church – God's mystical body – we become responsible in relation to Christ for the way we develop in our body His life or for the way we decide or not to receive in our flesh body His body deified, resurrected and spiritualized[15].

We are responsible, thus, to Christ, embodied Son of God, whenever we are not answering to the Holy Liturgy' call to communion uttered by priest – "with fear of God, faith and love, draw near"– to feed us with and to assimilate in our bodies the body of Christ[16], just as so does the cause of our precarious moral and spiritual nature we find ourselves unworthy to receive His Body and Blood (*cf*. 1 Co 11, 28-29).

However, beyond all of the above, we are responsible to Christ whenever we do not update in our own existence, both soul and body, the effects or gifts of the saving work God made for us in His earthy life. Or, from this point of view, the refusal or indifference to place in our personal work the gifts acquired through the saving work of the Son is a disregard of the role of His Incarnation in our lives as Christians and are, after all, attitudes stemming from not assuming responsibility.

c. Man's responsibility for his body is also shown in relation to the third Trinity Person, *God-Holy Spirit*, since after the Pentecost, in the life of Church, He is creator of the sanctification of our life, of our body. Through the grace of Christ he pours above us in the Holy Sacraments, the Holy Spirit transforms our souls and bodies by renewing and deifying more and more as we share in the grace of Mysteries[17]. Therefore, we also have a responsibility to the Spirit of God

---

[15] *Cf*. Ștefan Iloaie, *Responsabilitatea morală personală și comunitară. O perspectivă teologică*, Editura Renașterea, Cluj-Napoca, 2009, pp. 181-182.

[16] Dumitru Stăniloae, *Chipul nemuritor al lui Dumnezeu. Vol. 1*, coll. *Oikoumene. Mari autori creștini*, edited by Camil Marius Dădârlat, Editura Cristal, București, 1995, p. 204.

[17] Details on the sanctifying action of the Holy Spirit through the Holy Sacraments are found in Saint Chiril of Jerusalem, *Cateheze*, translation and notes by Teodor Bodogae, Editura Institutului Biblic și de Misiune al Bisericii Ortodoxe Române, Bucharest, 2003, pp. 271-292. See alsoJean-Claude Larchet, *Viața sacramentală*, translation by Marinela Bojin, Editura Basilica, Bucharest, 2015, pp. 77-94.

because through the grace of Baptism He expands, dwells in our body, imprinting in our soul and senses God's power to reborn to the spiritual life. It is the Holy Spirit that imprints Christ in our being. Thus, the renewal of our moral forces at Baptism represents an act of our direct responsibility and demands from us a work of these spiritual forces in order to work the salvation Ghrist brought to us.

Also, the responsibility comes from that at the Mystery of the Chrismation by sealing with the grace of the Holy Spirit, all the limbs and senses of our body are fortified by grace, they spiritualize, receiving the ability to participate with the soul to the life of Christ. This sealing of grace means, in fact, conferring a new sublime purpose of our body, a purpose originating from the identity and quality of the new Christian human condition (*cf*. 2 Co 5, 17; Gal 6, 15), namely being "a temple of the Holy Spirit" (1 Co 6, 19), so we, Christians, can no longer relate in any way to our body, being dedicated through Baptism to God, His presence and dwelling in our being. Therefore, the question and warning from the Apostle Pavel: "Do you not know that you are a temple of God and that the Spirit of God dwells in you?" (1 Co 3, 16) has the precisely purpose to remind Christians of Corinth, and indirectly to all Christians, the high spiritual status of the new human body (Ef 4, 24), and to make them plenary aware of the responsibility arising from this status.

Redeemed with the price of the blood of Christ, the Christians – Apostle Pavel highlights – no longer belong to themselves, but become wholly "owned" by God, as it also proves the act of bringing into existence. Thus, for the Christian the consciousness of this redemption and of that it belongs to God with all his body become two well-founded reasons for which he has to use also his body in the service for the Creator's honor "Glorify God in your body, and in your spirit" (1 Co 6, 20), and not to defile it through dishonest behavior or deeds. We can understand from here the moral responsibility the Christian has for his body in front of God-Holy Trinity.

3. Means of fulfilling the moral responsibility towards the body

Man's moral responsibility for his body is also established *in relation to himself*. This responsibility is based on the very consciousness of the man, based on the scriptural revelation and on the patristic testimonies, has on the purpose for which God brought the man to life as an *embodied* spiritual being. In other words, in Christianity there is a responsibility of the man for the body in relation to himself, a responsibility that comes from the way he chooses to or not to fulfill

the creaturely vocation of his body, that is to be, morally and spiritually, servant or faithful collaborator of the soul and together worker of human's salvation.

From this perspective, the court of judgement before which the man must respond is his own consciousness, presence of the divine voice in man, which warns him whenever, through various ways or contexts, the man disregards the purpose of the body, resorting to acts that do not conform to the standard of the human's life set by God.

For father Dumitru Stăniloae man's responsibility towards his body derives from "the quality of the human body" of becoming a partaker to the "character of subject man". The body as an object participates in all the experiences and acts of the soul, and these are printed in the human body, so that the body becomes subjective. Based on this relationship between soul and body, the man becomes responsible not only for his soul, but also for his body due to his participation in the lie of the soul[18]. But the Romanian theologian also vice-versa argues, namely that the man is responsible for soul through his own body[19], the concern for body God has given to the human being should not be limited or reduced only to the action of maintaining the body so that the life of the spirit manifest, but, more than that, the man must take care of the body to be an "even more apt tool" of the soul[20].

From the aforementioned, we could talk about a responsibility of the man to permanently maintain the quality of the body as participant to the subjectivity of the man, to the soul. Therefore, each human being must relate to its body in such a way that it is always ready to support the spiritual work of the soul.

In the opinion of Father Stăniloae, from the moment the concern for the biological existence of the body becomes a concern of itself, the human being in not fulfilling the responsibility for his body. In other words, the man fails in the genuine assumption of responsibility, when the duties towards the body, arising from the instinct of the conservation of nature, prevails over the spiritual ones. Or, moreover end up considered as the only ones that really matter. In this case, the moral consequence of such attitude of the man towards his body consists in canceling the spiritual character of the body. By not participating to soul's dynamism, the body loses its subjective character.

---

[18] *Cf.* DUMITRU STĂNILOAE, *Chipul nemuritor al lui Dumnezeu*, *Vol. 1*, p. 44, 94.

[19] „Dacă trupul n-ar fi şi obiect şi părtaş la calitatea de subiect, omul n-ar putea fi răspunzător de sine. Dar omul trăieşte şi participarea trupului la răspunderea faţă de sufletul său, în calitatea trupului de participant la însuşirea lui de subiect. Căci un trup fără această calitate n-ar putea accepta de bună voie trăirea unei responsabilităţi pentru suflet. Şi răspunderea aceasta a omului de amândouă componentele sale, prin amândouă e unită cu răspunderea pentru alţii în faţa lui Dumnezeu" – *cf.* DUMITRU STĂNILOAE, *Chipul nemuritor al lui Dumnezeu*, *Vol. 1*, pp. 94-95.

[20] DUMITRU STĂNILOAE, *Chipul nemuritor al lui Dumnezeu*, *Vol. 1*, p. 44.

The Romanian theologian writes that "pe măsură ce ne ocupăm mai mult de trup ca realitate exclusivă, el devine mai opac, mai puţin transparent şi cuprinzător a tuturor, inclusiv al lui Dumnezeu, devine mai puţin omenesc şi mai animalic"[21]. Of course, to give the body all necessary for the optimal maintenance of its biological condition is a natural moral duty of the man on earth, because, on the contrary, a shabby, sick body would often be unable to sustain the spiritual life in the most efficient way. But the attention of the human body for his body must be constantly focused on the tendency "de a nu-l socoti sigura realitate. El [omul, n.n.] trebuie să-l facă tot mai slujitor al spiritului, să-l pregătească pentru a fi, după înviere, deplin supus spiritului şi transparent spiritului şi, prin spirit, lui Dumnezeu"[22].

In another register, completing the above statements, the spiritual responsibility of man towards body also results from the fact that, by the nature of its composition it is a dichotomous being – his ontological unity and uniqueness were given by this intimate connection between the two components, soul and body – the man is never saved outside his body, but always through his human body. The body is good by nature, able of deification. Primarily, but not exclusively, the man must care for the salvation of his soul, since it is the engine of the spiritual life, but, on the other hand, the entirely scaffolding of this life depends on the pure guarding of the soul. Father Ştefan Iloaie states that "persoana este responsabilă, de asemenea, şi de *păzirea trupului* întrucât în el sălăşluieşte sufletul, iar cele două sunt legate intim şi se constituie într-o unitate de trăire a vieţii pământeşti, în care, împreună amândouă lucrează mântuirea, iar de aceasta nu va beneficia doar sufletul ci şi trupul, făcut şi el pentru înviere şi răsplată"[23].

Moreover, the man is responsible for his body and for that the final destiny, vocation of the body is its resurrection at the second coming of Christ (1 Co 15, 23). But what is really important, morally speaking, is the state in which our body will be resurrected. Thus, a filocalic priest, Isaiah the Solitary, urges us to care for our body as a Temple of God, because the body will have to resurrect and to give answer to Lord. He continue saying that as we are used to heal the body when it is in pain or suffering, also we need to care for the body because it has to be found pure at the second coming of our Lord Jesus Christ[24].

In the earthy life stage, any action or work of the soul in the spiritual area involved the human body or is performed also in the body, since it is the

[21] DUMITRU STĂNILOAE, *Chipul nemuritor al lui Dumnezeu*, *Vol. 1*, p. 44.

[22] DUMITRU STĂNILOAE, *Iisus Hristos, Lumina lumi şi îndumnezeitorul omului*, seria *Opere complete 6*, Editura Basilica a Patriarhiei Române, Bucureşti, 2014, p. 31.

[23] ŞTEFAN ILOAIE, *Responsabilitatea morală...*, p. 226.

[24] CUVIOSUL ISAIA PUSTNICUL, „Cuvântul XV. Despre lepădare", 1, în: *Filocalia*, Vol. 12, traducere din greceşte, introducere şi note de Dumitru Stăniloae, Ed. Harisma, Bucureşti, 1991, p. 113.

expressing organ of the spiritual life in relation to the world and the fellows. Since the spiritual efficiency of the soul's work depends also of the moral status of the body, of his ability to allow the soul to work through it, it follows that the man becomes responsible for the moral and physical purity of his body. This moral and physical status of the body can be obtained through ascetic effort sustained also through the work of the virtues, striving to remove the impulses and sinful thoughts of the body, that are a barrier in the manifestation of the spiritual life. The body that acquires purity gradually becomes translucent, pellucid. Only through such a body the soul makes its presence felt and can work in person and through it in the world as much as possible.

In the daily life plan, concretely, the responsibility for the bodily purity is realized through the cultivating and preserving of the virtue of virginity of the young before marriage and of the chastity virtues within the marriage by spouses. The two virtues – virginity and chastity – must be realized not only at the level of the body, case in which will be imperfect, but also of the conscience, of soul, of spirit, thus being the proof of a plenary moral integrity of the man. Also, from this last perspective, these become essential conditions for a moral and spiritual life – individual or familial – healthy and improved. If the energy is wrongly channeled to the satisfaction of the sexual desires, this thing creates not only a disorder in the human body, but also in his spiritual life, by the fact that psychologically and spiritually speaking the disordered sexuality outside and also during marriage distorts the normal way of relating to the other, it transforms him in a satisfaction object of the sexual desires and impulses. In this case, the human sexuality is thus distorted and diverted from its saving purpose in the man's life, that is, the union and fulfillment of the spouses' love, by reducing it to the status of a simple physiologic act, in which each seeks just pleasure. Thus, the chastity and virginity virtue have the role to strengthen man's will of not allowing man's spiritual powers to be directed to the way of a disordered sexuality. Through virginity and chastity, in fact, we fight for the spiritualization or transfiguration of the sensual through the energies of the Holy Spirit. Therefore, in both situations, of the unmarried young and the married ones, the main purpose of the cultivation of these virtues is to sanctify the soul and the body of those who strive to achieve them. From the Eastern thinking point of view, the cultivation of these virtues is not possible for man without the collaboration with the divine grace received in the Holy Sacraments, which renews, strengthens and helps him to grow in his life in Christ[25].

On the other hand, the man fulfils his responsibility towards his body and through an adequate reference, morally speaking, to those needed for his

[25] Regarding the importance of the virginity virtue for the young preparing for marriage see ILIE MOLDOVAN, *În Hristos şi în Biserică. Adevărul şi frumuseţea căsătoriei. Teologia iubirii II,* Editura Reîntregirea, [2]2014, pp. 113-122.

biological care and maintenance of his physical integrity, but the fulfillment of all these duties must be subsumed or must serve to the special purpose of the body as an environment of manifesting the spiritual life. The man concerns of food, cloth, rest etc., but all these needs that belong to the body the Christian sees them and must look at them in and through the perspective of his salvation (*cf*. Mt 6, 25-33)[26]. In this regard, writing to the young people of his time, as those who need advices on the concern and care for the body, St. Basil the Great said: „să slujim trupului numai în cele necesare. [...] şi în toate celelalte nu trebuie să ne îngrijim mai mult decât e necesar şi nici să purtăm grijă de trup mai mult decât e bine pentru suflet. [...] A-ţi da toată silinţa ca trupul să fie *mult prea îngrijit*, înseamnă a nu te cunoaşte pe ţine însuţi şi a nu înţelege porunca înţeleaptă, care spune că nu ceea ce se vede este omul (subl.n.)"[27]. The moral principle that emerges and that we keep in mind from the urging of the bishop of Caesarea of Cappadocia is the one of the man's necessity to cultivate an axiological balance regarding the attention given to the bodily needs[28]. In this perspective, St. Basil the Great warns that neglecting this principle damages not only the biological heath of the body, but also threatens the welfare of the spiritual life of man, so what is required in this case is to avoid the overestimation of the body needs: „deci când grija prea mare de trup este vătămătoare chiar pentru trup şi este o piedică pentru suflet, e curată nebunie să te laşi subjugat de trup şi să-i slujeşti"[29].

The moral duties towards his body are brought to the knowledge of man also through the catechetical-pastoral mission and liturgical-sacramental activity of the Holy Church. In all liturgical periods of the ecclesiastical year, but especially in the one of the Great Lent, through liturgical hymns and biblical

[26] For more details see NICOLAE MLADIN, OREST BUCEVSCHI, CONSTANTIN PAVEL, IOAN ZĂGREAN, *Teologia Morală Ortodoxă*. *Vol. 2 Morala specială*, Editura Reîntregirea, Alba-Iulia, [2]2003, p. 112.

[27] SFÂNTUL VASILE CEL MARE, „Omilia a XXII-a. Către tineri", 9, pp. 335-336.

[28] In the Cappadocian Parents, and especially in the writings of St. Basil the Great, we identify many principles and advices regarding the educability of the human body. This educability of the human body is subsumed generally to the educability of the human body in the holistic sense, soul and body. If for the Cappadocian Parents the educability of the man in general is seen as a remediation action of the consequences of the sin, the more the educability of the body is an action by which the body is controlled and disciplined to collaborate as effectively as possible with the spiritual part of the man, with his soul. Therefore, if in the works of St. Basil the Great we find advices regarding nutrition, clothing, sleep, gymnastics, bodily disease etc., all these means of educating the body are aimed at making the body a good collaborator of the soul. For more details see IOAN G. COMAN, „Concepţia despre educaţie a Sfinţilor Părinţi Capadocieni şi a Sf. Ioan Gură de Aur", în: *Frumuseţile iubirii de oameni în spiritualitatea patristică*, Editura Mitropoliei Banatului, Timişoara, 1988, pp. 41-44.

[29] SFÂNTUL VASILE CEL MARE, „Omilia a XXII-a. Către tineri", 9, p. 335.

readings read during the ceremonies, liturgical rituals that are performed in this period, through the constant calls for the increase of the lent, of the watching, prayer or mercy, the Church makes the Christian aware of the moral value of the body and of the importance of maintaining his physical, but especially spiritual purity for the encounter and communing with God. This is, actually, one of the messages of the biblical passage from the first epistle of St. Apostle Pavel to Corinthians, the Holy Church established to be read during the Holy Liturgy from the Sunday of the Prodigal Son, the second Sunday of the period before the Great Lent. By extrapolating a little the idea of the text, the human being is urged to much discernment on the way he uses his body, since not everything the society he lives in claims to be allowed is, in reality, spiritually useful, as well as the man has to maintain towards the declared premises an attitude of moral reserve so that he will not end under the control of the things he considered to be precisely the expression of freedom (1 Co 6, 12). In this sense, the Apostle to the Gentiles warns: "for you, brethren have been called for liberty; only do not use liberty as an opportunity for the flesh" (Gal. 5, 13). Therefore, the actual danger, morally speaking, is idolatry of our own body by transforming its irrational pleasures into life's desires.

The moral responsibility of man towards his body also implies the concern for the maintenance and valuing of the physical health of the body. The natural, paradisiacal state of the body was by excellence the state of health, of lack of diseases and of the body's weaknesses. Therefore, the man is responsible for any willful or necessary action that directly affects the health of his body. Ultimately, the unhealthiness of the body affects or imbalances the whole human person, as any suffering of the body is felt spiritually too, which can strengthen the spiritual work, but most often to compromise it when the bodily suffering is not fully assumed by the man. Actually, any lack of concern for the health of our body is, on short or long term, an unconscious suicidal attempt of one's own life. With regard to this aspect, and also others, father Ştefan Iloaie writes: „Suntem răspunzători înaintea lui Dumnezeu pentru modul în care nu percepem sau percepem distorsionat sensul vieţii noastre, pentru acceptarea tentaţiilor care ne acoperă ţinta şi ne poartă către falsitatea unui ţel iluzoriu al vieţuirii, pentru acţiunile de indiferenţă faţă de păstrarea sănătăţii duhovniceşti şi trupeşti, acte de natură să slăbească unitatea de simţire a sufletului şi a trupului – şi cu atât mai mult – pentru acţiunile voite şi conştiente îndreptate împotriva propriei vieţi"[30]. From this perspective, the supreme deresponsibilization of the man towards his body is the suicide, namely the cancelation or negation of one's own life by suppressing the biologic fundament that does little to manifest this life – the body.

[30] ŞTEFAN ILOAIE, *Responsabilitatea morală...*, p. 209.

4. Conclusions

Eastern theology emphasizes man's responsibility of the body before God. There is a responsibility towards the body in relation to God-Father, who as Creator of the man has created the body good in itself and adequate to express the spiritual life of the man. Then towards God-Son, as the Savior of man, the responsibility is based on the possibility of man's salvation and deification in the entirety of his person, soul and body. Least, the moral responsibility of the human body regarding its corporality is also shown in connection with the Holy Spirit, which offers the man the grace of sanctification of the body through the Holy Sacraments and the liturgical and sacramental life.

As regards to the fulfillment of the responsibility towards the body, the man is conscious of the importance of the moral purity of the body for the completion of his spiritual life, of the fact that his body is called to sanctification and deification.

Bibliografy:

Baumann Zygmunt, May Tim, *Gândirea sociologică*, translation in Romanian by Mihai C. Udma, Editura Humanitas, București, 2008.

Callinicos, Constantin, *The Foundations of Faith. An in-depth explanation of the Eastern Orthodox Creed*, translation and revision by Rev. George Dimopoulos, Scraton, Christian Orthodox Edition, 1975.

Clément, Olivier, *Viitorul Bisericii*, translation by Vasile Manea, Ciprian Vidican, Editura Patmos, Cluj-Napoca, 2014.

Coman, Ioan G., „Concepția despre educație a Sfinților Părinți Capadocieni și a Sf. Ioan Gură de Aur", în: *Frumusețile iubirii de oameni în spiritualitatea patristică*, Editura Mitropoliei Banatului, Timișoara, 1988.

Featherstone, Mike, „The body in Consumer Culture", in: *Theory, Culture and Society*, I (1982), pp. 21-22.

Iloaie, Ștefan. *Responsabilitatea morală personală și comunitară. O perspectivă teologică*, Editura Renașterea, Cluj-Napoca, 2009.

Isaia Pustnicul, Cuviosul, „Cuvântul XV. Despre lepădare", 1, în: *Filocalia*, Vol. 12, traducere din greceşte, introducere şi note de Dumitru Stăniloae, Ed. Harisma, București, 1991.

Le Breton, David, *Antropologia corpului și modernitatea*, coll. *Cartier istoric*, translation from French byLiliana Rusu, Cartier, Chișinău, 2009.

Lipovestky, Gilles, *Amurgul datoriei. Etica nedureroasă a noilor timpuri democratice*, coll. *Sophia*, translation and preface by Victor-Dinu Vlăduțescu, Editura Babel, București, 1996.

Lipovestky, Gilles, *Fericirea paradoxală. Eseu asupra societății de hiperconsum*, coll. *Plural M*, from French by Mihai Ungurean, Editura Polirom, Iași, 2007.

Mladin, Nicolae, et alii, *Teologia Morală Ortodoxă*. *Vol. 2 Morala specială*, Editura Reîntregirea, Alba-Iulia, [2]2003.

Moldovan, Ilie, *În Hristos și în Biserică. Adevărul și frumusețea căsătoriei. Teologia iubirii II,* Editura Reîntregirea, [2]2014.

Moulin, Anne Marie, "Corpul în fața medicinei", in: Alain Corbin, Jean-Jacques Courtine, Georges Vigarello (coord.), *Istoria corpului. III. Mutațiile privirii. Secolul XX* (volum coordonat de Jean-Jacques Courtine), coll. *Cărți cardinale*, translation from French by Simona Manolache, Mihael Arnat, Muguraș Constantinescu, Giuliano Sfichi, Editura Art, București, 2009.

Pălimaru, Cătălin, *Teologia experienței în Corpusul macarian*, coll. *Monografii 4*, Editura Renașterea, Cluj-Napoca, 2014.

Queval, Isabelle "Le corps et la performance", in: *Actualité et dossier en santé publique*, nº 67, juin 2009.

Saint Basil the Great, "Homily I to Psalm XIV", 1, in: *Omilii și cuvântări*, in coll. *Părinți și Scriitori bisericești 1*, New series, translation from Greek and introduction by Dumirru Fecioru, text revised and note on edition by Constantin Georgescu, notes by Dumitru Fecioru, Constantin Georgescu and Alexandru Mihăilă, Editura Basilica a Patriarhiei Române, Bucharest, 2009.

Stăniloae, Dumitru, *Iisus Hristos, Lumina lumi și îndumnezeitorul omului*, seria *Opere complete 6*, Editura Basilica a Patriarhiei Române, București, 2014.

Teampău, Petruța, „Corp trăit, corp gândit. Ipostaze teoretice în științele socio-umane", in: LAURA GRÜNBERG (coord.), *Corp – artă – societate: reflecții întrupate*, Editura UNARTE, Bucharest, 2010.

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 63-69)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.04

THE MEDICALIZATION OF SOCIETY. CONCEPTUAL AN ETHICAL CONTROVERSIES

ELENA ŞARGU[1]

ABSTRACT. In order to support the evolution of medicine and to overcome the existing challenges, the phenomenon of medicalization becomes more and more remarkable in the field of medicine. Being conscious about the importance of forming a mentality on one's own health is the primary desideratum in a society where pathologies have become more and more numerous due to the distortion of the boundaries between health and disease.

Keywords: *Medicalization, Health, Disease, Ethics*

Introduction

In contemporary times the well-being – both physical and mental – of the individual generated the emergence of a modern concept in medicine called *medicalization*. In general terms medicalization if the process by which non-medical problems come to be defined and treated as medical conditions, usually as diseases or disorders. In this order of ideas the health of individuals became the object of medical study, invariably including mechanisms of diagnosis, prevention or treatment. The truth is that our whole life is medicalized, in the sense that we pay more attention to hygiene, we try to have a balanced physical and mental life and in most cases we use modern, more efficient medicine in a timely manner and so on. These are all factors that medicalize our lives at a fast pace, at the same time generating a controversial phenomenon characteristic to contemporary societies.

Practically medicalization is present at all times during our lives. This is quite obvious if we look at the numerous media sources, especially internet and TV stations where medical topics are covered quite generously. Currently, a

[1] Lecturer, PHd, Department of Philosophy and Bioethics „Nicolae Testemițanu" State University of Medicine and Pharmacy, Chișinău, Republic of Moldova.

proper living means a healthy living. Health became the convergence point of all human concerns with body, beauty, nutrition, sex etc. Medicalization is not an authentic medical discourse, but the adaptation of a medical discourse in socio-cultural discourses. This discursive contagion would not have been possible without the contemporary, highly developed, tentacular media providing access to a range of medical information. In the mass media pedagogy of health we can distinguish two essential elements: the pathological aspect, namely the fact that diseases must be identified as manifestations, as well as aspects regarding risk and prevention – how, by what means can we prevent the respective diseases. As a result, by combining these aspects the media presents a medicalized discourse emphasizing prevention. The desire for a healthy lifestyle hides the fear of death, which is represented and stimulated by the media, and constitutes the basis for an effective social practice. In this context there are a lot of discussions about the benefits of certain food, thus removing the random element and instituting the impulse to control consumption in a broad sense. We eat food high in magnesium, zinc etc. so as to prevent lung cancer, strokes etc. And at this point we can start discussing ethical implications. The socio-medical discourse, based on research and discourses in effective medicine, creates a health moral that tends to be incorporated in general ethics, thus making the reverse valid: to have a healthy life means to have a correct life, namely to have an ethical life [15, accessed: 20.01.2016].

The key to medicalization is defining. Medicalization is to define a problem in medical terms, using a medical language to describe a problem, adapting a medical framework in order to understand such problem, or performing a medical intervention to treat it. This is a socio-cultural process that may or may not involve the medical profession, determined by social control or medical treatment, or it can be the result of the intentional expansion of the medical profession [11, p.211]. Medicalization implies a change in our perception on health and disease. This becomes evident if we consider the fact that health is the result of a complex combination of interrelated factors such as: genetic baggage, social position, lifestyle, "the attitudes and values regarding health"; nowadays modern people are opting more and more for a healthy lifestyle and quality medical services [12, p.276].

Ethics is struggling to gain status in the eyes of scientists. The reflection on normative issues in medicine goes back to Hippocrates, however, the institutionalization of the discipline as medical ethics or bioethics is relatively new. Ethical thinking in medicine and biology is divided between philosophical principles and methods or hypotheses oriented towards the sciences of nature. And herein lies the dilemma, as those operating within the science of nature paradigm have different methods of investigating the subject. Moral conflict in

medicine became a reality with the pre-modern period, although these issues were not discussed extensively. This is due to "a specific cultural situation, where there is «a predetermined harmony» between medical ethics and the moral-theological position of the Church" [8. p.5]. If at the beginning medical ethics included the moral principles that govern all medical activities, being in fact one of the first ethical profession, today it also includes all discussions on issues related to ensuring the physical and moral integrity of people when they are subjected to medical treatments. However, the medical world is wide, it has many values and virtues, and a single type of medical ethics applicable everywhere is not desirable [5, accessed: 17.01.2016]. Medical ethics is correlated with bioethics, professional, scientific ethic, however, there needs to be an integrated overview, they all need to be interpreted within concomitant interactions for the medical act to be performed at a high level.

The cult of the body and health, the development of science and technology and the commercialization of life are complementary factors that presently establish the conditions for medicalization. It is obvious that medicalization should not cause concern, even if it comes with certain risks, as any other social process or phenomenon. The main concern is its uncontrolled expansion in all spheres of human life and society. When a situation is medicalized doctors are the only experts and consequently their power over other groups increases. The medical treatment is the only answer to health, although often it is not exactly adequate. Thus, medicalization should be considered a complex socio-cultural phenomenon that requires extensive research, especially with concern to socio-human disciplines.

The medicalization of health has an obvious impact nowadays, in the sense that the only way to maintain a healthy lifestyle is to comply with the norms of modern medicine that controls every stage of human life. The process of medicalization labels human physiological processes and eliminates any alternative treatment by prioritizing the medical act. I find Foucault's observation very relevant in this regard, as he points out that all areas of our lives become medicalized: "the fact that starting with the eighteenth century human existence, human behaviour, and the human body were brought into an increasingly dense and important medicalization that allowed fewer and fewer things to escape" [8, p.81]. Medicalization is practically part of our daily existence until our deaths. As highlighted by Giorgio Agamben, we are dealing with a nationalization of the biological and a transformation of life care in a main objective of the state. However, "neither life nor death, but the production of a virtually infinite and modular survival is the decisive performance of biopower in our times" [2, p.107].

One of the major impacts of medicalization is the fact that we are only treated from a biological stance, and the spiritual or other aspects are

eliminated from the medical act. Medicalization is evident in the various states of the patient, and the intervention is often risky, for example in the case of mental disorders. For the treatment of disorders such as schizophrenia, affective psychoses and even severe depression the pharmaceutical market offers a variety of possibilities. In such cases it is important to carefully administer drugs and to gradually eliminate the treatment by replacing it with non-pharmaceutical therapies. However, the pharmaceutical companies do not operate under a Christian ethic, and their main interest is to sell; with big pharma it is all about profit and not mental health and curing sickness. As a result, the drugs prescribed for mental disorders prove to be an important risk factor for the general population. It seems that physical exercise is in fact very beneficial to mental health, as evidenced by several studies on the matter. Mental diseases could be healed much faster if this domain would not be moved by money, if research institutions, politicians and psychiatrists could not be bought. Unfortunately these therapies are either kept secret or simply avoided through medical protocols learned in medical school [14, p.66].

Consequently, in the 20th century we started witnessing the production of ethical-moral distortions which expanded in the 21st century with the technical-scientific progress impacting greatly on the medical field. The idea behind this ethical-moral disorder is the following: "Not everything that is technically possible is ethically or socially acceptable and legal – these are principles that act as a control mechanism against the increasingly technology driven medical acts. To know human beings as best as we can and still keep as close to what it means to be human as possible implies both technological and ethical interventions, in such a way as to maintain the integrity, individuality and intimacy of the human being [9, accessed: 29. 02. 2016]. As a result, in order to prevent a complete degradation of the medical act and the intervention on the human body, medicine and medical progress need to be looked at from an ethical point of view. In this situation ethics is like a savior of morality when: "The informed, scientific and technical men, overwhelmed by utilitarianism and material prosperity, give less and less importance to the spiritual universe, morality, religious beliefs, sacred feelings, even love. They pay an enormous tribute to scientific and technical performances, medicine – one of the oldest and always current part of culture and science that was always characterized by a harmonious "dualism", seeking to combine knowledge and actions with psychological and spiritual levers. Namely, the latter are experiencing an increasingly pressing crisis" [10, p.329-334].

Medicalization changed the manner in which the individual perceives himself: "Man is slowly learning what a living species is in a living world, what is a body, what are the conditions of existence, life expectancy, individual and collective

health, what are the forces that can be changed and where can they be best distributed" [7, p.106]. Ethical issues cannot be eliminated from the medicalization process as behavior needs to be governed by ethics in order to distinguish what is legitimate and fair in the medical act. In this case both the doctor and the patient are responsible. Of course, we humans wish for a long and good life. That is why it is important to take all the necessary measures to ensure the psychological, spiritual and physical comfort of patients when treating them.

In the modern society we are now experiencing a strictly medicalized lifestyle, which paved the way for labeling, which symbolizes a psychological process and not a pathological one. As a result, if one wishes to maintain a healthy life it is inevitable to comply with the directives of modern medicine that correlate each stage of human life. On the other hand, this lifestyle has labeled a series of natural human physiological processes, therefore, through medicalization, an intervention to inhibit physiological processes can be considered "treatment" [1, p.36]. Medicalization if frequently mentioned in risk situations, in connection with the polymerization of uncontrolled drug consumption, without medical prescription, as well as in issues related to biomedical ethics (transplantology, cosmetic surgery, euthanasia etc.). Here we can notice how versatile the medicalization phenomenon is, and thus the urgent need for research to understand its characteristics, its place in the socio-cultural space, the potential risks associated with it [6, accessed: 17.02.2016]. However, why is it that this phenomenon is increasingly striking in the contemporary society, and the natural physiological disorders that occur at a certain stage in life, especially in the case of seniors, are labelled as pathologies that require drug treatment, surgery etc.? One possible answer is the increasing life expectancy due to rising living standards and the progress of public health, the use of drugs in various situations where natural remedies are ineffective (for e.g. pneumonia, leprosy, plague, devastating diseases in the Middle Ages). Moreover, pregnancy/birth are being given special attention, as in the past, due to the lack of hygiene, they could expose the mother and child to infection and death.

Today, thanks to medicine people want a good life, social fulfilment and dignity. The modern man successfully tries to overcome his limits starting with his attitude towards life and health. Fear of illness, aging, death etc. has sensitized man making him more receptive to changes in his body. Medicalization is defined by this state of fear. Despite the fact that ethics imposes certain limits, people seem to impose their personal priorities when faced with a critical situation. So, in this scenario, is medicalization beneficial or not for modern society? If certain ethical requirements are complied with, the impact of medicalization is positive.

In the 19th century society assumed responsibility for a "normal prolongation" of the human life, so that each individual can „have the possibility

to exhaust his or hers biologic capital" [3, p.289]. The newly developed disorders are relevant in this aspect: depression, menopause, sexual dysfunctions, anorexia, apnoea, hyperactivity in children (lack of concentration, impulsivity etc.), hypersomnia (excessive daytime sleepiness) [4, p.101]. On the other hand, many ethical problems today did not cause any concern 200 years ago, for example the informed consent for the medical act. The fact that certain issues are considered moral proves that fundamental changes occurred, and here we can also differentiate between cultures and how they interpret moral issues and find proper solutions to overcome them. All this is due to history, tradition, existing prejudices, experiences etc. [13, p.].

Medicalization is a modem phenomenon that revolutionized medicine by imposing new ethical-moral perceptions. Thus, whether we refer to natural physiological processes such as birth, death, hyperactivism, menopause etc., or to other states influenced by other factors such as heart disease, high blood pressure, diabetes etc., when we use medicalization to improve illness it is crucial to consider ethical aspects that can lead to overcoming certain limits that can have devastating effects on the individual.

Therefore, considering all the medical possibilities we have today to treat, stop, cure various diseases, I believe it is ethical to weigh if it is really necessary to use any means to improve these conditions, or if medicalization has gone too far by overcoming certain limits and has infiltrated so deep into the consciousness of society that we can no longer ignore this phenomenon. Medicalization is trying to eliminate certain human states such as: pain, suffering etc. by setting up a state of pleasure, of supreme good. Generally, medicalization seeks to set up a state of happiness, even if under certain circumstances the moral validity is surpassed by certain purposes. Therefore, medicalization is a rigid phenomenon implemented in the contemporary civilization that needs to be studied in perspective, as a much more complex aspect.

Bibliography:

Arda Berna. *Trebuie sau nu trebuie să oprim procesul de creştere? Problematica la copiii fără şansă de recuperare.* În: Revista Română de Bioetică, 2010, Vol. 8, No.1, Ianuarie-Martie, p.136.

Agamben Giorgio. *Ce rămâne din Auschwitz. Arhiva şi martorul*. Traducere de Alexandru Cistelecan. Cluj: Editura Idea Design & Print ,2006, p.119.

Бодрийяр Ж. Символический обмен и смерть. Москва: Добросовет, 2000, p.387.

Бурганова Л.А., Савельева Ж.В. *Медикализация и эстетизация здоровья в рекламной коммуникации*. Социологические исследования, 2009, №8, Август, In: http://ecsocman.hse.ru/data/814/429/1224/Burganova.pdf (accesat: 17.02.2016).

Criveanu Silvia*. Exerciţiile fizice ne pot salva sănătatea mentală.* În: http://www.familiaortodoxa.ro/2013/02/02/exercitiile-fizice-ne-pot-salva-sanatatea-mentala/ (vizitat: 17.01.2016).

Доброродний Д.Г., Черняк Ю. Медикализация как социокультурный феномен и предмет междисциплинарного исследования. In: http://elib.bsu.by/bitstream/123456789/35142/1/82-88.pdf (accesat: 17.02.2016).

Foucault Michel. *Istoria sexualităţii*. Timişoara: Editura de Vest, 1995, p.480.

Foucault Michel. *Biopolitică şi medicină socială*. Cluj-Napoca: Editura Idea Design & Print, 2003, p.148.

Manea Teodor. Filosofia contemporană şi bioetica. În: Revista Română de Bioetică, 2003, vol.1, Nr. 2, p.134

Мещерякова Т.В. *Причины появления биоэтики*. Философия. Социология. Политология. Вестник томского государственного университета, 2010, №4(12), с.94-95. In: file:///c:/users/admin/downloads/prichiny-poyavleniya-bioetiki.pdf (accesat: 29. 02.2016).

Ojovanu Vitalie. *Context şi premise ale axiologiei medicale.* În: Analele Ştiinţifice ale USMF „Nicolae Testemiţanu", Chişinău, 2007, Vol.1, p.393.

Peter Conrad. *Medicalization and social control*. In: Annual Review of sociology, 1992, vol. 18, p. 540.

Pop Cosmina-Elena. *Starea de sănătate a populaţiei din România în context european. O abordare din perspectiva calităţii vieţii*. În: Revista Calitatea Vieţii, 2010, xxi, nr. 3-4, p.414.

Satava R.M. *Biomedical, Ethical, and Moral Issues Being Forced by Advanced Medical Technologies*. In: Proceedings of the American philosophical society, 2003, vol.147, no.3, September, p. 246

Sirbu Tanase.*Etică: Valori şi virtuţi morale.* Iaşi: Editura societăţii academice "Matei-Teiu botez", 2005, p.262.

Teodorescu Adrian. *Alcohol without "ism" or for the necessity of a literary cultural perspective on alcohol.* Alba-Iulia: Editura Universitară, 2001. În: http://www.upm.ro/gidni/GIDNI-01/Lit/Lit%2001%2048.pdf (accesat: 20.01.2016).

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 71-78)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.05

BIOETHIC PREMISSES IN SPIRITUAL ADVICE OF PRISIONERS WITH SUICIDAL ATTEMPTS

VIOREL COJOCARU[1]

ABSTRACT. The suicides problem concerns several categories of specialists. It becomes a psycho-social problem with spiritual tangents. In prison environments suicides prevail, as a result of an immoral habitat, a private environment and the compulsion of a different lifestyle. A recovery warrant for people with suicide attempt was assigned to the spiritual adviser, which highlights the value of life. The spiritual counseling of the prisoners with suicide attempt proves necessary both for prison environments as well as for the free society.

Key words: *Moral, Consulting, Spirituality, Prison System, Ethics*

REZUMAT. Premise bioetice în consilierea spirituală a deţinuţilor cu tentative de suicid. Problema sinuciderilor trebuie să fie abordată de mai multe categorii de specialişti deoarece devine o problemă psiho-socială cu tangenţe spirituale. În închisori rata sinuciderilor este cu mult mai crescută ca urmare a unui habitat imoral, a unui mediu privat de liberate şi a existenţei unui stil de viaţă diferit. Consilierului spiritual, care are rolul de a scoate în evidenţă valoarea vieţii, îi revine sarcina de a recupera persoanele care comit tentative de suicid. Consilierea spirituală a deţinuţi cu tentative de suicid se dovedeşte necesară atât din perspectiva lor înşişi, aflaţi la închisoare, cât şi din perspectiva celor aflaţi în societatea liberă.

Cuvinte cheie: *Morală, Consiliere, Penitenciare, Spiritualitate, Etică.*

Introduction

The problem of the persistence of the spiritual-moral climate within the penitentiary institutions remains a taboo element for the contemporary society. The individual sentenced to deprived of liberty imprisonment faces, from beginning, two types of problems: firstly the accommodation to the norms and

[1] Priest university lecturer, PhD student, Department of Philosophy and Bioethics of the State University of Medicine and Pharmacy „N. Testemitanu", Chisinau, the Republic of Moldova.

values of the environment specific to the prison and secondly the evolution or involution of his personality in the penitentiary system. For both aspects, the individual needs moral support and counseling as each stage in the complex deprivation of liberty has risks of moral fall. Behaviorally, the prisoner quickly passes from the conformist morality focused on guilt to the moral frustration, based on group beliefs, explaining the cases of the crimes, his attitude towards work, family, law, future etc. In both periods, the convict goes through moments of risk, either created by him, or favored by the entourage. The most dangerous moments are those ended with self-harm and sometimes leading to suicidal attempts.

Starting from the idea that the bioethics is the science that has an inter and trans-disciplinary approach, from sciences capable of offering the contemporary society methods forms of prolonging the life, quality of life, diminution of sufferings etc. The approach of the proposed topic starts from this premise, wishing to highlight the beneficial and acceptable effect for all of the spiritual advisor's effort in solving the suicidal attempts. The form and methods by which the advisor restores the meaning of life (psychic and physical), the confidentiality and trust have changed and kept the lives of many prisoners. The need of spiritual advisor, especially of those ignoring their own lives, can be observed from relationships build between advisor and prisoner, doctor and prisoner.

The problem of suicide is recorded as one of the most incomprehensible human actions. It was analyzed and researched by various specialists: doctors, sociologists, priests, psychologists, jurists etc. Many writings about this scourge have not come to meet the true causes of the contemporary society, as the number of suicides is increasing. Moreover, there is an increase of the young's interest to read novels or other works that illustrate the stages and the "fruits" of suicide. Most TV channels, internet posts etc. propose viewing artistic sequences or documentaries that bring glory to self-murderers.

In most European countries, the suicide is considered a public health problem since the statistics classify it among the top ten decease causes [9, p.142].

What suicide means?

The well-known Romanian explanatory dictionary describes suicide as "the action by which the man takes his own life" [4, p.1814]. Jurists define suicide as a "deadly self-harming that involves the absence of a judicial conflict" [5, p.213]. Therefore, from the penal point of view, nobody is responsible for this crime – it is easy to assign a murder as a suicide. We are witnesses to the

idea that suicide is differently defined by the scientific domains. From a bioethics point of view suicide is "intended suppression of life" [8, p.315]. The Orthodox Church moralists define suicide as an irreparable method by which we consciously voluntarily destroy our own life without a real reason [12, p.217-218]. The researchers who have closely studied this phenomenon claim that suicide is not necessarily seeking the death or abolition of one's person, but the escape from life, from problems, the way in which the victim represents [8, p.215]; or emotional blackmail [2, p.68] – often found in the penitentiary environment.

Suicide is considered as a moral disease that can be contagious, for example true epidemics of voluntary deaths are sometimes registered as specific to a certain time and place. Nowadays, a special place is presented by the penitentiaries. In the penitentiary institutions around the world are known the self-harm and self-mutilation phenomena. These intentions are characterized by a certain deviant behavior. These are the reaction to some crisis situations to intolerable stresses including: vein cuts, superficial wounds, swallowing of objects that cause serious injuries to the esophagus, hanging attempts or impulsive poisoning. The prisoner's behavior is a significant and persistent clinical problem in the penitentiary environment. In the penitentiaries all the directions in the institution are responsible of this phenomenon. It has been proven that the best way to counteract is the teamwork. Here, a special contribution can have also the spiritual advisor of the institution, who brings to the administration's knowledge the decisive factors in the evolution of the problem. The spiritual advisor in the penitentiary institutions is also called chaplain, no matter the religion.

How does this "epidemic" manifest in a deprived of liberty environment?

The risk factors that cause this self-aggression among detainees are different from case to case, but there are some predominant:

- The fact that *he/she was deprived of liberty* – whether is under a long-term imprisonment or is already sentenced - destroys his/hers future intentions, it produces a rupture from the society and family. These types of suicide are found in the preventive penitentiary institutions or in the temporary holding cells of the municipal or district police stations. Those taking such drastic decisions are the melancholic ones.
- In the penitentiaries, suicide is most often due to the break of the *link with the family*. The Family Code of the Republic of Moldova states that

a person may seek divorce if the other one is deprived of liberty for more than 3 years [3]. Braking the links with the family and children, relatives and friends causes solitude in facing the penitentiary problems and creates a strong impression of uselessness in the society. Also, in this situation, the stigmatization probability of the prisoners in post-detention period increases.

- Risk factors are also the *socio-economic status, the disadvantages, diseases (depressed neurotics, hormonal imbalance, weakening of certain neurotransmitters)* [9, p.141], *psychic and anxiety disorders, depression etc*.
- Sometimes, we find *a family predisposition for suicide or hereditary transmission*. Most convicts with suicide attempts come from families with law conflicts.

The real suicide attempts must be distinguished from the manipulative acts of self-harming or self-mutilation, which actually aim to receive attention or to force the achievement of some personal benefits. At this point the role of the spiritual advisor can be noticed, which after the personal discussions with the prisoner may distinguish the motivations of his acts. Most suicidal persons from the penitentiaries have a period of time with repeated attempts, until they actually do it. These attempts are often hidden by the cellmates so that they will not be seen as provocative or persecutors, even if things really are that way. Group spiritual counseling of those in cells is not possible, since it requires an intimate and private moment.

The role of the spiritual advisor in recovering the prisoners with suicidal attempts

In the penitentiary, the spiritual advisor plays the role of a parent and friend to most deprived convicts. His success in this context depends on his ability to initiate and to maintain a personal relationship with the prisoner with the obligation to respect the confidentiality. He does not distinguish between age, social status, religion, sex or the severity of the act for which he was convicted. He engages in solving the behavioral problems and as a result he can identify the prisoners with suicide attempts or problems. The detainee' behavior with this type of tendencies does not depend on the seriousness of the crime he was convicted for. All prisoners have the right to a moral life focused on ethical principles, which transforms them from delinquents into exemplary individuals. The frequent meeting of the advisor with the prisoner favors by increasing the confidence also the sincere openness for the spiritual advisor.

From the idea that suicide is considered first of all a crime against human beings and life, a crime against society, the disobedience is the most serious violation of the divine rules. At the beginning of the spiritual counseling of the prisoners with suicidal problems, the most successful approach is the one based on the premise that human's life is the greatest gift that God gave us [10, p.321]: The Creator and the Sustainer of the human bios, Creator of the human being in general, God is the only one to decide the end of our earthly existence. The human does not have the right to intervene in this chapter and neither in the birth one. In religious thinking, the value of life in the body is irreplaceable, since the body is the temple of the Holy Spirit (I Corinthians 3,17), and "the suicide is an act of insurrection against the life giver, a destruction of the Holy Spirit temple, which is the body" [1, p.184].

From the experience during the activity as a spiritual advisor in the penitentiaries from the Republic of Moldova, maintaining a profound spiritual life can be considered a very efficient method to keep the bios in the physiological and psychological norms. Its results are everyone's benefit. A profound spiritual life is not a random phenomenon because the man is isolated from the society, family, job etc. It is in this environment that the religious feeling is updated; the individual having great hopes on the possibilities of the divine intervention in solving his/hers problems. These hopes are strictly related to his/hers own behavior, both in relation to himself/herself and in relation with divinity, cellmates, family, guardians and doctors.

Three theses of Christian morality that condemn the suicidal act are on the basis of the spiritual counseling of the prisoners with suicidal attempts:

a) suicide is a crime against life and human nature;
b) suicide is a crime against society and family;
c) suicide is a crime against God.

On the other hand, the human being is endowed with a powerful defense instinct and uses the most unexpected methods of prolonging the life. The human body has defense instruments, using them when its existence is threatened by others. In many cases, the man is using all the means to prolong its existence, being also visible the progress of the techno-scientific treatment of incurable diseases. Or, in this context, suicide is a defiance to the human nature, and it transcends the barriers of the right on human life. Human's call is superior to the problems and troubles of this life, therefore the advisor will bring real examples of individual who have saved their own human nature by serving the good. The good is highly expected in a penitentiary and the spiritual advisor will support the prisoner's initiative to do good to its colleagues by initiating this process. To have a healthy spiritual life in the penitentiary we have to help the detainees to set moral principles of existence that prolong and sustain the life.

A successful counselling method and with prompt positive feedback is the explanation that suicide is a crime against society and family. Regardless the context, each person is useful to the society. The existence of a person is the basis to the existence of another one, but those who don't value their own life are indifferent of other individuals [9, p.143]. Updating and remembering the beautiful events from childhood or with the family, of those with positive social impact, gives greater value to the prisoner's counselling. This chapter is included in the widest forms of counselling and it represents important subject by which the prisoner can recover from depression. By remembering the glorious and beautiful moments of his life will sensitize him to the pain of the family, relatives and society. On long term, the spiritual advisor can support the re-establishment of the relationship with the family, relatives and friends who will visit the detainee during sentence and will justify his social utility.

The strictly spiritual method the advisor will use is to explain the detainee that suicide is a crime against God. The suicide is one of the most serious sins that ever existed; if in the case of other sins there is a possibility of returning and restoring the relationship with God, with suicide there is no chance of change. The pious Iustin Popovici states that "suicide is, in fact, the inevitable result of God's killing" [7, p.15]. The severity of this act is that the self-murderer gives up to the possibility of return, repentance and transformation of the human nature. The post-mortem encounter with God is inevitable for every person.

Life is the most beautiful gift God gave to us [6, p.210] and this gift must be protected. The spiritual advisor uses the Word of Life which offers the desperate prisoner the helping hand of the Creator's love. To justify the above, the spiritual advisor can read to the prisoner the word of the Bible, which give:

- the absolute forgiveness through Christ's sacrifice on the Cross, the forgiveness of any confessed sin (I John 1, 7-2);
- the exclusive right of the Savior to give or to take the life (Deuteronom 32, 39);
- God's vision on the sanctity of life (Acts 1, 26-27);
- God's care for those depressed and desperate (Psalm 27, 10).

All these scriptural arguments represent the basis of the spiritual counselling of the prisoners. The Holy Scripture is of great value for prisoners as a written act and their return to the status of a pure individual before God is the opportunity long awaited by many. The moment of human nature's redemption, in which God sacrificed His own Son, is the most beneficial means of returning the condemned from the hardest sufferings they face in the penitentiary. The immortality problem in religion and anthropology can justify advisor's approach. Suicide can be considered a violation of human's life

sanctity, which, "according to the bioethical beliefs, is inalienable, sacred, unique and inviolable, both physically and spiritually" [11, p.90].

The provision of examples of human's nature resistance in penitentiaries is an efficient means of the spiritual counselling of the prisoners. In the public counselling of the convicted, the most successful examples of Christian behavior in penitentiaries are the lives of self-taught persons, who have self-enlightened in prisons. After each discussion and offerings of books, describing these moments, the prevention of suicide in the penitentiaries will be facilitated. The most impressive events are those with politically convicted intellectuals during the communist period in Piteşti, Gherla or Aiud. Their works are requested not only in the penitentiary, but also by the whole society.

A problem that cannot be kept under strict control is the post-detention suicide of the convicted. The newly released convict who has unfunded illusions about society faces major problems after it. Even the fact that the family is insufficiently prepared to receive the new member carrying the moral and penal sequels makes the detainee feel useless. But the most serious problems are the stigmatization from the society that creates obstacles in the individual's achievements post-detention: he/she cannot get a job, his family and relatives reject him/her, his/her old friends avoid meetings etc. All of these factors lead the newly released individual to attempt suicide. If close relationships with the spiritual advisor have been created during detention, these moments can be easily overcome through periodic counseling and psycho-emotional support, but if these aspects are missing, the suicidal probability is higher. The most successful method to control suicide in the post-detention individuals' case is the context in which the spiritual advisor manages to create a large supporting family from former detainee or a club in which they meet and support each other, in which can also take part persons from different domains who will show solidarity.

Conclusion

The successes of an exceptional counseling are necessarily related to the behavioral therapy of the advisor. The moral value of the word in the spiritual counseling is enormous, but it can be infertile if the behavior does not meet the intentions. The best example of counseling is represented by the facts of the advisor. We also mention that the detainees have great reluctance to the free persons who want to help them. Therefore, the entire behavior of the advisor is what can guarantee the success or failure in collaboration with the prisoner.

An adequate spiritual counseling takes into account the contemplation in the meaning of life. For the convicted with suicidal problems, the spiritual advisor is a true lifeline. Educating the moral norms and principles of life is beneficial both for the individual deprived of liberty and the entire society.

Bibliographical references:

Andrutsos Hristu. *Sistemul de morală*. Sibiu, 1947.

Brînză Sergiu. *Infracţiuni contra vieţii, sănătăţii, libertăţii şi demnităţii persoanei*. Chişinău, 1999.

Codul Familiei al Republicii Moldova. Art. 36 alin. c., Chişinău, 2001.

Dicţonar Eplicativ Ilustart al Limbii Române. Bucurşeti: Ed. „Arc" „Gunivas", 2007.

Dongoroz Vintilă. *Explicaţii teoretice a Codului Penal român*. Vol. III. Partea Specială. Bucureşti: Editura Academiei, 1971.

Lemeni Adrian. *Asumarea vieţii ca dar al lui Dumnezeu în contextul morţii a societăţii cotemporane*. În:„Sensul vieţii, al suferinţei şi al morţii. Referatele Simpozionului Internaţional", Alba Iulia, 29 februarie-2 martie 2008. Alba Iulia: Ed. „Reîntregirea", 2008, p. 203-215.

Molodeţ Petru. *Nise conferă un nou drept: Dreptul de a ne sinucide şi de a fi eutanasiaţi*. În:„Presa Ortodoxă", 2009, nr. 6, p. 15-22.

Niţă Marian, Gheorghe Iuliana, Ionescu Florin, Otilie Bogdan, Mogoi Cristian, Buşe Violeta. *Dicţionar de Bioetică*. Craiova: Ed. „Aius", 2009.

Popescu Leontin. *Bioetica şi perspectiva creştină*. Brăila: Ed. „Istros", 2009.

Stăniloae Dumitru.*Teologia Dogmatică Ortodoxă*. Vol. I. Bucureşti: Editura Institutului Biblic şi de Misiune a Bisericii Ortodoxe Române, 1996.

Ţîrdea Teodor N. *Elemente de Bioetică*. Chişinău, 2005.

Zăgrean Ioan.*Morala Creştină*. Ediţia a V-a. Cluj-Napoca: Ed. „Renaşterea", 2006.

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 79-88)
(RECOMMENDED CITATION)
doi:10.24193/subbbioethica.2018.06

NON-COMPLIANT PATIENT – ETHICAL VIEWS

ANDREEA-IULIA SOMEŞAN[1]

ABSTRACT. Romania is among the top of European countries with the highest prevalence of self-medication. A better understanding of the present management of medical non-compliance could have a contribution in understanding and improving, from the ethical perspective, of the medical staff's behaviour for the purpose to reduce this phenomenon.

Keywords*: self-medication, medical non-compliance, doctor - patient collaboration*

REZUMAT. Pacientul necompliant – Perspective etice. România se află pe locurile fruntaşe ale Europei în privinţa automedicaţiei. O mai bună înţelegere a modului în care este gestionată în prezent necomplianţa medicală poate contribui la înţelegerea şi îmbunătăţirea din perspectivă etică a comportamentului personalului medical cu scopul de a reduce acest fenomen.

Cuvinte cheie*: automedicaţia, necomplianţa medicală, colaborarea doctor - pacient*

Introduction

Many mass-media articles were presenting in the last decades a problem the Romanian medical system is confronting: the non-compliance to treatment and, consequently, self-medication. The specialty literature discusses of an increased interest of the doctors and pharmacists for this topic[2]. However, in the actual pharmaceutical practice, patient monitoring is rarely encountered. Therefore, the magnitude of this phenomenon is not known in detail and it is

[1] Andreea-Iulia Someşan, PhD student Babeş-Bolyai University, Doctoral School of Philosophy, coordinator Prof. Dr. Ion Copoeru, Cluj-Napoca Romania.
Email: somesan.andreea.iulia@gmail.com

[2] Prof. Dr. Farm. Laura Vicaş, *Complianţa pacienţilor la tratamentul medicamentos. Patient compliance with the treatment, Practica farmaceutică*, vol. 6, nr. 4, an 2013, pp. 198-200, https://farma.com.ro/articles/2013.4/PF_Nr-4_2013_Art-2.pdf, p. 198

difficult to evaluate from the perspective of the ethical dimensions of doctor-patient relationship. Yet, in media, there are articles that discuss cases of explicit refusal from some patients – some even with tragic consequences. We are talking about patients refusing to take vaccines, sanguine products, invasive therapies etc. Leaving the problem of the existence or nonexistence of a reason for the refusal, many patients who don't find time for a medical consult or do trust their doctor opt for self-medication, contributing to the high percentage of this phenomenon in Romania[3]. Although we are talking about different terms – non-compliance, refusal, self-medication – depending on the meaning given to these notions, their extent is more or less overlapping.

Methodology

In order to carry out the study, a survey based on quantitative and qualitative data was given to the students and residents of various medical specialties at a medical congress, organized by a Health Center in Mures county[4], on this theme.

The participants were informed and asked, after a presentation session, to complete the questionnaires, emphasizing the importance of the qualitative data in the study – possibly presenting some cases. They were assured of the anonymity of the questionnaires. Of the eligible participants, a 23,45% percentage (19 persons) have completed it. It is worth mentioning that some participants did not take part in the session the proposed case was presented.

This survey was addressed mostly to medical students and medical residents as in the clinical practice, they are relatively neutral in relation to managing a non-compliance situation – they are not the ones to take decisions and to give treatments to patients. However, they are familiar with the attitude of the medical personnel responsible in these situations and can also understand the patient's point of view, observe the non-compliance to treatment from the perspective of their own experience with the medical system. On the other hand, by having a minimal experience in the clinical area and knowledge of concepts and practices of medical ethics, they are able to detect if a certain type of behavior of the medical staff is adequate or not. In addition to the 10 students and 4 residents, 4 specialist doctors who wanted to get involved in the survey {University clinic/dentistry-orthodontics (1), surgery (1), family medicine (2),}

[3] Dr. Alexandrina Constantinescu, Automedicaţia la români, Farmacist+ro, Anul IX • Nr. 146 (3/2012), http://www.prolekare.cz/pdf?id=38619, p. 54

[4] Centrul de Medicină Preventivă şi Lifestyle Herghelia, jud. Mureş, (2-5 martie 2017)

with an experience of 3, 7, 24 and respectively 29 years of practice decided to answer the questionnaires.

The respondents, voluntarily and anonymously, filled the questionnaires with the requested data. They answered only those questions they felt they could do.

Results

From the quantitative data, it can be noticed that the explicit refusal of the medical prescriptions is not perceived in the clinical area as a major problem and, generally speaking, sufficient information is provided to the patients, in a somewhat accessible language. In the medical decisions, from the perspective of the medical staff, there is moderation on the doctor-patient relationship, with a tendency towards patient autonomy.

No. Crt	The evaluated aspect	Total absence (1)	Low frequency (2)	Moderate frequency (3)	Majority frequency (4)	Absolute frequency (5)
1.	Frequency of refusal cases	2(2S)	12 (5S,3R,4M)	4(3S,1R)	1(1S)	–
2.	Providing treatment information	2(2S)	1(1S)	5(4S,1M)	5(1S,3R,1)	6(3S,1R,2)
3.	The ability to understand information provided	1(1S)	1(1S)	10(7S,2R,1M)	3(1R,2M)	3(2S,1R)
4.	Providing information on the possible consequences of refusing the treatment	–	2(2S)	5(1M)	5(2S,2R,1)	7(3S,2R,2)
5.	Providing information on the existence of possible medical alternatives, by highlighting their advantages and disadvantages	3(3S)	4(3S,1R)	2(2S)	6(1S,3R,2M)	4(2S,2M)
6.	Finding the type of doctor-patient relationship in making the decision (from the paternalist to a patient autonomy)	–	5(4S,1R)	6(3S,1R,2M)	6(3S,2R,1M)	2(1S,1M)
Legend		*S – student, R – resident, M - medic*				

The specialist doctors' answers tend to be positive on the doctor-patient relationship, the information offered and the respect for the patient's autonomy. Regarding the qualitative answers, they have presented the procedure for informing and mentioning the patient's refusal and offered some reasons for which the patients refuse the treatments, without specifying one to involve ethical aspects. Instead, the students tend to notice more the deficiencies in doctor-patient communication. Even in the section of open answers, they discuss more about patient's mistrust in the medical system and pharmaceutical industry.

On the other hand, bypassing the various reasons for not completing the questionnaires and specifying the unawareness of such situations, there were also people (students) mentioning their status in the clinical area as their reason for not completing it. They considered they are in the clinic only to learn and not the ones to take the medical decisions. They are not curing doctors and do not consider it ethical to talk about how the doctor and the medical staff manage their relationship with the patients, their informing and any other similar situations.

In a varying percentage, some participants in the study have chosen to answer also to the three fields focused on qualitative data, the most detailed answers being given by students. Most of the answers were given in the section regarding the presentation of some predominant reasons of treatment refusal (psycho-emotional, economic nature, etc.). Of those suggested as an example, the refusal for economic reasons was highly mentioned. Another aspect often mentioned was ignorance, the lack of an adequate education. Some participants offered some more explicit reasons, of which we mention the ones involving also behavioral aspects of the medical staff and the lack of a constant concern from the patient regarding his health.

The main reasons are:

> "The loss of confidence in the pharmaceutical industry that has become a big business. The interest is not the wellness of patient, but the financial one: between doctors and the big pharmacies there are agreements, therefore, to recommend patients as many medicines as possible."
> "I promote a healthy lifestyle and, sometimes, the treatment has more adverse reactions than benefits."
> "The patient does not find useful the prescribed treatment; the patient does not trust the doctor; the doctor-patient relationship is not beneficial"
> "A too sudden negative diagnosis was given; lack of financial support",
> "Economically, they were not willing to invest the necessary time in periodic medical checks",

"Fear – They don't feel prepared. They do not wish to assume the risks of possible secondary effects".

The next item refers to present some aspects considered essential in managing a refusal. These answers highlight attitudes by which the patient would gain more confidence in the medical staff, thus achieving a better compliance. Due to the fact that each answer highlights important aspects from an ethical perspective, will be presented below:

"Other treatment alternatives should be presented";
"Improving the communication between doctor and patient; earning the patient's confidence by the doctor";
"I consider that the doctors should take into account also the patients' opinion and moreover to explain them (possibly summary) the adverse reactions versus benefits, what benefits a certain treatments gives them and what can happen if they don't take it at all or fully respect it.";
"The explanation of the procedure was resumed; other patients with the same procedure were presented to the patient, which whom he/she spoke; saw the procedure on other patient.";
"Providing complete information; Advantages/Disadvantages; Risk/ Benefit Balance";
"It is essential for the doctor to explain clearly and complete the consequences of refusing the treatment so that the patient to be aware and to assume them. Furthermore, the patient will sign the refusal paper.";
"Giving understandable explanations of the disadvantages to the patient";
"It is very important the authority of the doctor and its power of conviction of following a treatment or procedures (in order to establish a correct diagnosis and an adequate treatment); the patient should feel empathy from the doctor.";
"The explanations are too abstract";
"The patient's choice must be always respected, but we have to be sure that he/she understood the consequences of refusing the treatment";
"The patient is explained once the consequences of refusing/ interrupting the treatment, the discussion is recorded, together with the patient's signature of assuming the decision.";
"Ensuring an emotional comfort; explaining the type of treatment proposed and the risk/benefit report; explaining in detail of the procedure or treatment, so that the patient is not taken by surprise."

The questionnaire offered the possibility to the participants to present some observed cases or to speak from their own experience, but most mentioned that they do not know or did not wanted to answer. However, one of the participants offered a case from its own experience, presenting the impact of the inappropriate attitude of the clinician towards the non-compliance of the patient:

> "I had an incomplete spontaneous abortion, and after the clinical examination and the trans-vaginal ultrasound this diagnosis resulted, the doctor recommended emergency surgery and an anti-hemorrhagic drug. I told her that I don't want the curettage, since the pregnancy was incipient, as I preferred to be in vigilant expertise (aware that I am healthy) and if the conception product wouldn't be eliminated after a period, I would have taken attitude (of course, I have explained the doctor that I will pay attention to temperature and pain, if it had occurred or I have suspected an infection).
> Mrs. Doctor didn't warned me that the lack of the curettage could have negative consequences, but told me "Do as you wish!" and then recommended me an anti-hemorrhagic treatment, since I have refused the surgery. I wanted the body to remove the remaining embryo and for this I had to bleed.
> Mrs. Doctor followed the protocol, but did not take into account my wish."

Discussions

The present study revealed that among the participants, the refusal of treatments/medical procedures, although present in the Romanian medical system, is not considered a major problem – its frequency being relatively low.

On the other hand, if giving information about the treatment and its refusal is considered to be at one of the highest level, the patient's ability to understand is evaluated as moderate. In this context, probably, it is necessary for the medical field professionals to be more self-critical on the way they offer information regarding the treatment and its refusal, using more often tools to evaluate the way in which the given information answers to the patient's concerns. This aspect also needs an evaluation from the perspective of the patient's apperception for the accuracy of the data about the clarity of the process of obtaining the patient's informed consent.

It is interesting how the certainty of the professional diminishes when bringing into question the problem of providing information about the advantages and disadvantages of the different alternatives. On the other hand, it should be noted that the doctor-patient relationship is evaluated from a balance between paternalism and autonomy to a slight tendency towards autonomy. By correlating this aspect with those mentioned above, we can conclude the following: 1) the curing doctor manages to find the medical alternative that responds to the patient's expectations to the greatest extent; 2) during the anamnesis, the doctor manages to bring in discussion aspects that lead to the acceptance of the alternative (from the patient's value commitment); 3) the doctor presents several alternatives, emphasizing, according to personal considerations, one of them as appropriate; 4) the doctor-patient relationship remains at a superficial level in which the doctor gives the treatment and the patient tends to approve its decision without exposing his personal considerations and perplexities. This last aspect might be the most possible explanation of the existence of such a high percentage of self-medication in Romania. And this perspective is also supported by the authors concerned with this problem, who describe the following paradox: "some patients ask for medical advice and then ignore it, in varying degrees and in different ways, the therapeutic recommendations"[5]. This situation leads us to the possibility of a deep distrust of the patient in the doctor: the patient does not reveals his questions and perplexities, but prefers that, once he arrives at home, to consult with the close ones on the treatments or to search on discussion forums and other internet sources.

From the close analysis of the items in the questionnaire, as a whole, a discrepancy can be observed between the quantitative and qualitative answers. If we take into consideration only the answers with multiple items, we could conclude that the medical staff-patient relationship is unfolding in relative good terms. However, if we analyze the firmness of some answers to the open questions, we could seriously question on the establishment of a medical care based on the respect of human dignity, such as: "The loss of confidence in the pharmaceutical industry that has become a big business. The interest is not the wellness of patient, but the financial one: between doctors and the big pharmacies there are agreements, therefore to recommend patients as many medicines as possible", etc.

[5] Al. Secăreanu şi T. Neamţu, *Complianţa terapeutică. Coordonate medicale şi psihologice*, Ed. Gloria, Cluj-Napoca, 1996, p. 8

The pathway followed by the non-compliant patient

1. Seeking information from unauthorized sources
2. Dilemmas, strong values, fears and expectations
3. The doctor's prescription
4. Contrary demands of the patient/dilemmas regarding the treatment scheme
5. Doctor's attitude "Do as you wish!"
6. Additional information in alternative sources that strengthen the distrust in doctors/medical system.
7. Mistrust in the doctor's proposal and, subsequently, in the entire medical system
8. Choosing self-medication
9. High probability of self-diagnosis/wrong treatment
10. Impairment of quality of life (new and, probably, severe health problems)

The answers to the questionnaire show cases of a possible lack of a real concern from the medical system professionals, in their daily activity, to meet the needs and expectancies of the patient through the proposed treatment/ procedure. Such an example is the response of the gynecologist to the patient's perplexity in the presented case: "Do as you wish!" Is it sufficient for the doctor to present the treatment scheme to the patient and in case of any confusion to answer in such a way? Doctor's conduct in the case of refusal of treatment is mentioned in article13 from *Law no. 46/2003 (The law on patient's rights)*[6]and in article649 from *Law no. 95/2006 on the reform in the medical system*[7]. According to these normative acts, the refusal is recorded in writing after the doctor has given information on: "the diagnosis, the nature and aim of the treatment, the risks and the consequences of proposed treatment, the viable alternatives of treatment, their risks and consequences, the prognosis of the disease without treatment".

[6] *Legea nr. 46/2003*,Art. 13, http://www.dreptonline.ro/legislatie/legea_drepturilor_pacientului.php, Pacientul are dreptul să refuze sau să oprească o intervenţie medicală asumându-şi, în scris, răspunderea pentru decizia sa; consecinţele refuzului sau ale opririi actelor medicale trebuie explicate pacientului.

[7] *Legea nr. 95/2006* Art. 649. https://lege5.ro/Gratuit/geydamrugi/legea-nr-95-2006-privind-reforma-in-domeniul-sanatatii -

(1) To be subject to methods of prevention, diagnosis and treatment, with potential risk for the patient, afer their explanation by the doctor, dentist, nurse/midwife, accordng to the provision of align. (2) and (3), the patient is asked for written consent.

(2) To obtain the written consent of the patient, the doctor, dentist, nurse/midwifeare obliged to give the patient information at a reasonable scientific level for his/her understanding.

However, this practice involves a comprehensive dialog by which the doctor ensures that the patient understood all the mentioned aspects regarding the medical condition and the report between advantages and disadvantages of different medical alternatives. But the statement "Do as you wish!", even though a pleasant expression, denotes the indifference of the doctor and the possibility of an abandon if the patient has a different option than the medical recommendation. This attitude of the curing doctor will lead the patient to inform himself, to seek for alternatives and self-medication. The potential steps in making such a decision could be those presented in the table.

From the obtained information, it can be noted a range of attitudes in managing the patient's refusal: from indifference to his decision, to the attempt to offer the patient new evidence in order to highlight that the proposal of the curing doctor is the best. Finally, we ask the question: To what extent does the curing doctor offer the patient the possibility to choose the alternative that best suits his expectations (e.g.in the context of strong personal beliefs), even if the alternative, medically speaking, is not the most indicated in relation to the patient's health condition?

Conclusions

The present study is a restricted exercise and its purpose was to observe attitudes and hypotheses in order to develop new approaches on the proposed topic. The validation and invalidation of the data and hypotheses can be done only after an in-deep study, using qualitative instruments adapted to the depth of these aspects that target the patients as subjects.

In this study, the following aspects were noticed regarding the refusal of medical support: inaccessibility of medical service (due to distance, financial problems, time), poor communication between the doctor and patient (the need of improving it), lack of time, medical information presented in specialized terms, which are not always understood, distrust in the medical and pharmaceutical system that has become a business, the wish to avoid confronting the doctor considering that he would not be able to understand and accept the personal context. According to the presented case, it is not enough for the doctor to do what it is medically necessary, but also to listen to the patient's wishes and to analyze to what extent could be followed in the proposed treatment scheme.

(3) The information must contain: the diagnosis, the nature and aim of the treatment, the risks and the consequences of proposed treatment, the viable alternatives of treatment, their risks and consequences, the prognosis of the disease without treatment.

Bibliography:

Al. Secăreanu, T. Neamţu, *Complianţă terapeutică. Coordonate medicale şi psihologice, Editura Gloria, Cluj-Napoca, 1996, 63 p.*

Laura Vicaş, *Complianţa pacienţilor la tratamentul medicamentos. Patient compliance with the treatment*, Practica farmaceutică, vol. 6, nr. 4, an 2013, pp. 198-200, https://farma.com.ro/articles/2013.4/PF_Nr-4_2013_Art-2.pdf

Alexandrina Constantinescu, *Automedicaţia la români*, Farmacist+ro, Anul IX • Nr. 146 (3/2012), http://www.prolekare.cz/pdf?id=38619, p. 53-55

Law no. 46/2003 on Patients Rights, Article 13, published in *Monitorul Oficial*, Part I no. 70 from 03/02/2003.

Law no. 95/2006 omn Health Reform, Article 649, published in *Monitorul Oficial*, Part I, no. 372 from 28/04/2006.

II. INTERVIU – INTERVIEW

STUDIA UBB BIOETHICA, LXIII, 1-2, 2018 (p. 91-93)
(RECOMMENDED CITATION)

ESTABLISHING A MASTER PROGRAM IN RESEARCH ETHICS AND METHODOLOGY IN CLUJ-NAPOCA, ROMANIA

An interview with Dr Horaţiu Colosi, Associate Professor at the Iuliu Haţieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania, Director and Principal Investigator of the program

Question 1*: "Next year, in 2020, a new master program will start in Cluj-Napoca, within the Iuliu Haţieganu University of Medicine and Pharmacy. What is this new program about?"*

The new program builds upon a previous master program in Medical Research Methodology, by significantly broadening its scope and curriculum to include Clinical and Research Ethics in Medicine.

The new and improved two-years curriculum has been developed together with faculty from the Icahn School of Medicine at Mount Sinai Hospitals in New York (ISMMS), as part of a research and development grant awarded by the Fogarty Foundation of the U.S. National Institutes of Health (NIH).

Throughout the project, ISMMS faculty will provide mentoring and support to assure sustainability of the program by ongoing activities to foster a collaborative community of bioethicists, researchers and healthcare professionals from Romania, Europe and the USA.

Question 2: *„What is the aim of the new master program?"*

The new training program will prepare its graduates to conduct ethically and methodologically sound research projects, to participate in the review of research projects, to participate in ethically sound clinical decision-making, to train others and to promote the development of clinical and research ethics infrastructure and policy in Romania and its surrounding region.

Question 3: *"Who can apply for this program?"*

We welcome applications from graduates of medical schools, including all specialties (e.g. general, dental and veterinary medicine, pharmacy, nursing, physiotherapy, etc.), graduates in biology, chemistry, law and philosophy, with an interest in bioethics, clinical ethics and medical research.

Each academic year, until 2023, there will be 5 stipends that will be awarded to cover the costs of tuition fees for graduate students who are not eligible for state-budgeted places in master's degree programs (e.g. graduates of undergraduate programs with a duration of 5 or 6 years). We also encourage students from disadvantaged socioeconomic backgrounds to apply for this master program and the before mentioned stipends.

Question 4: *"Which are the main topics of the program?"*

The program will cover topics like:

- History of Medical Research
- Research Methods in Fundamental Science
- Clinical Research Methods
- Dissemination of Medical Information
- Responsible Conduct of Research
- Legal Issues in Medical Research
- Legal Issues in Medical Practice
- Basic Concepts in Research Ethics (Equipoise, Clinical Equipoise, and Placebo-Controlled Trials, Informed Consent, the Therapeutic Misconception, and Variable Consent, Confidentiality and Privacy in Clinical Research, Concepts of good clinical practice in pharmaceutical research)
- Basic Concepts in Medical Ethics (The Virtues of a Clinician, The Fiduciary Responsibility and Personal Objections of Clinicians, Concepts of good clinical practice, Respect for Autonomy and Assessing Capacity, Non-judgmental regard, Truth-telling and Informed Consent, Confidentiality, Clinical Justice (Allocation of Benefits Among Individuals and Communities)
- Ethics in International Public Health Research and Practice
- Research with Vulnerable Groups
- Advanced Topics in Clinical and Research Ethics (Reproductive ethics, Organ transplantation issues, End-of-life issues, Advanced directives for treatment and refusal, Decisions for patients without Surrogates, Vaccine Development and Research, Use of human samples and genetic data for research, Incidental Findings and Returning Study Results, Translational Comparative Effectiveness Research, Embryo and Stem Cells Research)
- Ethical Issues in Research on Animal Models
- Teaching Clinical and Research Ethics
- Applied Bioethics and Professionalism

Question 5: *"In your opinion, why is such a program necessary in Romania?"*

A growing number of domestic and international pharmaceutical companies have been applying to conduct clinical trials in Romania while the country is in the process of reinforcing its rules for the conduct of animal and human research so as to conform more closely to European Union standards. At the same time, few individuals in Romania who serve on clinical and research review boards have formal training in clinical ethics and research ethics. Yet, it is critically important for reviewers and investigators to appreciate and respond to the developing multifaceted and subtle issues involved in both clinical practice and in the conduct of today's biomedical research and the evolving rules for the ethical conduct of research.

Thus, Romania needs to increase its capacity of educated professionals with expertise in clinical and research ethics. This program is designed to equip scientists, health professionals, research reviewers, and academics in Romania with in-depth knowledge of ethical principles, processes, and policies related to international, clinical and public health research, and to strengthen the capacity of healthcare and medical research institutions in the region for providing research ethics education, ethics consultation, and research review at their institutions.

INDICAŢII PENTRU AUTORI

Articole

Articolele trimise pentru publicare trebuie sa aibă între 6 000 şi 10 000 de semne.

Titlul să fie de maximum 80 de caractere, all caps, bold.

Textele vor fi însoţite de :

- un rezumat, maximum 250 de semne;
- 5 cuvinte cheie;
- prezentarea autorului (titlul ştiinţific, poziţia didactică, afilierea, informaţiile de contact, adresa e-mail);

Bibliografia se listează la sfârşitul articolului, în ordine alfabetică, cu fonturi Times New Roman 10 pt, la 1,5 rânduri, astfel: autorii, titlul articolului (italic), numele publicaţiei (între ghilimele), editor, volum, număr, an, pagini.
Materialele pot fi trimise prin e-mail, în *attachment*, în format doc. + pdf. la adresa:

centruldebioetica@yahoo.com

Textul scris cu font Times New Roman, 12 pt, la 1,5 rânduri.

Regulile de citare

- citaţiile scurte până la 3 rânduri pot fi puse între ghilimele
- citaţiile mai lungi de 3 rânduri pot forma singure un paragraf, cu font Times New Roman, 11 pt, la 1 rând.

Recenziile

Textele să aibă între 1 000 şi 1 500 de semne.

Note

1. Autorii îşi asumă întreaga responsabilitate a conţinutului articolului trimis spre publicare.
2. Autorii au obligaţia să respecte toate regulile privind legile privind copyright-ul.

Articolele care nu respectă indicaţiile menţionate vor fi trimise înapoi la autor pentru a se face corecturile necesare, întârziindu-se astfel publicarea materialului.

INSTRUCTIONS TO AUTHORS

Articles

The articles submitted for publication normally range between 6 000 to 10 000 Characters.

Title (maximum 80 characters; all caps; bold)

The texts will be accompanied by:

- an abstract, with a maximum of 250 characters;
- 5 key words;
- the author's presentation (scientific title, didactic position, institutional affiliation, contact information, e-mail address).

References: are listed at the end of the article, in alphabetical order, with Times New Roman font, 10 pt, 1.5 lines spacing, as follows: authors, article's title (italic), the name of the publication (double quotes), editor, volume, number, year, pages.
Materials can be sent via e-mail, as an attachment, formatted doc. + pdf. at

centruldebioetica@yahoo.com

The text should use the Times New Roman font, 12 pt, and a pagination of 1,5 lines.

Quotations Rules

- Quotations shorter than 3 lines should be marked with double quotes.
- Quotations longer than 3 lines should form a single paragraph with the following figures:
  Fonts: Times Roman
  Size: 11
  Line spacing: single line spacing

Book Reviews

The texts should range between 1000 and 1500 characters.

Notes

1. The author assumes all responsibility for the ideas expressed in the material published.
2. The authors have the obligation to respect all rules concerning the law governing copyright.

The articles which do not observe the mentioned indications will be sent back to the first author for the necessary corrections, thus delaying the material publication.